

South Australia

A. Karlsson and C. Breen

**South Australia DRUG TRENDS 2016
Findings from the
Illicit Drug Reporting System (IDRS)**

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South Australian Drug Trends 2016



Findings from the Illicit Drug Reporting System (IDRS)

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ABBREVIATIONS

ABS	Australian Bureau of Statistics
ACC	Australian Crime Commission
ACIC	Australian Criminal Intelligence Commission
ADHD	Attention deficit hyperactivity disorder
ADIS	Alcohol and Drug Information Service
AFP	Australian Federal Police
AIHW	Australian Institute of Health and Welfare
AUDIT-C	Alcohol Use Disorders Identification Test – Consumption
AVO	Apprehended Violence Order
BBVI	Blood-borne viral infection(s)
CI	Confidence interval(s)
CNP	Clean Needle Program
DASSA	Drug and Alcohol Service South Australia
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders IV
DMT	Dimethyltryptamine
EDRS	Ecstasy and related Drugs Reporting System
GP	General Practitioner
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
Hydro	Hydroponically grown cannabis
ICD-9	International Classification of Diseases, 9th Revision
ICD-10	International Classification of Diseases, 10th Revision
IDRS	Illicit Drug Reporting System
K10	Kessler Psychological Distress Scale
KE	Key expert(s); see <i>Method</i> section for further details
LSD	Lysergic acid diethylamide
MDMA	3,4-methylenedioxymethamphetamine
N (or n)	Number of participants
NCIS	National Coronial Information System
NDARC	National Drug and Alcohol Research Centre
NDSHS	National Drug Strategy Household Survey
NNDSS	National Notifiable Diseases Surveillance System
NPS	New psychoactive substances
NSP	Needle and Syringe Program(s)
NSW	New South Wales
OCD	Obsessive compulsive disorder
OST	Opioid substitution treatment
OTC	Over the counter
PDI	Party Drug Initiative
PWID	Person/people who inject drugs
QLD	Queensland
RAH	Royal Adelaide Hospital
ROA	Route of administration
SA	South Australia
SAPOL	South Australia Police
SCID	Structured Clinical Interview for DSM
SDS	Severity of Dependence Scale
SPSS	Statistical Package for the Social Sciences
VIC	Victoria
WA	Western Australia
WHO	World Health Organization

GLOSSARY OF TERMS

Cap	Small amount, typically enough for one injection.
Daily use	Use occurring on each day in the past six months, based on a maximum of 180 days.
Diverted/Diversion	Selling, trading, giving or sharing of one's medication to another person, including through voluntary, involuntary and accidental means.
Eightball	3.5 grams.
Halfweight	0.5 grams.
Illicit	Illicit obtainment refers to pharmaceuticals obtained from a prescription in someone else's name, e.g. through buying them from a dealer or obtaining them from a friend or partner. The definition does not distinguish between the inappropriate use of licitly obtained pharmaceuticals, such as the injection of methadone syrup or benzodiazepines, and appropriate use.
Licit	Licit obtainment of pharmaceuticals refers to pharmaceuticals (e.g. methadone, buprenorphine, morphine, oxycodone, benzodiazepines, antidepressants) obtained by a prescription in the user's name. This definition does not take account of 'doctor shopping' practices; however, it differentiates between prescriptions for self as opposed to pharmaceuticals bought on the street or those prescribed to a friend or partner.
Lifetime injection	Injection (typically intravenous) on at least one occasion in the participant's lifetime.
Lifetime use	Use on at least one occasion in the participant's lifetime via one or more of the following routes of administration: injecting, smoking, snorting and/or swallowing.
Point	0.1 grams.
Recent injection	Injection (typically intravenous) on at least one occasion in the last six months.
Recent use	Use in the last six months via one or more of the following routes of administration: injecting, smoking, snorting and/or swallowing.
Session	Period of continuous use.

Guide to days of use/injection

180 days	Daily use/injection* over preceding six months
90 days	Use/injection* every second day
24 days	Weekly use/injection*
12 days	Fortnightly use/injection*
6 days	Monthly use/injection*

* As appropriate

EXECUTIVE SUMMARY

Demographic characteristics of IDRS participants

Demographic characteristics for the 2016 Illicit Drug Reporting System (IDRS) in South Australia (SA) were similar to previous years. Sixty-one percent of the sample were male, the majority were unemployed (86%) and 54% had a history of previous imprisonment. The median number of years spent at school was 10, with over half (55%) reporting post-secondary qualification (primarily a trade or technical qualification). One-third of the sample was currently in treatment for drug use, most commonly pharmacotherapy. There were no significant changes in the demographic characteristics of the IDRS sample from 2015 to 2016.

Patterns of drug use

The median age of first injection among the IDRS sample was 18 years. The first drug ever injected by participants was methamphetamine (71%) and heroin (24%). Methamphetamine remained the preferred drug of choice among participants and the drug injected most often in the last month.

Polydrug use was common among participants in 2016, a consistent finding from all years of the IDRS. There were significant changes in the lifetime use and recent use of certain drugs. In regards to lifetime use, there were significant increases in the use of methamphetamine base ($p<0.05$) and illicit pharmaceutical stimulants ($p<0.05$). There were significant decreases in the use of illicit methadone ($p<0.05$) and 'other opioids' ($p<0.05$). In terms of recent use, significant decreases were observed in the use of 'other opioids' ($p<0.000$), methamphetamine powder ($p<0.05$) and any Seroquel use ($p<0.05$).

Heroin

In 2016, 37% of the sample reported recent use of heroin on a median of 75 days (72 days in 2015). Daily heroin use remained consistent with 2015 reports at 30% (of recent heroin users). White powder or rock continued to be the most common form of heroin used by participants in the six months prior to interview.

The median price paid for heroin at last purchase remained stable in 2016, at \$200 for a half weight and \$50 for a cap. Over two-fifths of participants able to comment reported that heroin purity was medium (41%), with 44% reporting that purity had remained stable over the preceding six months. Heroin was reported to be easy (46%) or very easy (46%) to obtain, and the vast majority of those able to answer (94%) perceived that availability had remained stable, a significant increase from participants reporting stability in 2015 (72%).

Data from the SA Alcohol and Drug Information Service (ADIS) revealed that telephone calls relating to any opioid substance decreased in the 2015/16 financial year. Similarly, data from Drug & Alcohol Services SA (DASSA) revealed a decrease in the proportion of clients nominating heroin as their primary drug of concern from 8.5% in 2014/15 to 5.7% in 2015/16.

Methamphetamine

In 2016, 77% of participants had used some form of methamphetamine in the six months preceding interview (76% in 2015). Considered separately, the most commonly used form of methamphetamine was crystal methamphetamine (75%) followed by base (24%) and then speed (19%), which had significantly decreased from 2015. Only three participants reported use of liquid amphetamine in the six months prior to interview. Powder methamphetamine was used on a median of 5 days in 2016 (12 days in 2015). Base was used on a median of 22 days (12 days in 2015), and crystal

methamphetamine was used on a median of 72 days (45 days in 2015). Injecting remained the main route of administration for all forms of methamphetamine.

In 2016, the median price paid for powder, base and crystal methamphetamine was \$50 for a point. Few participants were able to comment on the current price for a gram of methamphetamine. The majority of participants able to answer reported that the price of methamphetamine powder had remained stable (79%), and 52% of participants reported that base had also remained stable. On the contrary, over two-fifths of participants reported that the price of crystal methamphetamine had decreased over the preceding six months (41%).

Reports regarding the current purity of the three main forms of methamphetamine were mixed. The purity of base methamphetamine, as perceived by participants, was largely reported as medium (55%). The purity of methamphetamine powder was largely reported as high (50%), as was crystal methamphetamine (40%). Purity had largely remained stable for all three forms of methamphetamine in the preceding six months and all forms were considered easy or very easy to obtain in 2016. Availability had reportedly remained stable over the preceding six months.

The number of methamphetamine-related calls received by ADIS in SA increased slightly in 2016. Similarly, the proportion of DASSA clients nominating amphetamines as their primary drug of concern also increased from 21.1% in 2014/15 to 25.1% in 2015/16. There was also an increase in the number of clients admitted to DASSA inpatient (detox) services with amphetamine as the primary drug of concern, from 215 clients in 2014/15 to 319 in 2015/16.

Cocaine

Cocaine use remained low and infrequent in SA with six participants reporting that they had used cocaine on a median of two and a half days within the preceding six months. Five of these recent users had injected cocaine within the preceding six months. The main forms of cocaine used by PWID were powder (n=4), followed by rock (n=2). No participants reported using 'crack' cocaine.

Due to low numbers of participants reporting on price, purity and availability of cocaine, data will not be presented.

Cannabis

Cannabis, though generally not the drug of choice among participants, was used by 73% of the sample in the six months prior to interview – this remained stable from 2015 (74%). Frequency of use occurred on a median of 175 days in the six month period, and 50% reported daily use (36% in 2015). The majority of cannabis users reported that hydro was the form they had used most in the preceding months but bush cannabis was also commonly used.

In 2016, the price last paid for a bag of both hydro and bush remained stable at \$25, as it has done for many years. There were mixed reports regarding the potency of hydro versus bush cannabis; most of those who were able to comment perceived the potency of hydro to be high and those commenting on bush perceived the potency to be medium. These reports had remained stable in the six months preceding interview. Both hydro and bush cannabis were considered easy or very easy to obtain, and the availability had remained stable.

The number of calls to ADIS concerning cannabis remained stable in 2016, as did the proportion of DASSA clients who nominated cannabis as their primary drug of concern.

Other Opioids

In 2016, 34% of people who inject drugs (PWID) reported recent use of some type of illicit opioid (excluding heroin) (64% in 2015). Eighteen percent of participants reported they had used illicit morphine in the six months prior to interview on a median of 51 days (range: 1–180 days). According to participant comments, the price of illicit morphine appeared to remain stable in 2016. Due to small numbers, no real comparison can be made with 2015 data. The largest proportion of participants (40%) reported that the availability of illicit morphine was easy (26% in 2015). As in previous years, the majority of morphine users reported use by injecting and they had mainly used illicit supplies of 100mg Kapanol[®] and 100mg MS Contin[®].

In 2016, oxycodone was divided into three different forms, consisting of 'generic oxycodone', 'OP oxycodone' and 'other oxycodone'.¹ Eight participants reported recent use of illicit generic oxycodone on a median of two days (range: 1–70 days) in the six months prior to interview. Four participants reported recent use of illicit OP oxycodone on a median of 3.5 days (range: 1–20 days) and eight participants reported recent use of illicit other oxycodone on a median of 4.5 days (range: 3–20 days).

Similarly, the recent use of illicit methadone syrup remained stable in 2015 at 4% (7% in 2015), on a median of 26 days (range: 1–60 days). Four participants reported the recent use of illicit Physeptone[®] tablets on a median of five days in the last six months (range: 2–18 days). Twenty-two percent of PWID reported recent use of 'any' (licit and illicit) methadone (25% in 2015).

Compared to 2015, the number of participants reporting recent use of illicit buprenorphine, Suboxone[®] and over the counter codeine remained relatively stable.

Other drugs

Tobacco use remains highly prevalent among PWID, with 97% of the sample reporting that they had consumed tobacco on a median of 180 days in the six months preceding interview (range: 1–180 days). More specifically, 92% of PWID who had recently used tobacco reported daily use of tobacco. Fifty-six percent of the sample reported alcohol use on a median of 24 days in the past six months (range: 1–180 days). Eight participants reported daily use of alcohol. Alcohol and tobacco use remained stable from 2015.

Six participants had used ecstasy and four participants had used some type of hallucinogen in the six months prior to interview; neither had been consumed frequently.

In 2016, ten percent of PWID reported recent use of illicit alprazolam (13% in 2015) and 25% of other illicit benzodiazepines (31% in 2015).

The recent use of illicit pharmaceutical stimulants remained low in 2016, with six participants reporting use over the preceding six months on a median of 2.5 days (range: 1–5 days).

Six participants reported recently using illicit Seroquel[®], compared to seven participants in 2015, and they had done so on a median of three days within the six months preceding interview (range: 2–20 days).

¹ In April 2014 'Reformulated OxyContin[®]' (branded with an 'OP' on each tablet) was introduced designed to be tamper resistant. The 'original oxycodone' OxyContin[®] (branded with an 'OC') was withdrawn. In September 2014 generic 'non-tamper-resistant oxycodone' was made available in Australia.

Health-related issues

Four participants reported overdosing on heroin in the previous 12 months (n=10 in 2015) and sixteen participants had accidentally overdosed on another drug within the preceding 12 months.

Thirty-three percent of the IDRS sample reported being in treatment at the time of interview, and they had been in treatment for a median of 36 months. One-third of the IDRS sample had been on opioid substitution treatment for their opioid use on a median of one occasion in the past year. Twenty-one percent of the sample reported current methadone treatment with a median of 48 months. Nine percent of the sample reported a hospital admission for methamphetamine psychosis on a median of one occasion in the past year. Sixteen percent of participants had tried to access treatment over the preceding six months but were unable to.

In 2016, IDRS participants were asked questions from the Severity of Dependence Scale (SDS) for the use of stimulants and opioids. Of those who recently used a stimulant drug (mainly methamphetamine) and commented, the median SDS score was four, with 51% scoring four or above indicative of methamphetamine dependence. Of those who recently used an opioid drug and commented, the median SDS score was six, with 61% scoring five or above, an indication of opioid dependence.

In 2016, 49% of participants reported experiencing a mental health problem (other than drug dependence) in the six months preceding interview. This was stable from 2015 (51%). Among those who had experienced a mental health disorder, depression and anxiety continued to be the most commonly reported problems. Sixty-five percent of those who had experienced a mental health problem reported that they had sought professional help for such problems.

Using the Kessler Psychological Distress Scale (K10) (Kessler and Mroczek 1994), over one-quarter of the sample (26%) were at a high or very high risk of psychological distress. This was a decrease from 2015 (59%), yet continues to be much higher than the population norms.

For the sixth year running, participants of the IDRS have been asked the AUDIT-C as a valid measure of identifying heavy drinking. In 2016, among those who drank alcohol recently, the mean score on the AUDIT-C was 5.3. Forty-five percent of males and 65% of females scored five or more on the AUDIT-C indicating the need for further assessment of drinking behaviour.

In 2016, IDRS participants were asked a series of questions about take-home naloxone and naloxone more generally. Seventy percent of the sample had heard of naloxone, and among these participants, two-thirds (67%) reported that naloxone was used to 'reverse heroin' and 35% believed that it was used to 're-establish consciousness'. In addition, a couple of participants (n=2) reported that they had been resuscitated with naloxone by somebody who had been trained through the take-home naloxone program. Three participants had completed training in naloxone administration and had received a prescription for naloxone. Of those who had completed the course, one participant had used the naloxone to resuscitate someone who had overdosed. Six participants had heard about the rescheduling of naloxone (available OTC without a prescription). Twenty-seven percent stated that naloxone bought OTC should be free and cost \$0.

Risk behaviours

The number of participants who reported 'borrowing' needles remained low and stable in 2016 (n=4), as did the number of participants who had lent a used needle to someone else (n=8). The proportion of participants who had shared injecting equipment (other than needles) was 34% (30% in 2015). Consistent with 2015 reports, spoons/mixing containers and tourniquets were the most commonly shared items. Forty percent of the sample had re-used their own needle in 2016 (27% in 2015).

In 2016, 66% of the sample reported experiencing at least one type of injecting-related health problem in the month prior to interview (62% in 2015). By far the most commonly experienced problem was prominent scarring/bruising around the injection site (72%), followed by difficulty injecting (60%).

Driving

Of the 55 participants who had recently driven a vehicle, 9% (n=5) had driven while over the legal alcohol limit and 80% reported they had driven within three hours of taking illicit drug(s).

Law enforcement

In 2016, 41% of participants reported involvement in any type of crime during the last month (28% in 2015). The prevalence of past year arrest (24%) remained stable from 2015 (25%).

Drug dealing and property crime remained the most commonly committed crimes. Furthermore, the proportion of participants who reported a prison history also remained stable in 2016.

In 2016, the median expenditure on illicit drugs the day before interview remained stable at \$100.

Special topics of interest

Blood donations

Of those who commented, 11% reported that they had given blood in their lifetime. Five participants who had given blood reported that they had commenced injecting drug use before donating blood.

Homelessness

In 2016, 79% of the sample reported a lifetime prevalence of homelessness, with six percent currently homeless at the time of interview. The mean duration of their current episode of homelessness was reported to be one year and nine months. The most commonly experienced forms of homelessness during both lifetime and the past six months were couch surfing (63%; 15% respectively) and sleeping rough (57%; 9% respectively).

Unfair Treatment

Of those who commented, over half (53%) reported unfair treatment in the past year. Over one-quarter (26%) reported unfair treatment 'monthly', 18% 'weekly but not daily' and 8% experienced unfair treatment 'daily or more'. Just under one-third (32%) of those who were treated unfairly reported that they had been treated unfairly in the last 12 months mostly by family; mainly in a public location or home. Thirty percent reported that they had 'never' been unfairly treated and 18% reported that they had not experienced any unfair treatment in the last 12 months.

1 INTRODUCTION

The Illicit Drug Reporting System (IDRS) was trialled in 1997 under the coordination of the National Drug and Alcohol Research Centre (NDARC) to examine drug trends in three Australian jurisdictions. This work was commissioned and supported by the Australian Government Department of Health. The trial consisted of conducting the complete IDRS in New South Wales (NSW), Victoria (VIC) and South Australia (SA) (see Hando, Darke et al. (1998) for a national comparison; and Cormack, Faulkner et al. (1998) for the SA findings). The 'core' IDRS incorporated a triangulated approach to data collection on drug trends, and consisted of a survey of injecting drug users, a semi-structured survey of key experts (KE), who had regular contact with injecting drug users, and secondary data sources or indicators relevant to drug use.

The IDRS process was repeated in 1998 in the same three jurisdictions, and in 1999 all states and territories were involved. For a review of the history and progression of the IDRS nationally up to 2000, see Darke (2000). Two thousand and sixteen marks the 20th year in which the IDRS has been conducted in SA, and the 18th year it has included all states and territories (see Stafford and Breen (2017) for a national comparison of the 2016 findings).

The IDRS provides a co-ordinated and ongoing monitoring system predominantly focusing on heroin, methamphetamine, cocaine and cannabis. The IDRS is a sensitive and timely indicator of drug trends both nationally and by jurisdiction. As well as drug trends, the findings highlight areas where further research is required, or where changes may need to be made in terms of education, health promotion, treatment services and policy. The IDRS provides direction for more detailed data collection on specific issues such as those listed above.

The 2016 *South Australian Drug Trends Report* summarises information collected by the SA component of the national IDRS. The information comes from three sources: a survey of people who inject drugs (PWID; the participants); Key Expert (KE) interviews with professionals working in drug and alcohol or related fields; and existing and up-to-date data indicators relating to drugs and drug use. The three sources complement each other, each having its own strengths and weaknesses. It should be noted that PWID participants are recruited as a sentinel group that are active in illicit drug markets. The information from the IDRS survey is not representative of illicit drug use in the general population, nor is it indicative of all illicit drug use or of all people who inject drugs, but identifies emerging trends that require further monitoring. The results are summarised by drug type in tables designed to provide the reader with a 'snapshot' overview of drug trends in SA.

1.1 Study aims

The aim of the SA component of the 2016 IDRS is to provide information on drug trends in SA (specifically the Adelaide metropolitan area), particularly focusing on the 12 months between mid-2015 and mid-2016.

2 METHOD

A triangulated approach was utilised for this study, with information on drug trends coming from three primary sources. This approach is based on a procedure outlined by Hando, Darke et al. (1998). The three sources were as follows:

- a survey of a sample of current regular illicit drug users who use injection as a route of administration and who represent a population likely to be aware of trends in illicit drug markets;
- a semi-structured survey of KE who work in the drug and alcohol area, or some related field, and who have regular contact with or knowledge of people who use drugs by injection; and
- an examination of existing and current indicators (other indicators) relating to drugs, drug use and drug-related issues.

2.1 Participants

The sample consisted of people who had regularly used illicit drugs and used injection as a route of administration (N=101) in the six months prior to interview. Participants were recruited through Clean Needle Program (CNP) sites across Adelaide. Clients of the service were invited to participate by a study flyer, displayed at CNP sites, or were recruited on site. Informed consent was sought and gained from all participants, who were interviewed individually. Ethics approval was obtained prior to commencement of the study.

2.2 Procedure

Participants were interviewed in mid-2016. Criteria for entry into the study were having injected drugs at least once a month in the previous six months, being over 18 years of age and living (not incarcerated) in the Adelaide metropolitan area for at least the 12 months prior to interview.

In order to be consistent with the IDRS data collection procedures in other jurisdictions, trained research interviewers conducted the interviews with participants. In 2016, five research interviewers with a sound working knowledge of issues related to illicit and injecting drug use were trained on administration of the survey instrument. The purpose and content of the survey was fully explained, and informed consent was obtained from participants prior to the interviews being conducted. Interviews were conducted at a time convenient to the participant and generally in a room provided by the agency associated with the CNP or at an agreed location nearby. Participants were compensated \$40 for their time and travel.

The structured interview was based on previous research conducted at NDARC (Darke, Hall et al. 1992; Darke 1994). The survey consists of sections designed to collect information including participant demographic details; lifetime and recent drug use; knowledge of price, purity and availability of drugs (e.g. heroin, methamphetamine, cocaine, cannabis, morphine and methadone); criminal behaviour patterns; engagement in risk-taking behaviours; health-related issues; and general trends in drug use. In general, participants were asked to consider changes on the above parameters over the six to 12 months prior to interview (mid-2015 to mid-2016).

2.3 Survey of KE

The KE interview was semi-structured and took approximately 30 minutes to administer via telephone. KE also had the option of completing the interview online. The instrument used

was based on previous research conducted at NDARC for the World Health Organization (WHO) (Hando and Flaherty 1993) and included sections on demographics, drug use patterns, drug price, purity and availability, criminal behaviour, police activity and health issues. In general, KE were asked to consider changes on the above parameters over the six to 12 months prior to interview (mid-2015 to mid-2016). The responses to the semi-structured interview were transcribed and analysed for content and trends. Information gained from these interviews was largely qualitative in nature.

Entry criteria for the KE were at least weekly contact with illicit drug users in the previous six months, or contact with 10 or more illicit drug users in the previous six months, or specialist knowledge of drug markets in SA. All KE were paid or volunteer workers in drug treatment agencies, other health and community services, drug user advocacy groups, South Australia Police (SAPOL), or research organisations. KE were recruited based on their participation in previous IDRS surveys, and on recommendations made by existing KE and colleagues. Potential KE were contacted via telephone, and/or email and assessed for suitability according to the criteria. A mutually convenient time was made for those completing the interview via telephone. Informed consent was sought and gained from all KE, who were interviewed individually.

In 2016, 10 KE were interviewed from August to October 2016. Five KE worked in the health sector and five worked in law enforcement.

2.4 Other indicators

To complement and validate data collected from the participants and KE surveys, a range of secondary data sources was utilised including population surveys and other health and law enforcement data. The pilot study for the IDRS (Hando, O'Brien et al. 1997) recommended that secondary indicator data should:

- be available at least annually;
- include 50 or more cases;
- provide brief details of illicit drug use;
- be located in the main study site (Adelaide or SA for the present study); and
- include details of the four main illicit drugs under investigation.

Data sources that fulfilled the above criteria and were included in the report were:

- Telephone advisory data provided by the Alcohol and Drug Information Service (ADIS) of South Australia;
- Australian Needle and Syringe Program (NSP) survey data;
- Admissions data from Drug and Alcohol Services South Australia (DASSA);
- Drug-related attendances to the Royal Adelaide Hospital (RAH) Emergency Department;
- State-wide and national rates of amphetamine, cocaine and opioid-related fatalities provided by the Australian Bureau of Statistics (ABS);
- Purity of drug seizures made by South Australia Police (SAPOL) and the Australian Federal Police (AFP) provided by the Australian Criminal Intelligence Commission (ACIC) (formerly Australian Crime Commission (ACC));
- Data on consumer and provider arrests by drug type provided by the Australian Criminal Intelligence Commission (ACIC);
- Drug-related hospital admissions data (state and national) provided by the Australian Institute of Health and Welfare (AIHW); and
- National Notifiable Diseases Surveillance System (NNDSS) data, from the Australian Government Department of Health.

2.5 Data analysis

Statistical analyses (descriptive and inferential) were performed using the IBM Statistical Package for the Social Sciences (SPSS) for Windows, Version 22.0. Continuous, normally distributed variables were analysed using *t*-tests and means reported. Where continuous variables were skewed, medians were reported and the Mann-Whitney *U*-test, a non-parametric analogue of the *t*-test (Siegel and Castellan 1988) was employed. Confidence intervals (CI) were calculated using an Excel spreadsheet available at <http://www.cebm.net/index.aspx?o=1023> (Tandberg). This calculation tool was an implementation of the optimal methods identified by Newcombe (1998).

2.6 Notes

2.6.1 Methamphetamine

Prior to 2001, IDRS reports used the overarching term 'amphetamines' to refer to both amphetamine and methamphetamine. Amphetamine is used to denote the sulphate of amphetamine, which throughout the 1980s was the form of illicit amphetamine most available in Australia (Chesher 1993). Chemically, amphetamine and methamphetamine differ in molecular structure but are closely related. In Australia today, the powder traditionally known as 'speed' is almost exclusively methamphetamine rather than amphetamine. The more potent forms of this family of drugs – known by terms such as ice/crystal, shabu, crystal meth, base and paste – had been identified as becoming more widely available and used in all jurisdictions in the early years of the IDRS (Topp and Churchill 2002). These forms are also methamphetamine. Therefore, the term 'methamphetamine' was used from 2001 onward to refer to the drugs available that were previously termed 'amphetamines'. The terms are used interchangeably within this report unless specifically noted within the text. For a further discussion of this issue, see White, Breen et al. (2003).

2.6.2 Price, purity and availability

It should be noted that the price, purity and availability sections of the participant survey were not restricted to users of the particular drug but to those who felt confident of their knowledge of these parameters of the market. In addition, participants may answer any or all price, purity and availability sections, thereby the sample sizes (*n*) per section may fluctuate for any given drug. In addition, people who answered 'don't know' to the initial question for each of the price, purity and availability sections were eliminated from the sample for these sections to increase the validity of remaining categories. The sample sizes are therefore reported in each table. Furthermore, within the text of these sections, findings may also be expressed as a percentage of the entire sample to highlight the fact that the proportion answering was not equivalent to the whole IDRS participant sample. Care should be taken in interpreting category percentages that may be associated with small sample sizes.

3 DEMOGRAPHICS

Key Findings

- The median age of the 2016 sample was 44 years (45 years in 2015).
- The majority of the sample was male (61%; 66% in 2015) and the majority were unemployed (86%; 81% in 2015).
- Fifty-four percent reported a previous history of imprisonment (46% in 2015).
- Two-fifths of the sample (40%) had completed Year 11 and/or 12 (48% in 2015). Forty-six percent of the sample had no tertiary qualifications, 48% had a trade/technical qualification and 7% had a university education.
- One-third of the sample (33%) reported being in current drug treatment, primarily opioid substitution treatment (31% in 2015).
- The majority of the sample (95%) received a government allowance/pension (91% in 2015).
- The majority the sample (79%) lived in rental accommodation.

3.1 Overview of the IDRS participant sample

The demographic characteristics of the 101 participants interviewed in 2016 are summarised in Table 1.

The median age of the sample remained stable in 2016 at 44 years (range: 27–60 years). Over three-fifths of the sample was male (61%), the majority (86%) were unemployed and 54% had a history of previous imprisonment. Of those reporting a prison history, significantly more males (69%) than females (32%) reported a history of imprisonment ($p < 0.000$). The median number of years spent at school was 10 (range: 3–12 years), with two-fifths of the sample (40%) reporting completion of years 11 and/or 12. Forty-six percent of the sample reported having no tertiary qualifications; this is slightly above what participants reported in 2015 (43%). Of those who did report having a tertiary qualification, most had completed a technical or trade qualification (48%), while 7% had completed a university qualification.

In regards to income, 95% of participants reported receiving some form of government pension, allowance or benefit (88% in 2015) in the previous month. Moreover, eight participants received income from child support, seven participants received income from criminal activity, four participants received a wage or salary and one participant received income from sex work. In 2016, participants were not asked to specify their main source of income.

The majority of the participant sample resided in rental accommodation (79%) (72% in 2015). Eight participants reported residing in their own house/flat, followed by five participants living at their family/parent's home. Four participants reported having no fixed address or were homeless, two participants reported living in a boarding house/hostel and a further two participants did not specify their place of residence.

Over two-thirds of the sample (68%) was single at the time of interview (49% in 2015) and 14% were married or in a de facto relationship. Nine participants had a regular partner, three participants were separated and a further three participants were divorced. Two participants reported being widowed.

In 2016, one-third of the sample (33%) was in drug treatment at the time of the interview, with the majority of participants in maintenance pharmacotherapy treatment. More specifically, 21% reported being on a methadone program (17% in 2015) and 8% reported being on a buprenorphine program, including those receiving Suboxone® treatment (9% in 2015). Three participants were receiving drug counselling at the time of interview, and one participant did not specify what treatment they were receiving. The median amount of time spent in current treatment was 36 months (range: 1–240 months). Eight percent of the sample reported being in methamphetamine treatment, with six participants beginning treatment at a drug treatment centre on one occasion in the past year, and two participants commencing treatment on two occasions in the past year.

In summary, compared to 2015, the 2016 sample characteristics remained relatively stable.

Table 1: Demographic characteristics of IDRS sample, 2012–2016

Characteristic	2012	2013	2014	2015	2016
	(N=93)	(N=100)	(N=106)	(N=102)	(N=101)
Age (median in years)	39	42	43	45	44
Range	(22-58)	(22-62)	(24-60)	(20-62)	(27-60)
Sex (% male)	59	56	59	66	61
Sexual Identity (%)					
Heterosexual	85	90	92	91	86
Gay male	1	2	0	1	2
Lesbian	4	1	0	3	1
Bisexual	9	6	8	5	10
Other	1	1	1	0	1
English speaking (%)	97	94	96	96	97
A&TSI (%)	11	9	9	14	7
Employment (%)					
Not employed	61	75	80	81	86
Full time	4	5	3	5	2
Part time/casual	13	6	5	6	4
Full time student	2	0	1	0	2
Both studying and employed	1	1	0	1	0
Home duties	15	9	9	0	6
Other	3	3	3	6	0
Median income per week (\$)	365	363	393	383	388
School education (median in years)	11	10	10	10	10
Range	(4-12)	(3-12)	(7-12)	(8-12)	(3-12)
Tertiary education (%)					
None	40	43	48	43	46
Trade/technical	41	50	46	46	48
University/college	19	7	6	11	7
Prison history (%)	50	52	51	46	54
Current drug treatment (%)*	32	31	27	31	33

Source: IDRS participant interviews.

*Includes all types of pharmacotherapy treatment and drug counselling, detoxification, therapeutic community and narcotics anonymous.

4. CONSUMPTION PATTERNS

Key Findings

- The median age of first injection was 18 years.
- The majority of participants reported that methamphetamine was the first drug injected.
- Methamphetamine remained the preferred drug of choice among participants, particularly due to crystal methamphetamine (26%) and speed powder (15%).
- Methamphetamine was the drug injected most often in the last month and the most recent drug injected.
- Polydrug use over the last six months remained widespread among the sample.
- With regards to lifetime use, in 2016, there were significant increases in the use of methamphetamine base and illicit pharmaceutical stimulants. There were significant decreases in the use of illicit methadone and 'other opioids'.
- In regards to recent use, in 2016, there were significant decreases in the use of 'other opioids', methamphetamine powder and any Seroquel use.

4.1 Lifetime and current drug use

As shown in Table 2, the median age of first injection by the participant sample was 18 years (range: 8–39 years). The drug most commonly first injected by the sample was methamphetamine (71%), followed by heroin (24%). When first injection of methamphetamine is examined according to type, methamphetamine powder (63%) is the most commonly first injected drug, with smaller numbers reporting first injection of methamphetamine base (5%) and crystal methamphetamine (3%).

Table 2: Injecting drug history, 2015-2016

	2015 (N=102)	2016 (N=101)
Median age first injected in years (range)	18 (10-47)	18 (8-39)
First drug injected (%)		
Heroin	28	24
Methamphetamine*	66	71
Cocaine	1	0
Morphine	3	2
Methadone	0	0
Buprenorphine**	0	0
Other	1	2

Source: IDRS participant interviews.

