

Drug and Alcohol Services South Australia

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Substance use and associated harms among Aboriginal
and/or Torres Strait Islander South Australians

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Substance use and associated harms among Aboriginal and/or Torres Strait Islander South Australians

Background

This Bulletin is the thirteenth in a series providing the most up-to-date data available on the prevalence of alcohol and other drug use, the harms associated with misuse, and alcohol and other drug treatment services in South Australia. This issue focuses on Aboriginal and/or Torres Strait Islander Australians¹, is an updated version of a previous bulletin², and includes revised guidelines for risky alcohol consumption³.

The information in this bulletin is taken from a number of sources. Population prevalence data were obtained from two national surveys; each carried out approximately every six years by the Australian Bureau of Statistics: the National Aboriginal and Torres Strait Islander Social Survey (NATSISS)⁴, and the Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS)⁵. Data on non-Aboriginal Australians were taken from the triennial National Health Survey (NHS)⁶. Treatment data were taken from the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS)⁷, and hospital data from principal diagnosis information in the Integrated South Australian Activity Collection (ISAAC) covering the period 2007-08 to 2015-16. More detailed information on mortality and morbidity can be found in a previous bulletin.⁸

Key findings

Tobacco

In 2014-15, 35% of Aboriginal South Australians were daily smokers, a significant decrease from 49% in 2002. This is slightly lower than the national prevalence (39%). Recent data on age and sex were only available nationally, and show that the significant decrease in daily smoking between 2002 and 2014-15 occurred among both men and women (from 51% to 41% and from 47% to 36%, respectively). South Australian data from 2012-13 are generally consistent, with 40% reporting daily smoking (42% nationally). The prevalence of smoking in 2014-15 was significantly higher among Aboriginal South Australians (35%) than non-Aboriginal South Australians (14%), although both have decreased over time. Smoking has also decreased among Aboriginal pregnant women. Smoking among Aboriginal South Australians was highest in outer regional and remote areas, and three times higher in major cities than non-Aboriginal South Australians.

Smoking prevalence is higher among Aboriginal South Australians, especially in non-metropolitan areas, although there have been decreases over time.

Alcohol

In 2014-15, 9.6% of Aboriginal South Australians consumed alcohol at levels that increased their risk of injury or disease over a lifetime, a significant decrease from 37% in 2002. Single occasion risk also decreased from 37% in 2002 to 25% in 2014-15. Results are lower than those reported nationally (15% for lifetime risk and 30% for single occasion risk). Decreases in both types of risky drinking were observed among Aboriginal men and women, but of greater magnitude among men. Although risky drinking was higher among Aboriginal South Australians, abstinence rates were also higher: 28% reported not having consumed alcohol in the last 12 months or ever, compared with 18% of non-Aboriginal South Australians.

The prevalence of risky drinking, particularly on a single occasion, is higher among Aboriginal South Australians, although there have been decreases over time, and abstinence rates are higher than among non-Aboriginal South Australians.

Illicit drugs

In 2012-13, 20% of Aboriginal South Australians used cannabis in the last 12 months, similar to 2008 (21%) and to the national prevalence (19%). This is almost double that reported among the general population (11% in 2013), and a higher percentage of men (27%) used cannabis than women (14%). Other substances were used by 10% of Aboriginal South Australians, 12% in 2008.

There is a paucity of data on illicit drug use; one-fifth of Aboriginal South Australians use cannabis.

Hospitalisations

Hospitalisation rates for alcohol in 2015-16 were much higher among Aboriginal patients (141 per 10,000 population compared with 17 among non-Aboriginal patients). Similarly, the hospitalisation rate for stimulants and cannabis was greater among Aboriginal patients (47.2 compared with 6.4 for stimulants, and 12.8 compared with 1.4 for cannabis).

Hospitalisation rates for alcohol and illicit drugs are much higher among Aboriginal patients, and the rate of hospitalisation for stimulants has increased substantially among both groups.

Treatment data

Alcohol was the most common principal drug of concern for closed treatment episodes among Aboriginal clients in South Australia in 2015-16 (46%), which was almost double the proportion among non-Aboriginal South Australian clients (24%). This was followed by amphetamines (23%) and cannabis (18%).

Alcohol is the most common primary drug of concern among Aboriginal clients, followed by amphetamines and cannabis.

Conclusions

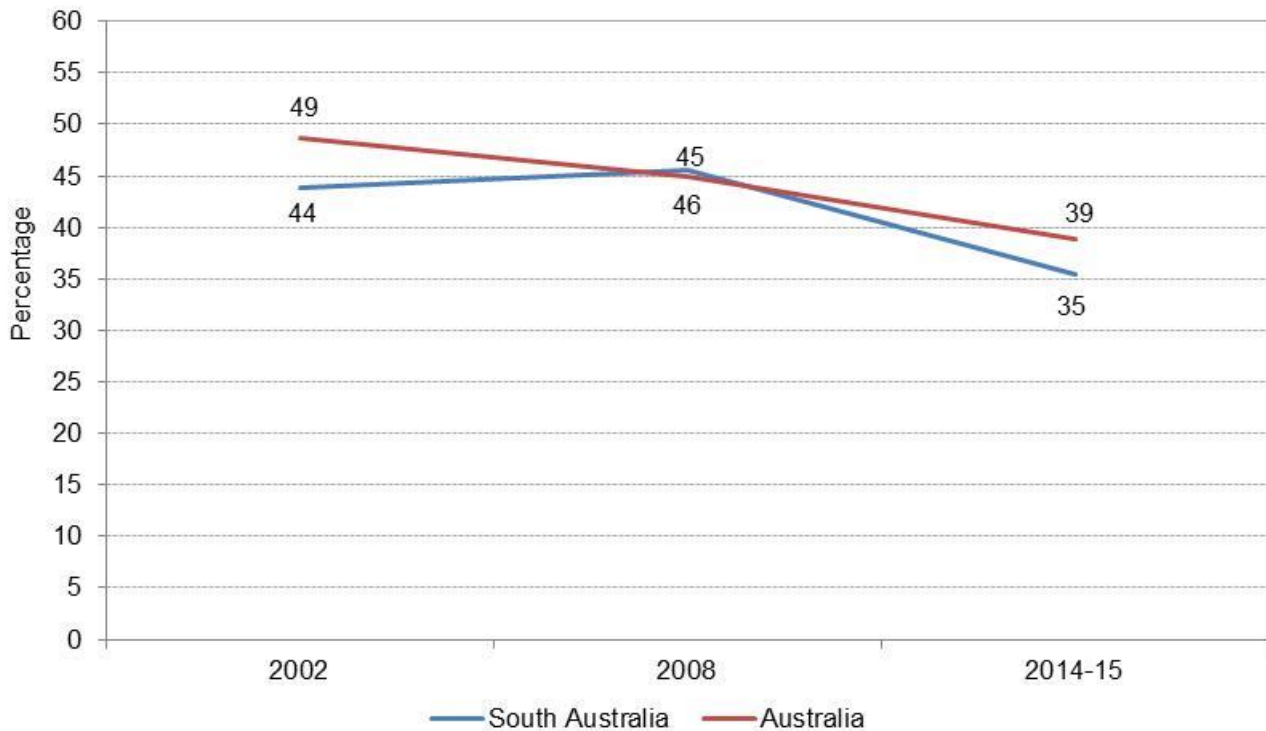
Although there is evidence that tobacco and risky alcohol consumption are decreasing, these data suggest that use among Aboriginal South Australians contributes to the greater burden of disease and injury observed when compared with non-Aboriginal South Australians, and may be indicative of broader social issues facing this population. The information provided in this bulletin may assist policy makers and health and welfare organisations in the development and implementation of appropriate services and initiatives to address the needs of Aboriginal people in South Australia.

Tobacco

Aboriginal and Torres Strait Islander Australians

Daily smoking decreased significantly between 2002 and 2014-15, from 49% to 39% in Australia, and from 44% to 35% in South Australia (see Figure 1). Daily smoking in South Australia was also lower than in all other jurisdictions: the highest rates were in the Northern Territory (45%) and Western Australia (42%), followed by NSW, Victoria and QLD (38%) and the ACT and Tasmania (37%).

Figure 1: Percentage of daily smokers among Aboriginal South Australians and Australians aged 15 years and over, 2002 to 2014-15

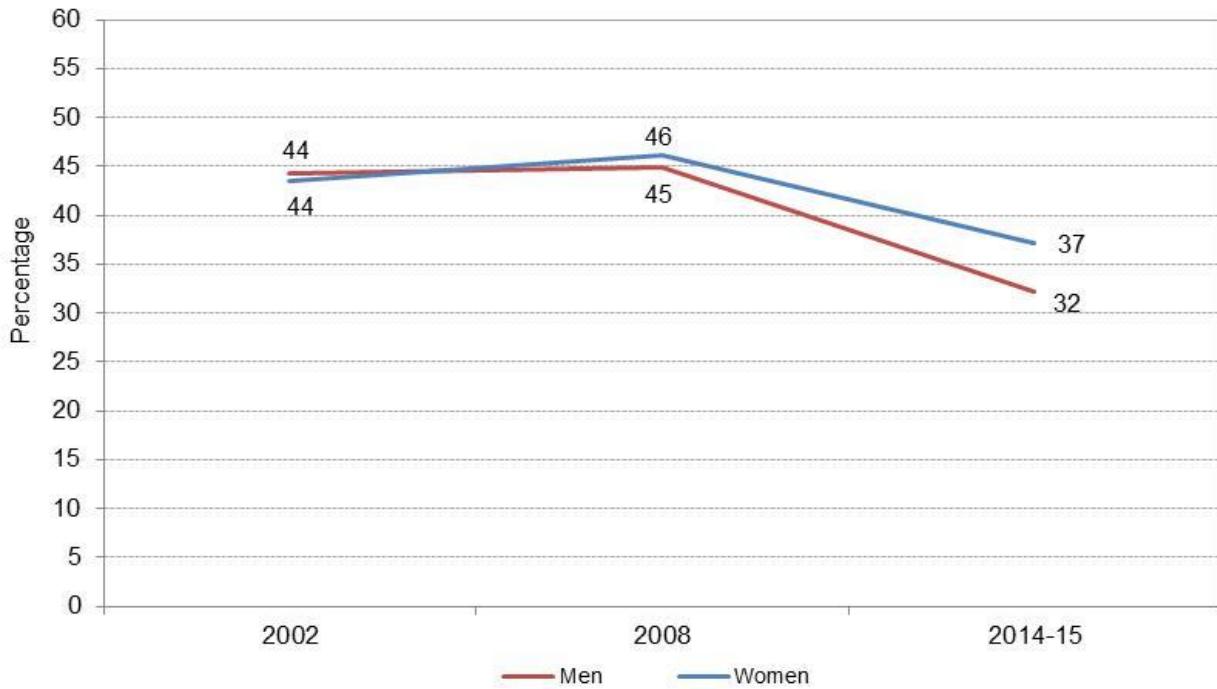


Source: National Aboriginal and Torres Strait Islander Social Survey, Australian Bureau of Statistics

Figure 2 shows that the prevalence of daily smoking among South Australian Aboriginal men and women was similar in both 2002 (44%) and 2008 (46% of women and 45% of men), with a decrease among both in 2014-15. Daily smoking among women decreased by nine percentage points (to 37%), and by 13 percentage points among men (to 32%). Changes between 2008 and 2014-15 were statistically significant. Data are consistent with those found nationally: the prevalence of daily smoking decreased significantly by 10 percentage points for Australian Aboriginal men (from 51% in 2002 to 41% in 2014-15) and 11 percentage points for Australian Aboriginal women (from 47% in 2002 to 36% in 2014-15).

South Australian NATSISS data on tobacco use by age are not publicly available for 2014-15. Australian data reported that the prevalence of daily smoking decreased significantly between 2008 and 2014-15 among 15-24 and 25-34 year olds (from 39% to 31% and from 53% to 45%, respectively).