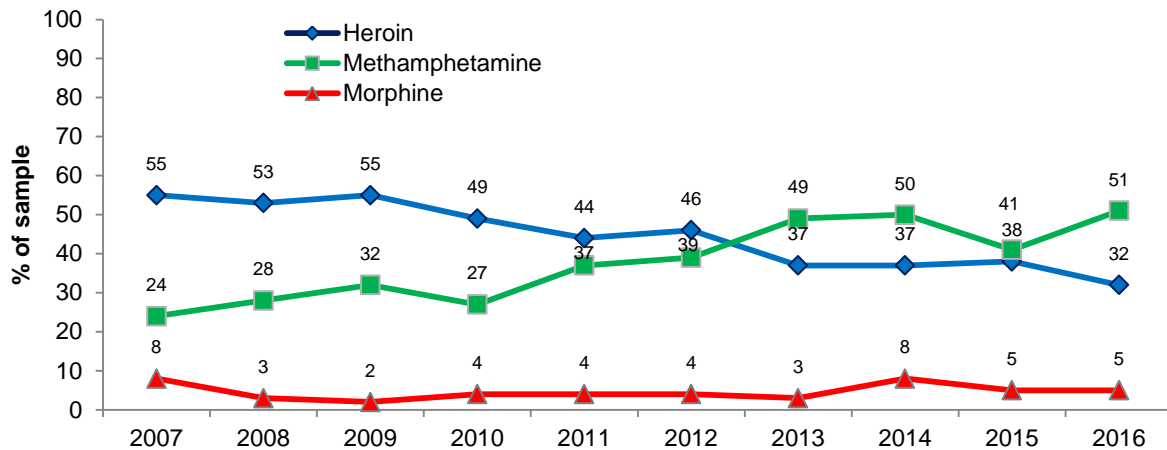
*Collapsed categories: powder, base and crystal forms.

** Excludes buprenorphine-naloxone (Suboxone®).

4.1.1 Drug of choice

Methamphetamine continued to be the drug of choice for 51% of PWID in 2016 (41% in 2015). Looking at Figure 1, it can be seen that this follows the long-term trends that have been observed from 2007 onwards. Since 2007, there has been a downward trend in the proportion of PWID who nominated heroin as their drug of choice and an upward trend in those nominating methamphetamine as their drug of choice, mainly due to the increase in use of crystal methamphetamine, whereby 26% specified that crystal was their drug of choice. Participants reporting morphine as their drug of choice has remained consistently low across the years.

Figure 1: Trend for drug of choice, 2007–2016



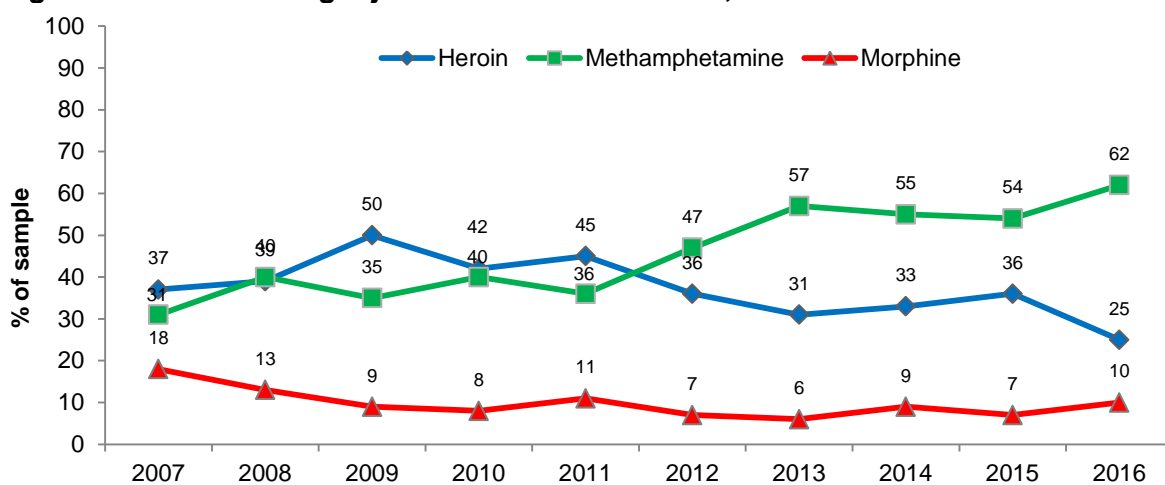
Source: IDRS Participant interviews.

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

Sixty-two percent reported that methamphetamine was the drug most frequently injected in the month preceding interview, 54% of which was due to crystal methamphetamine. Twenty-six One quarter (25%) reported heroin as the drug most frequently injected in the last month (see Figure 2). This remained stable from 2015.

Similarly, 66% of PWID reported that methamphetamine was the drug they had injected most recently, 56% of which was due to crystal methamphetamine. Twenty-two percent reported that heroin was the last drug injected (see Table 3), which was a significant decrease from 2015 ($p < 0.05$).

Figure 2: Trend for drug injected most in last month, 2007–2016



Source: IDRS participant interviews.

Table 3: Injecting drug preferences, 2015–2016

	2015 (N=102)	2016 (N=101)
Drug injected most often in last month (%)		
Heroin	36	25
Methamphetamine#	54	62
Cocaine	0	0
Morphine	7	10
Methadone	1	2
Buprenorphine**	1	1
Oxycodone	0	0
Other	1	0
Most recent drug injected (%)		
Heroin	35	22
Methamphetamine*	55	66
Morphine	7	8
Methadone	1	2
Buprenorphine**	1	1
Oxycodone	0	0
Other	1	1
Frequency of injecting in last month (%)		
Weekly or less	29	9
More than weekly but less than daily	40	52
Once a day	18	13
2-3 times a day	13	25
>3 times a day	0	2

Source: IDRS participant interviews.

*Collapsed categories: powder, base and crystal forms.

** Includes buprenorphine (Subutex[®]) and buprenorphine-naloxone (Suboxone[®]).

Frequency of injecting any drug in the last month was greater than weekly (but not daily) for 52% of the sample (40% in 2015), with 40% reporting they had injected at least once a day during that period (31% in 2015). Nevertheless, nine percent of the sample had reported injecting weekly or less in the last month, significantly less than that reported in 2015 ($p < 0.000$).

Polydrug use was common in 2016, and has remained consistently so across the years. In 2016, participants were asked about their history of use of 25 separate substances. These substances consisted of heroin, any methadone, any oxycodone, any morphine, any buprenorphine, any buprenorphine-naloxone, any benzodiazepine, any pharmaceutical stimulant, methamphetamine powder, methamphetamine base, liquid methamphetamine, crystal methamphetamine, cocaine, cannabis, inhalants, hallucinogens, ecstasy, fentanyl, steroids, any new psychoactive stimulant, OTC codeine, other opioids, Seroquel®, alcohol and tobacco. Only illicit use of a drug was analysed. In 2016, participants reported use of a median of 15 (range: 6–24) drug types across their lifetime and a median of eight (range: 5–19) during the six months prior to interview (see Table 4).

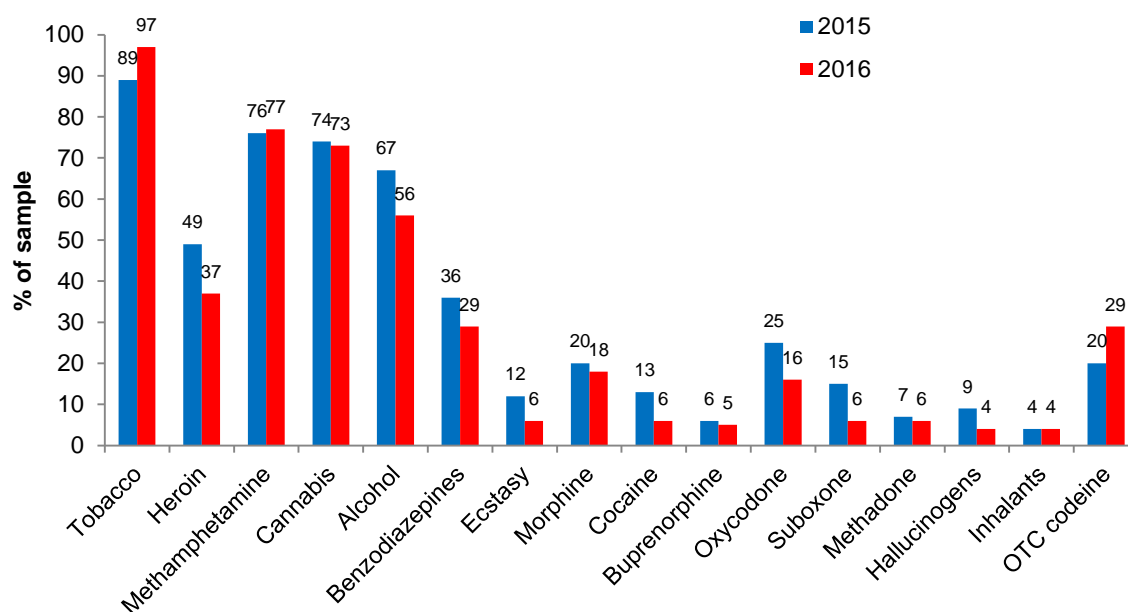
Table 4: Polydrug use, 2015–2016

Polydrug use (median)	2015 (N=102)	2016 (N=97)
Number of drug classes ever used	14 (3-24)	15 (6-24)
Number of drug classes used in last 6 months	6 (2-15)	8 (5-19)

Source: IDRS participant interviews.

The drugs most commonly used among the participants in the last six months were tobacco, ‘any’ methamphetamine, cannabis, alcohol and heroin (see Figure 3). This order remained stable from 2015.

Figure 3: Recent drug use, percentage of the participants to have used each substance type in the last six months, 2015–2016



Source: IDRS participant interviews.

Note: use of pharmaceutical drugs (e.g. of methadone, morphine etc.) relates to illicit use.

In 2016, there were a number of significant changes in the lifetime and recent use of certain drugs. In regards to lifetime use, there were significant increases in the use of methamphetamine base ($p < 0.05$) and illicit pharmaceutical stimulants ($p < 0.05$). There were significant decreases in the use of illicit methadone ($p < 0.05$) and ‘other opioids’ ($p < 0.05$).

In regards to recent use, there was a significant decrease in the use of ‘other opioids’ ($p < 0.000$), methamphetamine powder ($p < 0.05$) and any Seroquel use ($p < 0.05$). A more detailed history of participants’ drug use can be found in Table 5.

Table 5: Drug use history and routes of administration of the sample, 2016 (% of total sample; N=101)

Drug Class	Ever used %	Ever inject %	Use last 6 months %	Inject last 6 months %	Smoke last 6 months %	Snort last 6 months %	Swallow last 6 months %	Days used last 6 months ^{A*}	Days inject last 6 months*
Heroin	70	70	37	37	1	1	0	75	75
Homebake	34	33	9	9	1	1	1	6	6
Any Heroin	71	71	37	37	1	2	1	78	78
Methadone - licit	42	25	20	4			20	180	48
Methadone – illicit	24	15	4	3			3	26	48
Physeptone – licit	7	2	1	0	0	0	1	8	0
Physeptone – illicit	27	17	4	3	0	0	2	5	12
Any Methadone	53	32	22	7	0	0	21	180	48
Buprenorphine – licit	25	9	1	0	0	0	1	170	0
Buprenorphine – illicit	23	16	5	3	0	0	4	4	3
Any Buprenorphine	98	21	6	3	0	0	5	5	3
Buprenorphine Naloxone – licit	30	10	9	1	1	0	9	60	48
Buprenorphine Naloxone – illicit	22	13	6	5	1	0	3	4	4
Any Buprenorphine Naloxone	43	17	14	5	1	0	11	42	4
Generic Oxycodone – licit	10	3	3	2	0	0	2	12	11
Generic Oxycodone – illicit	20	16	8	5	0	0	3	2	5
OP Oxycodone – licit	3	2	1	1	0	0	0	90	90
OP Oxycodone – illicit	18	16	4	2	0	0	3	4	11
Other Oxycodone – licit	23	9	3	0	0	0	3	14	0
Other Oxycodone – illicit	40	34	8	5	0	1	2	5	6
Any Oxycodone	67	51	21	12	0	1	11	10	11.5
Morphine – licit	23	18	8	7	0	0	2	20	20
Morphine – illicit	51	47	18	17	0	0	5	51	48
Any Morphine	60	53	25	23	0	0	7	48	48
Other Opioids	58	8	16	0	0	0	16	9	0
OTC Codeine	50	2	29	1	0	0	29	10	5
Methamphetamine Powder	89	85	19	19	7	2	2	5	5
Methamphetamine Base	61	60	24	24	5	1	1	22	20
Methadmpphetamine Crystal	93	92	75	75	31	4	4	72	66
Any form Methamphetamine	98	98	77	77	33	5	5	80	80
Pharmaceutical Stimulants – licit	12	4	1	0	0	0	1	2	0
Pharmaceutical Stimulants – illicit	39	14	6	3	0	0	3	3	1
Any Pharmaceutical Stimulants	44	15	6	3	0	0	4	4	1
Cocaine	59	43	6	5	1	4	1	3	2
Hallucinogens	75	14	4	0	2	0	2	2	0
Ecstasy	73	31	6	4	0	1	4	4	3
Alprazolam – licit	25	6	8	1	0	0	7	90	90
Alprazolam – illicit	38	11	10	0	0	0	10	3	0
Other Benzodiazepines – licit	58	7	33	0	0	0	33	90	0
Other Benzodiazepines – illicit	44	2	25	1	1	0	23	3	3

Drug Class	Ever used %	Ever inject %	Use last 6 months %	Inject last 6 months %	Smoke last 6 months %	Snort last 6 months %	Swallow last 6 months %	Days used last 6 months ^{A*}	Days inject last 6 months [*]
Any Benzodiazepines (including Alprazolam)	75	18	54	2	1	0	53	22	51
Seroquel – licit	15	1	3	0	0	0	3	12	0
Seroquel – illicit	21	0	3	0	0	0	3	3	0
Any Seroquel	35	1	6	0	0	0	6	8	0
Alcohol	96	7	56	0			56	24	0
Cannabis	97		73		73		12	175	
Tobacco	99		97					180	
E-Cigarettes	30		20					3	
Inhalants	28		4					4	
Steroids	11	7	5	1	0	0	3	65	4
Fentanyl	21	15	9	5	0	0	0	2	2
NPS	11	7	4	3	2	1	2	3	32
Synthetic Cannabis	8	1	0	0	0	0	0	0	0

Source: IDRS Participant Interviews.

^A Refers to any ROA, i.e. includes use via injection, smoking, swallowing and snorting.

*Among those who used/injected.

4.2 Heroin

Key Findings

- In 2016, 37% reported recent use of heroin (49% in 2015).
- Heroin was used on a median of 75 days within a six month period (72 days in 2015). Daily use remained stable (30%).
- White/off white powder or rock was the most commonly used form of heroin used by participants in 2016.

4.2.1 Heroin use among PWID

Thirty-seven percent of the IDRS participants interviewed in 2016 had used heroin in the six months prior to interview (49% in 2015) (see Table 6). The proportion of PWID who nominated heroin as their drug of choice (32%) and the drug injected most often in the past month (36%) remained stable from 2015 (see Figure 4). Nevertheless, there was a significant decrease in the proportion of PWID who nominated heroin as the last drug injected ($p < 0.05$).

Heroin was used on a median of 75 days in the preceding six months, stable from 2015, unlike the sharp downward trend which was observed from 2014 to 2015 (see Figure 4). All recent heroin users reported injecting heroin within the preceding six months (100%), and the median number of injection days was 75 (range: 1–180 days). Among recent users of heroin, daily use remained stable at 30%.

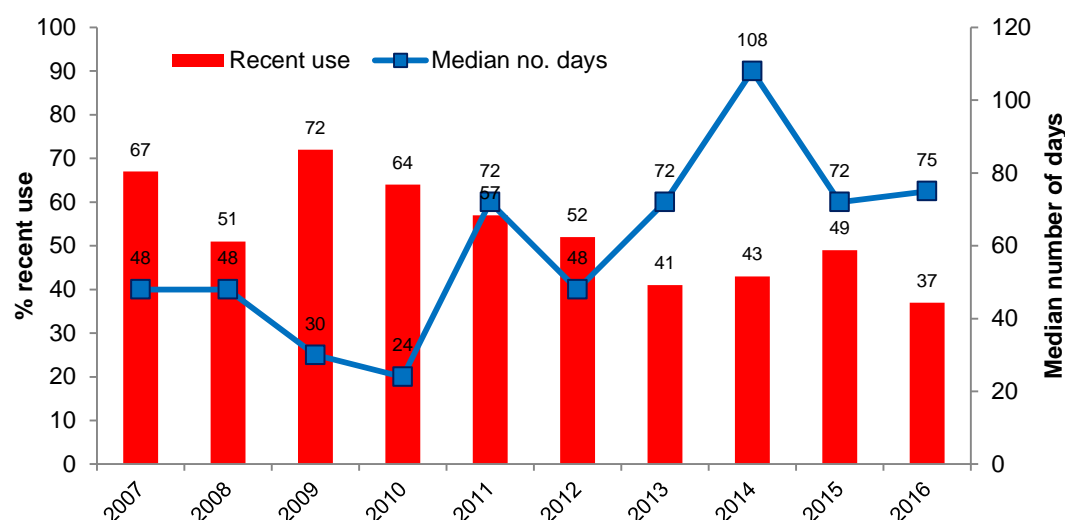
Table 6: Recent heroin use of IDRS participants, 2015–2016

	2015	2016
Recent use (%)	49	37
Median days of use*	72	75
Daily use * (%)	30	30

Source: IDRS participant interviews.

*Among those who had used. Maximum number of days, i.e. daily use, is 180. See page xi for guide to days of use/injection.

Figure 4: Heroin: recent use and median number of days used, 2007–2016



Source: IDRS participant interviews.

4.2.2 Forms of heroin used

As in previous years, participants were asked about the forms of heroin they had used over the preceding six months. Of the 37 participants who had recently used heroin, 81% (n=30) reported use of a white/off-white powder or rock form of heroin, and 57% (n=21) reported using a brown powder or rock. This was stable from 2015. The forms most used in the last six months differed somewhat from 2015, with 68% using mostly white/off-white powder or rock (52% in 2015) and 32% using brown powder or rock most often (40% in 2015).

Homebake is a form of heroin made from pharmaceutical products and involves the extraction of diamorphine from pharmaceutical opioids such as codeine and morphine. In 2016, over one-third (34%) of participants reported that they had used homebake heroin at least once in their lifetime (31% in 2015). Nine percent reported the use of homebake heroin in the six months preceding interview, stable from 2015. All participants who reported recent use of homebake heroin had injected it. In 2016, homebake heroin was used for a median of six days (range: 1–14 days) in the preceding six months.

Table 7: Reports of heroin forms used in the last six months among those who had recently used heroin, 2015–2016

	2015	2016
Used last 6 months (%)	(n=50)	(n=37)
White/off-white powder or rock	74	81
Brown powder or rock	70	57
Form most used last 6 months	(n=50)	(n=37)
White powder or rock	52	68
Brown powder or rock	40	32
Homebake	2	0
Other colour	6	0

Source: IDRS participant interviews.

4.2.3 Quantity of heroin use

Participants were asked about the quantity of heroin used on an average day in the six months prior to interview. Sixty-eight percent (n=25) reported using points, 27% (n=10) reported using 'other' and two participants reported using grams. On an average day, the median amount used was one point (range: 0.5–5 points) or 0.63 grams (range: 0.25–1 gram) in the last six months.

KE Comments

- One KE nominated heroin as the most problematic drug at the moment.
- The majority of KE reported that though heroin is still available, it is not as extensive and prevalent as it once was.
- One KE noted that there was a higher rate of clients entering into programs for heroin use, indicative that it is still readily available.
- On the contrary, one KE reported that there appears to be a 'diminishing population of heroin users'.
- One KE stated 'we've been treating people for years' and indicated that clients in the treatment program range from 'their early 20s through to clients in their 60s' for heroin use.

4.3 Methamphetamine

Key Findings

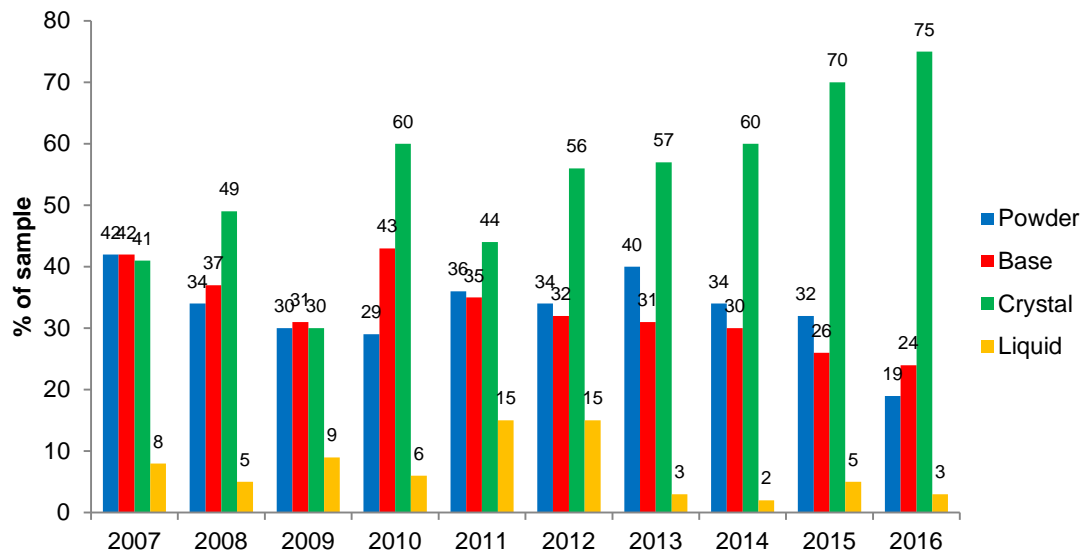
- The recent use of speed powder decreased significantly from 32% in 2015 to 19% in 2016.
- Recent use of crystal methamphetamine was reported by 75% of the sample (70% in 2015).
- The recent use of base (24%) and liquid methamphetamine (3%) remained stable in 2016.
- Any methamphetamine was used on median 80 days, a significant increase from 48 days in 2015. Specifically, there was a significant increase in the frequency of crystal use (from 45 days in 2015 to 72 days in 2016).
- Seventeen percent of recent users reported using methamphetamine on a daily basis (8% in 2015).
- Participants using all forms of methamphetamine reported having done so by injection in the six months prior to interview.

Data is collected for three different forms of methamphetamine: methamphetamine powder (referred to here as 'speed' or 'speed powder'); methamphetamine base ('base'); and crystal methamphetamine ('crystal'). 'Speed' can sometimes be used as a generic term for methamphetamine; however, here it refers only to the powder form. It is typically a fine-grained powder, generally white or off-white in colour, but may range from white through to beige or pink due to differences in the chemicals used to produce it. 'Base' (which can also be known as 'pure', 'wax' or 'point') is the paste methamphetamine that is 'moist', 'oily' or 'waxy' and is often brownish in colour. It can be difficult to dissolve for injection due to its oily consistency. 'Crystal' methamphetamine comes in crystalline form, in either translucent or white crystals (sometimes with a pink, green or blue hue) that vary in size. A fourth form, liquid amphetamine or 'oxblood', has also been identified, and is typically red/brown in colour. However, as it is used infrequently, PWID are not surveyed regarding its price, purity or availability. Previous research indicated that participants were able to differentiate between these forms when surveyed (Breen, Degenhardt et al. 2003), and clarification was made with participants that they and the interviewer were referring to the same forms of methamphetamine.

4.3.1 Use of methamphetamine

In 2016, 77% of participants had used any form of methamphetamine in the six months preceding interview (76% in 2015). Considered separately, the most commonly used form of methamphetamine was crystal methamphetamine (75%; 70% in 2015), followed by base (24%; 26% in 2015) and then speed (19%; 32% in 2015), which had significantly decreased from 2015 ($p < 0.05$). Liquid amphetamine (also known as 'oxblood') remained considerably less common, with only three participants reporting use in the last six months (five participants in 2015) (see Figure 5).

Figure 5: Methamphetamine, percentage of participants that used in the last six months, 2007–2016



Source: IDRS participant interviews.

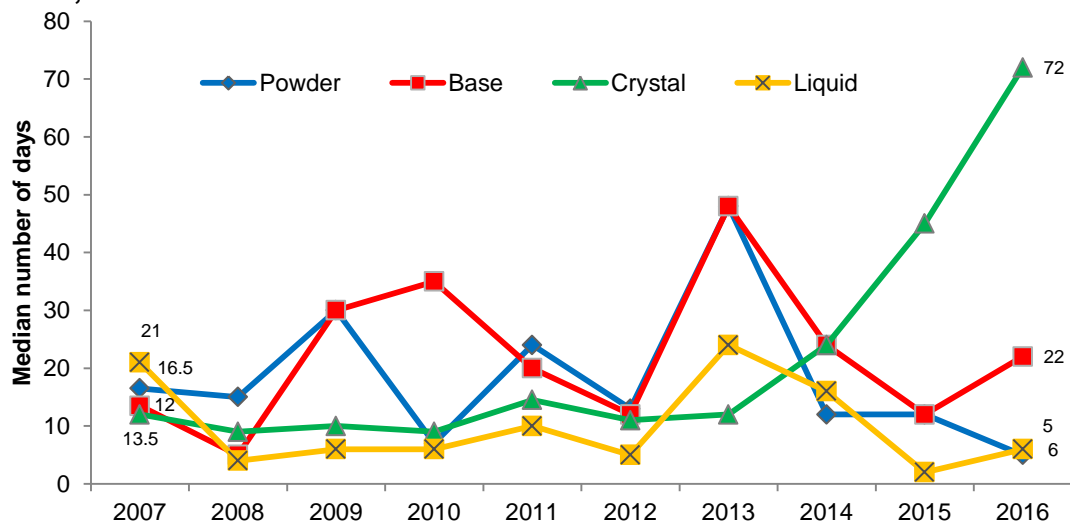
Note: Liquid methamphetamine; $n \leq 10$ results should be interpreted with caution.

4.3.2 Methamphetamine frequency of use

Participants reported using methamphetamine powder on a median of 5 days (range: 1–180 days) (12 days in 2015). There was a significant increase in the frequency of crystal use (from 45 days in 2015 to 72 days in 2016; $p < 0.01$). A slight increase was noticed in the last 12 months for base (from 12 days in 2015 to 22 days) and liquid (from 2 days in 2015 to 5 days), though neither of these changes were significant.

As can be seen from Figure 6, there have been changes in the median days of different forms of methamphetamine over time. The decline in the frequency of powder and base from 2013 corresponds with the increase in the frequency of crystal use.

Figure 6: Methamphetamine, median number of days used in the last six months, 2007–2016



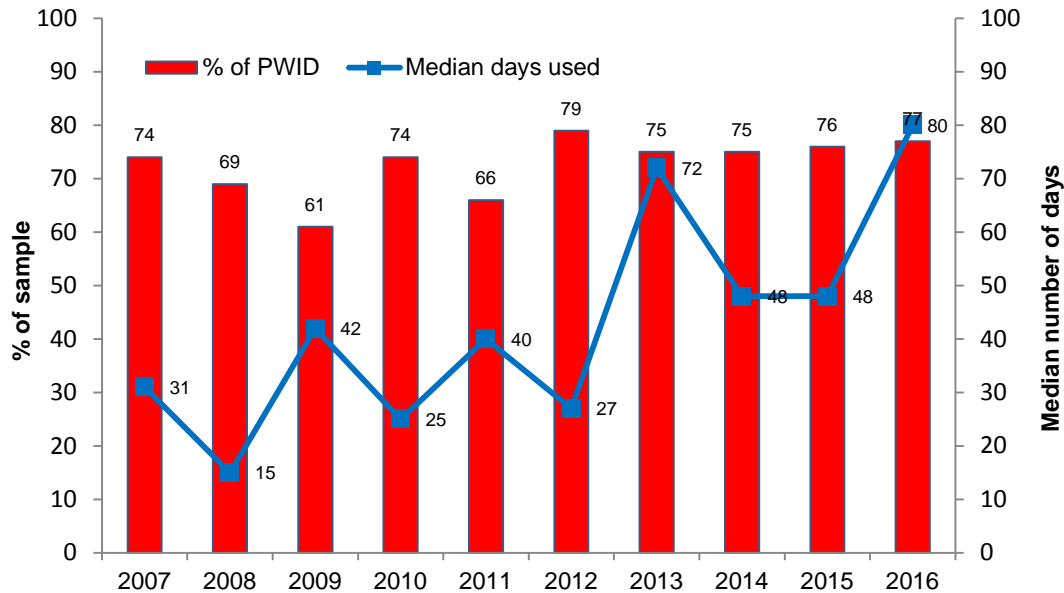
Source: IDRS participant interviews.

Note: Used by those participants who reported use of each form in the six months prior to interview.

Note: Liquid methamphetamine; $n \leq 10$ results should be interpreted with caution.

The long-term trend in the use any form of methamphetamine is depicted in Figure 7. Overall in 2016, 77% of participants had used some form of methamphetamine (powder, base, crystal, and liquid) in the six months prior to interview; this remained stable from 2015. Recent users of methamphetamine reported that they had used on a median of 80 days (range: 1-180 days in a six month period, a significant increase from 48 days in 2015 ($U = 1905.00, p < 0.01$)).

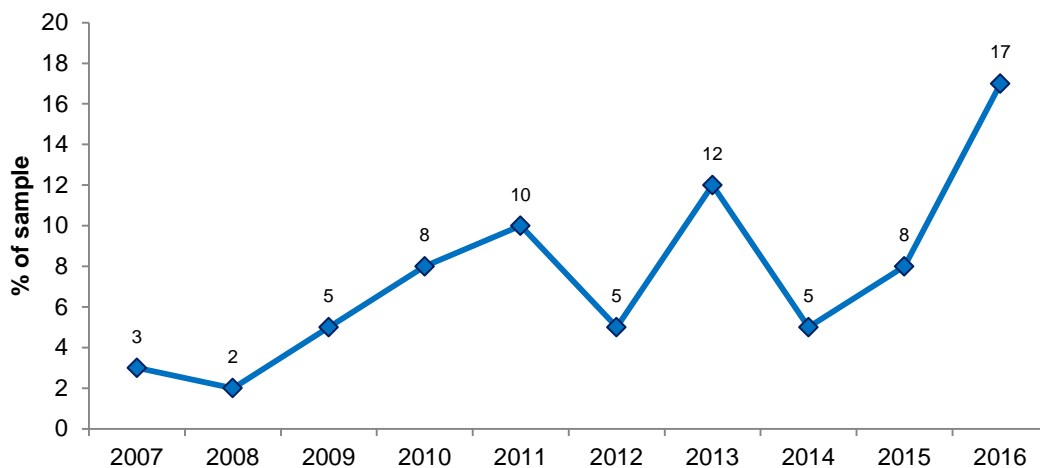
Figure 7: Recent use and median number of days used of any form of methamphetamine, 2007–2016



Source: IDRS participant interviews.
Note: Results of those reporting recent use in the previous six months.

Of the 78 participants who reported using some form of methamphetamine in the last six months, thirteen participants (17%) reported daily use during that period (n=6 in 2015). The long-term trend for the percentage of participants using some form of methamphetamine on a daily basis is depicted in Figure 8. As shown, the prevalence of daily methamphetamine use has fluctuated over the past 10 years with the highest proportion reporting daily use in 2016.

Figure 8: Methamphetamine, percentage that used daily in the last six months[#], 2007–2016



Source: IDRS participant interviews.
[#] Among those who had used methamphetamine in the past six months.

All participants using any form of methamphetamine reported having done so by injecting in the six months prior to interview. In addition to injecting, 7% of participants reported smoking powder, 2% reported snorting and 2% had swallowed powder in the preceding six months. This was stable from 2015. Five percent of the sample reported smoking base methamphetamine (10% in 2015), and 1% had swallowed it in the preceding six months. In addition to injecting, 31% reported smoking crystal methamphetamine in the past six months, while the proportion of participants who reported snorting and swallowing crystal remained low (4%, respectively) (see Table 5).

4.3.3 Quantity of methamphetamine use

Participants were asked about the quantity of the different forms of methamphetamine used in the last six months in an average day. The median quantities reported for speed, base and crystal are reported below.

4.3.3.1 Speed

Of those who used speed, 95% (n=18) reported using points, and one participant reported using grams. The median amount used on an average day in the last six months was one point (range: 0.3–6 points) or one gram.

4.3.3.2 Base

Of those who used base, 88% (n=21) reported using points, 8% (n=2) reported using grams, and one participant used 'other'. On an average day in the last six months, the median amount used was 1.5 points (range: 0.5–5 points) or 0.5 grams.

4.3.3.3 Crystal

Of those who used crystal, 99% (n=75) reported using points, and one participant reported using grams. The median amount of crystal used on an average day in the last six months was two points (range: 0.25–18 points) or 0.5 grams.