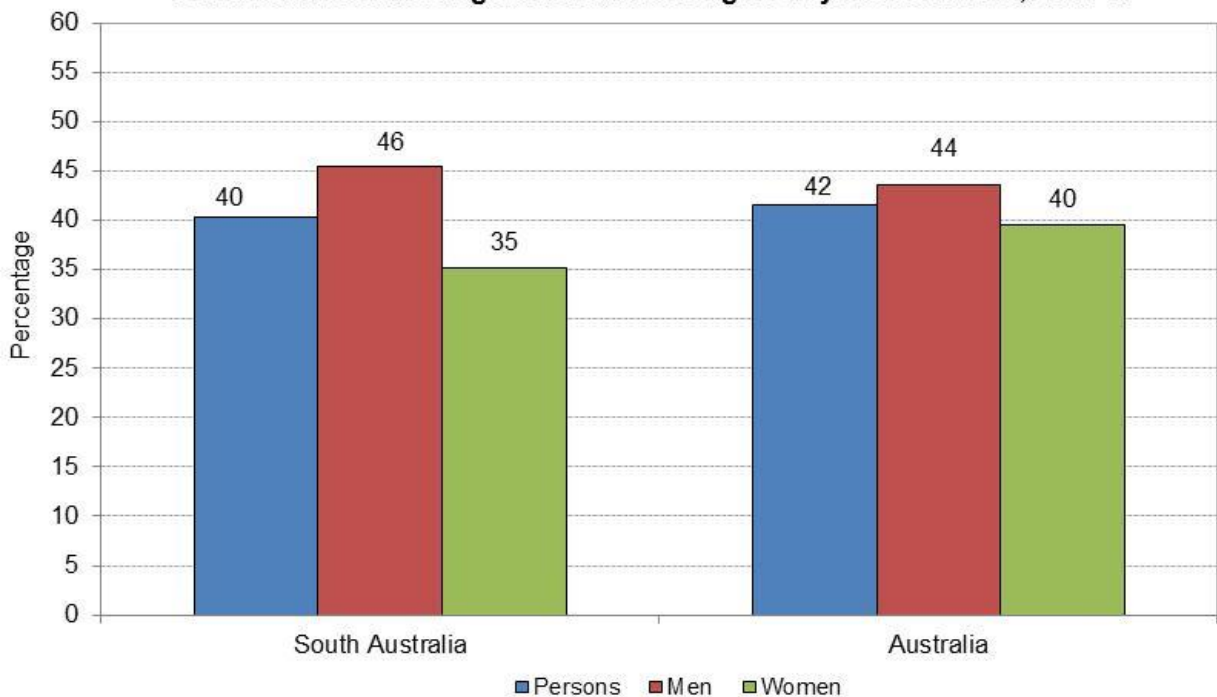
Figure 2: Percentage of daily smokers among Aboriginal South Australians aged 15 years and over by sex, 2002 to 2014-15



Source: National Aboriginal and Torres Strait Islander Social Survey (2002, 2008), Australian Bureau of Statistics. Data for 2014-15 from Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W. 2017. *South Australian Aboriginal Health Needs and Gaps Report: Women's and Children's Health Network, 2017.* Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide.

The 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS)⁹ also provides data on smoking prevalence by sex. Figure 3 shows that 40% of Aboriginal South Australians aged 15 years and over were daily smokers in 2012-13, lower than the National figure of 42%. While daily smoking among men was higher in South Australia (46% compared with 44% nationally), it was five percentage points lower among women (35% compared with 40% nationally). These data suggest that there has been a consistent decrease in smoking from 2008 to 2014-15.

Figure 3: Percentage of daily smokers among Aboriginal South Australians and Aboriginal Australians aged 15 years and over, 2012-13

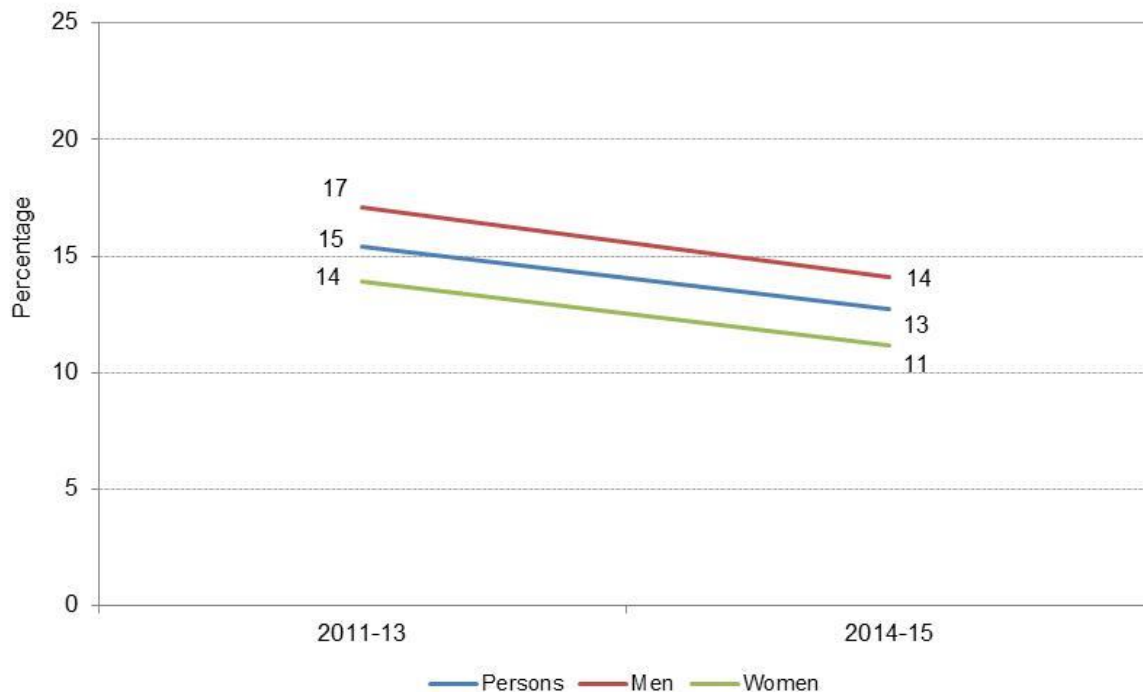


Source: Australian Aboriginal and Torres Strait Islander Health Survey, Australian Bureau of Statistics

Comparison with Non-Aboriginal Australians

Figure 4 shows the percentage of smokers over time from the National Health Survey (NHS)¹⁰. There has been a change over time for both men and women, with daily smoking among South Australians aged 15 years and over decreasing from 15% in 2011-13 to 13% in 2014-15 (from 17% to 14% for men and from 14% to 11% for women). In 2007-08, 19% of 18 year olds reported daily smoking. Daily smoking among non-Aboriginal Australians aged 15 years and over was stable at 16% in both 2011-13 and 2014-15 (18% in 2007-08).