KE Comments

- Nine KE nominated methamphetamine as the most problematic drug at the moment.
- The majority of KE noted the prevalence of methamphetamine use remained very high.
- The majority of KE perceived crystal methamphetamine to be the most common/popular form of methamphetamine.
- The majority of KE considered methamphetamine to be the most problematic drug at the present time. The reasons for this were varied and ranged from the fact that it was highly prevalent and addictive, to the physical (sleep deprivation, poor dental health), mental (e.g. aggression, psychosis) and social impacts (e.g. financial problems, relationship problems, criminal activity) it can have on the individual and their family/friends.
- One KE expressed concern regarding the lack of advertising on the physical aspects of methamphetamine; aggression and violence is usually the focus of methamphetamine users. There should be greater emphasis on the physical effects, such as cardiovascular effects and the possibility of cardiac problems, hypertension, brain damage, stroke etc.
- One KE stated that clients with methamphetamine dependence appear to have 'very limited motivation or ability to reduce or abstain from drug use'.

- Several KE also noted that there are limited treatment options for methamphetamine dependence, making it very difficult to successfully treat those who seek help.
- There were mixed reports regarding the way in which methamphetamine is used. KE reported that most users smoke or inject methamphetamine and that in the last few years smoking has become more prominent. One KE stated 'there is the fear of the needle and the stigma associated with it, and also the hassle of actually having to get the needles'.

4.4 Cannabis

Key Findings

- Lifetime and recent use of cannabis remained stable in 2016.
- Cannabis was used on a median of 175 days in the past six month period (90 days in 2015).
- Fifty percent of recent cannabis users (n=37) stated that they had used on a daily basis in the last six months.
- Of the participants who had used cannabis recently, 61% reported the use of hydro and 47% reported the use of bush within that period.
- Nine percent reported use of 'hash', which was a significant decrease from 22% in 2015.

The current legal approach to cannabis use in SA is one of 'prohibition with civil penalties'. Under this approach, the production, possession or use of cannabis is illegal. Any cultivation of a cannabis plant by hydroponic means (hydro) will result in the accused being arrested/reported and required to attend court. A single cannabis plant grown in the ground, i.e. not grown hydroponically, and/or 20 grams of resin, will attract an expiation fee. In cases where more than one cannabis plant is grown outdoors (bush cannabis), the accused is arrested and required to attend court. There are varying penalties for possession of cannabis offences and these penalties are dependent on the amount the person is located with. Under the Cannabis Expiation Notice Scheme, police issue the offender with an 'on-the-spot' fine notice. If the offender disagrees with any aspect of the charge, he or she can elect to go to court and defend the case rather than pay the expiation fee. Failure to pay the prescribed fee within the expiation period results in a summons being issued for the offender to appear in court. The original expiation fee becomes the fine, with the additional court costs. Changes to the legislation were introduced in 2007 codifying trafficking offences.

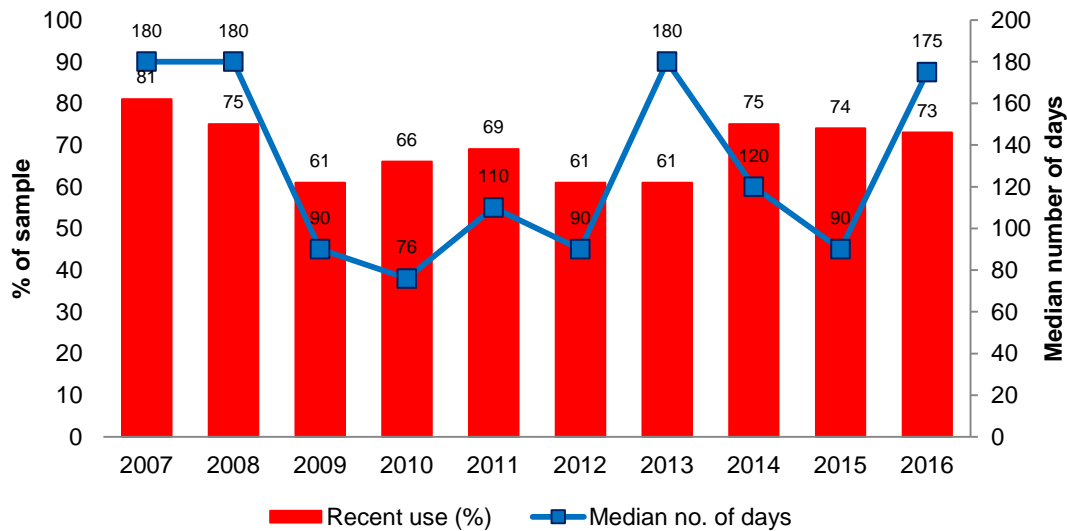
4.4.1 Current patterns of cannabis use

It is worth noting that participants were recruited on the basis of their injecting drug use (rather than use of illicit drugs in general), therefore the following data may not be representative of cannabis users in general. That is, the IDRS reports on cannabis use by a sample of PWID.

In 2016, the proportion of PWID who reported lifetime use of cannabis remained stable at 97%. Of those who had ever used cannabis, 73% reported having used cannabis in the preceding six months (74% in 2015). Cannabis was used on a median of 175 days (range: 2–180 days), indicating use almost every day in the previous six months (90 days in 2015) (see Figure 9).

Fifty percent of recent cannabis users (n=37) stated they had used on a daily basis in the last six months (36% in 2015).

Figure 9: Cannabis, recent use and median number of days used, 2007–2016



Source: IDRS participant interviews.

Note: Results from those reporting recent use in the previous six months.

4.4.2 Cannabis forms used

Among participants who had used cannabis recently, 61% reported use of hydro (68% in 2015) and 47% reported use of bush (55% in 2015). In addition, 9% reported use of ‘hash’ (cannabis resin) which was a significant decrease from 22% in 2015 ($p < 0.05$) and 4% reported use of ‘hash oil’ (9% in 2015). Forty-nine percent of recent cannabis users reported that hydro was the form they had used the most (58% in 2015), and 18% reported that bush was the form they had used most in the six months preceding interview (13% in 2015).

4.4.3 Quantity of cannabis use

Participants who had used cannabis in the six months prior to interview were asked to report the average amount of cones and joints they had used per day. ‘Other’ means of using cannabis was also reported. Readers should note that the term ‘cone’ refers to the indentation in a pipe/bong or a pipe/bong attachment in which cannabis is inserted to be ignited. The term ‘cones’, in the context of the question, refers to the average number of times the ‘cone’ was filled and the contents smoked per day. A ‘bong’ is a water-pipe apparatus which enables the filtering of cannabis smoke through a chamber.

The majority of participants reported smoking cannabis in ‘cones’ ($n=47$; 64%) and the median amount of cones used in the last 6 months on a typical day was 3 (range: 0.5–100 cones). Seven participants reported smoking cannabis in ‘joints’ (10%) the median amount of joints used in the last 6 months on an average day was 1.5 (range: 1–10 joints). Among daily users, the median number of cones smoked in the last six months was 8 (range: 1–100 cones) and the median number of joints used among daily users in the last six months was 3 (range: 1.5–10 joints).

KE Comments

- One KE nominated cannabis as one of the most problematic drugs at the moment, although this KE believed that it was the second most problematic drug after methamphetamine.
- There was a general consensus among KE that the price, prevalence and availability of cannabis has remained stable.
- One KE commented that young people feel 'fairly comfortable' using cannabis because there is a perception that 'everybody else is using it'.
- KE commented that cannabis use is problematic because the clients who use it view cannabis as not causing problems. It appears that clients minimise the concerns of cannabis use to a high degree.
- KE noted the strong correlation between cannabis use and mental health issues, specifically depression and/or anxiety.

4.5 Cocaine

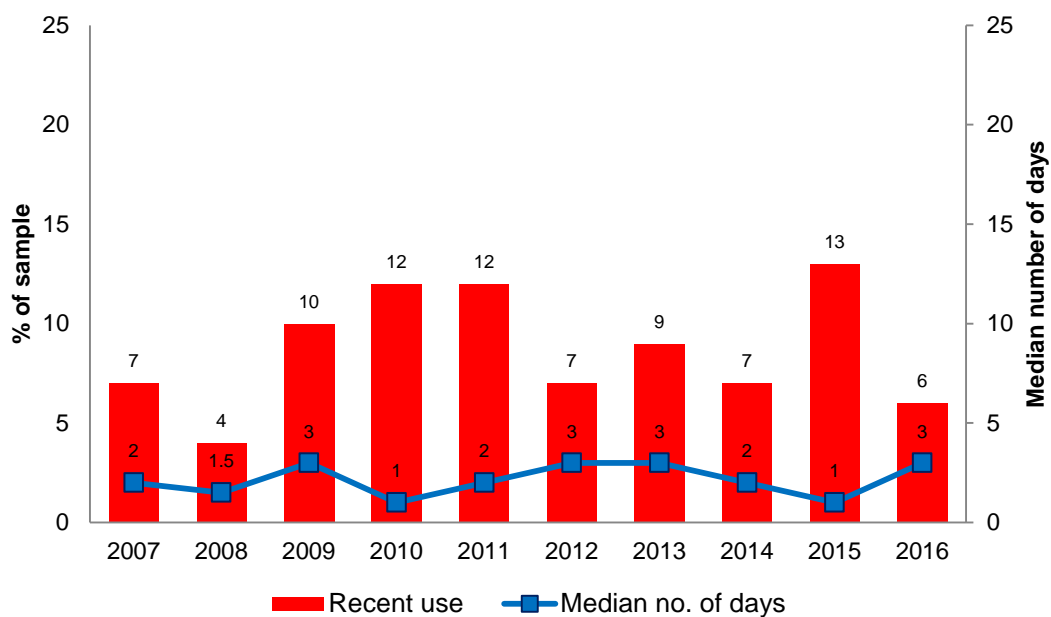
Key Findings

- Cocaine use remained low (6%) and infrequent among PWID in 2016.

4.5.1 Use of cocaine

Six participants reported the use of cocaine on a median of 2.5 days (range: 1–12 days) in the six months prior to interview (13 participants in 2015) (Figure 10). Five participants reported that they had injected cocaine during that time. The main forms of cocaine used by PWID were powder (n=4), followed by rock (n=2). These results indicate that cocaine use among PWID in Adelaide remains relatively rare.

Figure 10: Cocaine, recent use and median number of days used, 2007–2016



Source: IDRS participant interviews.

Note: Results from those reporting recent use in the previous six months.

4.5.2 Quantity of cocaine use

Participants were asked about the quantity of cocaine used on an average day in the six months prior to interview. Two participants reported using points, three participants reported using grams and one participant reported using an 'other' amount (unspecified). On an average day, the median amount used was 0.75 points (range: 0.5–1 point) or 2 grams (range: 0.5–3.5 grams).

KE Comments

- The majority of KE reported that cocaine use had remained low among their clients over the preceding 12 months, though one KE believed there to be more cocaine available on the streets compared to previous years.

4.6 Opioids

Key Findings

- Heroin was the most commonly used opioid in the six months prior to interview (37%), followed by OTC codeine (29%), licit or illicit morphine (25%) and licit or illicit methadone (22%).
- Eighteen percent of participants reported they had used illicit morphine in the six months prior to interview.
- Small numbers reported using opioids in the six months prior to interview. Nine participants reported recently using fentanyl; four participants reported recently using illicit methadone syrup and Physeptone® tablets, respectively; five participants reported recently using illicit buprenorphine and six participants reported having used illicit buprenorphine-naloxone.
- The use of 'other opioids' (i.e. those not elsewhere classified) decreased significantly from 40% in 2015 to 16% in 2016.

The IDRS investigates the use patterns, harms and market characteristics of a number of pharmaceutical opioids including methadone, buprenorphine, buprenorphine-naloxone, morphine, oxycodone, fentanyl, over the counter codeine, and other opioids (not specified elsewhere). Use of these substances is broadly split into the following categories:

Use

1. Use of licitly obtained opioids, i.e. use of opioids obtained by a prescription in the user's name, through any ROA (includes the use of these medications as prescribed).
2. Use of illicitly obtained opioids, i.e. those obtained from a prescription in someone else's name, through any ROA ('illicit use').
3. Use of 'any' opioids, i.e. includes both licit and illicit obtained opioids.

Injection

1. Injection of licitly obtained opioids.
2. Injection of illicitly obtained opioids.
3. Injection of 'any' opioids.

Note on interpretation: The IDRS documents the use of opioid medications, licitly obtained or otherwise, among a sentinel sample of PWID. These include opioids prescribed for opioid substitution treatment (OST) – i.e. methadone, buprenorphine and buprenorphine-naloxone maintenance treatments – in addition to opioids prescribed for pain relief (including morphine and oxycodone). It is important to note that while a proportion of the 2016 sample were in treatment at the time of interview, responses are not representative of clients engaged in drug treatment services.

4.6.1 Overview of opioid use among participants

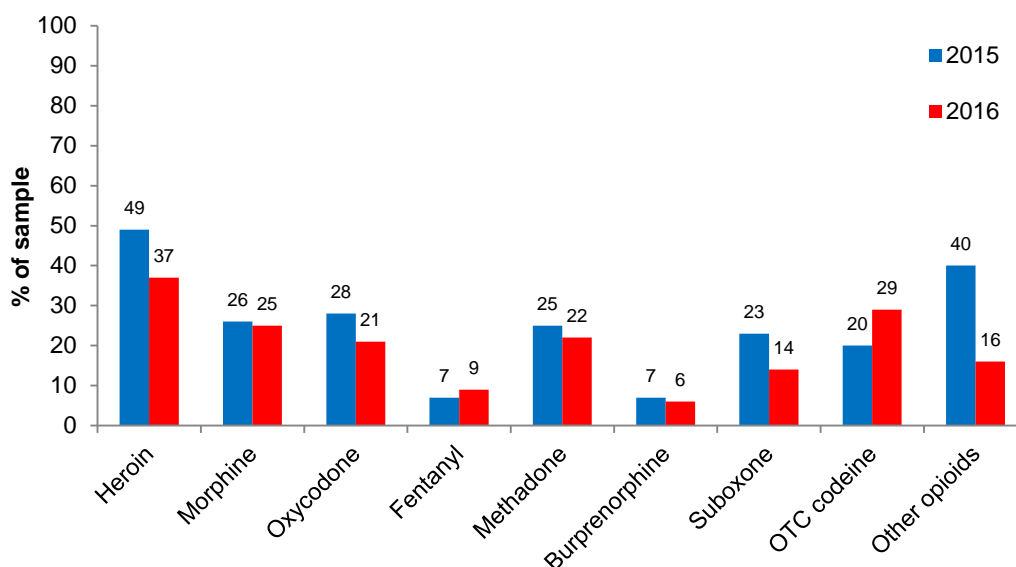
Table 5 provides data on the recent use and route of administration of opioids for the 2016 participant sample.

Heroin use among participants is described in detail in section 4.2, with the focus on the use of other opioids described in this section. Data is presented for illicit use only, except for fentanyl and other opioids which do not distinguish between licit and illicit

use. It should be noted that some of the sample sizes for these sections were relatively small and should be interpreted with caution.

As can be seen in Figure 11, heroin was the most commonly used opioid in the six months prior to interview (37%), followed by OTC codeine (29%), licit or illicit morphine (25%) and licit or illicit methadone (22%). The use of 'other opioids' decreased significantly in 2016 (16% in 2016 vs. 40% in 2015; $p < 0.000$).

Figure 11: Recent use of licit and illicit opioids amongst PWID, 2015-2016



Source: IDRS participant interviews.

Note: these figures include licit and illicit use, except for heroin and OTC codeine which include illicit/non-medical use only.

Note: Other opioids include opioids not specified elsewhere (e.g. Panadeine Forte®).

When all the opioid substance categories are collapsed (i.e. methadone, morphine, other opioids, OTC codeine, oxycodone, fentanyl, buprenorphine and buprenorphine-naloxone), 67% of participants had used some type of opioid substance (including licit and illicit use) in the six months prior to interview (77% in 2015). Excluding licit use of methadone, morphine, buprenorphine, buprenorphine-naloxone and oxycodone and excluding heroin use, 34% had used opioids illicitly in 2016 (64% in 2015).

4.6.2 Use of illicit morphine

Eighteen percent of participants reported they had used illicit morphine in the six months prior to interview on a median of 51 days (range: 1–180 days), and the average amount of illicit morphine used per day in the last six months amounted to a median of 75mg (range: 20–400). Seventeen participants reported that they had injected illicit morphine in the preceding six months, and they had done so on a median of 48 days (range: 1–180 days).

The majority of all morphine users (68%, $n=17$) reported that the type they had used most during the last six months was illicit. The main brand of morphine used was Kapanol® (76%, $n=19$).

4.6.3 Use of illicit Oxycodone

In 2016, the use of oxycodone was divided into the generic form of oxycodone, oxycodone 'OP' and 'other' forms of oxycodone².

Two-thirds of the sample reported lifetime use of any form of oxycodone (62% in 2015) and over one-fifth (21%) reported recent use (28% in 2015). Twenty-one participants reported using any form of oxycodone on a median of 10 days (range: 1–90 days) in the six months preceding interview (11.5 days in 2015). Twelve participants reported recent injection of any form of oxycodone on a median of 11.5 days (range: 2–90 days).

4.6.3.1 Generic Oxycodone

Eight participants reported recent use of illicit generic oxycodone on a median of two days (range: 1–70 days). Of those, five participants reported injecting illicit generic oxycodone on a median of five days (range: 2–70 days) in the preceding six months. The average amount of illicit generic oxycodone used per day in the last six months was a median of 90mg (range: 10–160mg).

4.6.3.2 OP Oxycodone

Four participants reported recent use of illicit OP oxycodone on a median of 3.5 days (range: 1–20 days). Of those, two participants reported injecting illicit OP oxycodone on a median of eleven days (range: 2–20 days) in the six months prior. The average amount of illicit OP oxycodone used per day in the last six months was a median of 90mg (range: 20–100mg).

4.6.3.3 Other Oxycodone

Eight participants reported recent use of illicit 'other oxycodone' on a median of 4.5 days (range: 3–20 days). Of those, five participants reported injecting illicit other oxycodone in the six months preceding interview. The main brand of 'other oxycodone' used was Endone (n=8; 73%). The average amount of illicit other oxycodone used per day in the last six months was a median of 45mg (range: 5–160mg).

The form most used for all oxycodone users was illicit (n=7; 70%, for Generic Oxycodone; n=4; 80%, for OP Oxycodone; and n=8; 73%, for Other Oxycodone).

4.6.4 Use of fentanyl (licit and illicit)

Nine participants reported using fentanyl on a median of two days (range: 1–12 days) in the six months preceding interview, and the average amount used per day was a median of 75mg (range: 25–100mg). Five participants who reported recent use of fentanyl had done so by injection on a median of two days (range: 1–3 days). Six participants had used illicit fentanyl in the six months preceding interview.

4.6.5 Over the counter (OTC) codeine

Codeine is a mild opioid. In Australia, over the counter (OTC) codeine is readily available in pharmacies. It is mainly used for the relief of mild to moderate pain. OTC codeine medications vary in codeine quantity and are only available in combination (usually with analgesics or decongestants). There are associated health concerns with the prolonged use of OTC codeine, most notably the risk of liver damage. There are also health risks associated with the overdose of combination drugs such as paracetamol.

² In April 2014 'Reformulated OxyContin®' (branded with an 'OP' on each tablet) was introduced designed to be tamper resistant. The 'original oxycodone' OxyContin® (branded with an 'OC') was withdrawn. In September 2014 generic 'non-tamper-resistant oxycodone' was made available in Australia.

Since 2009, participants have been asked about their use of OTC codeine (from 2012 onwards participants were asked about non-medicinal use only). These questions were included to investigate the extra-medical use of OTC codeine, frequency of use, main brands used and the amount of tablets/capsules used per dose. For more information on the harms associated with OTC codeine use, see Dutch (2008) and Dyer, Martin et al. (2004).

In 2016, 50% of participants reported ever using OTC codeine for non-medicinal purposes (39% in 2015). Twenty-nine percent reported use within the preceding six months (20% in 2015) on a median of ten days (range: 1–180 days) (median of 9 days in 2015). One participant reported that they had injected OTC codeine in the six months preceding interview, and they had done so on a median of five days. The main brand of OTC codeine used by participants was Chemists Own Pain tablets/capsules (44%; n=10).

4.6.6 Use of illicit methadone

In 2016, for the 14th year running, IDRS survey participants were asked to provide separate information on the use of licit and illicit methadone syrup and Physeptone[®] tablets.

Four participants reported having used illicit methadone syrup on a median of 26 days (range: 1–60 days) in the last six months and the average amount used per day in the last six months was a median of 35ml (range: 10–200ml). Of those, three participants reported injecting illicit methadone syrup on a median of 48 days (range: 2–48 days).

Four participants reported having used illicit Physeptone[®] tablets on a median of five days in the last six months (range: 2–18 days), and the average amount recently used per day was a median of 80mg (range: 20–100mg). Of those, three participants reported injecting illicit Physeptone[®] tablets and had done so on a median of twelve days (range: 5–18 days).

4.6.7 Use of illicit buprenorphine³

Five participants reported having used illicit buprenorphine on a median of four days (range: 1–50 days) in the six months prior to interview. Of these, three participants reported injecting illicit buprenorphine and had done so on a median of three days (range: 1–5 days). The average amount used per day in the last six months was a median of 4mg (range: 2–12mg).

The majority of all buprenorphine users (83%, n=5) reported that the type they had used most during the last six months was illicit.

4.6.8 Use of illicit buprenorphine-naloxone (Suboxone[®])

In 2016, participants were asked about the use of any form of buprenorphine-naloxone which included either ‘tablet’ or ‘film’ forms. In previous years, participants were asked about buprenorphine-naloxone tablets and films separately.

³ Buprenorphine has been available for opioid substitution therapy (OST) in Australia since 2001. Initially mono-buprenorphine sublingual tablets (marketed as Subutex[®]) were introduced, followed by buprenorphine-naloxone sublingual tablets (marketed as Suboxone[®]) from 2006, and buprenorphine-naloxone (Suboxone[®]) sublingual film from October 2011. There is jurisdictional variation in the policy regarding prescribing and uptake of the different forms (Larance, B., P. Dietze, et al. (2015).

Six participants reported having used illicit buprenorphine-naloxone on a median of four days (range: 2–180 days) in the six months prior to interview. Of these, five participants reported injecting illicit buprenorphine-naloxone and had done so on a median of four days (range: 2–180 days). The average amount used per day in the last six months was a median of 2mg (range: 2–40mg). Of the fourteen participants that were able to comment, half of all Suboxone[®] users (50%; n=7) reported that the type they had used more during the last six months was licit Suboxone[®] film. Six participants reported using illicit Suboxone[®] film, and one participant reported using licit suboxone tablets.

4.6.9 Use of other opiates (not elsewhere specified) (licit and illicit)

Sixteen participants reported that they had used other opiates in the six months preceding interview. This was a significant decrease from the forty-one participants who had used other opiates six months prior to the interview in 2015 (p<0.000). Participants had used other opiates on a median of 8.5 days (range: 1–180 days). No participants reported recent injection of other opiates.

Among those who recently used other opiates, the form most used was licit (75%; 25% illicit), and the majority of participants reported that Panadeine Forte[®] (n=11, 69%) was the main brand used.

KE Comments

- KE commented that opiates remain an obvious problem in the sense that there are many people who need to be treated for their opioid dependencies.
- The use of OTC codeine was considered to be an ongoing problem by many KE. Currently, OTC codeine, such as nurofen plus, is too easy to obtain and more people are being treated for codeine dependency.
- Hospital presentations have increased due to the side effects associated with clients using excessive amounts of codeine.
- One KE stated that over the past 12 months, an increased number of clients attended his health service to start a pharmacotherapy program for codeine dependence, more so than for heroin dependence.
- One KE reported on the recent concern regarding the use of fentanyl, partly because 'it is so dangerous' and partly because 'seizures (of fentanyl) have been increasing'.

4.7 Other drugs

Key Findings

- Six percent of IDRS participants had used ecstasy and 4% had used a hallucinogen in the six months prior to interview. Frequency of use was low, with a median of four days and one and a half days, respectively.
- Among participants who had recently used benzodiazepines (excluding alprazolam), the main brand used was diazepam (Valium®), which remained stable from 2015.
- Use of illicit pharmaceutical stimulants remained low, with six participants reporting recent use.
- The consumption of Seroquel® was also low, with six participants reporting recent use.
- Alcohol had reportedly been consumed by 96% of participants in their lifetime, with 56% having consumed alcohol in the preceding six months.
- As in previous years, tobacco use remains highly prevalent among PWID, with 99% reporting lifetime use and 97% reporting use within the six months preceding interview. Ninety-two percent of PWID who had recently used tobacco reported smoking daily.
- Thirty percent of the sample reported lifetime use of e-cigarettes, with 20% reporting e-cigarette use in the last six months.
- The prevalence and frequency of new psychoactive substances (NPS), steroids and inhalants remained low in 2016.
- Participants reported no recent use of synthetic cannabinoids in the six months preceding interview in 2016.

4.7.1 Ecstasy and Hallucinogens

Details regarding the use of ecstasy (3,4-methylenedioxymethamphetamine – MDMA), hallucinogens, lysergic acid diethylamide (LSD) or ‘trips’, and naturally occurring compounds such as magic mushrooms, are provided in Table 5.

The majority of participants reported that they had used ecstasy (73%; n=74) and hallucinogens (75%; n=76) within their lifetime. Six participants had used ecstasy and four participants had used some type of hallucinogen in the six months prior to interview, although neither had been consumed frequently. Ecstasy had been consumed on a median of four days (range: 1–10 days) and hallucinogens on a median of one and a half days (range: 1–15 days). Four recent ecstasy users also reported that they had injected ecstasy on a median of 2.5 days (range: 1–3 days). The main forms of ecstasy used by PWID were pills (n=5), followed by capsule (n=1). One participant reported using LSD/trips, one participant used mushrooms and two PWID used ‘other’ hallucinogens. No participants reported injecting hallucinogens during the past six months.

As noted above, use of ecstasy and related drugs among regular PWID is low and infrequent. Since 2000, the use of ecstasy and related drugs among a separate sample of primarily non-injecting drug users has been examined on an annual basis. This is currently conducted as a separate study known as the Ecstasy and Related Drugs Reporting System (EDRS) – formerly the Party Drugs Initiative (PDI). State

and national reports are produced annually: see <http://ndarc.med.unsw.edu.au/group/drug-trends>.

4.7.2 Pharmaceutical stimulants

Since 2004, participants have been asked about their use of pharmaceutical stimulants. This includes drugs such as Dexamphetamine[®] and methylphenidate, which are medications most commonly prescribed for attention deficit hyperactivity disorder (ADHD) and have the potential for misuse. From 2006, the IDRS has asked about licit and illicit forms of pharmaceutical stimulants.

In 2016, 39% of the sample reported using illicit pharmaceutical stimulants at least once in their lifetime (23% in 2015). However, only six participants reported use within the preceding six months (n=5 in 2015), and they reported using on a median of 2.5 days (range: 1–5 days). Recent injection of illicit pharmaceutical stimulants was reported by three participants on a median of one day (range: 1–2 days).

Among those who had used illicit pharmaceutical stimulants, most participants reported that the most common brand used was Dexamphetamine[®] (n=4).

4.7.3 Illicit benzodiazepines⁴

In 2016, participants were again asked to distinguish between their use of alprazolam (Xanax[®]) and other benzodiazepines. Ten percent of PWID reported recent illicit use of alprazolam on a median of three days (range: 1–60 days); and 25% reported illicit use of other benzodiazepines on a median of three days (range: 1–96 days) within the preceding six months.

All participants who had used illicit alprazolam and other illicit benzodiazepines reported use by swallowing; one participant also reported injecting illicit benzodiazepines on a median of three days, in the preceding six months.

Among those who had used 'other benzodiazepines' in the preceding six months, the main brand used was diazepam (Valium[®]) (46%; n=23). This remained stable from 2015 (43%; n=24).

4.7.4 Seroquel[®] (quetiapine)

In 2016, participants were asked about their use of Seroquel[®]; an antipsychotic which is used to treat major psychotic and depression disorders. Twenty-one percent of the sample reported lifetime use of illicit Seroquel[®], whilst six participants reported using illicit Seroquel[®] on a median of three days (range: 2–20 days) in the six months preceding interview. Swallowing was the only ROA for illicit Seroquel[®], with no participants reporting injection within the preceding six months.

4.7.5 Alcohol, tobacco and e-cigarettes

The majority of participants reported that they had consumed alcohol within their lifetime (96%). Fifty-six percent of the sample (67% in 2015) had used alcohol in the six months preceding interview; and they had done so on a median of 24 days (range: 1–180 days). Among recent users of alcohol, eight participants reported daily use of alcohol.

Tobacco remains highly prevalent among PWID, with 99% of the sample reporting lifetime use and 97% reporting use in the six months preceding interview. The

⁴ It was recognised that alprazolam was a benzodiazepine that was potent and may be prone to abuse. The IDRS research team decided to collect data separately for alprazolam from 2011. The abuse liability was recognised nationally with the rescheduling of alprazolam from Schedule 4 to Schedule 8 from February 1 2014 <http://www.tga.gov.au/book/part-scheduling-proposals-referred-march-2013-meeting-acms>

median days of use among those who had recently used tobacco was 180 days (range: 1–180 days). The vast majority (92%) of PWID who had recently used tobacco reported daily use of tobacco and this greatly exceeds the daily smoking prevalence rate in the general South Australian population aged 14 years and over (12.8%; AIHW, 2014).

Thirty percent of the sample reported lifetime use of e-cigarettes, and 20 participants reported using e-cigarettes on a median of three days (range: 1–48 days) in the six months preceding interview.

4.7.6 New psychoactive substances

Eleven participants reported lifetime use of new psychoactive substances (NPS) such as synthetic cathinones (e.g. mephedrone), tryptamines (e.g. dimethyltryptamine [DMT]) and phenethylamines (e.g. 2C-x class). Four participants reported recent use of NPS on a median of three days (range: 1–60 days) and three participants reported injecting NPS in the six months preceding interview.

4.7.7 Synthetic cannabinoids

Eight participants reported lifetime use of synthetic cannabinoids (e.g. K2, Spice). There was no recent use of synthetic cannabinoids in the six months preceding interview.

4.7.8 Steroids

Eleven participants reported lifetime use of steroids, and five participants reported using steroids on a median of 65 days (range: 4–180 days) in the past six months. One participant reported injecting steroids in the six months preceding interview.

4.7.9 Inhalants

Twenty-eight percent of the sample reported lifetime use of inhalants, such as amyl nitrate, petrol, glue and/or lighter fluid. Four participants reported using inhalants on a median of 3.5 days (range: 2–180 days) in the preceding six months.

KE Comments

- KE reported that ecstasy was generally perceived as being a 'clean party drug, consumable without stigma'. It is cost effective and is getting cheaper.
- The presence of other drugs in 'ecstasy' pills continued to be raised as a concern by KE. 'Ecstasy' pills have been found to contain NBOME, a mixture of MDA, MDMA, Ethylone and caffeine, as well as other analogues, some of which have been responsible for nasty overdose episodes across South Australia.
- Alcohol use was generally reported as prevalent and stable, though was considered very problematic by some KE. Of particular concern was the widespread use and social acceptability of alcohol consumption, as well as bingeing behaviours and problems associated with intoxication and dependence, as well as behavioural inhabitation issues.
- One KE commented 'Alcohol can be cheaper than bottled water. You can buy a bottle of wine for \$2.'

5 PRICE, PURITY AND AVAILABILITY

5.1 Heroin

Key Findings

- The median price of heroin was reported to be \$50 for a cap and \$200 for a half weight, with the price reported as 'stable' over the preceding six months.
- The purity of heroin was largely perceived as 'low' to 'medium'; with over three-quarters (76%) of those that commented reporting that purity had remained 'stable' over the preceding six months.
- The vast majority of participants reported that heroin was either 'easy' or 'very easy' to obtain, and that availability had remained 'stable' over the preceding six months.
- Fifty-eight percent of the sample obtained heroin from a 'known dealer', most commonly at an 'agreed public location'.

5.1.1 Price of heroin

Among those who could comment on the price of heroin, the majority of participants reported price per cap/point, or per half weight. The median price at last purchase for a cap of heroin was \$50 (range: \$30–\$200; n=25) and the last purchase price for a half weight of heroin was \$200 (range: \$170–\$400; n=17). This remained stable from 2015.

Of those participants who were confident to report on the current price of heroin (n=34), 97% reported the price as 'stable' over the last six months (see Table 8) (92% in 2015).