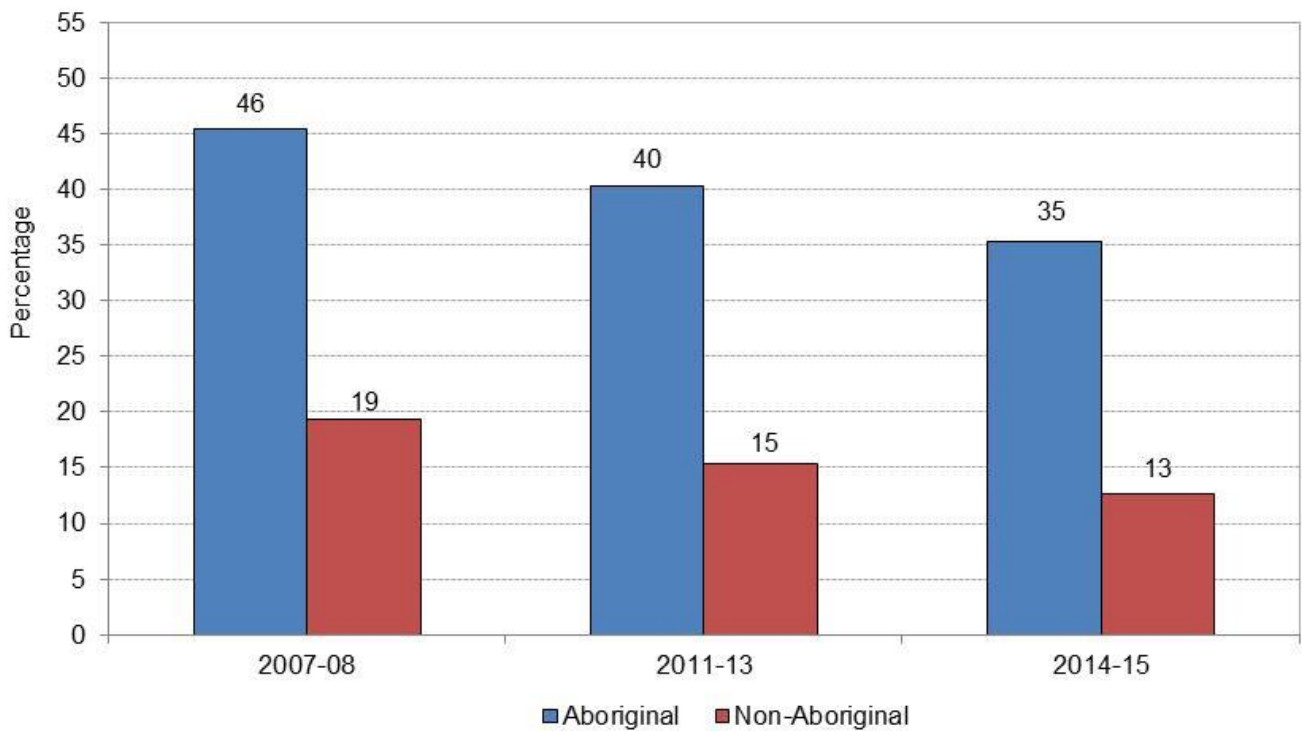
Figure 4: Percentage of daily smokers among non-Aboriginal South Australians aged 15 years and over by sex, 2011-13 to 2014-15



Source: National Health Survey (2011-13 and 2014-15), Australian Bureau of Statistics

Figure 5 compares daily smoking between Aboriginal and non-Aboriginal South Australians over time. It is clear that a significantly higher proportion of Aboriginal South Australians smoke than non-Aboriginal, although both have decreased over time. In 2014-15, 35% of Aboriginal South Australians were daily smokers, compared with 13% of non-Aboriginal South Australians.

Figure 5: Percentage of daily smokers among Aboriginal and non-Aboriginal South Australians aged 15* years and over, 2007-08 to 2014-15

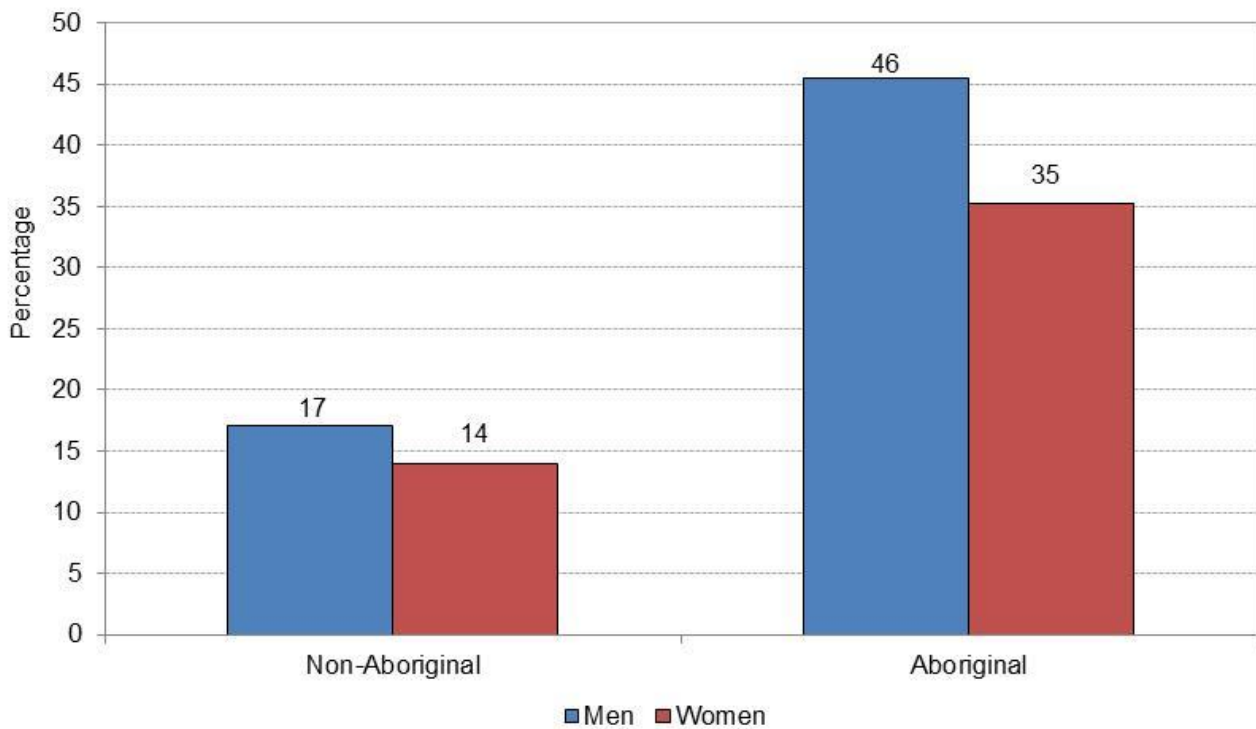


* Non-Aboriginal data for 2007-08 include persons aged 18 years and over

Source: National Health Survey (2007-08, 2011-13 and 2014-15), Australian Aboriginal and Torres Strait Islander Social Survey (2008, 2014-15), Australian Aboriginal and Torres Strait Islander Health Survey (2012-13), Australian Bureau of Statistics