Table 8: Change in price of heroin over last six months, 2015–2016

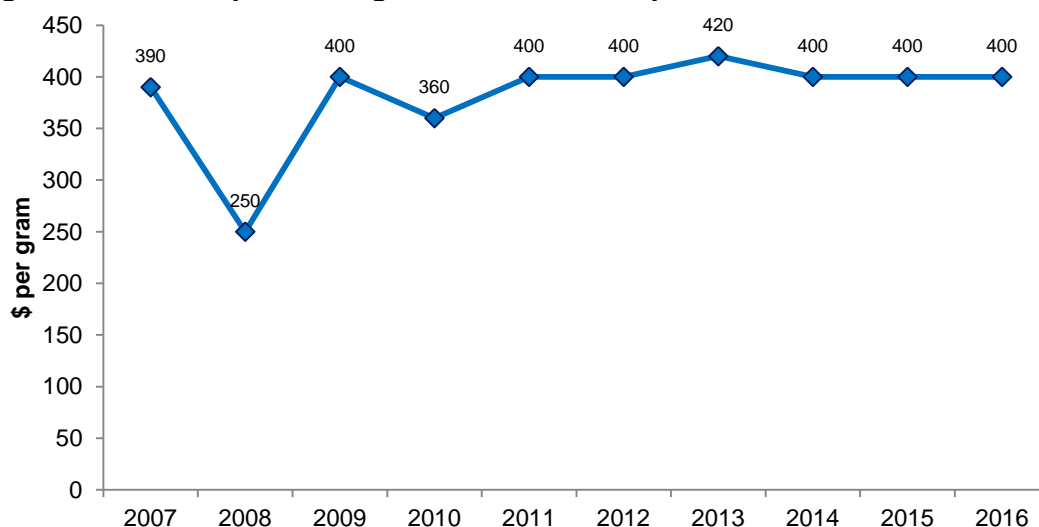
Reported price status	2015	2016
	(n=52)	(n=34)
	% able to answer	
Increasing	2	3
Stable	92	97
Decreasing	6	-
Fluctuating	0	-

Source: IDRS participant interviews.

Note: 'Don't know' was excluded.

Long-term trends in the median price paid for a gram of heroin are shown in Figure 12. Despite a decrease being observed in 2008, it can be seen that the median price paid for a gram of heroin at last purchase has remained relatively stable since 2007. As mentioned above, data on price for 'grams' of heroin have generally been based on small sample sizes (n=10 in 2016), with most participants buying heroin in 'caps' (n=25).

Figure 12: Median price of a gram of heroin, last purchase, 2007–2016



Source: IDRS participant interviews.
 Note: $n \leq 10$ results should be interpreted with caution.

5.1.2 Purity of heroin – participant reports

Table 9 and Table 10 summarise the current purity of heroin and the changes in heroin purity over the last six months, as reported by participants. In 2016, the largest proportion of those able to answer ($n=34$) reported that the current purity of heroin was ‘medium’ (41%), 35% reporting that the purity was ‘low’, and 21% reporting that the purity was ‘high’. This remained relatively stable from 2015. Of those able to answer ($n=34$), 44% reported that the purity of heroin had remained ‘stable’ over the preceding six months, with under one-quarter reporting that it had ‘decreased’ and 12% reporting that it had ‘increased’ in purity. Over one fifth of participants believed that the purity had ‘fluctuated’ in the last six months.

Table 9: Current purity/strength of heroin, 2015–2016

How pure would you say heroin is at the moment?	2015 ($n=49$)	2016 ($n=34$)
	% able to answer	
High	12	21
Medium	39	41
Low	43	35
Fluctuates	6	3

Source: IDRS participant interviews.
 Note: ‘Don’t know’ was excluded.

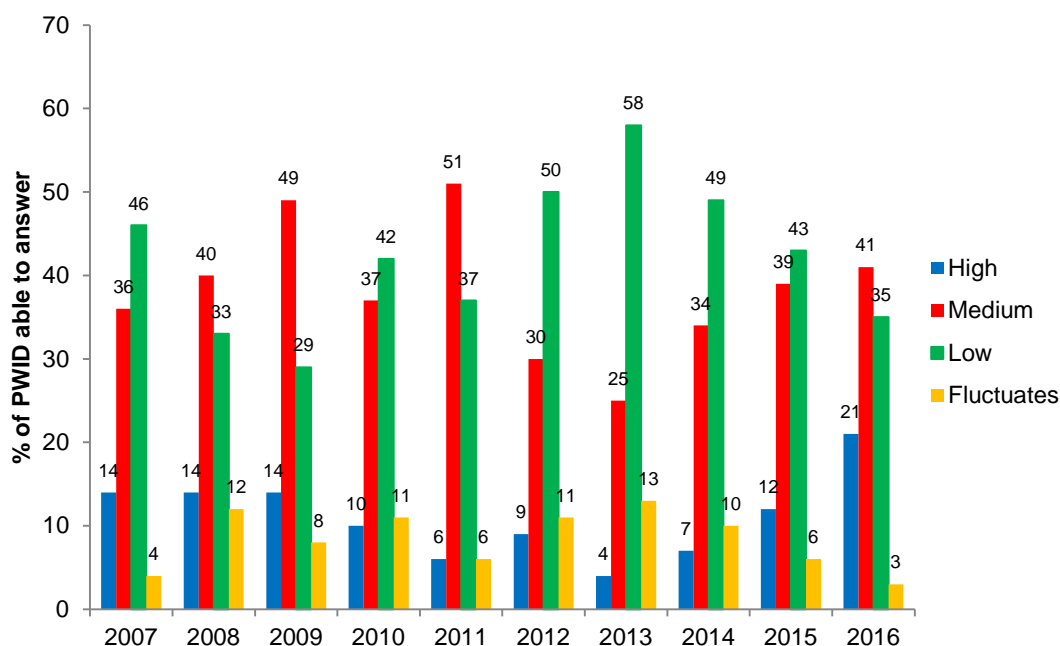
Table 10: Change in purity/strength of heroin in last six months, 2015–2016

Has the purity of heroin changed in the last 6 months?	2015 ($n=48$)	2016 ($n=34$)
	% able to answer	
Increasing	19	12
Stable	42	44
Decreasing	19	24
Fluctuating	21	21

Source: IDRS participant interviews.
 Note: ‘Don’t know’ was excluded.

Figure 13 shows the trend in purity of heroin, as perceived by participants, from 2007 onwards. Despite various fluctuations over the years, it can be seen that purity has generally been reported as 'medium' or 'low'.

Figure 13: Perception of current purity of heroin, 2007–2016



Source: IDRS participant interviews.
 Note: 'Don't know' was excluded from 2009 onwards.

5.1.3 Purity of heroin – drug seizure data

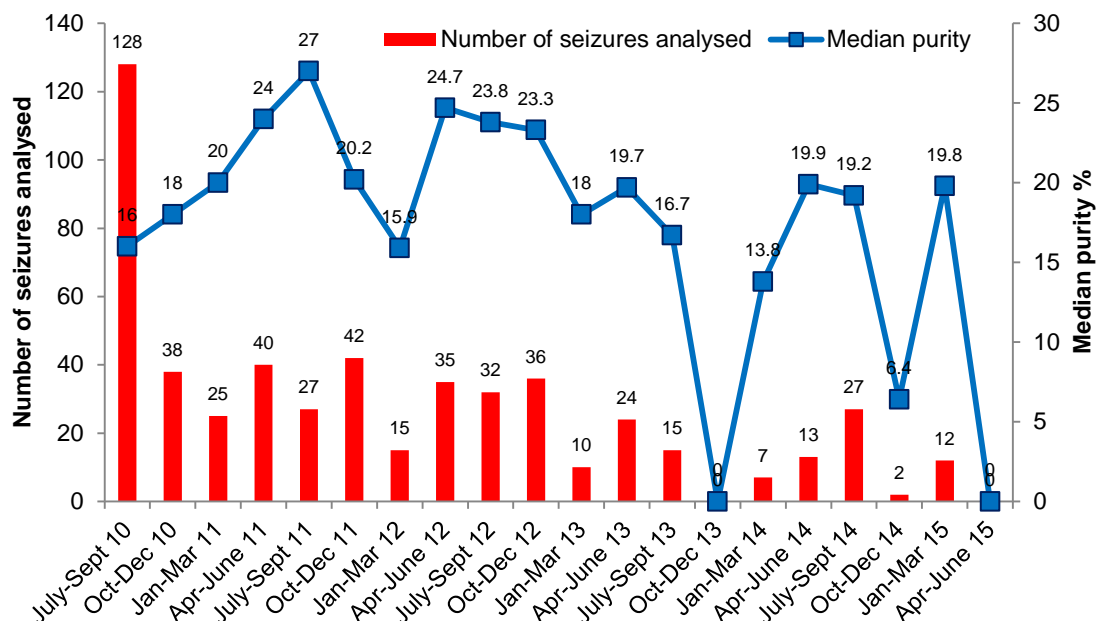
Participant reports of purity are subjective and depend on a number of factors including the health and tolerance of the individual. A more objective measure of purity is derived from the analysis of drug seizures. The purity figures reported below are provided by the Australian Criminal Intelligence Commission (ACIC) (formally the Australian Crime Commission (ACC)) and there are some important issues to consider when examining purity measures. These data do not reflect the total weight of a particular drug seized in each year, but only those samples and seizures submitted for analysis. They relate to an unrepresentative sample of the illicit drugs available in Australia, and this should be considered when drawing conclusions from the purity data presented. In addition, there is typically a lag of several months between the seizure and receipt of profiling results (Australian Criminal Intelligence Commission, 2016).

The ACIC provide data on state/territory police and Australian Federal Police (AFP) seizure data, including the number and weight of seizures. Data reported include seizures ≤ 2 grams and > 2 grams, reflecting both street and larger seizures. Figure 13 and Figure 17 do *not* represent the purity of all heroin seizures – only those that have been analysed at a forensic laboratory.

ACIC data were unavailable for 2015/16 at the time of publication and the data presented below relates to the purity data on heroin seized in SA during the last financial year: 2014/15 (Australian Criminal Intelligence Commission 2016). Figure 13 shows the number of seizures received and analysed by the state forensic laboratory per quarter, and the median purity of those seizures, from 2010/11 to 2014/15.

Despite quarterly variation, and variation in the number of seizures, the median purity of South Australia Police (SAPOL) heroin seizures remained relatively stable in 2014/15 at 19% (17% in 2013/14). The total number of seizures received and analysed increased slightly to 41 (35 in 2013/14). The majority of SAPOL seizures analysed (n=24) were less than two grams.

Figure 14: Number of heroin seizures analysed and median heroin purity in SA 2010/11–2014/15



Source: Australian Crime Commission, 2010; Australian Crime Commission, 2011; Australian Crime Commission, 2012; Australian Crime Commission, 2013; Australian Crime Commission, 2014; Australian Crime Commission, 2015; Australian Criminal Intelligence Commission, 2016.
NB: Data for 2015/16 were not available at the time of publication.

5.1.4 Availability of heroin

Table 11 and Table 12 summarise the current availability of heroin and changes in heroin availability over the last six months, as perceived by participants. Of those who were able to answer questions regarding the availability of heroin (n=35), the majority reported it was either ‘easy’ or ‘very easy’ to obtain heroin (92%), with only 9% reporting that it was ‘difficult’ to obtain. The vast majority (94%) of those able to answer (n=35) perceived that heroin availability had remained ‘stable’ in the six months preceding interview; this was a significant increase from 2015 (p<0.05).

Table 11: Availability of heroin currently, 2015–2016

How easy is it to get heroin at the moment?	2015 (n=51)	2016 (n=35)
	% able to answer	
Very easy	49	46
Easy	37	46
Difficult	14	9
Very difficult	0	0

Source: IDRS participant interviews.
Note: ‘Don’t know’ was excluded.

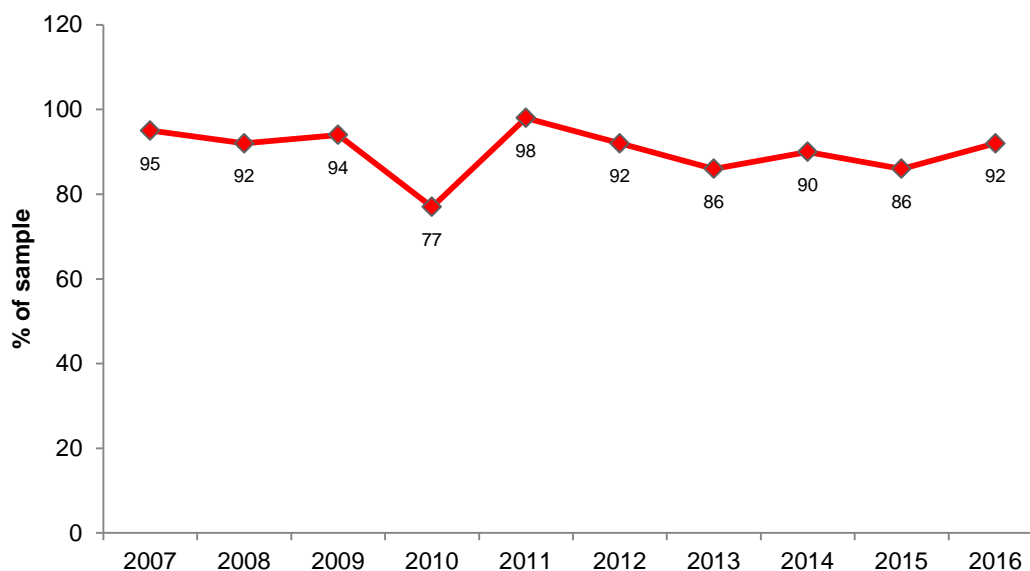
Table 12: Change in availability of heroin over the last six months, 2015–2016

Has availability changed in the last 6 months?	2015 (n=50)	2016 (n=35)
	% able to answer	
More difficult	10	3
Stable	72	94
Easier	12	3
Fluctuates	6	-

Source: IDRS participant interviews.
 Note: 'Don't know' was excluded.

Long-term trend data for the availability of heroin are presented in Figure 14. As can be seen, the proportion of participants who reported that heroin was 'very easy' or 'easy' to obtain in the six months prior to interview has remained relatively high and stable over the past decade. In 2016, 92% of participants able to answer reported that heroin was 'easy' or 'very easy' to obtain (86% in 2015).

Figure 15: Availability of heroin as easy or very easy in the last six months, 2007–2016



Source: IDRS participant interviews.
 Note: 'Don't know' was excluded from 2009 onwards.

5.1.5 Purchasing patterns of heroin

Participants were also asked about the person from whom and the location from where they had last obtained heroin (see Table 13). The largest proportion of participants who provided information on the source of their heroin in the six months prior to interview (n=33) reported they usually obtained heroin from 'known dealers' (58%). About a quarter (24%) obtained heroin from a 'friend' in 2016.

An 'agreed public location' was the most commonly reported last purchase venue (29%) and less than one quarter (24%) reported the heroin being 'delivered to their home' or acquiring from the 'dealer's home', respectively.

Table 13: Source person and source venue last time obtained heroin in the last six months, 2015–2016

Last source person and venue	2015 (n=48)	2016 (n=33)
Person		
Street dealer	4	9
Known dealer	46	58
Friends	23	24
Acquaintances	13	6
Mobile dealer	6	-
Unknown dealer	6	-
Partner	2	-
Venue	(n=48)	(n=34)
Home delivery	25	24
Dealer's home	8	24
Friend's home	13	18
Acquaintance's home	8	6
Agreed public location	38	29
Street market	6	-
Other	2	-

Source: IDRS participant interviews.

KE Comments

- It was largely reported that the heroin market had remained stable at \$100 per point.
- There were mixed reports regarding heroin purity, with one KE reporting it as 'medium', one stated that purity 'fluctuates' and a further KE reported that purity was 'low' at approximately 15%.

5.2 Methamphetamine

Key Findings

- The median price for all three forms of methamphetamine was \$50 per point.
- The price was largely reported to have remained 'stable' in the six months preceding interview for powder (79%); about half reported base as remaining 'stable' (52%) and similar proportions reported that base had 'decreased' (19%) or had 'fluctuated' (24%). Forty-one percent of those who had purchased crystal methamphetamine reported the price to be 'decreasing' and 37% reported that the price had remained 'stable'.
- The majority of those commenting considered all three forms of methamphetamine to be of 'medium' to 'high' purity and this had reportedly remained 'stable' over the six months prior to interview.
- The availability of all forms of methamphetamine was reported as 'easy' or 'very easy' to obtain (72% for powder; 77% for base; 95% for crystal methamphetamine). This had remained 'stable' over the preceding six months.
- Participants reported obtaining all forms of methamphetamine from 'friends', most commonly from a 'friend's home'.

5.2.1 Price of methamphetamine

5.2.1.1 *Methamphetamine – powder*

The last reported price paid for a point of methamphetamine powder was a median of \$50 (range: \$20–\$100; n=11). Less than 10 participants were able to comment on the price of a half weight or gram of powder and therefore the data is not presented (see Table 14).

5.2.1.2 *Methamphetamine – base*

The last reported price paid for a point of base was a median of \$50 (range: \$40–\$100, n=16) (\$100 in 2015). Less than 10 participants were able to comment on the price of a half weight or gram of base and therefore the data is not presented (see Table 14).

5.2.1.3 *Methamphetamine – crystal*

The last reported price paid for a point of crystal was a median of \$50 (range: \$20–\$100; n=62) (\$100 in 2015). Crystal methamphetamine was the only form where more than ten participants were able to comment on price of quantities other than a point. The median price for a half weight of crystal was \$250 (range: \$120–\$600; n=39), and \$400 for a gram (range: \$200–\$700; n=26). The median price for an 'eightball' was \$775 (range: \$280–\$1300; n=18) (see Table 14).

Table 14: Reported price of all forms of methamphetamine, 2015–2016

	2015	2016
Price (\$) SPEED		
Per point	50	50
Price (\$) BASE		
Per point	100	50
Price (\$) CRYSTAL		
Per point	100	50
Per gram	450	400

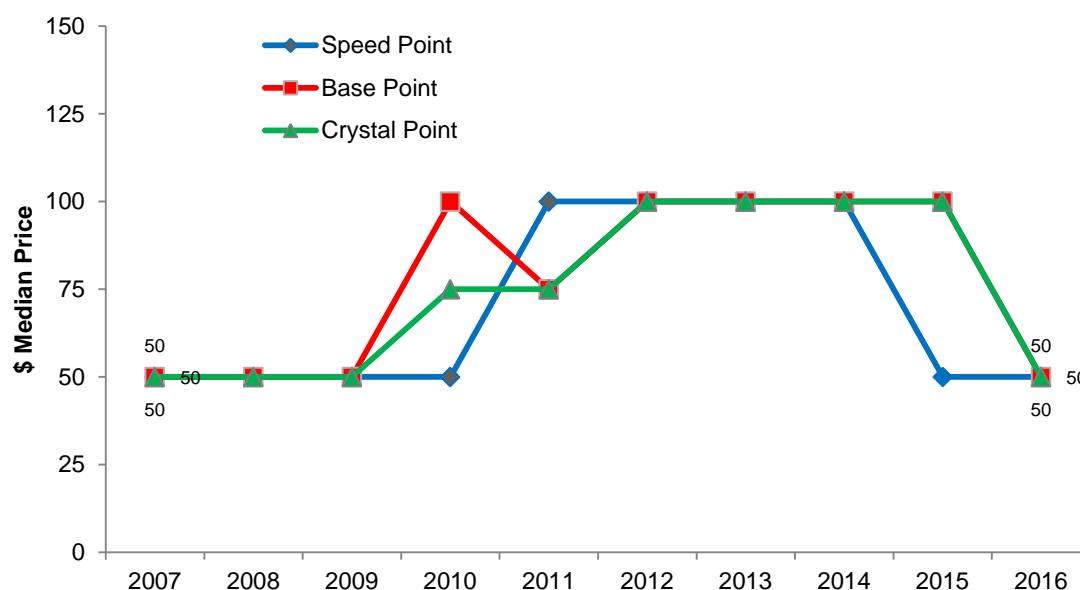
Source: IDRS participant interviews.

*Small numbers (n<10) were able to comment; data not reported.

Note: 'Don't know' was excluded.

Table 14 shows price data for 2015 and 2016. It is important to note that long-term changes in the last purchase price of a gram for the different forms of methamphetamine have been difficult to gauge, mainly due to the fact that few participants have been able to comment.

Figure 16: Median price of points per form of methamphetamine, 2007-2016



Source: IDRS participant interviews.

Figure 16 shows median price data from 2007 to 2016 for three forms of methamphetamine by points. It can be seen that crystal methamphetamine and base commenced an upward trend from 2009, with speed powder following in 2010 and all forms plateauing from 2012 to 2014, until the median price of speed powder decreased in 2015, with base and crystal methamphetamine following in 2016.

Table 15 summarises participant reports of recent changes in the price of the three forms of methamphetamine. In 2016, the majority of participants answering this section reported the price of base and powder methamphetamine to be 'stable', yet the majority of those who had purchased crystal methamphetamine reported the price to be 'decreasing'.

Table 15: Change in price of methamphetamine over last six months, 2015–2016

Reported price status	Powder		Base		Crystal	
	2015	2016	2015	2016	2015	2016
	(n=33)	(n=14)	(n=21)	(n=21)	(n=68)	(n=75)
	% able to answer					
Increasing	27	7	14	5	13	5
Stable	67	79	67	52	66	37
Decreasing	6	14	19	19	18	41
Fluctuating	0	-	0	24	3	16

Source: IDRS participant interviews.
Note: 'Don't know' was excluded.

5.2.2 Purity of methamphetamine - participant reports

Table 16 and Table 17 summarise the current purity of the three forms of methamphetamine and the changes in methamphetamine purity over the last six months. As can be seen, participant reports were quite varied. In regards to methamphetamine powder, the largest proportion of participants perceived current purity as 'high', unlike 2015 reports. In 2016, the largest proportion of those able to comment regarded methamphetamine base to be of 'medium' purity, which also differed from 2015 reports. In regards to crystal methamphetamine, two-fifths (40%) of participants continued to describe current purity as 'high' and one-third reported the purity to be of 'medium' quality.

Table 16: Purity/strength of methamphetamine currently, 2015–2016

How pure would you say powder/base/crystal is at the moment?	Powder		Base		Crystal	
	2015	2016	2015	2016	2015	2016
	(n=30)	(n=14)	(n=20)	(n=22)	(n=67)	(n=76)
	% able to answer					
High	23	50	45	27	57	40
Medium	53	43	20	55	25	33
Low	23	0	10	14	8	15
Fluctuates	0	7	25	5	10	13

Source: IDRS participant interviews.
Note: 'Don't know' was excluded.

Across all three forms of methamphetamine, the largest proportion of participants reported that purity had remained 'stable' in the six months preceding interview, as can be seen in Table 17.

Table 17: Change in purity/strength of methamphetamine in last six months, 2015–2016

Has the purity of powder/base/crystal changed in the last 6 months?	Powder		Base		Crystal	
	2015	2016	2015	2016	2015	2016
	(n=28)	(n=13)	(n=21)	(n=21)	(n=65)	(n=75)
	% able to answer					
Increasing	11	15	10	10	17	16
Stable	64	62	43	48	52	39
Decreasing	21	8	14	29	8	23
Fluctuating	4	15	33	14	23	23

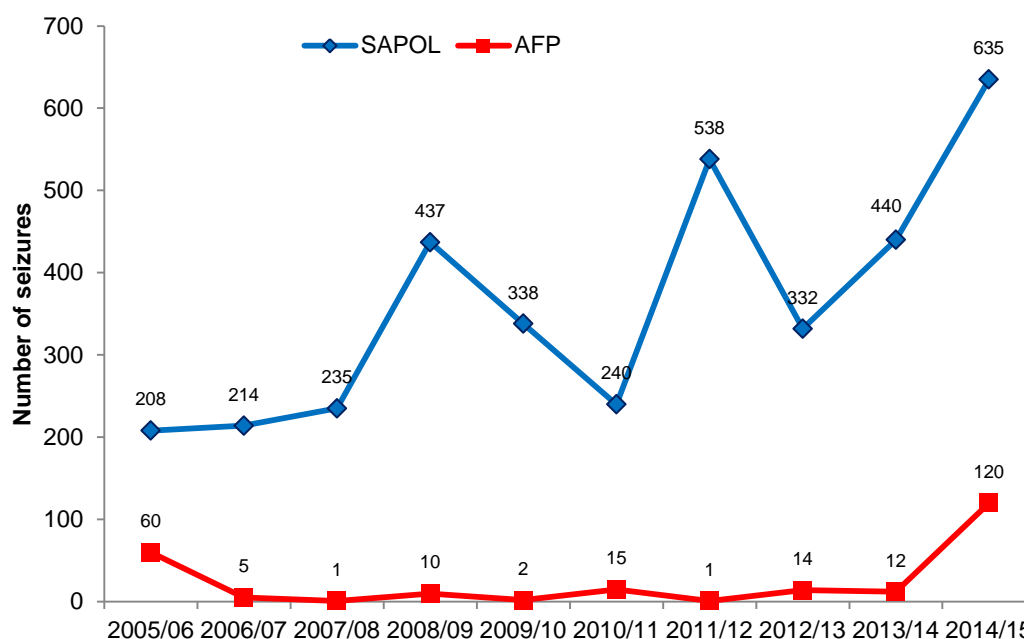
Source: IDRS participant interviews.
Note: 'Don't know' was excluded.

5.2.3 Purity of methamphetamine - drug seizure data

The ACIC provides purity data for state/territory police and AFP seizures that have been analysed for methamphetamine. There are important caveats (in addition to those already discussed within the heroin section) to consider when interpreting these data. The purity of methamphetamine fluctuates widely in Australia as a result of a number of factors, including the type and quality of chemicals used in the production process and the expertise of the 'cooks' involved, as well as whether the seizure was locally manufactured or imported. During 1999/2000 and 2014/15, forensic analysis of seizures of methamphetamine in Australia revealed purity levels ranging from less than 1% to 83.6%, with higher purity often relating to one single seizure rather than being representative of a large number of seizures. This wide range in both purity and numbers of seizures analysed should be considered when looking at the median purity figures presented.

The ACIC data were unavailable for 2015/16 at the time of publication. As such, data provided by the ACIC relates to methamphetamine seizures in SA during the last financial year: 2014/15 (Australian Criminal Intelligence Commission 2016) (Figure 17). SAPOL seizures increased in 2014/15, as did the weight of the seizures (127,197 grams in 2014/15 vs. 14,265 grams in 2013/14). Seizures reported by the AFP increased sharply from 12 in 2013/14 to 120 in 2014/15, with the weight of the seizures also increasing (17,722 grams in 2014/15 vs. 10,809 grams in 2013/14).

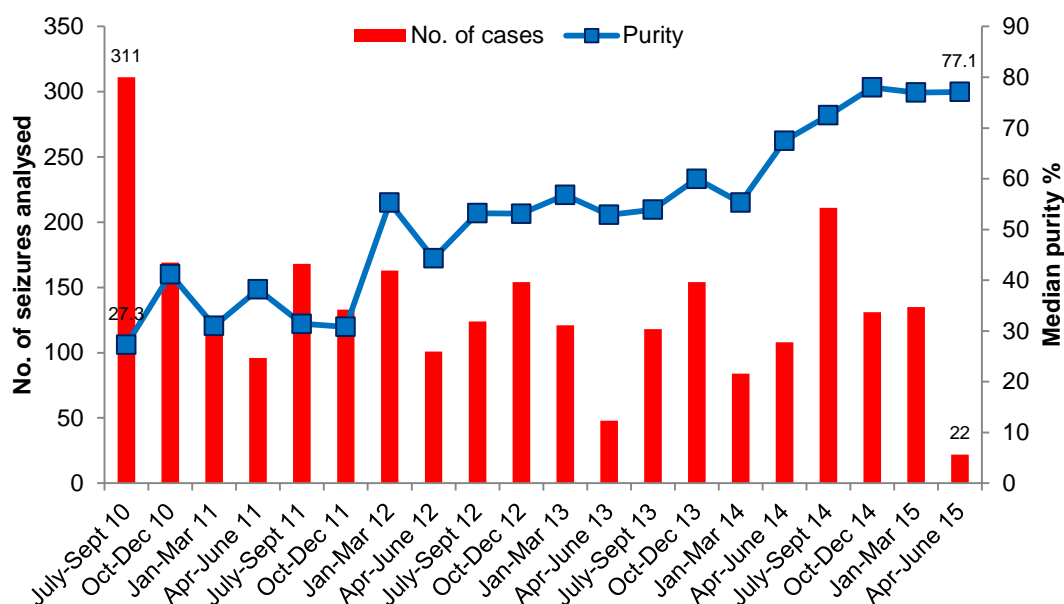
Figure 17: Number of seizures: amphetamine-type stimulants, 2005/06–2014/15



Source: Australian Crime Commission 2006; Australian Crime Commission 2007; Australian Crime Commission 2008; Australian Crime Commission 2009; Australian Crime Commission 2010; Australian Crime Commission 2011; Australian Crime Commission 2012; Australian Crime Commission 2013; Australian Crime Commission 2014; Australian Crime Commission 2015, Australian Criminal Intelligence Commission 2016.

Figure 18 shows the number of methamphetamine seizures received and analysed by the state forensic laboratory (within the quarter depicted) and the median purity per quarter of those seizures from 2010/11 to 2014/15. The total number of SAPOL methamphetamine seizures analysed from July 2014 to June 2015 was 499, which was stable from the 2013/14 financial year (464). The overall median purity of the seizures analysed was 75.7% (59.7% in 2013/14). The majority of seizures analysed were more than 2 grams (n=347).

Figure 18: Number of methamphetamine seizures analysed and median methamphetamine purity in SA, 2010/11–2014/15



Source: Australian Crime Commission 2010; Australian Crime Commission 2011; Australian Crime Commission 2012; Australian Crime Commission 2013; Australian Crime Commission 2014; Australian Crime Commission 2015, Australian Criminal Intelligence Commission 2016.

5.2.4 Availability of methamphetamine

Table 18 and Table 19 summarise the current availability of the three main forms of methamphetamine and the changes in availability over the last six months, as reported by participants. In 2016, crystal methamphetamine was largely reported as ‘easy’ or ‘very easy’ to obtain. Significant minorities reported powder (29%) and base (23%) as ‘difficult’, whereas crystal methamphetamine was reported by only 5% as ‘difficult’ to obtain. The majority of those able to comment also reported that the availability of all three forms of methamphetamine had remained ‘stable’ over the preceding six months.

Table 18: Availability of methamphetamine currently, 2015–2016

How easy is it to get powder/base/crystal at the moment?	Powder		Base		Crystal	
	2015	2016	2015	2016	2015	2016
	(n=32)	(n=14)	(n=23)	(n=22)	(n=70)	(n=76)
	% able to answer					
Very easy	47	29	44	41	63	61
Easy	31	43	30	36	36	34
Difficult	19	29	22	23	1	5
Very difficult	3	0	4	0	0	0

Source: IDRS participant interviews.

Note: ‘Don’t know’ was excluded.

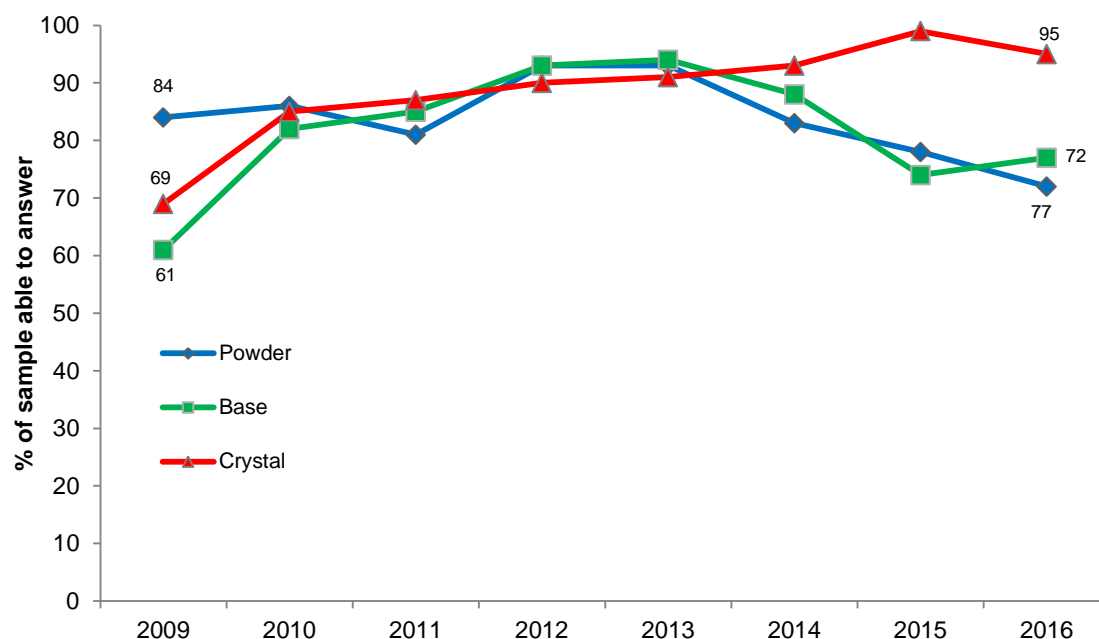
Table 19: Change in availability of methamphetamine over the last six months, 2015–2016

Has availability changed in the last 6 months?	Powder		Base		Crystal	
	2015	2016	2015	2016	2015	2016
	(n=30)	(n=14)	(n=21)	(n=23)	(n=70)	(n=77)
	% able to answer					
More difficult	23	21	14	9	0	3
Stable	67	71	76	74	79	78
Easier	7	7	10	13	19	18
Fluctuates	3	-	0	4	3	1

Source: IDRS participant interviews.
Note: 'Don't know' was excluded.