Figure 6 presents smoking data by sex for Aboriginal and non-Aboriginal South Australians. State and Territory data were not available in 2014-15 so the most recent are from 2011-13. This graph again highlights the substantially higher rate of smoking among Aboriginal South Australians, which is evident for both men and women. The 11 percentage point difference in smoking among Aboriginal men (46%) and women (35%) was statistically significant.

Figure 6: Percentage of daily smokers among Aboriginal and non-Aboriginal South Australians aged 15 years and over by sex, 2011-13

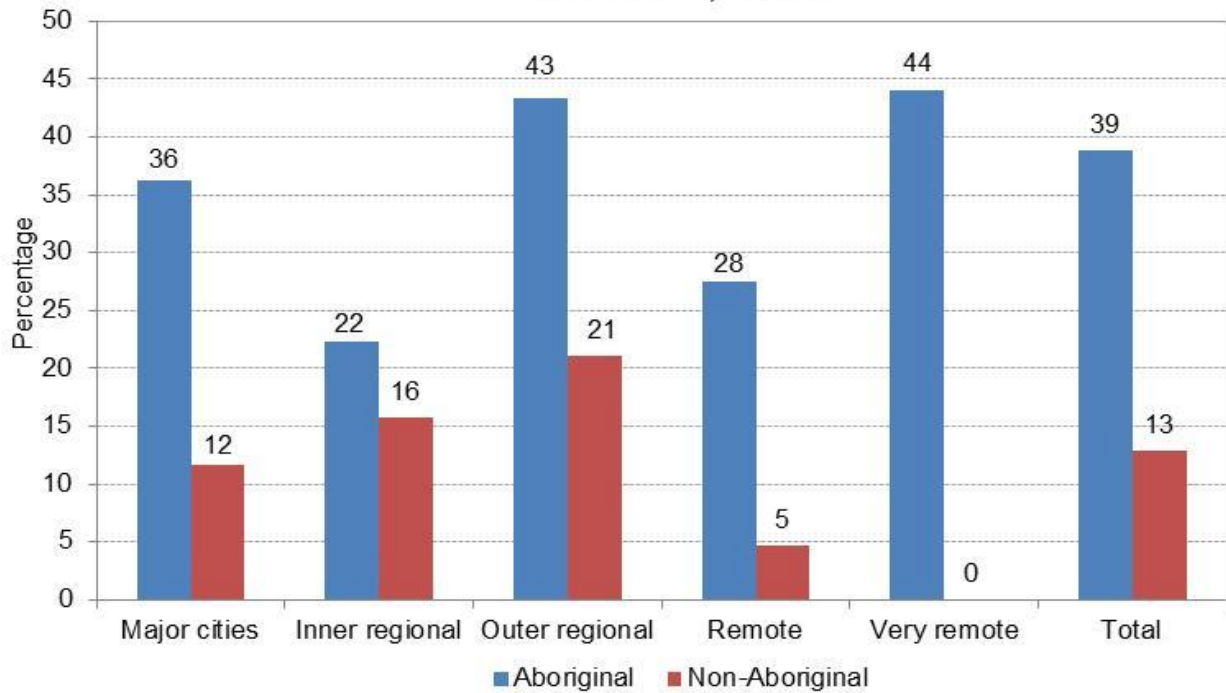


Source: National Health Survey (2011-13), Australian Aboriginal and Torres Strait Islander Health Survey (2012-13), Australian Bureau of Statistics

Remoteness

Figure 7 shows the daily smoking rate by Indigenous status and remoteness. There is a large discrepancy in smoking rates between the two groups, which was especially apparent in major cities (a difference of 25 percentage points). There was also a difference of 22 percentage points in outer regional areas. Overall, 39% of Aboriginal South Australians reported daily smoking, compared with 13% of non-Aboriginal South Australians (a difference of 26 percentage points). Figure 7 also shows that the highest percentage of daily smokers among non-Aboriginal South Australians was in outer (21%) and inner (16%) regional areas, whereas among Aboriginal South Australians, it was highest in very remote (44%) and outer regional (43%) areas.

Figure 7: : Percentage of daily smokers among Aboriginal* and non-Aboriginal South Australians and aged 18 years and over by remoteness, 2014-15



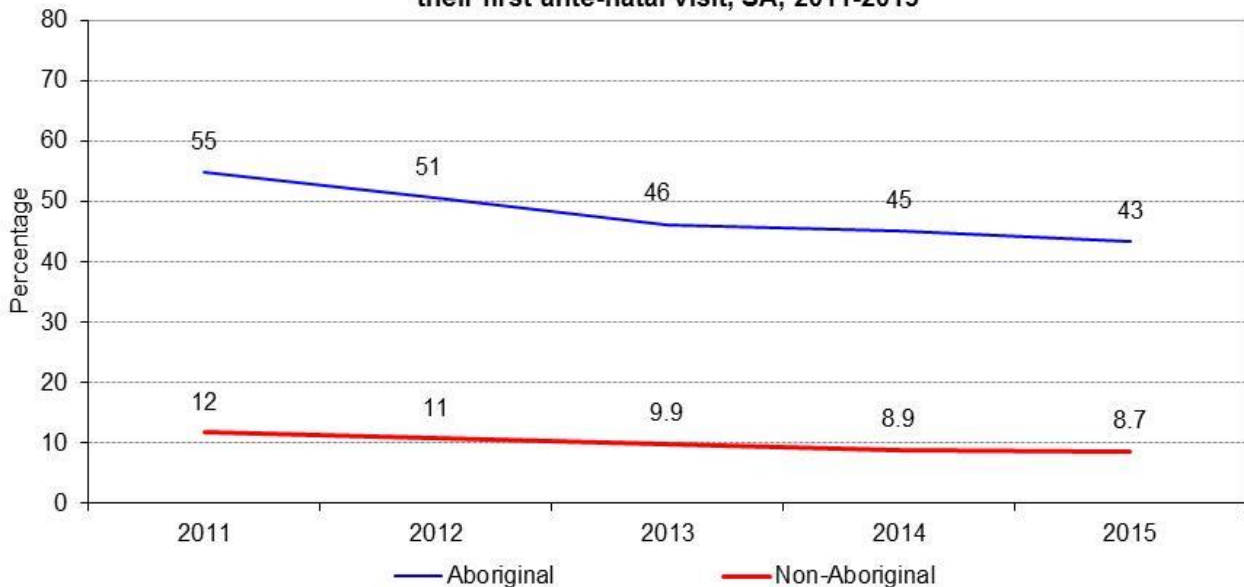
*Proportions of inner regional and remote/very remote among Aboriginal South Australians had relative standard errors between 25% and 50% and should be used with caution.

Source: National Health Survey (2014-15), National Aboriginal and Torres Strait Islander Social Survey (2014-15), Australian Bureau of Statistics.

Smoking in Pregnancy

Figure 8 shows that in 2011, 55% of Aboriginal women were identified to be smokers at their first ante-natal visit, compared with 12% of non-Aboriginal women. In 2012, there was a significant decrease in non-Aboriginal (11%) women smoking, and a non-significant decrease in Aboriginal women (51%). Data from 2013 to 2015 show further decreases among both Aboriginal women (from 46% to 43%) and non-Aboriginal women (from 9.9% to 8.7%).

Figure 8: Proportion of Aboriginal and non-Aboriginal women smoking* at their first ante-natal visit, SA, 2011-2015



*Based on two questions asked of pregnant women: 'do you smoke?' and 'number of cigarettes smoked daily'. In 2015, total sample size 19,100 non-Aboriginal women and 718 Aboriginal women; unknown smoking status excluded.

Source: Pregnancy Outcome Statistics Unit, SA Health

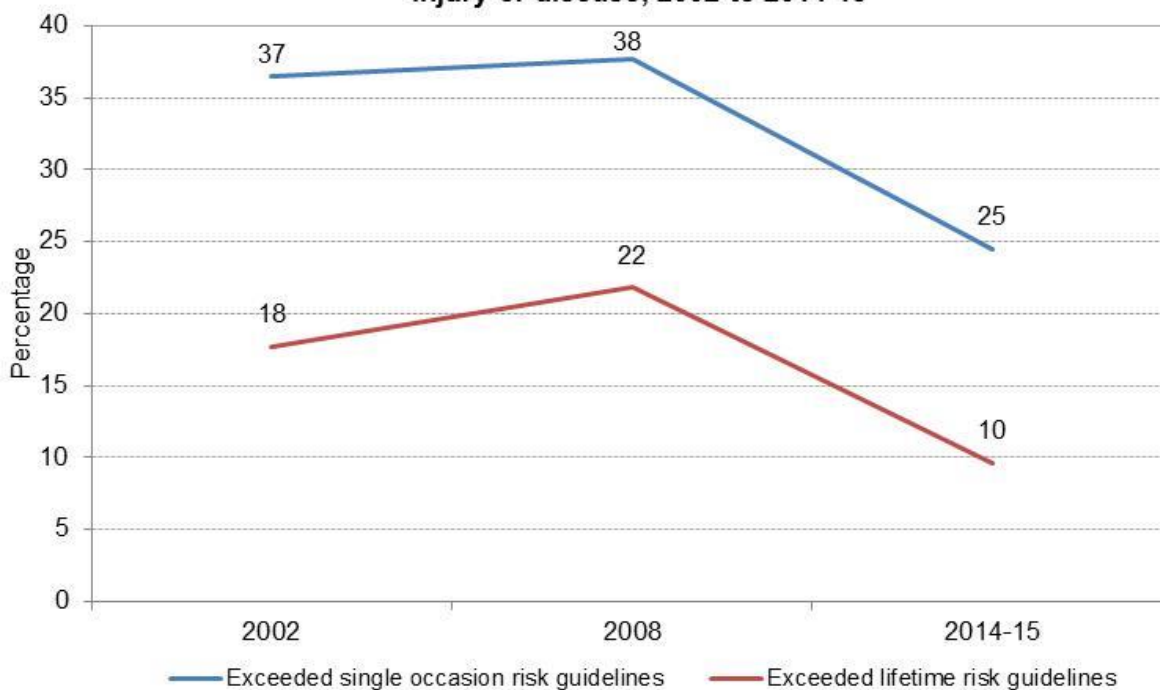
Alcohol

The methods for calculating risky drinking in the AATSIHS, NATSISS and NHS are not as comprehensive as those used in the National Drug Strategy Household Survey (NDSHS¹¹) and as such, may be a less accurate measure of risky drinking. The questions used to determine single occasion and lifetime risk use shorter time frames than those used in the NDSHS¹². Despite this, it is still possible to monitor trends over time between Aboriginal and non-Aboriginal Australians using these surveys.