Long-term trend data depicting the availability of methamphetamine from 2009 onwards, as reported by participants, are presented in Figure 19. As shown, methamphetamine has generally been considered 'easy' or 'very easy' to obtain across all years and for all forms (for figures prior to 2009, please see previous editions of the IDRS SA report).

Figure 19: Availability of methamphetamine in the last six months, easy or very easy, 2009–2016



Source: IDRS participant interviews.
Note: 'Don't know' was excluded.

5.2.5 Purchasing patterns of methamphetamine

Participants were asked about both the source and location from which they had last obtained the various forms of methamphetamine. Table 20 shows that the majority of methamphetamine users who were able to answer reported obtaining all forms of methamphetamine from 'friends' and 'known dealers'.

The location/venue from which participants most commonly obtained all forms of methamphetamine was from a 'friend's home'.

Table 20: Last usual source person and venue used for obtaining various forms of methamphetamine in the last six months, 2016

Usual source person and venue of those able to answer (%)	Powder	Base	Crystal
Person#	n=14	n=22	n=72
Street dealer	7	-	3
Friend	43	46	53
Known dealer	29	41	31
Workmates	-	5	-
Acquaintances	14	5	8
Unknown dealer	-	-	3
Mobile dealers	-	-	-
Other	-	-	1
Venue#	n=14	n=22	n=70
Home delivery	7	23	24
Dealer's home	21	18	21
Friend's home	43	36	36
Acquaintance's home	-	9	4
Street market	-	5	3
Agreed public location	21	-	9
Work	-	5	1
Other	7	5	1

Source: IDRS participant interviews.

Only one response allowed.

KE Comments

- The price of methamphetamine varied among KE, with some reporting \$50 per point depending on 'who you know and who you don't know', and others reported \$100 per point. Most KE reported that in their opinion the price had decreased. One KE reported that the price had reduced 'significantly' which is likely to affect usage in the near future.

- KE commented that methamphetamine was 'very available' and as one KE stated, '[it] appears to be the most common drug on the streets at the moment'.

- Reports regarding the purity of methamphetamine were mixed: five KE reported that the purity was 'high', with one KE stating 'it's as close as can be to being 100% pure'; two KE reported that it was 'stable', and one KE reported that it 'fluctuates'. All KE who commented stated that the purity had either 'increased' in the past six months or had remained 'stable'.

- The majority of methamphetamine is still manufactured from pseudoephedrine.

- KE reported a significant increase in crystal methamphetamine seizures in the past 12 months.

- KE revealed that the use of encrypted communications (i.e. encrypted Blackberrys and use of applications such as Snapchat) has increased in the last 12 months. There is also increasingly a new breed of trafficker operating on the dark net to import and onsupply a range of substances, including methamphetamine, anonymously. Often these people have little or no criminal history, but who are competent in the use of technology.

5.3 Cannabis

Key Findings

- The price for both hydro and bush cannabis remained stable in 2016 at \$25 for a bag.
- The potency of hydro cannabis was reported to be 'high' and bush cannabis purity was reported as 'medium'. This has largely remained stable over the preceding six months.
- The majority of participants reported both types of cannabis as 'easy' or 'very easy' to obtain. Availability had remained 'stable' over the preceding six months.
- Participants obtained cannabis primarily from 'friends', most often from a 'friend's home'.

From 2003, to ensure more detailed information was collected on the different forms of cannabis, the cannabis section was separated into hydro (hydroponically grown) and bush (grown outdoors).

The following sections refer to a bag as a standard measure (particular to the SA cannabis market). A detailed investigation of the weight/content of a bag of cannabis was undertaken in 2002 (Longo et al. 2003). Briefly, in the 2002 survey, 33 participants gave a single value of the average weight of cannabis bags sold in SA; the results yielded a median of two grams and a mean of two and a half grams. A further 19 participants gave both a lower and upper weight range for cannabis bags. The median lower range was two grams (mean=2.1) and the median upper range was three grams (mean=2.9). It can be understood, therefore, that the amount of cannabis in a bag may fluctuate, but that a bag in SA generally conveys a weight of cannabis between two and three grams.

5.3.1 Price of cannabis

Participants reported the price for their last purchase to be a median of \$220/ounce for hydro (range: \$150-\$280, n=13). Less than ten participants commented on the price of grams. Regarding bush cannabis, less than ten participants reported the price of grams and ounces. The most common amount purchased in the last six months was a bag and the reported median price paid by participants at last purchase was \$25, for both hydro (range: \$20-\$25, n=34) and bush (range: \$25-\$25, n=20). As such, there was no difference in the reported price of a bag of hydro compared to bush cannabis (see Table 21).

Table 21: Price of last cannabis purchases, 2015–2016

	2015	2016
Price (\$) HYRDO		
Per quarter ounce	60	60
Per ounce	200	220
Per bag	25	25
Price (\$) BUSH		
Per quarter ounce		60
Per ounce	220	
Per bag	25	25

Source: IDRS participant interviews.

^Small numbers (n<10) were able to comment - data not reported.

The price of both hydro and bush cannabis was generally reported as 'stable' over the last six months (see Table 22).

Table 22: Change in price of cannabis over the last six months, 2015–2016

Reported price status	Hydro		Bush	
	2015 (n=63)	2016 (n=52)	2015 (n=44)	2016 (n=31)
	% able to answer			
Increasing	11	8	11	0
Stable	79	87	75	94
Decreasing	2	0	5	0
Fluctuating	8	6	9	7

Source: IDRS participant interviews.

Note: 'Don't know' was excluded. Due to rounding % may not add to 100.

5.3.2 Potency of cannabis

Table 23 and Table 24 summarise the current potency of cannabis and the changes in cannabis potency over the last six months, according to participant reports. In 2016, the strength of hydro was reported as 'high' by the majority of participants, and most participants reported the potency of bush cannabis to be 'medium', much the same as 2015 reports. The majority of participants reported that the potency of both hydro and bush cannabis had remained 'stable' over the last six months, consistent with 2015 reports. Significant minorities reported potency fluctuates.

Table 23: Current potency/strength of cannabis, 2015–2016

How potent would you say cannabis is at the moment?	Hydro		Bush	
	2015 (n=66)	2016 (n=53)	2015 (n=47)	2016 (n=32)
	% able to answer			
High	62	51	40	38
Medium	27	32	49	53
Low	8	8	9	9
Fluctuates	3	9	2	0

Source: IDRS participant interviews.

Note: 'Don't know' was excluded.

Table 24: Change in potency/strength of cannabis in last six months, 2015–2016

Has the potency of cannabis changed in the last 6 months?	Hydro		Bush	
	2015 (n=65)	2016 (n=54)	2015 (n=44)	2016 (n=31)
	% able to answer			
Increasing	9	4	5	10
Stable	71	56	84	65
Decreasing	9	15	2	7
Fluctuating	11	26	9	19

Source: IDRS participant interviews.

Note: 'Don't know' was excluded.

5.3.3 Availability of cannabis

Table 25 and Table 26 summarise the current availability of cannabis and the changes in cannabis availability over the last six months, according to participant reports. In 2016, the majority of participants reported both types of cannabis as ‘easy’ or ‘very easy’ to obtain; 90% for hydro and 81% for bush. The majority of participants who were able to answer reported that the availability of hydro (83%) and bush (81%) was ‘stable’ in the last six months.

Table 25: Availability of cannabis currently, 2015-2016

How easy is it to get cannabis at the moment?	Hydro		Bush	
	2015 (n=65)	2016 (n=53)	2015 (n=48)	2016 (n=31)
	% able to answer			
Very easy	54	43	27	39
Easy	40	47	46	42
Difficult	6	9	21	16
Very difficult	0	0	6	3

Source: IDRS participant interviews.

Note: ‘Don’t know’ was excluded.

Table 26: Change in availability of cannabis over the last six months, 2015–2016

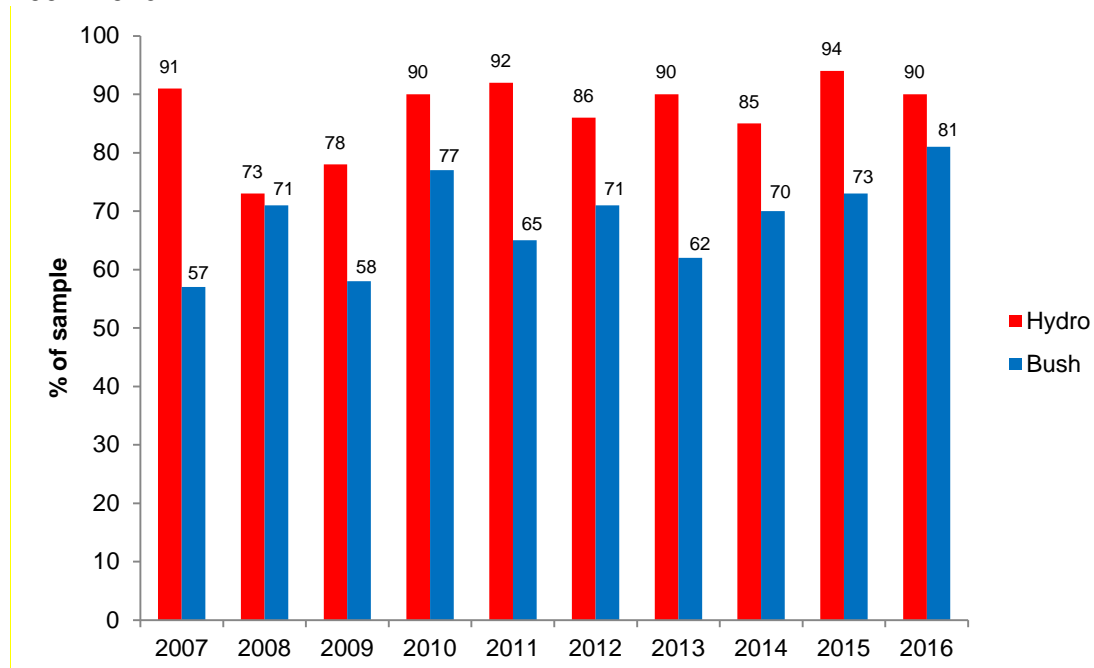
Has availability changed in the last 6 months?	Hydro		Bush	
	2015 (n=65)	2016 (n=54)	2015 (n=48)	2016 (n=32)
	% able to answer			
More difficult	5	11	6	6
Stable	85	83	69	81
Easier	6	2	15	6
Fluctuates	5	4	10	6

Source: IDRS participant interviews.

Note: ‘Don’t know’ was excluded.

Figure 20 shows the long-term trend in the proportion of participants reporting availability of cannabis as ‘easy’ or ‘very easy’, from 2007 onwards. As can be seen, the reported ease of availability has generally remained high. In 2016, the majority of the sample reported that both hydro and bush cannabis were ‘easy’ or ‘very easy’ to obtain. This was mostly stable from 2015.

Figure 20: Availability of cannabis in the last six months, easy or very easy, 2007–2016



Source: IDRS participant interviews.
Note: 'Don't know' was excluded from 2009 onwards.

5.3.4 Purchasing patterns of cannabis

Table 27 presents information collected from participants on the source (both person and venue) from which participants had last obtained cannabis. In 2016, the majority of participants who were able to comment reported that they usually obtained cannabis from a 'friend' (hydro: 62%; bush: 55%) in the six months prior to interview. Participants reported that the venue they had usually obtained cannabis from was a 'friend's home' (39% for both forms) or 'home delivery' (hydro: 27%; bush: 13%).

Table 27: Source person and source venue of last purchase of hydro and bush cannabis, 2016

Usual source or method of obtainment of those able to answer (%)	Hydro	Bush
Person#	n=52	n=31
Street dealer	2	-
Friend	62	55
Known dealer	19	23
Mobile dealer	2	-
Acquaintances	12	16
Unknown dealer	-	-
Partner	-	-
Other	-	-
Venue#	n=52	n=31
Home delivery	27	13
Dealer's home	17	16
Friend's home	39	39
Acquaintance's home	6	10
Street market	2	3
Agreed public location	6	13
Other	2	7

Source: IDRS participant interviews.

Only one response allowed.

KE Comments

- The majority of KE agreed that the price, purity and availability of cannabis had remained stable in the 12 months preceding interview. The price of cannabis was reported to have remained stable at \$25 per bag.

- One KE reported that commercial transactions are usually in pounds which cost between \$2,200 and \$3,500. Cannabis is regularly exported from SA where it can sell for over \$4000 per pound in capital cities such as Peth, and more again if sold in rural and remote areas.

5.4 Morphine

Key Findings

- The median last purchase price for 100mg of MS Contin[®] was \$40 and 100mg of Kapanol[®] was \$45; this had generally remained stable in the six months preceding interview.
- Illicit morphine was mostly reported as 'easy' to obtain (40%), though one-third reported it as being 'difficult' to attain. The majority of those able to answer reported that availability had remained 'stable'.
- Participants most commonly obtained illicit morphine through 'friends' at a 'friend's home'.

In 2016, 15% of the sample was confident enough to complete survey items relating to the illicit morphine market.

5.4.1 Price of morphine

In 2016, the median price paid by participants at last purchase was \$45 for 100mg of Kapanol[®] (see Table 28). Few participants (n<10) were able to provide price information for MS Contin; therefore, data will not be reported.

Thirteen participants were able to comment on whether the price of morphine had changed in the six months prior to interview. Nine participants (69%) reported that the price had remained 'stable', three participants reported that the price had 'increased', and one participant reported that it had 'decreased'. Comparisons were not made with 2015 due to small numbers.

5.4.2 Availability of morphine

Table 28 and Table 29 summarise the current availability of morphine and the changes in its availability over the last six months, according to participant reports. Among those able to comment, six participants reported that illicit morphine was 'easy' to obtain and conversely, five participants reported that illicit morphine was 'difficult' to obtain. Among those able to comment (n=15), more than half (n=10) reported that the availability of morphine had remained 'stable' over the past six months. Five participants reported that it had become 'more difficult' to obtain.

Table 28: Availability of illicit morphine currently, 2015–2016

How easy is it to get morphine at the moment?	2015 (n=23)	2016 (n=15)
	% able to answer	
Very easy	30	20
Easy	26	40
Difficult	35	33
Very difficult	9	7

Source: IDRS participant interviews.

Note: 'Don't know' was excluded.

Table 29: Change in availability of illicit morphine over the last six months, 2015–2016

Has availability changed in the last 6 months?	2015 (n=23)	2016 (n=15)
	% able to answer	
More difficult	39	33
Stable	57	67
Easier	4	-
Fluctuates	0	-

Source: IDRS participant interviews.

Note: 'Don't know' was excluded.

5.4.3 Purchasing patterns of morphine

Table 30 presents information collected from participants on the person(s) from whom they had bought morphine, and the venues from which they had normally obtained morphine in the six months prior to interview. Of those who were able to answer (n=12), the majority of participants reported that they had obtained morphine from a 'friend' (75%). Seven participants (58%) reported that the venue they had usually obtained morphine from was a 'friend's home', followed by 'home delivery' (n=3; 25%).

Table 30: Usual source person and source venue used to obtain illicit morphine in the last six months, 2015–2016

Usual source person and venue of able to answer (%)	2015	2016
Person#	n=17	n=12
Street dealer	0	8
Friend	65	75
Known dealer	12	-
Mobile dealer	0	-
Acquaintances	24	8
Unknown dealer	0	-
Partner	-	8
Other	0	-
Venue#	n=18	n=12
Home delivery	17	25
Dealer's home	0	-
Friend's home	28	58
Acquaintance's home	6	-
Street market	0	-
Agreed public location	33	17
Other	17	-

Source: IDRS participant interviews.
 # Only one response allowed.

5.5 Benzodiazepines

Key Findings

- The price of illicit benzodiazepines was predominantly reported as being 'stable' in the preceding six months.
- Sixty-two percent of participants reported that illicit benzodiazepines were 'easy' to 'very easy' to obtain, and changes to availability had remained 'stable' in the six months prior to interview.
- Illicit benzodiazepines were mainly obtained through 'friends', and primarily from a 'friend's home' followed by 'home delivery' or at an 'agreed public location'.

As with other drug types, all participants were asked about the illicit benzodiazepine market. Fourteen participants were able to comment on the price and/or availability of illicit benzodiazepines. Among these participants, the majority of participants (43%; n=6) had used Valium® in the preceding six months, followed by generic Diazepam (21%; n=3). The median purchase price for one diazepam pill was \$2 (range: \$1–\$10; n=9), and the median price paid for alprazolam, per pill, was \$10 (range: \$10–\$10; n=2).

Fourteen participants were able to comment on whether the price of illicit benzodiazepines had changed in the six months prior to interview. Nine participants (64%) reported that the price had remained 'stable' and five participants reported that the price had 'increased' (36%). Comparisons were not made with 2015 due to small numbers.

With regards to the current availability of street benzodiazepines, 62% (n=8) of those who commented said that it was 'very easy' (8%) to 'easy' (54%) to obtain. Five participants reported that it was 'difficult' to obtain (39%). When asked whether availability had changed over the preceding six months, the majority of those commenting (54%; n=7) reported that it had remained 'stable', whilst 39% (n=5) reported that it had become 'more difficult' to access. One participant reported that it had become 'easier' to obtain.

Among those that had recently bought illicit benzodiazepines, 50% of participants reported purchasing from 'friends' (n=6) and one-third of participants had purchased from 'known dealers' (n=4). Furthermore, one-third of participants reported that the venue they had usually obtained illicit benzodiazepines from was a 'friend's home' (n=4), followed by 'home delivery' and an 'agreed public location' (n=3; 25% respectively). Two participants reported purchasing illicit benzodiazepines from a 'dealer's home'.

5.6 Other drugs

The number of participants who answered questions relating to cocaine, ecstasy, hallucinogens, Oxycodone, illicit buprenorphine (Subutex®), illicit buprenorphine-naloxone (Suboxone®), illicit methadone, illicit antidepressants, illicit antipsychotics, illicit pharmaceutical stimulants, steroids and fentanyl markets were extremely low (n ≤10). Data from these sections will not be presented.

6 HEALTH-RELATED TRENDS ASSOCIATED WITH DRUG USE

Key Findings

Overdose and Drug-Related Fatalities

- Four participants reported overdosing on heroin in the previous 12 months (n=10 in 2015) and one participant had overdosed in the past month.

Drug Treatment

- Thirty-three percent of the SA IDRS sample reported being in drug treatment at the time of interview, and they had been in treatment for a median of 36 months. The predominant form of treatment being received was maintenance pharmacotherapy treatment. Specifically, 21% reported being on a methadone program, and 8% reported being on a buprenorphine or buprenorphine/naloxone program.

- Nine percent of the sample reported a hospital admission for methamphetamine psychosis on a median of one occasion in the past year. Five percent of the sample reported admission to hospital for other methamphetamine related issues on a median of three occasions.

- Sixteen percent of participants had tried to access treatment over the preceding six months but were unable to. Thirty-one percent had tried to access treatment for methamphetamine use and 25% had tried to access treatment for heroin use.

Health Service Use

- Telephone calls to ADIS decreased for alcohol and opioids and increased slightly for amphetamines, though calls regarding cannabis remained relatively stable. Cocaine and ecstasy related calls continued to remain very low.

- Consistent with 2015 reports, alcohol continues to dominate as the primary drug of concern for the largest proportion of total clients to DASSA treatment services, followed by amphetamines, cannabis, opioid analgesics and heroin. Both ecstasy and cocaine accounted for only a very small fraction of the total attendances.

- The substances most commonly involved in a primary diagnosis for SA drug-related hospital admissions were opioids (heroin, morphine, methadone etc.), followed by amphetamines, cannabis and cocaine.

- Drug-related attendances to the Royal Adelaide Hospital (RAH) emergency department were largely alcohol-related, consistent with previous years. Of the illicit drugs, amphetamines accounted for the largest number of drug-related attendances, followed by heroin.

Opioid and Stimulant Dependence

- Of those who recently used a stimulant drug and commented (n=79) (mainly methamphetamine), the median SDS score was four, with 51% scoring four or above, indicative of methamphetamine dependence.

- Of those who recently used an opioid drug and commented (n=60) and median SDS score was six, with 61% scoring five or above, indicative of opioid dependence.

Mental Health

- Almost half of the sample (49%) self-reported mental health problems in the six months preceding interview. Among those who had suffered from a mental health problem, depression and anxiety continued to be the most commonly reported disorders.

- Among those who had recently experienced a mental health problem, 65% reported that they had attended a professional for such problems.

- Fifty-nine percent of the IDRS sample was assessed as having high to very high levels of psychological distress, much higher than general population norms (10%).

Alcohol Use Disorders Identification Test

- Forty-five percent of males and 65% of females scored 5 or more on the AUDIT-C, indicating a need for further assessment.

Naloxone Program and Distribution

- Seventy percent of the sample had heard of naloxone, which was substantially lower than what was reported in the national IDRS survey (86%). Among those who had heard of naloxone, two-thirds reported that naloxone was used to 'reverse heroin'; and 35% believed that it was used to 're-establish consciousness'.

- The majority (79%) reported that they had not heard of the take-home naloxone program, which is not surprising as although naloxone was available OTC at the time of interview, a take-home naloxone program had not yet been implemented in SA.

- Three participants reported that they had completed training in naloxone administration. Of the three participants who had completed the course, one participant had used the naloxone to resuscitate one person who had overdosed.

- Six participants reported that they had heard about the rescheduling of naloxone.

- Twenty-seven percent of the sample believed that naloxone OTC should be free and cost \$0. No participants reported that they had been resuscitated with naloxone which was obtained OTC at a pharmacy.

- Ninety-five percent of those who commented reported that they would stay with someone after giving them naloxone, 98% reported that they would administer naloxone after witnessing someone overdose, and 76% reported that they would carry naloxone on their person.

6.1 Overdose and drug-related fatalities

6.1.1 Heroin and other opioids

6.1.1.1 Non-fatal overdose

Of the seventy-one participants who reported lifetime use of heroin, thirty (44%) participants reported that they had overdosed on heroin on a median of two occasions (range: 1–20 occasions). In 2016, 43% reported that they had overdosed twice in their lifetime (n=13; 43%), which was a significant increase from 2015 (p<0.01) and significantly fewer participants reported overdosing once in their lifetime (p<0.05) (see Table 31).

Table 31: Lifetime experience of heroin overdose*, 2012–2016

Heroin overdose variable	2012 (n=34)	2013 (n=36)	2014 (n=30)	2015 (n=30)	2016 (n=30)
Overdosed once (%)	35	53	40	37	10
Overdosed twice (%)	21	22	30	10	43
Overdosed 3 times or more (%)	44	25	30	53	47

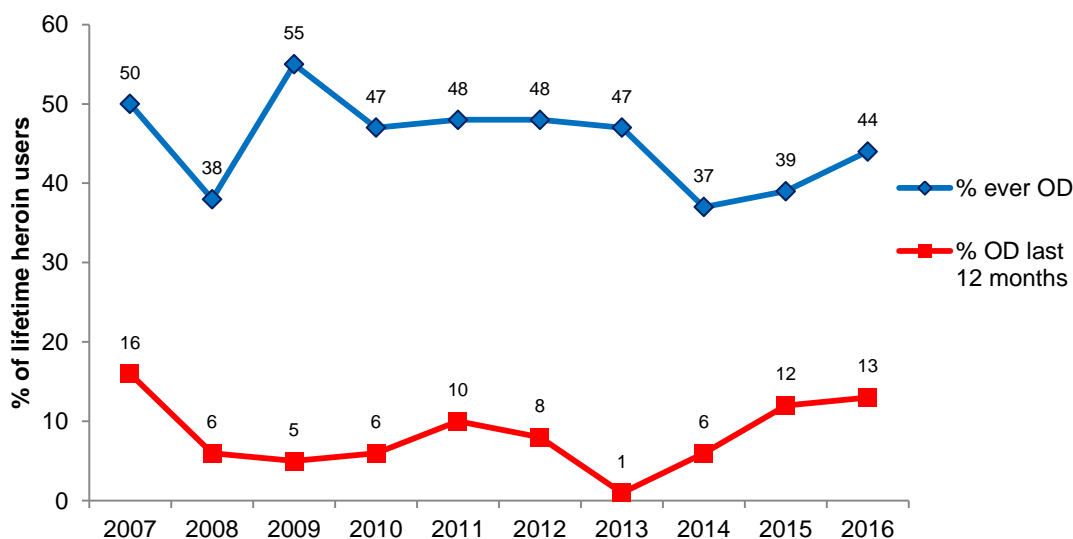
Source: IDRS participant interviews.

*Of those who had ever overdosed on heroin.

Among participants who had ever overdosed on heroin, 13% (n=4) had done so in the past 12 months and one participant (3%) had overdosed in the past month.

Long-term trends in the experience of lifetime and past 12 month overdose, among those who had ever used heroin, is depicted in Figure 21. As can be seen, heroin overdoses in the past 12 months declined in 2008 and remained fairly low and stable until 2012. A decline in overdoses was noted again in 2013 and the number of overdoses doubled from 2014 to 2015, and remained stable in 2016.

Figure 21: Experience of lifetime and past 12 month heroin overdose, as a proportion of participants that had ever used heroin, 2007–2016



Source: IDRS Participant interviews.

Participants were also asked about the treatment they received following a recent (past year) heroin overdose. Four participants commented; two participants had an ambulance attend, two participants received Narcan® and one participant attended the hospital emergency department.

Participants were also asked about the treatment or information they received following their most recent heroin overdose. Of the four participants who commented, three participants did not receive any information or treatment after the recent overdose, and one participant received information from a generalist health service.

6.1.1.2 Fatal opioid overdose

The Australian Bureau of Statistics (ABS) collates and manages the national causes of death database, utilising information from the National Coronial Information System (NCIS). Prior to 2003, ABS staff visited coronial offices to manually update information about the cause of death for records that had not yet been loaded onto the NCIS. Since 2003, the ABS has progressively ceased visiting jurisdictional coronial offices, therefore ceasing manual updates of deaths that were not already included on the NCIS.

In 2006, the ABS relied solely on the data contained on the NCIS at the time the ABS ceased processing the deaths data. Since 2007, the causes of death data have been subject to a revisions process. The preliminary data is released and then two successive revisions are released 12 months apart from the date of the release of preliminary data. The 2006 data were not subject to this revision process, and are therefore likely to be incomplete. This is likely to result in an underestimate of the

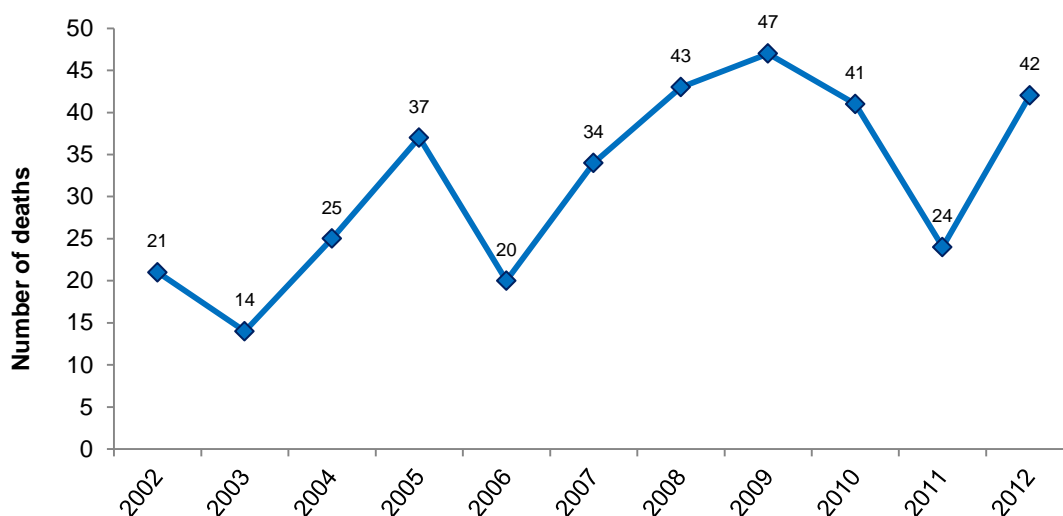
number of opioid induced deaths recorded in 2006. We have tried to offset this underestimate by analysing the changes between preliminary and final findings for both 2007 and 2008. We have averaged the changes across both years, and applied it to the 2006 figures. This data should be interpreted with caution.

Data for the years 2007–2010 represent the second and final revision of each dataset, and are therefore methodologically comparable. Again these data should be interpreted with caution as figures may change. The result of the revisions process is a longer time from the reporting of a death to finalisation by the coroner. These revisions will most likely result in an increase in the number of deaths. This is particularly true for deaths that are drug related, as coronial investigations can be complex and lengthy in nature.

The ABS has implemented a number of additional strategies, including examination of death certificates and coroners reports, to ensure that as many of the deaths as possible have a cause of death coded at the time the data file is closed.

In 2012, there were 564 accidental deaths due to opioids at a national level (617 in 2011). Most of these deaths occurred in New South Wales (n=157) and Queensland (n=128), with 42 deaths being recorded in SA (7% of the total number of deaths). This reflected an increase from 2011, in which SA recorded 24 deaths due to accidental opioid overdose (see Figure 22). It should be noted that the deaths reported are opioid-related and not necessarily heroin overdose deaths. Note that 2012 has the most recent available data.

Figure 22: Number of accidental deaths due to opioids among those aged 15-54 years in SA, 2002–2012



Source: ABS causes of death data (Roxburgh and Breen 2016).

Note: The 2006 data will be underestimated and not necessarily reflective of a downward trend (given that enhanced methodology was not introduced until 2007); the 2007-2010 data are the final figures after two revisions.

6.1.1.3 Accidental overdose (other drugs)

Participants were asked to specify how many times they had accidentally overdosed on any other drug (excluding heroin, morphine, methadone or oxycodone), how long since that had happened, and which drugs were involved. Thirty-four percent (n=34) reported that they had accidentally overdosed on another drug within their lifetime, and they had done so on a median of eighteen occasions (range: 0–180 occasions). Of these, sixteen participants had overdosed in the past 12 months, and six participants had overdosed in the last month.

6.2 Drug treatment

6.2.1 IDRS participant survey

As mentioned in section 3.1, thirty-three percent of the sample was in drug treatment at the time of the interview, with the majority of participants in maintenance pharmacotherapy treatment. Participants interviewed for the IDRS who were currently in treatment (33%) were asked a number of questions about their treatment. Participants reported a median of 36 months (ranging from one month to 20 years) in any current treatment. Those in current methadone treatment (21% of the sample) reported a median of 48 months (ranging from three months to 20 years). Seven percent of the sample reported current buprenorphine-naloxone treatment, 1% buprenorphine and 3% reported drug counselling.

Participants were asked 'What forms of treatment have you been in over the last six months?' Of those participants who commented (n=16); eight participants reported previous methadone syrup treatment; four participants reported drug counselling; two participants reported detoxification, buprenorphine-naloxone treatment and other unspecified treatment, respectively; and one participant reported buprenorphine treatment and therapeutic community, respectively.

In 2016, participants were specifically asked about opioid and methamphetamine treatment in the past year. One-third of the IDRS sample had been on opioid substitution treatment for their opioid use in the past year. The median number of times this group had started opioid treatment in the past year was one (range: 1–3 times).

Among those who commented (n=8), the median number of times methamphetamine treatment was started at a drug treatment centre in the past year was one (range: 1–2 times). Nine percent of the sample (n=9) reported a hospital admission for methamphetamine psychosis on a median of one occasion (range: 1–3 times) in the past year, and five percent of the sample (n=5) reported admission to hospital for other methamphetamine related issues on a median of three occasions (range: 1–5 times) in the past year.

In 2016, 16% of participants had tried to access treatment over the preceding six months but were unable to. Thirty-one percent (n=5) had tried to access treatment for methamphetamine use, and 25% (n=4) had tried to access treatment for heroin use. Participants attempted to access a range of services including: a general practitioner (GP) (n=9), rehab/therapeutic community (n=6), a counsellor (n=4), a psychologist (n=4), a psychiatrist (n=4), an opioid substitution program (n=3), an opioid substitution prescribing doctor (n=1), rehab/therapeutic community (n=6) and detox (n=3).

There were mixed reports regarding the availability of treatment. One-third of those who commented (33%) reported that it was 'easy' to get into treatment at the moment, 24% reported that it was 'difficult', 11% 'very difficult', 7% 'very easy' and 26% did not know.

6.2.2 Treatment services

The following drug treatment data for SA comes from two sources: telephone calls to ADIS and DASSA. In order to provide a clearer picture of trends in the number of individuals seeking treatment for various illicit substances, DASSA data will be presented in terms of clients per drug type. For information regarding episodes of treatment per drug type – which gives a more accurate measure of demand, or total load, on treatment services – the reader is directed to the Alcohol and Other Drugs

Treatment Services report (Australian Institute of Health and Welfare 2015). This report details findings from DASSA and other non-government treatment agencies in SA.