Aboriginal and Torres Strait Islander Australians

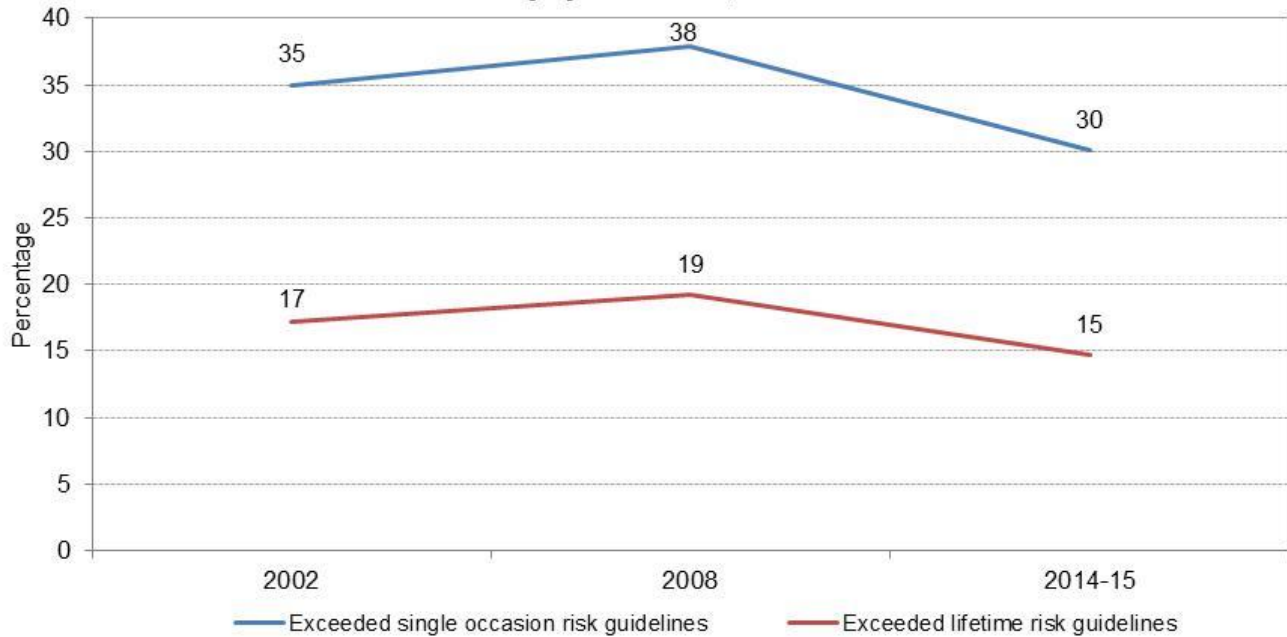
Risky drinking over time among Aboriginal respondents is presented in Figures 9 and 10 for South Australia and Australia, respectively. There were significant decreases in single occasion (at least once in the last two weeks) and lifetime risk among both South Australians and Australians between 2008 and 2014-15. Moreover, the magnitude of the change was greater in South Australia, with a decrease of 13 percentage points in single occasion risk (eight in Australia) and 12 percentage points for lifetime risk (four in Australia). Nationally, these changes were largely due to decreases in non-remote areas; this information was not available for South Australia.

Figure 9: Percentage of Aboriginal South Australians aged 15 years and over who consumed alcohol at levels that increased their risk of injury or disease, 2002 to 2014-15



Source: National Aboriginal and Torres Strait Islander Social Survey, Australian Bureau of Statistics

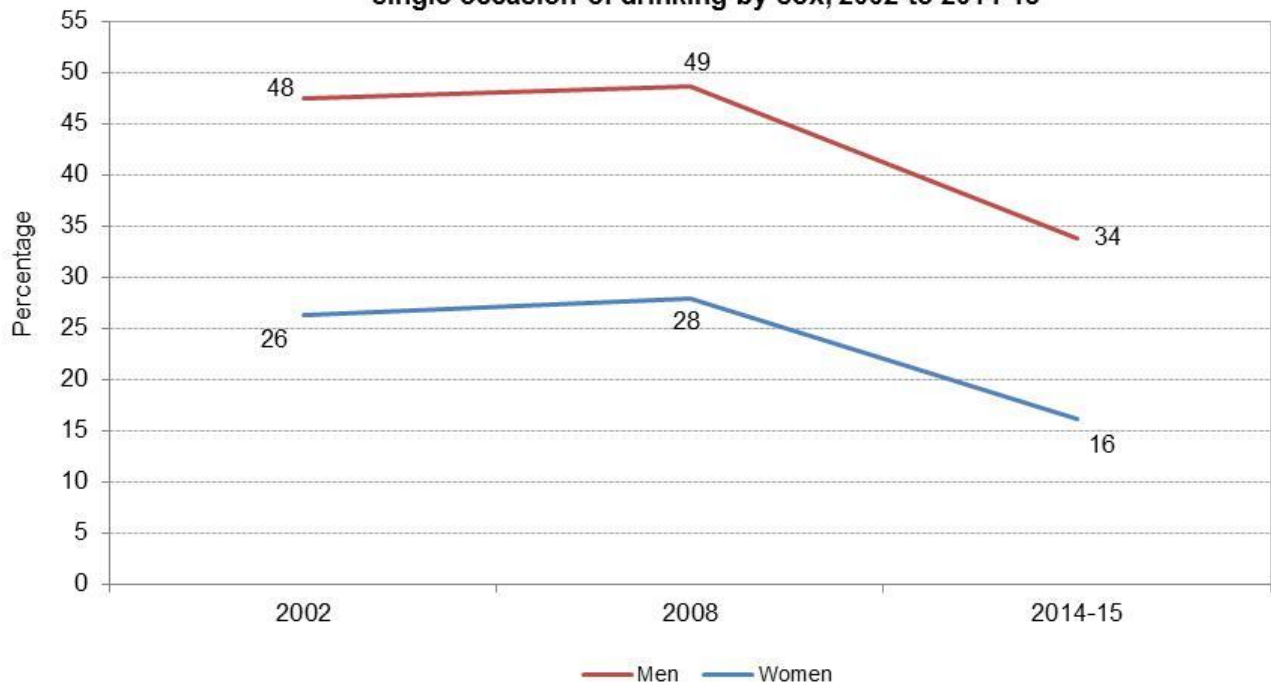
Figure 10: Percentage of Aboriginal Australians aged 15 years and over who consumed alcohol at levels that increased their risk of injury or disease, 2002 to 2014-15



Source: National Aboriginal and Torres Strait Islander Social Survey, Australian Bureau of Statistics