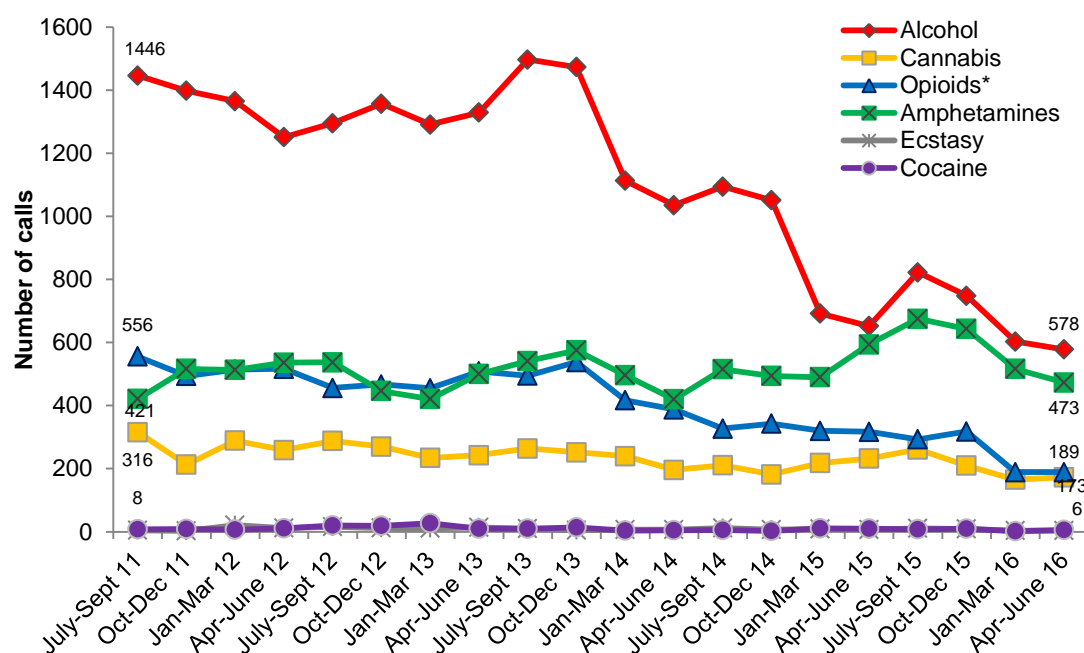
6.2.3 Heroin and other opioids

6.2.3.1 Treatment services – ADIS

Telephone calls to ADIS regarding any opioid substance accounted for 9.4% of the total coded telephone contacts (drug-related) in the 2015/16 financial year (n=10,564) a slight decrease from 12.5% of 10,494 calls in 2014/15. For the second time in eleven years, a breakdown of number of calls per opioid substance category (e.g. heroin, methadone) became available. Heroin was responsible for the largest number of calls in the 2015/16 period (n=240), followed closely by methadone (n=226).

Figure 23 depicts the number of opioid-related calls, per quarter, for the last five financial years compared to calls related to other drug types. It can be seen that the majority of drug-related calls to SA ADIS across the time period depicted have been alcohol-related, though the number of alcohol-related calls have been declining over the past two financial years, as have calls regarding opioids. Calls regarding amphetamines and cannabis appear to have remained relatively stable in 2015/16. Calls relating to ecstasy or cocaine have constituted less than 1% of the total coded calls to SA ADIS across all years depicted.

Figure 23: Number of drug-related calls to ADIS per quarter, by selected drug type, July 2011–June 2016



Source: SA ADIS.

* 'Opioids' includes all calls coded under the categories heroin, methadone, buprenorphine, naltrexone, opioid pharmacotherapies and other opioids.

6.2.3.2 Treatment services – DASSA

The primary drug of concern nominated by DASSA clients, as a proportion of the total number of clients, is presented in Table 32. In 2015/16, the proportion of clients nominating heroin as their primary drug of concern (5.7%) decreased quite considerably from 2014/15 (8.5%). In keeping with this, the proportion of total DASSA

clients nominating heroin as their primary drug of concern was lower than that for opioid analgesics (9.2%), cannabis (11.9%) amphetamines (25.1%) and substantially less than that for alcohol (42%).

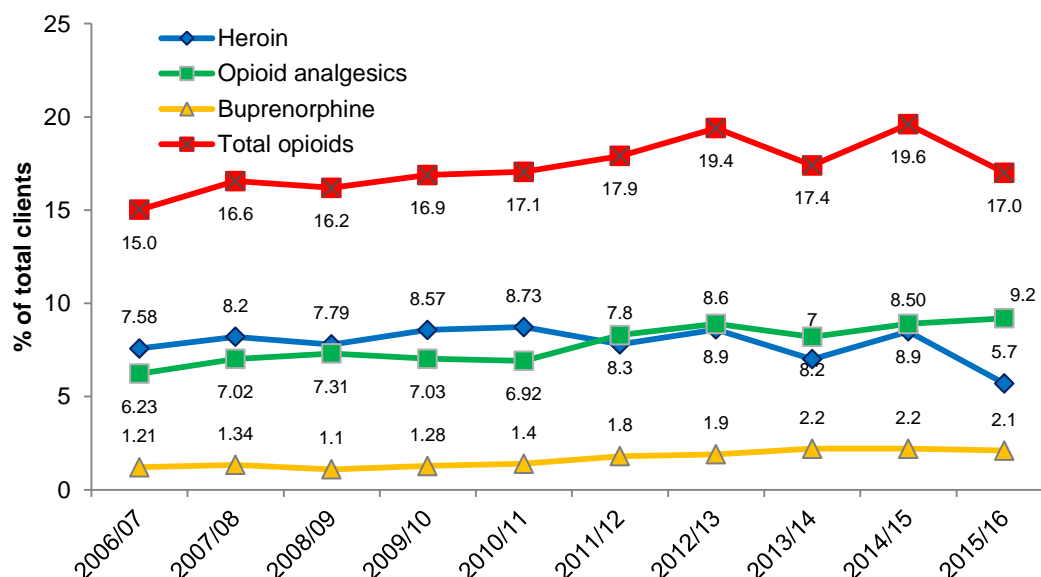
Table 32: Primary drug of concern nominated by clients of DASSA as a percentage of total number of clients, 2011/12–2015/16

Drug Type (%)	2011/12	2012/13	2013/14	2014/15	2015/16
	N=5,438	N=5,262	N=4,932	N=4,604	N=4,495
Alcohol	49.4	47.5	47.1	42.9	42
Amphetamines	19.4	19.1	18.5	21.1	25.1
Heroin	7.8	8.6	7	8.5	5.7
Opioid analgesics	8.3	8.9	8.2	8.9	9.2
Cannabis	13.9	13.9	13.3	11.6	11.9
Benzodiazepines	1.9	2	1.9	1.9	1.8
Ecstasy	0.5	0.3	0.5	0.2	0.2
Cocaine	0.2	0.2	0.2	0.2	0.1
Tobacco	0.5	0.5	0.4	0.5	0.7
Unknown	0.3	0.1	0.4	0.2	0.3
Buprenorphine/Buprenorphine Naloxone	1.8	1.9	2.2	2.2	2.1
Other	1.2	3	0.4	0.9	0.9

Source: DASSA.

Note: Total percentages for each year may not equal 100% as clients may have presented with more than one primary drug of concern within that time.

Figure 24: Percentage of total DASSA clients with opioid as the primary drug of concern, 2006/07–2015/16



Source: DASSA.

As can be seen in Figure 24, the percentage of DASSA clients nominating heroin as their primary drug of concern has remained relatively stable over the past decade, apart from a slight decrease from 7.6 in 2006/07 to a current level of 5.7. In contrast, there has been a slight but overall upward trend in those nominating opioid

analgesics as their primary drug of concern, from 6.2% in 2006/07 to 9.2% in 2015/16. The nomination of buprenorphine as a primary drug of concern has remained low and relatively stable apart from a very slight increase from 1.2 in 2006/07 to 2.1% currently. In 2015/16, the proportion of clients nominating 'any' type of opioid substance as their primary drug of concern was 17%, a visible decrease from 2014/15 (19.6%).

Table 33 depicts the number of clients (individuals) who have been admitted to DASSA's inpatient detoxification services over the last five financial years. It can be seen that attendance at these services was the most common for alcohol-related treatment, and this has remained consistent across all five years. Aside from alcohol, in 2015/16 the greatest number of clients attended inpatient detoxification services for treatment related to amphetamines, followed by cannabis. Interestingly, the number of clients attending inpatient detoxification services for amphetamines has steadily increased from 2011/12, with a substantial increase occurring in 2014/15, with the number of clients almost doubling, increasing again in 2015/16.

Table 33: Number of clients to DASSA inpatient detoxification treatment services, by primary drug of concern, 2011/12–2015/16

Drug Type	2011/12	2012/13	2013/14	2014/15	2015/16
Alcohol	494	478	511	534	544
Amphetamines	111	116	119	215	319
Heroin	74	44	46	59	48
Opioid analgesics	78	76	77	82	69
Cannabis	121	87	111	134	141
Benzodiazepines	30	26	27	16	13
Cocaine	2	5	4	6	1
Tobacco	0	0	0	0	0
Buprenorphine	18	7	9	16	10
Unknown	0	1	0	0	0
Other	10	10	15	5	2
TOTAL	896	807	867	1067	1147

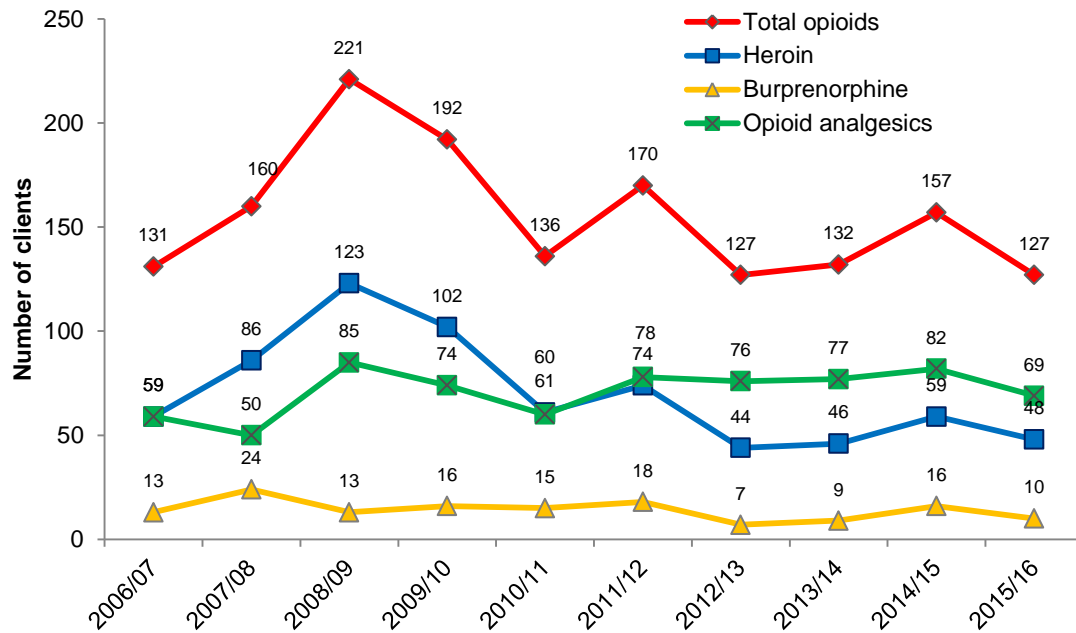
Source: DASSA.

Note: Results show the number of clients, i.e. the number of individuals who started one or more new episodes of treatment during the period; totals for each year may exceed the sum of clients per drug type as an individual client may have attended detox for more than one drug within the given year.

Figure 25 presents the number of clients admitted to DASSA's inpatient detoxification treatment services for heroin, opioid analgesics or buprenorphine, from 2006/07 to 2015/16. As can be seen, the number of clients nominating heroin as their primary drug of concern remained generally stable in 2015/16. Similarly, a slight decrease was observed in relation to the number of clients nominating opioid analgesics as their primary drug of concern (82 in 2014/15 vs. 69 in 2015/16). The number of clients nominating buprenorphine (16 in 2014/15 vs. 10 in 2015/16) as their primary drug of concern generally remained stable.

In 2015/16, the number of inpatient admissions for amphetamines (319) far and away surpassed that for heroin (48). Furthermore, when the data was analysed in terms of whether the primary drug of concern was amphetamines or *any* opioid substance (heroin or other opioid), it was found that the total number of clients entering treatment for *any* opioid substance (127) was still less than that for amphetamines (319).

Figure 25: Number of clients to DASSA inpatient detoxification treatment services per year, with heroin or other opioid as the primary drug of concern, 2006/07–2015/16



Source: DASSA.

6.2.4 Methamphetamine

6.2.4.1 Treatment services – ADIS

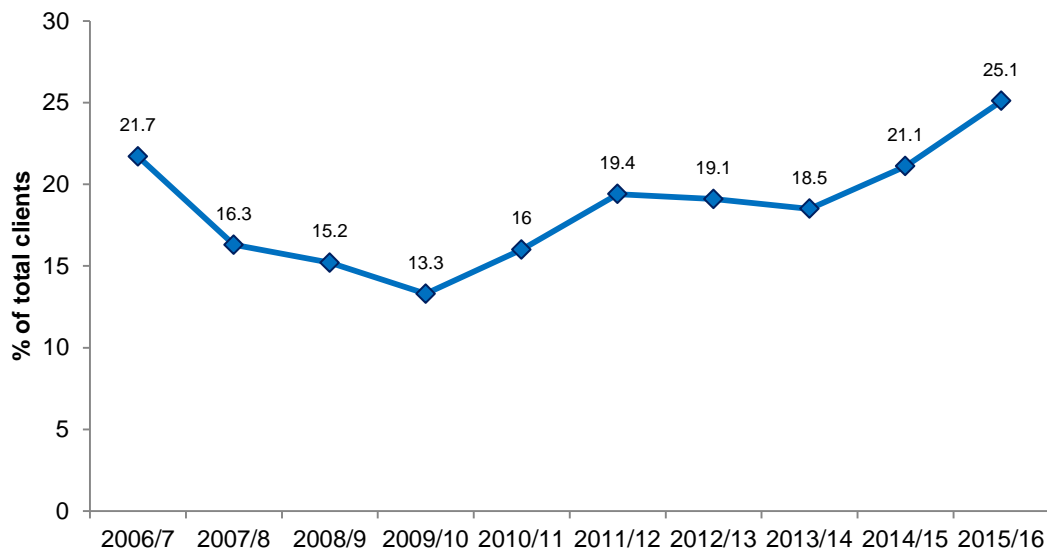
Telephone calls to ADIS regarding amphetamines accounted for 22.8% (n=2,307) of the 10,564 total drug-related calls in the 2015/16 financial year. This was a slight increase from the previous financial year (19.9% of a total 10,494 calls). Figure 22 depicts the number of amphetamine-related calls per quarter for the last five financial years compared to calls related to other drug types. As can be seen in 2015/16, calls regarding methamphetamine continued to be higher than those for cannabis and opioids. This was a contrast to the amount of calls regarding amphetamine-related substances in the year 2013/14 and prior, whereby the number of calls regarding opioids were very similar.

6.2.4.2 Treatment services – DASSA

The proportion of clients nominating amphetamines as their primary drug of concern increased in 2015/16, indicating that an upward trend originally observed from 2009/10–2011/12 (see Figure 26).

In 2015/16, amphetamines (25.1%) remained the second most commonly nominated drug of concern by DASSA clients, and ruled as the most common illicit drug of concern, more than double that of cannabis (11.9%).

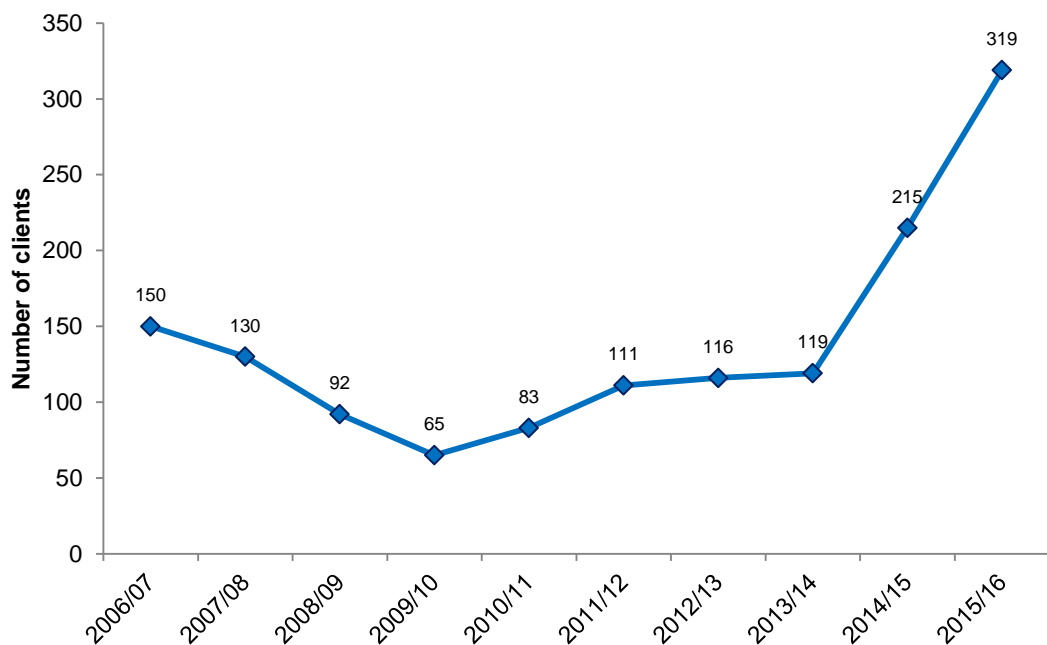
Figure 26: Percentage of total DASSA clients with amphetamines as the primary drug of concern, 2006/07–2015/16



Source: DASSA.

Figure 27 presents the number of clients attending DASSA’s inpatient detoxification treatment services for amphetamines from 2006/07 to 2015/16. The number of inpatient detoxification clients who nominated amphetamines as their primary drug of concern rose dramatically in 2014/15 and again in 2015/16, from 119 clients to 319 clients, over the two year period.

Figure 27: Number of clients to DASSA inpatient detoxification treatment services, with amphetamines as the primary drug of concern, 2006/07–2015/16



Source: DASSA.

6.2.5 Cocaine

6.2.5.1 Treatment services – ADIS

Telephone calls to ADIS regarding cocaine accounted for only 0.2% (n=26) of total drug-related telephone calls in 2015/16, stable from 2014/15 (0.3%; n = 30). Figure 22 depicts the number of cocaine-related calls per quarter for the last five financial years compared to calls related to other drug types. As can be seen, the number of calls regarding cocaine has remained consistently low over the years.

6.2.5.2 Treatment services – DASSA

The proportion of clients nominating cocaine as their primary drug of concern has remained consistently low and stable across all years reported (Table 34). Of the clients attending any DASSA treatment services in 2015/16, 0.09% (n=4 of 4,495 individuals) nominated cocaine as their primary drug of concern.

6.2.6 Cannabis

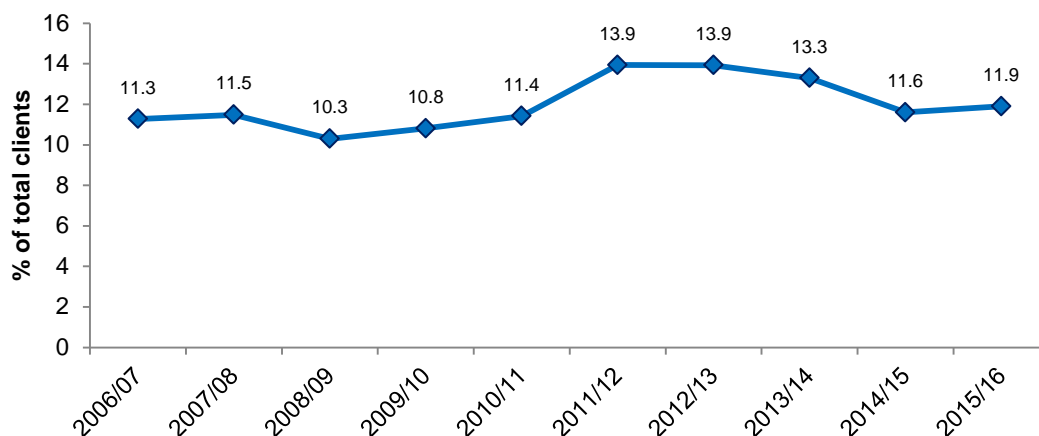
6.2.6.1 Treatment services – ADIS

Telephone calls to ADIS regarding cannabis accounted for 7.7% (n=809) of the total coded telephone contacts (drug-related) in the 2015/16 financial year (8%; n=843 in 2014/15). Figure 22 depicts the number of cannabis-related calls per quarter for the last five financial years compared to calls related to other drug types. As can be seen, the number of cannabis-related calls has remained relatively stable over the past five years.

6.2.6.2 Treatment services – DASSA

The proportion of clients nominating cannabis as their primary drug of concern remained stable in 2015/16. Of clients to all DASSA treatment services, 11.9% (n=536 of 4,495 individuals) nominated cannabis as their primary drug of concern in 2015/16 (see Figure 28). This represents a plateauing of the upward trend observed from 2008/09–2011/12.

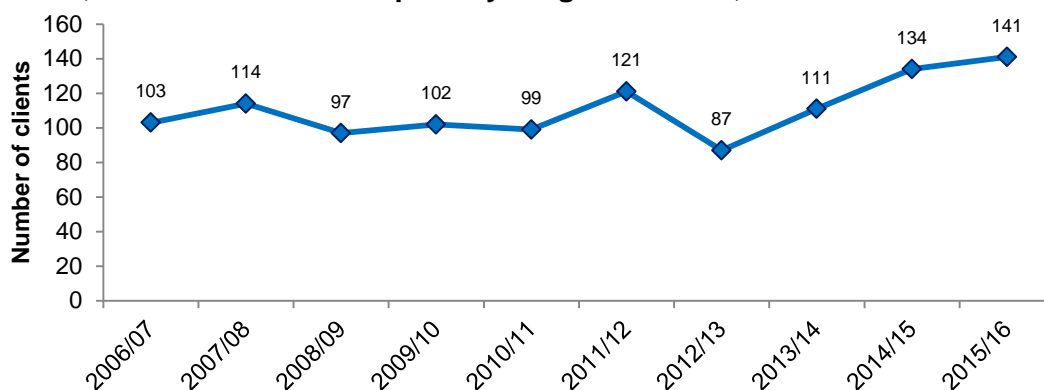
Figure 28: Percentage of total DASSA clients with cannabis as the primary drug of concern, 2006/07–2015/16



Source: DASSA.

Figure 29 presents the number of DASSA clients attending inpatient detoxification treatment services for cannabis, from 2006/07 onwards. In 2015/16, the number of cannabis-related clients attending inpatient detoxification generally remained stable at 141 (compared to 134 in 2014/15). In addition, the number of clients entering inpatient detoxification for cannabis continued to be higher than those entering treatment for heroin and all opioid analgesics combined.

Figure 29: Number of admissions to DASSA inpatient detoxification treatment services, with cannabis as the primary drug of concern, 2006/07–2015/16



Source: DASSA.

6.3 Hospital admissions

An analysis of data from the National Hospital Morbidity Dataset (NHMD) (provided by the AIHW for the period 1997/98 to 2014/15) was undertaken by NDARC. This data reports on both state-specific and national drug-related hospital admissions⁵ for the four main illicit drug classes (see Appendix 2 for national data). The data is adjusted so that all years reflect International Classification of Diseases, 9th Revision (ICD-9) classifications for comparability across this time period. Readers should note that the major impact of this adjustment is the exclusion of admissions for drug-related psychosis and withdrawal, due to incomparability between ICD-9 and International Classification of Diseases, 10th Revision (ICD-10) coding for these conditions.⁶ It should also be noted that these data lag behind other indicators by one year. At the time of printing, data was not available for 2015/2016.

The substances most commonly involved in a primary diagnosis for SA drug-related hospital admissions were opioids (heroin, morphine, methadone, etc.), followed by amphetamines, cannabis and cocaine. Ecstasy-related admissions are not specifically coded. Interestingly, SA data differed quite substantially to the trends observed at the national level (see Appendix).

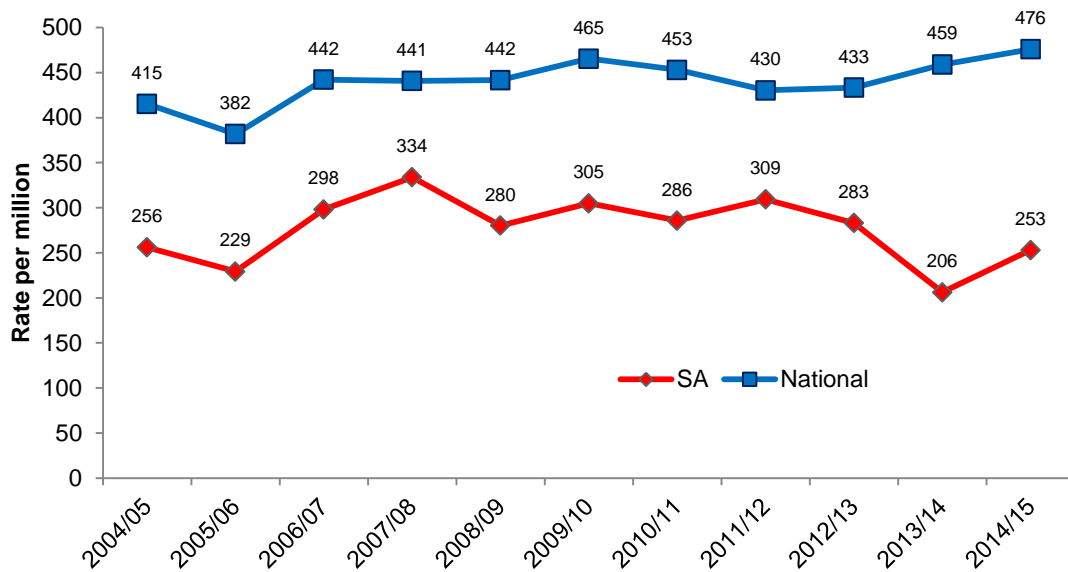
6.3.1 Opioid-related hospital admissions

Figure 30 shows the rates of opioid-related admissions from 2004/05 onwards. In 2014/15, there was a slight increase in admissions following a considerable decrease the year before; from 206 per million in 2013/14 to 253 per million. At the national level, opioid-related admissions have remained relatively stable over the past several years.

⁵ The National Hospital Morbidity Dataset includes admissions data from public and private hospitals across metropolitan, regional and remote locations.

⁶ ICD-9 coding for drug-related psychosis and withdrawal was non-specific for drug type, where ICD-10 coding is specific for drug type.

Figure 30: Rate of opioid-related admissions (primary diagnosis) to hospital in SA and nationally, per million people, 2004/05–2014/15

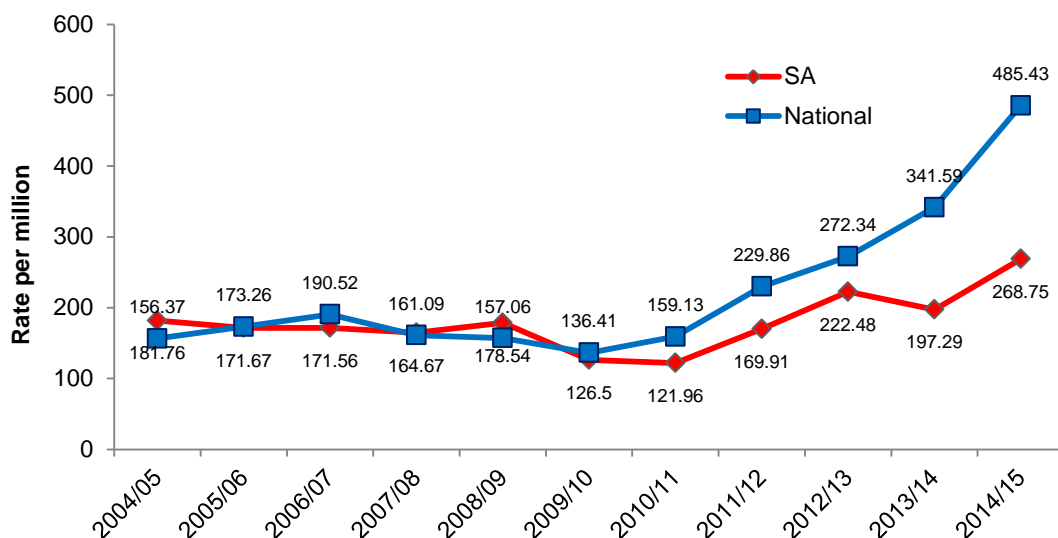


Source: Australian Institute of Health and Welfare, SA Health, (Roxburgh and Breen, 2017).
Note: Results are for persons aged between 15 and 54 years, excluding opioid withdrawal and psychosis admissions. A 'primary diagnosis' was given when opioids were considered chiefly responsible for the patient's episode of care in hospital.

6.3.2 Amphetamine-related hospital admissions

Figure 31 shows the long-term trend of amphetamine-related hospital admissions, from 2004/05 onwards. Admissions with amphetamines as a primary diagnosis increased sharply in 2014/15 at the national level; from 341 per million in 2013/14 to 485 per million. This continues an upward trend that has been observed from 2009/10 onwards. SA admissions increased slightly, from 197 per million in 2013/14 to 268 per million. Readers are reminded that this figure does not include amphetamine-related psychosis or withdrawal admissions.

Figure 31: Rate of amphetamine-related admissions (primary diagnosis) to hospital in SA and nationally, per million people, 2004/05–2014/15

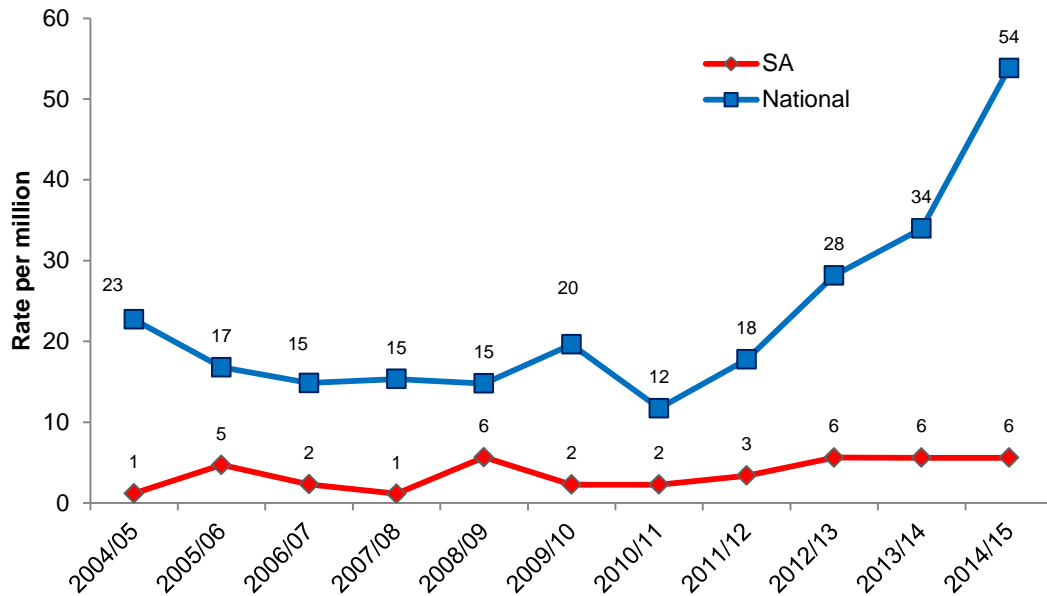


Source: Australian Institute of Health and Welfare, SA Health, (Roxburgh and Breen, 2017).
Note: Results are for persons aged between 15 and 54 years, excluding amphetamine withdrawal and psychosis admissions. A 'primary diagnosis' was given when amphetamines were considered chiefly responsible for the patient's episode of care in hospital.

6.3.3 Cocaine-related hospital admissions

Figure 32 shows the long-term trend of cocaine-related hospital admission, from 2004/05 onwards. The national rate of cocaine-related admissions has remained consistently higher than what has been observed in SA. Admissions with cocaine as a primary diagnosis continued to increase at the national level, from 34 per million in 2013/14 to 54 per million in 2014/15. Cocaine-related admissions remained stable in South Australia at 6 per million in 2014/15, consistent with 2013/14 and 2012/13.

Figure 32: Rate of cocaine-related admissions (primary diagnosis) to hospital in SA and nationally, per million people, 2004/05–2014/15

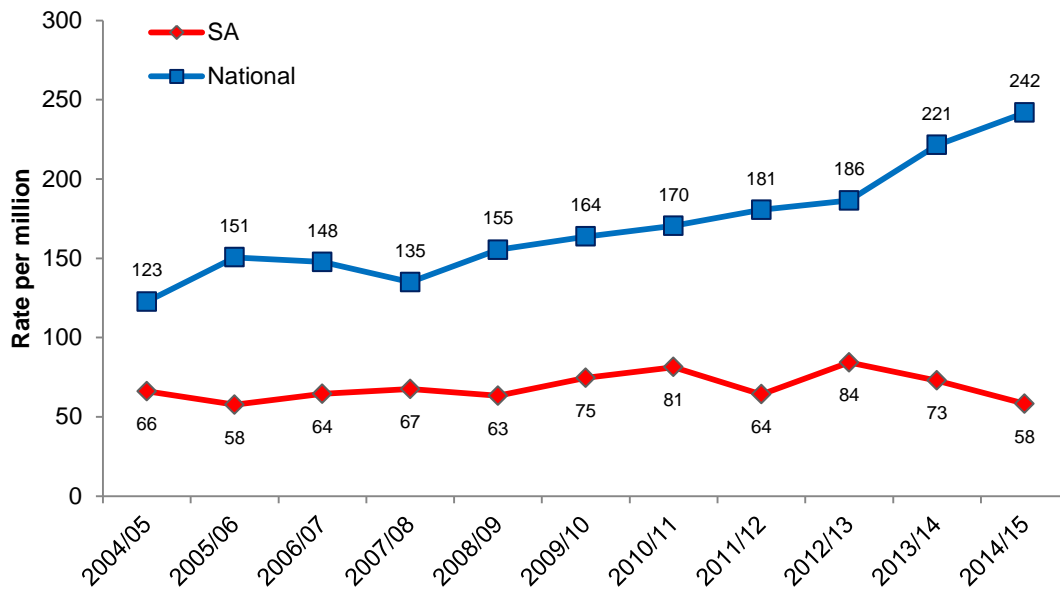


Source: Australian Institute of Health and Welfare, SA Health, (Roxburgh and Breen, 2017).
Note: For persons aged between 15 and 54 years, excluding cocaine withdrawal and psychosis admissions. A 'primary diagnosis' was given when cocaine was considered chiefly responsible for the patient's episode of care in hospital.

6.3.4 Cannabis-related hospital admissions

Figure 33 depicts the long-term trend in cannabis-related hospital admissions (primary diagnosis), both nationally and in South Australia from 2004/05 onwards. As can be seen, national rates have been trending upwards over the last decade, whilst SA rates have remained relatively stable. Interestingly, in 2014/15 the rates of admissions observed at the national level increased slightly (from 221 per million in 2013/14 to 242 per million), whilst in SA, admissions decreased slightly (from 73 per million in 2013/14 to 58 per million). Readers are reminded that this figure does not include cannabis-related psychosis or withdrawal admissions.

Figure 33: Rate of cannabis-related admissions (primary diagnosis) to hospital in SA and nationally, per million people, 2004/05–2014/15



Source: Australian Institute of Health and Welfare, SA Health, (Roxburgh and Breen, 2017).
Note: Results include persons aged between 15 and 54 years, excluding cannabis withdrawal and psychosis admissions. A 'primary diagnosis' was given when cannabis was considered chiefly responsible for the patient's episode of care in hospital.

6.4 Emergency department attendances

Information on drug-related attendances to the emergency department was provided by the RAH, the largest central public hospital in Adelaide, and is presented in Table 34. It is important to note that these data were likely to be an underestimate of drug-related emergency department presentations. Drug involvement may not always be coded accurately, and coding accuracy is also dependent on accurate self-report of those presenting. Data should be interpreted with these caveats in mind. Readers are also warned that these are 'uncleaned' data and should be interpreted with caution. They are included here to give a picture of trends over time, rather than to provide precise numbers.

It can be seen that alcohol has continued to account for the largest portion of attendances across all years, with the number of alcohol-related attendances remaining relatively stable in 2014/15, as did heroin-related attendances. Amphetamines continued to dominate as the most common illicit drug-related attendances, though the number of amphetamine-related attendances increased from 121 attendances in 2014/15 to 170 in 2015/16. The number of attendances in relation to cannabis increased slightly from 19 in 2014/15 to 28 in 2015/16.

Table 34: Number of attendances to the emergency department at the Royal Adelaide Hospital, SA, from 2007/08–2015/16 (per drug or diagnosis)

	2007/ 2008	2008/ 2009	2009/ 2010	2010/ 2011	2011/ 2012	2012/ 2013	2013/ 2014	2014/ 2015	2015/ 2016
Amphetamines	67	58	61	61	83	109	136	121	170
Cocaine	1	4	5	1	2	4	4	3	8
LSD	3	7	7	3	2	2	1	6	4
GHB	15	15	17	20	20	17	25	10	26
Alcohol	1,554	1,585	2,078	2,119	1,835	1,860	1,739	1,636	1,795
Cannabis	15	13	11	14	22	14	16	19	28
Heroin	44	66	51	66	63	55	35	51	50
Other opioids*	28	38	36	38	40	47	21	32	28
Benzodiazepines	145	151	169	162	147	117	130	135	109
Antidepressants	78	67	58	71	73	67	60	51	36
Antipsychotics	0	0	0	0	0	0	0	2	0
Drug addiction[#]	8	1	0	0	0	0	0	0	0
Drug withdrawal[#]	0	0	0	0	0	0	0	0	0
Other^{##}	528	464	480	471	439	448	446	447	450
TOTAL	2,514	2,469	2,973	3,026	2,726	2,740	2,613	2,513	2,704

Source: RAH Emergency Department.

Note: Results show attendances coded as drug- or poisoning-related.

* Includes opium, methadone, other narcotics (morphine, codeine, pethidine, etc.) and opioid withdrawal.

[#] Not otherwise specified.

^{##} Includes all other poisonings related to food, drug (medical and non-medical), chemical and other toxins.

6.5 Opioid and stimulant dependence

In 2016, the participants in the IDRS were asked questions from the Severity of Dependence Scale (SDS) for the use of stimulants and opioids. Understanding whether participants are dependent is an important predictor of harm, and provides information to complement quantity and frequency of use measures.

The SDS is a five-item questionnaire designed to measure the degree of dependence on a variety of drugs. The SDS focuses on the psychological aspects of dependence, including impaired control of drug use, and preoccupation with and anxiety about use. The SDS appears to be a reliable measure of the dependence construct. It has demonstrated good psychometric properties with heroin, cocaine, amphetamine, and methadone maintenance patients across five samples in Sydney and London (Dawe, Loxton et al. 2002).

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

Of those who had recently used a stimulant and commented (n=79), the median SDS score was four (mean 4.7, range: 0–15), with 51% scoring four or above indicative of stimulant dependence. Females reported a mean stimulant SDS score of 5.6 and than males 4.2. There was no difference regarding gender and those who scored four or above (44% females and 56% males). Of those who scored four or above (n=41), all participants attributed their responses to methamphetamine specifically.

Of those who had recently used an opioid and commented (n=60), the median SDS score was six (mean 6.0, range: 0–15), with 61% scoring five or above indicative of opioid dependence. There was no gender differences in the proportion of males (65%) and females (35%) who scored five or above. Of those who scored five or above (n=37), 60% reported specifically attributing their responses to heroin, 16% to morphine, 14% to methadone, 5% to buprenorphine, and 3% to oxycodone and 'other', respectively.

6.6 Mental and physical health problems and psychological distress

6.6.1 Self-reported mental health problems

In 2016, 49% of participants reported experiencing a mental health problem (other than drug dependence) in the six months preceding interview (51% in 2015). Among those who had experienced a mental health disorder, depression and anxiety continued to be the most commonly reported problems (see Table 35).

Table 35: Mental health problem reported by participants, 2015–2016

Mental health problem (%)	2015 (n=42)	2016 (n=49)
Depression	69	63
Mania	0	0
Manic depression	7	10
Anxiety	52	43
Phobias	2	0
Panic	17	16
Obsessive compulsive disorder (OCD)	0	0
Paranoia	12	12
Personality disorder	7	0
Drug-induced psychosis	10	16
Other psychosis	0	0
Schizophrenia	10	10
Post-traumatic stress disorder	17	0
Other	14	0

Source: IDRS participant interviews.

Note: Percentages in each column do not total 100% as participants could report more than one mental health problem.

Among those who had experienced a mental health problem in the preceding six months, 65% (n=32) reported that they had attended a professional for such problems; this was stable from 2015 (69%). Of those who reported attending a mental health professional, 78% reported visiting a GP, 34% visited a psychologist, 31% visited a psychiatrist and 18% visited a counsellor.

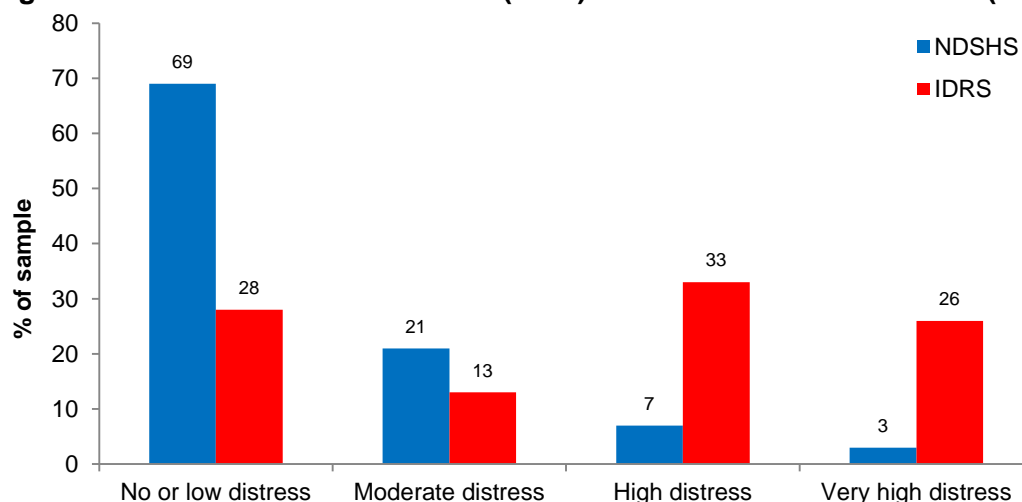
Twenty-four participants reported that they had been prescribed medication for their mental health disorder in the preceding six months; predominantly antidepressants (n=16), followed by benzodiazepines (n=14) and antipsychotics (n=10).

6.6.2 Psychological distress

The Kessler Psychological Distress Scale (K10) was also administered to participants in order to obtain a measure of psychological distress. The K10 is a 10-item standardised measure with good psychometric properties that identifies clinical levels of psychological distress as measured by the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV) and the Structured Clinical Interview for DSM disorders (SCID) (Andrews and Slade 2001; Kessler, Andrews et al. 2002). The K10 asks about the level of anxiety and depressive symptoms that a person may have experienced in the preceding four week period (Australian Institute of Health and Welfare 2014). It should be noted that the K10 does not require that individuals give reasons for the psychological distress reported in the previous month, nor whether this was an unusual or normal month for the individual.

The minimum score that can be obtained is 10 (indicating no distress) and the maximum is 50 (indicating very high psychological distress) (Andrews and Slade 2001). The 2013 National Drug Strategy Household Survey (NDSHS) (Australian Institute of Health and Welfare 2014) provided the most recent Australian population norms available for the K10, and used four categories to describe degree of distress: scores from 10–15 were considered to be low, 16–21 as moderate, 22–29 as high and 30–50 as very high. Using these categories, IDRS participants reported greater levels of high and very high distress compared to the general population (see Figure 34).

Figure 34: K10 scores in the NDSHS (2013) and the SA IDRS interviews (2016)



Source: IDRS participant interviews; (Australian Institute of Health and Welfare 2014).

Note: The extent to which cut-offs derived from population samples can be applied to the IDRS population is yet to be established and, therefore, these findings should be taken as a guide only. NDSHS findings refer to participants aged 18 and older.

Twenty-eight percent of the IDRS sample had scores between 10 and 15 on the K10 (low risk), 13% scored between 16 and 21 (moderate distress), 33% scored from 22 to 29 (high distress), and 26% scored from 30–50 (very high distress). The median total score for the sample was 23.5 (range: 10–48).

When asked to rate their health, 7% of the sample reported that their health was 'excellent', 8% reported that it was 'very good', 44% reported it as 'good', 29% said it was 'fair' and 12% reported that it was 'poor'.

6.7 Alcohol Use Disorders Identification Test

PWID are at particular risk of alcohol-related harms due to a high prevalence of the hepatitis C virus (HCV). Data from the Australian NSP Survey, annually undertaken by the Kirby Institute suggest HCV antibody prevalence is stable among PWID at between 53% and 57% over the period 2011 to 2015 (Iversen and Maher 2015). Given that the consumption of alcohol has been found to exacerbate HCV infection and to increase the risk of both non-fatal and fatal opioid overdose and depressant overdose (Darke, Ross et al. 1996; Schiff and Ozden 2004; Coffin, Tracy et al. 2007), it is important to monitor risky drinking among PWID.

The information on alcohol consumption available from the IDRS includes the prevalence of lifetime and recent use, and number of days of use over the preceding six months. Ninety-six percent of PWID had used alcohol in their lifetime, and 56% had used alcohol in the six months preceding interview, on a median of 24 days. Participants of the IDRS were asked the Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) as a valid measure of identifying heavy drinking (Bush, Kivlahan et al. 2005). The AUDIT-C is a three item measure, derived from the first three consumption questions in the AUDIT. Dawson, Grant et al. (2005) reported on the validity of the AUDIT-C, finding that it was a good indicator of alcohol dependence, alcohol use disorder and risky drinking.

In 2016, the overall mean score on the AUDIT-C was 5.3 (SD=3.3, range: 1–12). There was no significant difference between male and female scores. According to Dawson, Grant et al. (2005) and the Australian Government Department of Health's Guidelines for the Treatment of Alcohol Problems (Haber, Lintzeris et al. 2009), a cut-off score of five or more indicates the need for further assessment.

Fifty-three percent of the sample scored five or more on the AUDIT-C (42% in 2015); Forty-five percent of males and almost two-thirds of females (65%) (Table 36).

Table 36: AUDIT-C among PWID, 2015–2016

	2015 (n=81)	2016 (n=64)
Mean AUDIT-C score* (SD; range)	4.7 (3.3; 1-12)	5.3 (3.3; 1-12)
Score of 5 or more* (%)	42	53
Males	46	45
Females	35	65

Source: IDRS participant interviews.

* Amongst participants who had consumed alcohol in the past 12 months.

6.8 Naloxone program and distribution

Naloxone is a short-acting opioid antagonist that has been used for over 40 years to reverse the effects of opioids, particularly in the case of overdose. In Australia, naloxone has largely only been available for use by medical doctors (or those auspiced by medical doctors such as nurses and paramedics) for overdose response. In 2012, a take-home naloxone program commenced in the ACT through which naloxone was made available to peers and family members of people who inject drugs for the reversal of opioid overdose as part of a comprehensive overdose response package. This program was shortly followed by similar programs in NSW, VIC, and WA. In early 2016, the Australian Therapeutic Goods Administration (TGA) effectively placed 'naloxone when used for the treatment of opioid overdose' on a dual listing of Schedule 3 and Schedule 4, meaning naloxone can be purchased over-the-counter (OTC) at pharmacies without a prescription (Lenton et al., 2016) but dual listing means it is still available at reduced cost via prescription.

Since 2013, the IDRS has included a series of questions about take-home naloxone and naloxone more broadly. Of those participants in the SA IDRS sample who were able to comment in 2016 (n=100), 70% had heard of naloxone. Two-thirds of those who had heard of naloxone (n=42) reported that naloxone was used to 'reverse heroin', while 35% reported the use of naloxone to 're-establish consciousness'. Four participants said naloxone was used to 'help start breathing' and eight participants gave 'other' reasons.

Participants were then asked if they had heard about take-home naloxone programs. Of those who commented (n=100), 19% reported that they had heard of take-home naloxone programs, two participants were unsure if they had heard of the programs. The majority (79%) reported that they had not heard of the take-home naloxone program which is not surprising as although naloxone was available OTC at the time of interview, a take home naloxone program had not been implemented in SA. Two participants reported that they had been resuscitated with naloxone by somebody who had been trained through the take-home naloxone program.

Of those who commented (n=100), three participants reported that they had completed training in naloxone administration and had received a prescription for naloxone. Of the three participants who had completed the course, one participant had used the naloxone to resuscitate one person who had overdosed.

In 2016, participants were asked if they had heard about the rescheduling of naloxone (which is now available OTC without a prescription). Of those who commented (n=100), six participants had heard about the rescheduling. Participants were then asked how much they would be willing to pay OTC at a pharmacy for naloxone in a prefilled syringe with accompanying needle and instruction materials. Twenty-seven percent stated that naloxone OTC should be free and cost \$0.

Participants were then asked if they had been resuscitated with naloxone by someone who obtained naloxone OTC from a pharmacy. No participants reported that they had been resuscitated with naloxone which was obtained OTC at a pharmacy. One participant reported that they had themselves obtained naloxone OTC without a prescription from a pharmacy and this participant had resuscitated someone who had overdosed.

Participants who had not obtained naloxone OTC without a prescription from a pharmacy were asked: 'now that naloxone is available OTC would you purchase it from a pharmacy?' Of those who commented (n=99), 61% reported that they would

purchase naloxone OTC. Participants were asked if they would (a) carry naloxone on your person? (b) administer naloxone after witnessing someone overdose? and (c) stay with someone after giving them naloxone? Seventy-six per cent of those who commented (n=57) reported that they would carry the naloxone on their person, 98% reported that they would administer naloxone after witnessing someone overdose and 95% reported that they would stay after giving the naloxone.

7 RISK BEHAVIOURS

Key Findings

- Receptive sharing (borrowing) and lending of needles/syringes remained low in 2016, at 4% and 8% respectively, consistent with 2015 reports. Sharing of injecting equipment such as mixing containers (e.g. spoons), tourniquets and filters was more common (34%).
- Forty percent of the sample reported re-using their own needles in the last month (27% in 2015). Sterile needles and syringes were most commonly obtained from a NSP, although a range of other sources were also used. The majority of participants (88%) reported that they had last injected in a private home.
- Two-thirds of the sample (66%) reported experiencing an injection-related problem in the preceding month (62% in 2015). The most common problems experienced were prominent scarring/bruising around the injection site and difficulty injecting (e.g. in finding a vein), consistent with 2015 reports.
- Thirty-two percent of the sample reported injecting either a partner or friend after injecting themselves, and 24% reported that somebody else injected them after injecting themselves.
- In Australia, HCV continued to be more commonly notified than Hepatitis B (HBV), though in 2016, a decrease in both HBV and HCV infections was observed. The incidence (newly acquired) of human immunodeficiency virus (HIV) among PWID decreased to zero in 2016.
- Over half (55%) of participants had reported that they had driven a vehicle in the six months prior to interview.
- Nine percent of those who had recently driven (n=5) reported driving while over the legal alcohol limit.
- Forty-four recent drivers (80%) reported driving within three hours of taking illicit or non-prescribed drug(s) in the six months preceding interview.

7.1 Injecting risk behaviour

7.1.1 Access to needles and syringes

Participants reported that they had obtained needles and syringes on a median of two occasions in the month preceding interview (range: 0–20 occasions; n=97). In addition, the median number of new needles and syringes obtained within the preceding month was 100 (range: 0–550; n=95), with participants reporting that they had given away or sold a median of ten needles or syringes (range: 0–450; n=98). The median number of needles and syringes collected for oneself the last time they were obtained was 50 (range: 0–500; n=95) and the median number participants had stored away was 10 (range: 0–700; n=97). Seven participants reported that they had experienced difficulty in obtaining needles/syringes in the preceding month.

Participants had injected on a median of 24 days in the preceding month (range: 2–180 days; n=99), a significant increase from a median of 15 days in 2015 ($p<0.01$). The median number of needles required to successfully inject each hit was 1 (range: 1–5; n=99), though the majority of participants (90%) needed only one needle to successfully inject a hit.

In 2016, participants were also asked if they were able to access filters from the same place from which they obtained their needles and syringes. Over four-fifths (81%) of those who answered reported that they were able to obtain filters if they wanted them. The main filters comprised of wheel filters (41%), followed by cotton filters (38%) and cigarette filters (24%). Twenty-eight percent of those who commented did not know what filters they were able to access.

NSPs were by far the most common source of needles and syringes in the preceding six months (91%), followed by NSP vending machines (12%) and friends (7%). As can be seen in Table 37, a range of other sources were also used.

Table 37: Main sources of needles and syringes in the preceding six months, 2016

Accessing from (%)	2016 (n=100)
NSP	91
NSP vending machine	12
Chemist	4
Partner	3
Friend	7
Dealer	5
Hospital	-
Outreach/peer worker	-

Source: IDRS participant interviews.

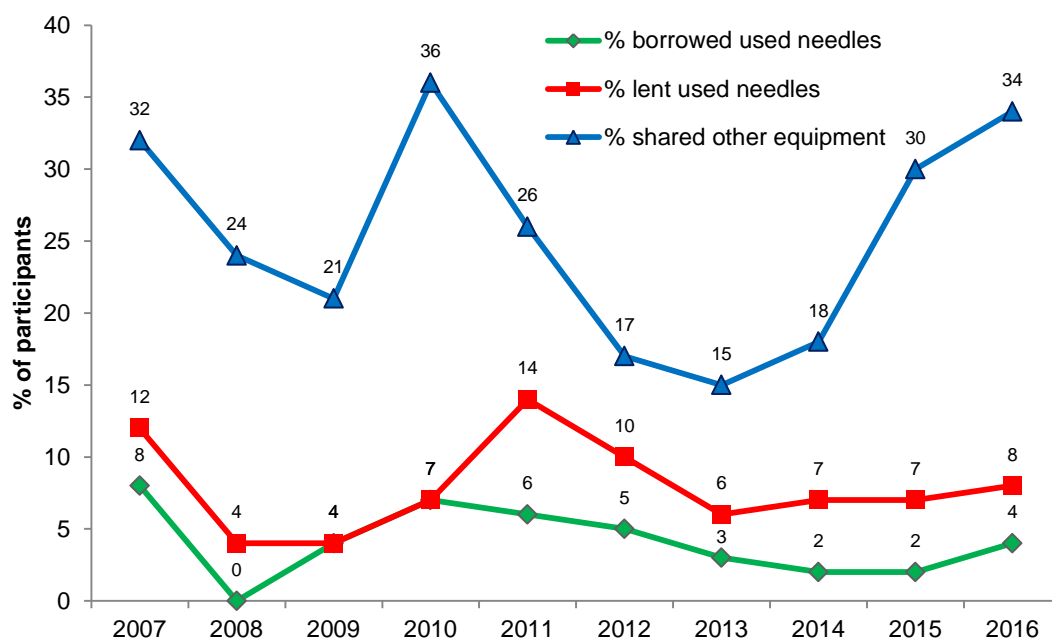
Note: Multiple responses allowed.

7.1.2 Sharing of injecting equipment

The sharing of injecting equipment remains an issue of concern due to the risk of transmission of blood-borne viral infections (BBVI) such as HIV and HCV. In 2016, four participants reported that they had used a needle *after* someone else ('borrowed'). This was stable from 2015 (n=2). In comparison, eight participants reported that they had used a needle *before* someone else in the month prior to interview (i.e. 'lent'). This was stable from 2015 (n=7) (see Figure 35). Participants who had used a needle after someone else in the last month (n=4) had typically used after a regular partner (n=2) or a casual sex partner (n=2).

Under one-third (32%) of the sample reported injecting either a partner or friend after injecting themselves with either a new or used needle in the last month. Less than one-quarter (24%) reported that somebody else injected them after injecting themselves with either a new or used needle in the last month.

Figure 35: Sharing of needles and injecting equipment by participants in the month preceding interview, 2007–2016



Source: IDRS participant interviews.

Thirty-four percent of the sample reported that they had shared injecting equipment other than needles and syringes in the preceding month (Table 38). As can be seen from Figure 34, the sharing of used needles remained low and relatively stable in 2016. There has been an increase in the sharing of other equipment from 2013. Spoons/mixing containers and tourniquets were the most commonly shared items in 2016 (n=15, respectively).

Table 38: Sharing of injecting equipment (other than needles) among participants who shared equipment in the month preceding interview, 2015–2016

Injecting equipment (%)	2015 (n=31)	2016 (n=34)
Spoons/mixing container	36	44
Filters	13	15
Tourniquet	39	44
Water	10	27
Swabs	0	6
Other	3	-

Source: IDRS participant interviews.

Note: Multiple responses allowed.

Forty percent of the sample had re-used their own needle in 2016 (27% in 2015). Ten participants had re-used their needle once, twenty-one participants had re-used their own needle twice, six participants re-used 3-5 times and three participants re-used their own needles 6-10 times. The most common syringe size which was used in the last month was 1ml (83%; n=81), which was also the most common syringe size re-used in the last month (33%; n=33).

7.1.3 Location of injecting

In 2016, the majority of participants reported that the last location in which they had injected drugs was a private home (88%), with very small proportions reporting use in public locations (see Table 39). The last location of injecting was unchanged compared to 2015.

Table 39: Location when last injected in the month preceding interview, 2015–2016

Location when injecting (%)	2015 (N=100)	2016 (n=98)
Private home	88	88
Street / car park / beach	0	1
Car	6	7
Public toilet	2	3
Other	2	1

Source: IDRS participant interviews.

Not surprisingly, the majority of participants reported that their last injection ‘site’ was their arm (84%) (78% in 2015), followed by their hand/wrist (8%), their neck (5%) their foot (2%) and their groin (1%).

7.1.4 Self-reported injecting-related health problems

Participants were asked if they had experienced any of six different injecting-related health problems in the last month (Table 40). In 2016, 66% of the sample reported experiencing at least one type of injection-related health problem in the month prior to interview (62% in 2015). By far the most commonly experienced problems were prominent scarring or bruising around the injection site (72%) and difficulty injecting (60%), both of which were stable with 2015 reports. The majority of participants reported that they required only one needle to successfully inject themselves (90%), five participants required two needles, three participants required three needles, and two participants reported needing five needles for their last successful injection.

Table 40: Injecting-related health problems experienced in the month preceding interview, 2015–2016

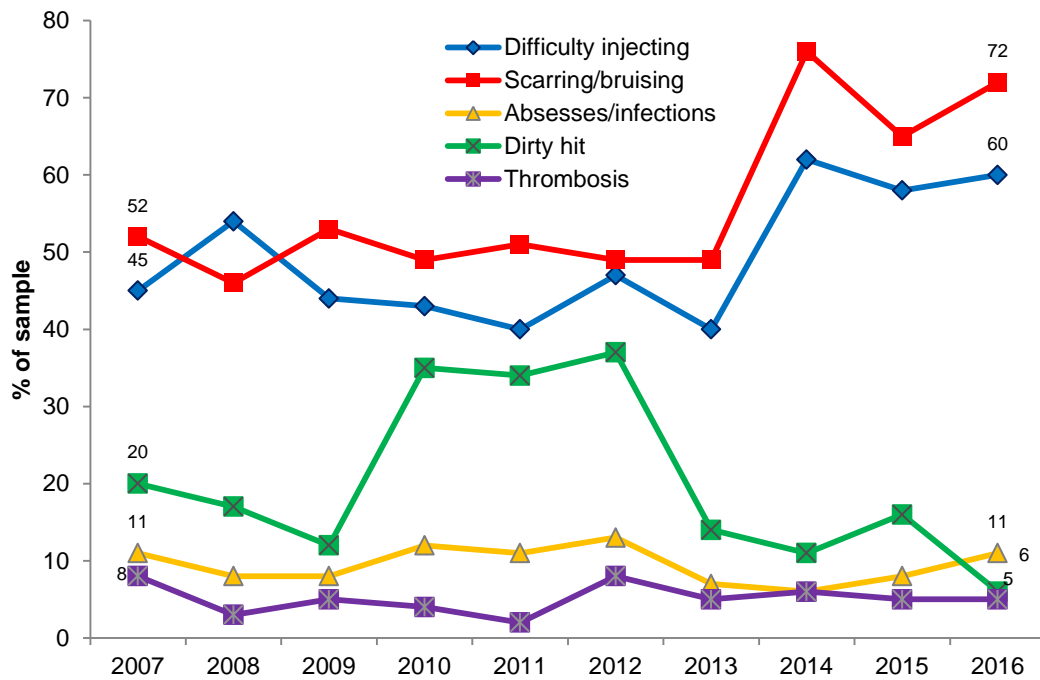
Reported injection related health problems (%)	2015 (N=100)	2016 (n=99)
Overdose	3	12
Dirty hit	16	6
Abscesses/infections	8	11
Prominent scarring/bruising	65	72
Difficulty injecting	58	60
Thrombosis	5	5
Any problems (%)	62	66

Source: IDRS participant interviews.

Among those who had experienced an overdose in the last month (n=8), six participants had overdosed on methamphetamine, one participant had overdosed on ‘other opiates’ and one participant had overdosed on heroin. Among those who had experienced a ‘dirty’ hit in the last month (n=4), three participants attributed it to methamphetamine and one participant attributed it to suboxone.

Figure 36 depicts the long-term trends for experience of injection-related problems from 2007 onwards. It can be seen that, despite some fluctuations over the years, particularly for a 'dirty' hit, prominent scarring/bruising and difficulty injecting have remained the most common across all years, while thrombosis and abscesses/infections have remained relatively low.

Figure 36: Experience of injection-related problems by participants in the month preceding interview, 2007–2016



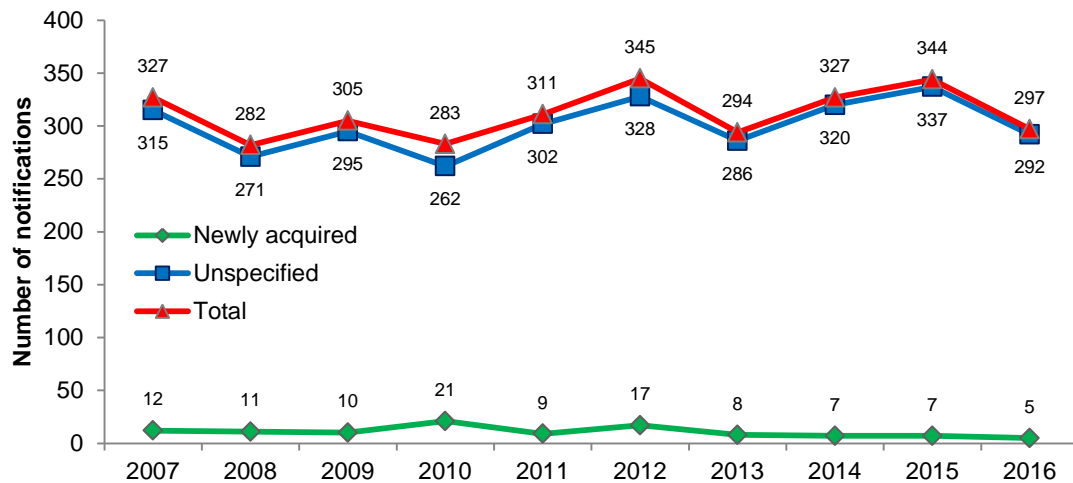
Source: IDRS participant interviews.

7.2 Blood-borne viral infections

PWID are at significantly greater risk of acquiring HBV, HCV and HIV because blood-borne viral infections (BBVI) can be transmitted via the sharing of needles, syringes and equipment.

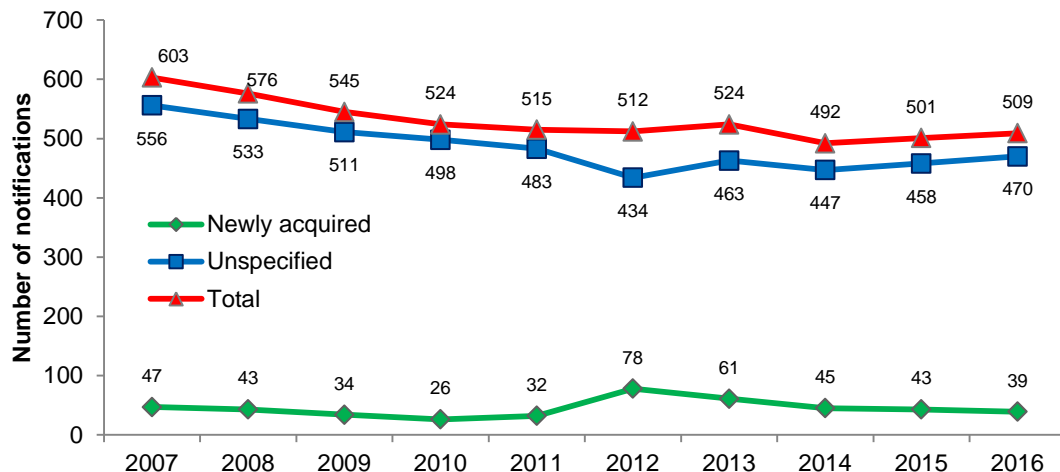
Figure 37 and Figure 38 present the total number of notifications for HBV and HCV in Australia from the Communicable Diseases Network – National Notifiable Diseases Surveillance System (NNDSS). Incident or newly acquired infections, and unspecified infections (i.e. where the timing of the disease acquisition is unknown) are presented. In 2016, HCV continued to be more commonly notified than HBV, though there were decreases in both HBV and HCV infections.

Figure 37: Notifications for HBV infections, SA, 2007–2016



Source: Communicable Disease Network – Australia - National Notifiable Diseases Surveillance System (NNDSS).
Note: Data accessed on 14th February 2017. Figures are updated on an ongoing basis.

Figure 38: Notifications for HCV infections, SA, 2007–2016

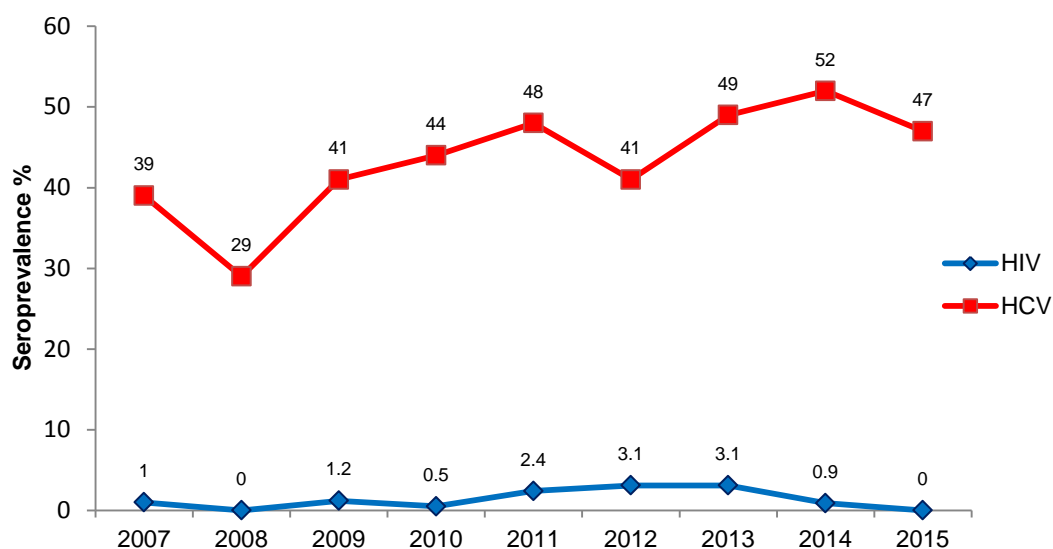


Source: Communicable Diseases Network – Australia - (NNDSS)⁷.
Note: Data accessed on 14th February 2017. Figures are updated on an ongoing basis.

⁷ Notes on interpretation: There are several caveats to the NNDSS data that need to be considered. As no personal identifiers are collected, duplication in reporting may occur if patients move from one jurisdiction to another and are notified in both. In addition, notified cases are likely to only represent a proportion of the total number of cases that occur, and this proportion may vary between diseases, between jurisdictions, and over time.

In 2015, the prevalence of HIV among PWID in Australia remained low and decreased from 0.9 to 0. HCV prevalence among this group was much higher at 47%, which was a slight decrease from 2014 (52%) (see Figure 39).

Figure 39: HIV and HCV antibody prevalence among NSP survey participants, SA, 2007–2015



Source: Australian NSP Survey (Iversen and Maher 2015)

7.3 Driving

7.3.1 Self-reported driving under the influence of alcohol and illicit drugs

Random breath testing assesses blood alcohol content, and roadside saliva drug testing looks for the presence of cannabis, methamphetamine and MDMA. Drivers undergo confirmatory laboratory testing if found to be positive. Random breath testing (RBT) for alcohol has been widely implemented in Australia for some time; saliva drug testing is becoming more common. Roadside drug testing was first introduced in South Australia in July 2006.

Fifty-five participants reported that they had driven a vehicle in the six months prior to interview ('recent drivers'). Among these participants, five participants (9%) had driven while over the legal alcohol limit and forty-four participants (80%) had driven within three hours of taking illicit or non-prescribed drug(s) in the previous six months.

8 LAW ENFORCEMENT-RELATED TRENDS ASSOCIATED WITH DRUG USE

Key Findings

- Forty-one percent reported committing ‘any crime’ in 2016, with drug dealing being the most commonly reported crime.
- The proportion of the sample who had been arrested in the preceding 12 months remained stable at 24%.
- Lifetime prison history also remained relatively stable, with 55% of the sample reporting that they had been incarcerated at some point throughout their life.
- The median expenditure on illicit drugs the day before interview was \$100, stable from 2015.

8.1 Reports of criminal activity among participants

In 2016, 41% reported involvement in any type of crime during the last month (28% in 2015). The most commonly reported types of crime remained stable from 2015, with participants primarily reporting involvement in drug dealing (29%), followed by property crime (19%), and small numbers reporting fraud (1%) and violent crime (4%). In 2016, the number of participants who reported having ever been in prison remained stable (55%; n=54).

Similarly, the proportion of participants who reported being arrested in the 12 months prior to interview also remained stable at 24% (see Table 41). Of the 24 participants who had been arrested in the preceding 12 months, six participants were arrested for property crime and six for a driving offence, four participants reported violent crime, and two reported breaching an apprehended violence order (AVO). Two participants reported being arrested for use/possession of drugs and one participant was arrested for use/possession of weapons. One participant was arrested for dealing/trafficking drugs. Other reasons for arrest included resisting arrest coupled with offensive language, and ‘aiding and abetting’.

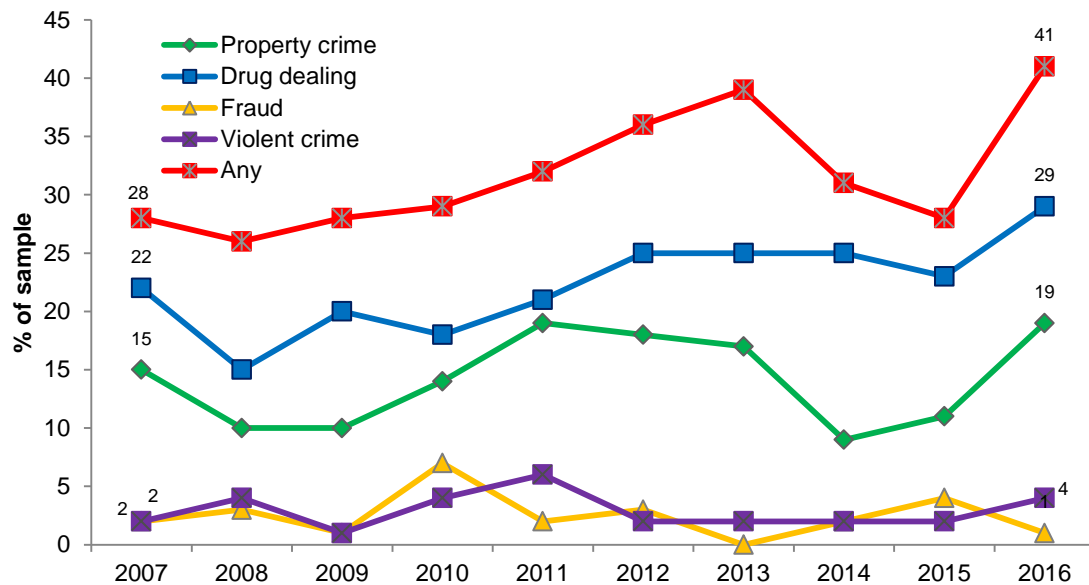
Table 41: Criminal activity as reported by participants, 2015–2016

Criminal behaviour (%)	2015 (n=97)	2016 (n=99)
Criminal activity in last month		
Property crime	11	19
Drug dealing	23	29
Fraud	4	1
Violent crime	2	4
<i>Any crime</i>	28	41
Arrested in last 12 months	25	24
Ever in prison	(n=47) 46	(n=54) 55

Source: IDRS participant interviews.

Figure 40 shows the long-term trends in criminal activity, by offence type, from 2007 onwards. From 2013, there has been a declining trend in the prevalence of ‘any’ past month criminal activity among PWID, which ended the gradual upward trend observed from 2008. However, an increase in ‘any crime’ has been observed in 2016, corresponding to increases primarily in drug dealing and property crime, the two most prominent types of criminal activity across all years. Fraud and violent crime remained consistently low.

Figure 40: Self-reported involvement in crime, by offence type, in the month prior to interview, 2007–2016



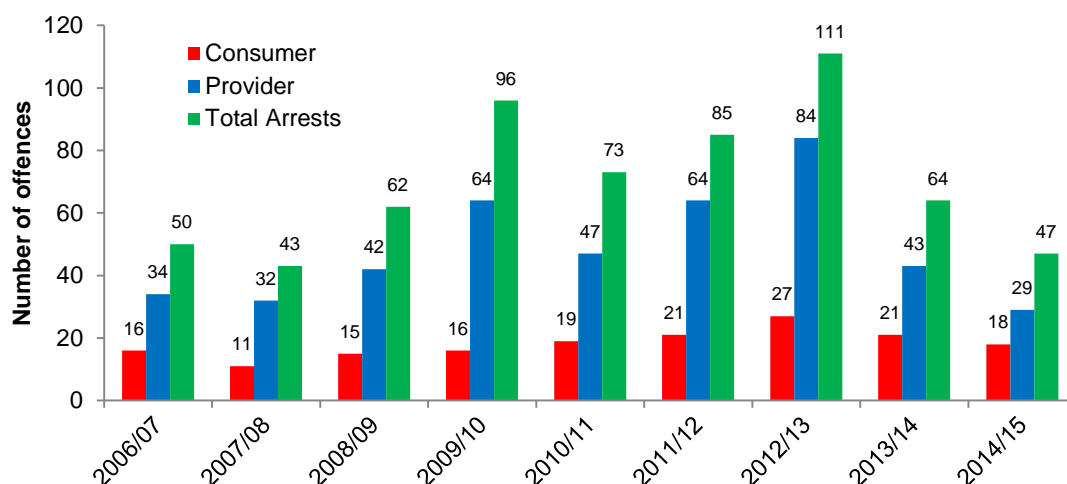
Source: IDRS participant interviews.

8.2 Arrests

8.2.1 Heroin and other opioids

presents the number of consumer and provider arrests for heroin and other opioids made in SA between 2006/07 and 2014/15. ‘Heroin and other opioids’ include opioid analgesics such as heroin, methadone and pethidine and opiate analgesics including codeine, morphine and opium. The Australian Criminal Intelligence Commission (ACIC) classifies consumers as offenders who are charged with user-type offences (e.g. possession and use of illicit drugs), whereas providers are offenders who are charged with supply-type offences (e.g. importation, trafficking, selling, manufacture or cultivation). In 2014/15, the number of consumer arrests remained relatively stable at 18, compared with 21 consumer arrests in 2013/14, yet the number of provider arrests decreased from 43 in 2013/14 to 29 in 2014/15.

Figure 41: Number of heroin and other opioid consumer and provider arrests, 2006/07–2014/15



Source: Australian Crime Commission 2007; Australian Crime Commission 2008; Australian Crime Commission 2009; Australian Crime Commission 2010; Australian Crime Commission 2011; Australian Crime Commission 2012; Australian Crime Commission 2013; Australian Crime Commission 2014; Australian Crime Commission 2015; Australian Criminal Intelligence Commission 2016.

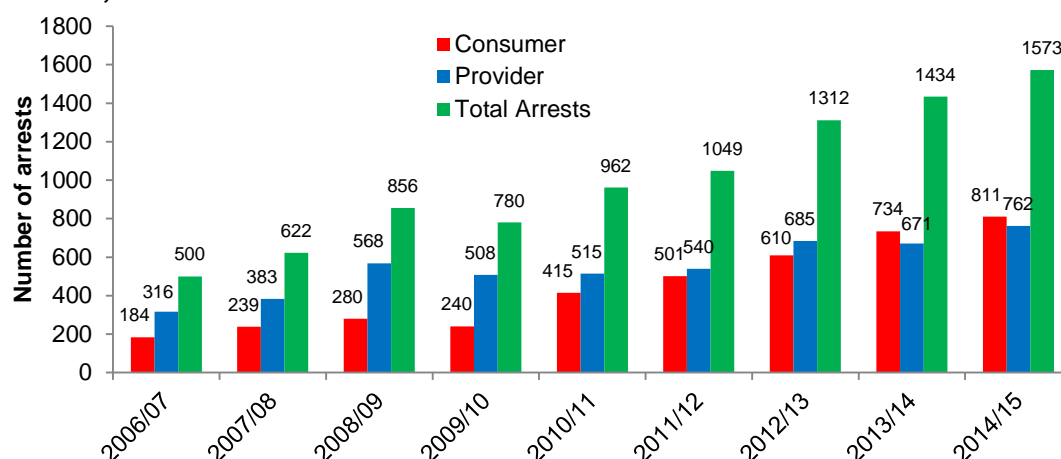
Note: Data not available for the 2015/16 financial year. Also, total arrests include those offenders for whom consumer/provider status was not stated and thus may exceed the sum of consumer and provider arrests.

Please also note that in previous reports, data from SAPOL was used for the number of illicit drug-related possession and provision offences. However, in 2012–13, SAPOL changed the way they collect their data (i.e. they no longer break the offences down by drug type) and hence the SA IDRS will now present data from the Illicit Drug Data Report (ACIC).

8.2.2 Amphetamine-type stimulants

Figure 42 presents the number of consumer and provider arrests for amphetamine-type stimulants made in SA between 2006/07 and 2014/15. Amphetamine-type stimulants include amphetamine, methamphetamine and phenethylamines. The number of total arrests increased in 2014/15 from 1,434 in 2013/14 to 1,573 arrests, continuing an overall upward trend that has been observed since 2006/07.

Figure 42: Number of amphetamine-type stimulants consumer and provider arrests, 2006/07–2014/15



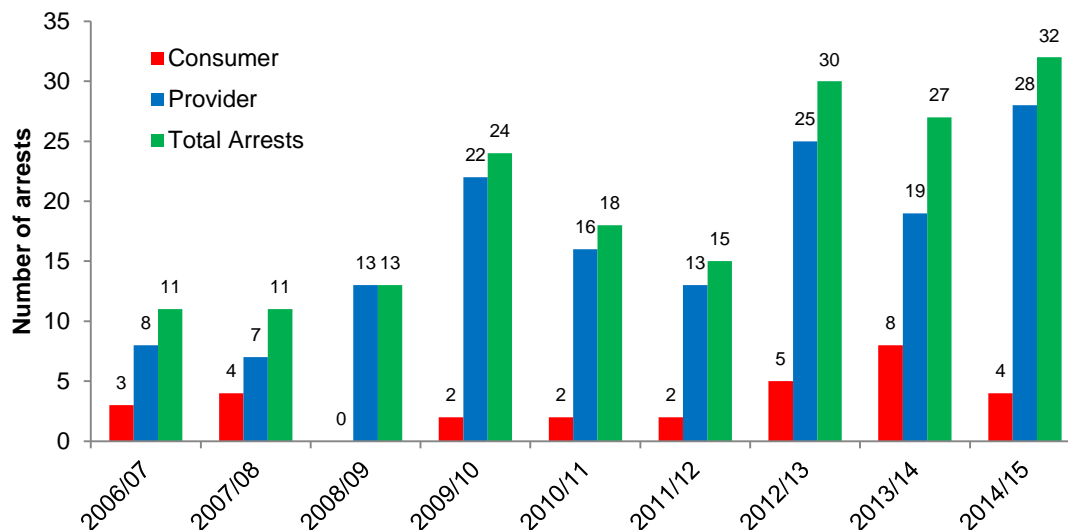
Source: Australian Crime Commission 2007; Australian Crime Commission 2008; Australian Crime Commission 2009; Australian Crime Commission 2010; Australian Crime Commission 2011; Australian Crime Commission 2012; Australian Crime Commission 2013; Australian Crime Commission 2014; Australian Crime Commission 2015; Australian Criminal Intelligence Commission 2016.

Note: Data not available for the 2015/16 financial year. Also, total arrests include those offenders for whom consumer/provider status was not stated and thus may exceed the sum of consumer and provider arrests.

8.2.3 Cocaine

In 2014/15, consumer arrests remained low at four, (eight in 2013/14). Provider arrests increased from 19 in 2013/14 to 28 in 2014/15, and the total number of cocaine-related arrests also increased from 27 to 32 (see Figure 43).

Figure 43: Number of cocaine consumer and provider arrests, 2006/07–2014/15



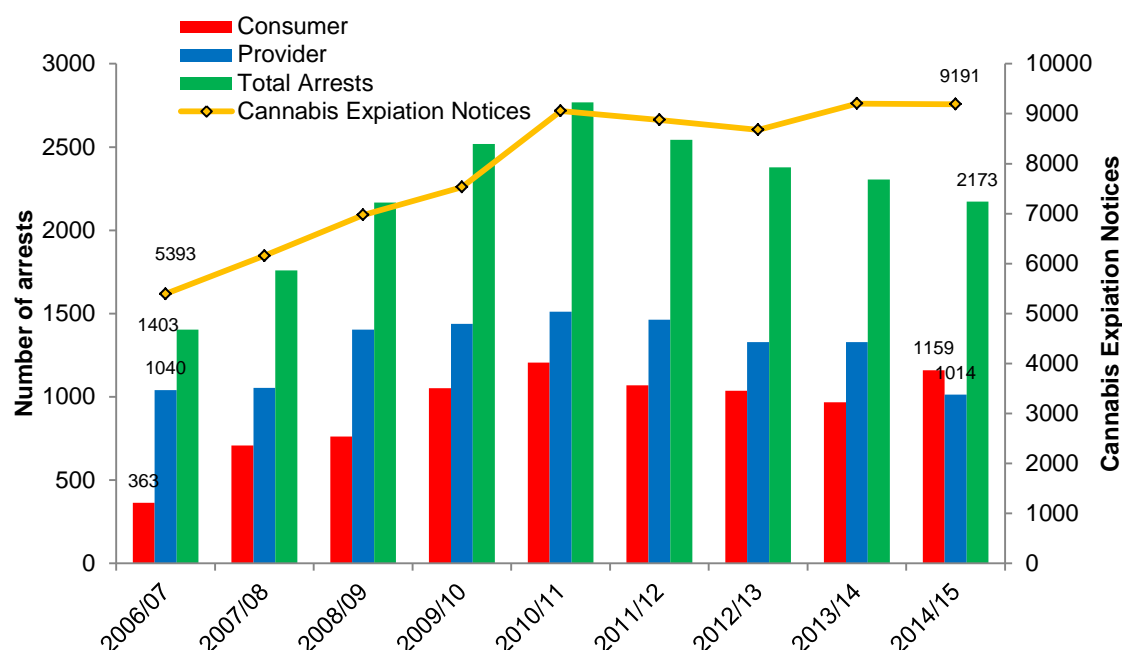
Source: Australian Crime Commission 2007; Australian Crime Commission 2008; Australian Crime Commission 2009; Australian Crime Commission 2010; Australian Crime Commission 2011; Australian Crime Commission 2012; Australian Crime Commission 2013; Australian Crime Commission 2014; Australian Crime Commission 2015; Australian Criminal Intelligence Commission 2016.

Note: Data not available for the 2015/16 financial year. Also, total arrests include those offenders for whom consumer/provider status was not stated and thus may exceed the sum of consumer and provider arrests.

8.2.4 Cannabis

Figure 44 presents the number of cannabis consumer and provider arrests in SA from 2006/07 to 2014/15. It also presents the total number of Cannabis Expiation Notices, which is a small fine used to deal with minor cannabis offences, whereby the offence is expiated on payment of the fine. In SA, a higher number of drug-specific arrests were due to consumer-type cannabis offences, which has never been the case since 2006/07. Total cannabis arrests remained relatively stable in 2014/15, yet an overall decrease has been noted since 2011/12, perhaps signifying a downward trend and thus a reversal of the upward trend observed from 2006/07–2010/11. The number of Cannabis Expiation Notices issued in SA remained stable, from 9,204 in 2013/14 to 9,191 in 2014/2015.

Figure 44: Number of cannabis consumer and provider arrests, 2006/07–2014/15



Source: Australian Crime Commission 2007; Australian Crime Commission 2008; Australian Crime Commission 2009; Australian Crime Commission 2010; Australian Crime Commission 2011; Australian Crime Commission 2012; Australian Crime Commission 2013; Australian Crime Commission 2014; Australian Crime Commission 2015; Australian Criminal Intelligence Commission 2016.
Note: Data not available for the 2014/2015 financial year. Also, total arrests include those offenders for whom consumer/provider status was not stated and thus may exceed the sum of consumer and provider arrests.

8.3 Expenditure on illicit drugs

Forty-nine participants had purchased illicit drugs on the day prior to interview. Among these participants, the median amount spent on illicit drugs was \$100 (range: \$5–\$400). This was similar to 2015 (\$100; range: \$1–\$600). Table 42 presents the breakdown of the amounts spent on illicit drugs (i.e., excluding alcohol, tobacco and licit supplies of prescription medications) by the whole sample on the day before interview.

Table 42: Expenditure on illicit drugs on the day preceding interview, 2015–2016

Expenditure (%)	2015 (n=101)	2016 (n=101)
Nothing	47	52
Less than \$20	5	2
\$20-\$49	4	8
\$50-\$99	13	11
\$100-\$199	22	16
\$200-\$399	7	10
\$400 or more	3	2
Median expenditure* (\$)	\$100	\$100

Source: IDRS participant interviews.
 *Among those who had spent money on drugs.

9 SPECIAL TOPICS OF INTEREST

9.1 Blood donations

Key Findings

- Of those who commented, 11% reported that they had given blood in their lifetime.
- Five participants who had given blood reported that they had commenced injecting drug use before donating blood.

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

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

Of those who commented, (n=99), 11% reported that they had given blood in their lifetime. Five participants that had given blood reported that they had commenced injecting drug use before donating blood. Participants were asked about their most recent episode between injection and blood donation. One participant reported that they had injected less than one month before they donated blood, two participants reported injecting between one month and one year before donating blood, and another two participants reported injecting more than one year before donating blood.

9.2 Homelessness

Key Findings

- In 2016, 79% of the sample reported a lifetime prevalence of homelessness; 6% were homeless at the time of interview.
- The mean duration of their current episode of homelessness was one year and nine months.
- The most commonly experienced forms of homelessness during both lifetime and the six months prior to interview were couch surfing and sleeping rough.

A notable proportion of people who are homeless experience higher rates of mental health disorders compared to the general population. Specifically, substance use disorders have been repeatedly recorded as the most common mental health diagnosis amongst homeless populations throughout Western countries (Fazel et al., 2008). Research examining substance use among homeless populations has been undertaken, but very few studies have looked at the relationship of homelessness among heavy substance users, including PWID. The aim of this module was to obtain information on the lifetime and recent homelessness experiences among PWID.

In 2014, the IDRS included a module on homelessness which revealed the high lifetime (79%) and current (5%) prevalence of homelessness among the SA IDRS participants. To better understand the risk factors associated with different degrees of homelessness severity, four questions from the 2014 module were repeated in 2016.

Among those who commented (N=101), the lifetime prevalence of homelessness among the 2016 SA PWID sample was 79% (Table 43). Of those PWID with a homelessness history, five participants were currently homeless at the time of interview. It is clear that the rate of homelessness among PWID is notably higher than the general Australian population estimate of 0.5% (Australian Bureau of Statistics, 2012). For those PWID who were currently homeless, the mean duration of their current episode of homelessness was reported to be one year and nine months (range: 3-37 months).

Table 43: Homelessness history among people who inject drugs, 2016

	N=101
% Lifetime homelessness history	79
% Length of time since last homeless episode*	(n=80)
Currently homeless	6
In the past six months	14
7–12 months	1
1–2 years	10
2–5 years	10
More than 5 years	59
% Total duration of homelessness over lifetime*	(n=78)
Less than six months	37
6–11 months	18
1–2 years	22
3–5 years	19
6–10 years	0
More than 10 years	4

Source: IDRS participant interviews.

* Among those with a homelessness history and commented.

Table 44 shows within the subsample of PWID with a homeless history, the proportion that have experienced various states of homelessness in their lifetimes and in the past six months. The most commonly experienced forms of homelessness during both lifetime and the past six months were couch surfing (63%; 15% respectively), sleeping rough (57%; 9% respectively), a caravan park (41%; 3% respectively) and boarding rooms/hostels (39%; 5% respectively). South Australia data from 2014 is presented for comparison with 2016 data, but no significant differences were found between the two years.

Table 44: Different forms of homelessness (lifetime & last six months), 2014, 2016

	2014 n=84	2016 n=98
% Lifetime		
Slept rough	71	57
Crisis or emergency accommodation	49	38
Medium or long term accommodation	26	15
Lived with relatives, friends or acquaintances (couch surfing)	75	63
Boarding or rooming houses or hostels (other than on holiday)	45	39
Caravan park (other than on holiday)	45	41
% Last six months		
Slept rough	6	9
Crisis or emergency accommodation	2	4
Medium or long term accommodation	6	1
Lived with relatives, friends or acquaintances (couch surfing)	10	15
Boarding or rooming houses or hostels (other than on holiday)	5	5
Caravan park (other than on holiday)	1	3

Source: IDRS participant interviews.

9.3 Unfair Treatment

Key Findings

- Sixty-eight participants reported being unfairly treated in the last 12 months, mostly by a family member (32%).
- Eight participants admitted to being unfairly treated 'daily or more'.
- Of those who commented, 30% reported that they had 'never' been unfairly treated.

Being discriminated against is a common event for people who use illicit drugs, particularly those who inject drugs. The IDRS provided an opportunity to obtain important insights into the multiple origins and impacts of unfair treatment against PWID.

The questions included in the IDRS aimed to clarify the relationships between unfair treatment, quality of life and help to inform policy and improve the quality of services. The questions also aimed to identify the location in which PWID are most likely to experience unfair treatment to help reduce future occurrences of this.

The 'Unfair Treatment' questions are based on previous 2013 IDRS questions, developed in conjunction with the Australian Injecting and Illicit Drug Users League (AIVL) (Stafford and Burns, 2014), and two validated and well-accepted scales. The personal well-being index (PWI-A) (International Wellbeing Group, 2013) has been previously used in the IDRS and was well-accepted by participants, while the DISC-12 has been used to evaluate discrimination against people with mental health disorders (Thornicroft et al., 2009).

In 2016, 53% of those who commented (n=95) reported they had been unfairly treated in the previous 12 months; 26% reported unfair treatment 'monthly', 18% 'weekly but not daily' and eight participants experienced unfair treatment 'daily or more'.

Just under one-third (30%) of those who commented (n=99) reported that they had 'never' been unfairly treated, and 18% reported that they had not experienced unfair treatment in the last 12 months.

Sixty-eight participants admitted to being treated unfairly in the last twelve months, and reported that they had been treated unfairly by family (32%), by the police (19%), when getting help for physical health problems (22%), in keeping or making friends (21%) and by people in the neighbourhood (19%). A public location and home was reported as the venues at which most of the unfair treatment occurred (21%, respectively); mainly by a family member (27%) or the general public (18%).

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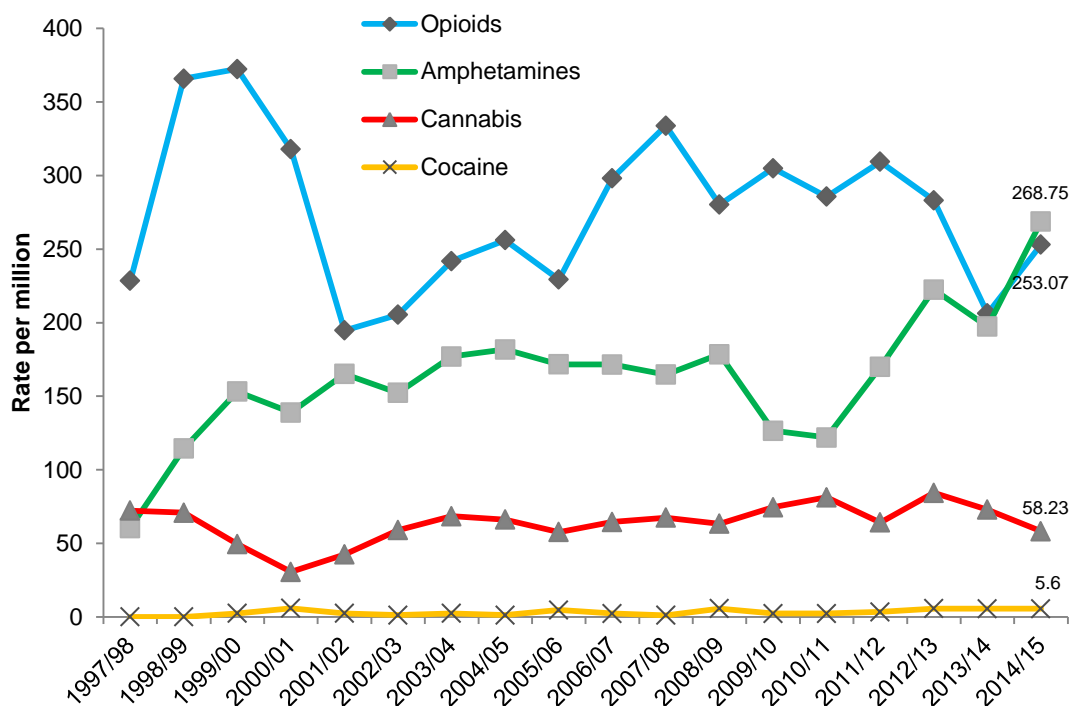
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APPENDIX: SUBSTANCE-RELATED ADMISSIONS TO HOSPITALS IN SOUTH AUSTRALIA AND AUSTRALIA

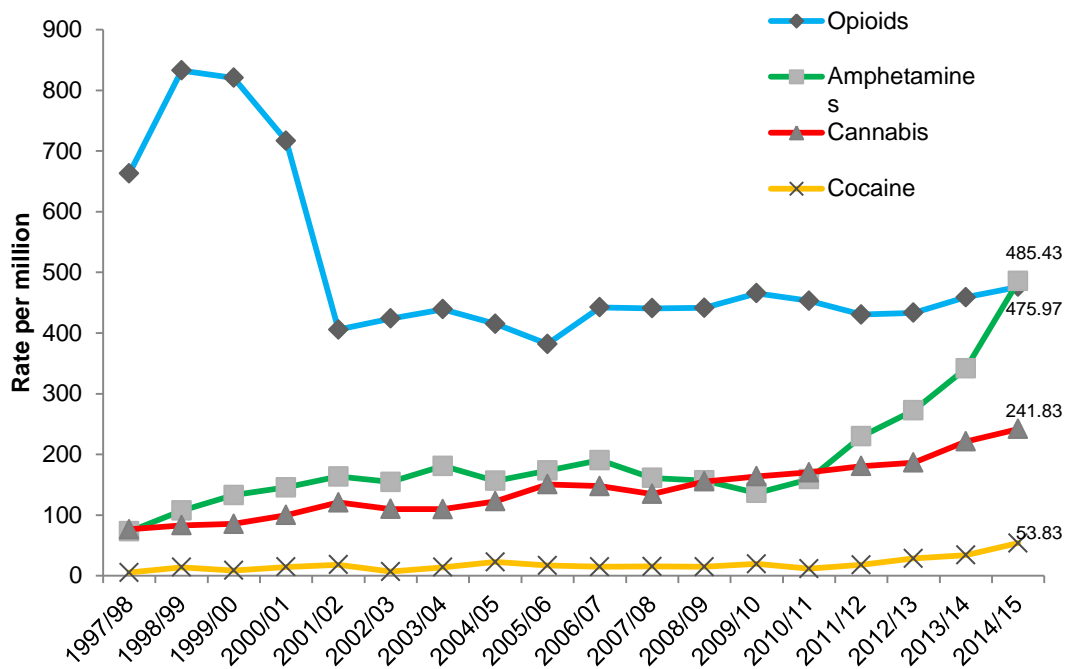
Appendix 1: Rate of substance-related admissions (primary diagnosis) to hospitals in South Australia, 1997/98–2014/15



Source: Australian Institute of Health and Welfare, SA Health (Roxburgh and Breen, 2017).

Note: Results relate to persons aged between 15 and 54 years; 'Primary diagnosis' was given to those admissions where the substance was considered the primary reason for the patient's episode of care.

Appendix 2: Rate of substance-related admissions (primary diagnosis) to hospitals in Australia, 1997/98–2014/15



Source: Australian Institute of Health and Welfare, SA Health (Roxburgh and Breen, 2017).

Note: Results relate to persons aged between 15 and 54 years; 'Primary diagnosis' was given to those admissions where the substance was considered the primary reason for the patient's episode of care.