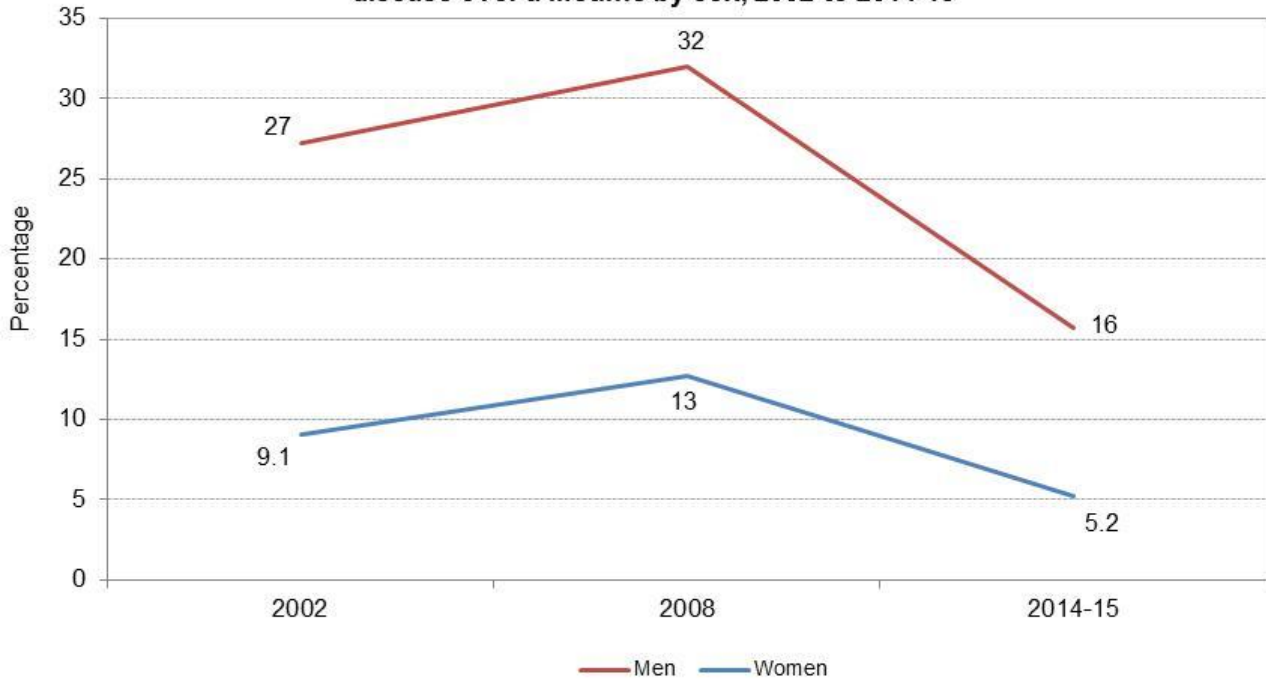
Figures 11 and 12 present risky drinking data over time for South Australian Aboriginal men and women. A similar pattern was evident for both types of risky consumption, with small increases between 2002 and 2008 followed by substantial decreases between 2008 and 2014-15, which were of greater magnitude among men. Single occasion risk decreased from 49% in 2008 to 34% in 2014-15 among men, and from 28% to 16% among women. Lifetime risk decreased from 32% in 2008 to 16% in 2014-15 among men, and from 13% to 5.2% among women. The proportion of men who report drinking at risky levels is significantly higher than those of women in all years.

Figure 11: Percentage of Aboriginal South Australians aged 15 years and over who consumed alcohol at levels that increased their risk of injury from a single occasion of drinking by sex, 2002 to 2014-15



Source: National Aboriginal and Torres Strait Islander Social Survey, Australian Bureau of Statistics

Figure 12: Percentage of Aboriginal South Australians aged 15 years and over who consumed alcohol at levels that increased their risk of injury or disease over a lifetime by sex, 2002 to 2014-15

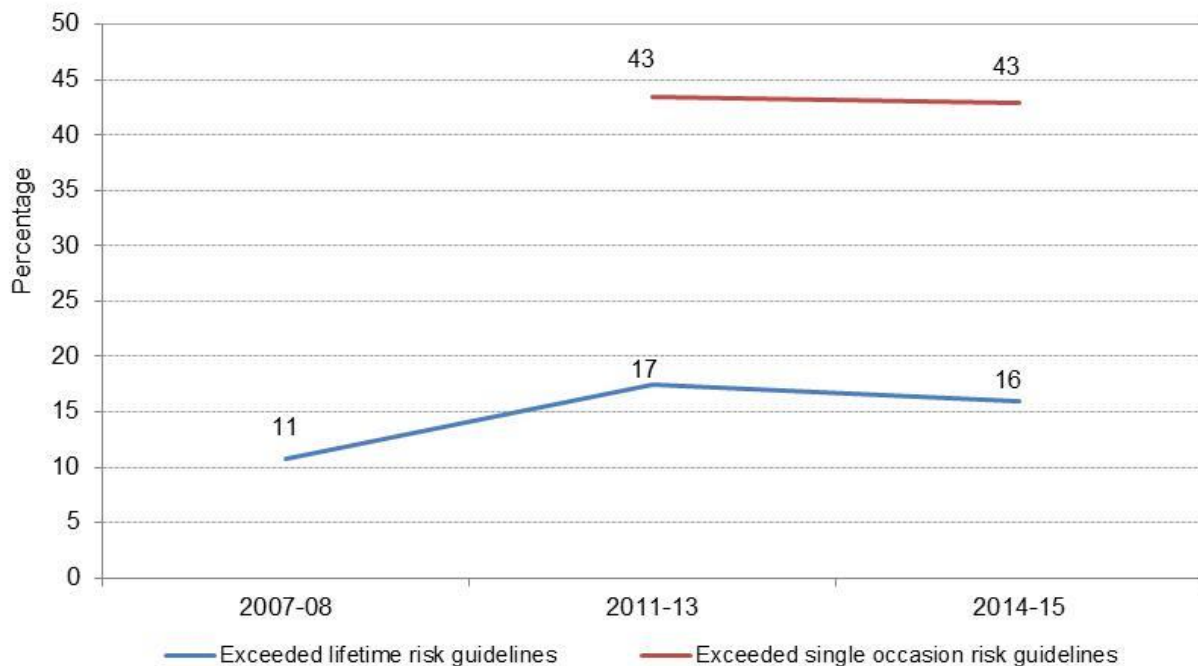


Source: National Aboriginal and Torres Strait Islander Social Survey, Australian Bureau of Statistics

Comparison with Non-Aboriginal Australians

Figure 13 shows risky alcohol consumption among non-Aboriginal South Australians over time. Lifetime risk increased from 11% in 2007-08 to 17% in 2011-13, and remained stable at 16% in 2014-15. Despite differences in how risky drinking was calculated, these data are similar to those reported in the NDSHS and the SA Health Omnibus Survey (HOS): in the 2013 NDSHS¹³, 19% of South Australians drank alcohol at levels that increased their risk of injury or disease over a lifetime, with 17% in the 2016 HOS¹⁴. Single occasion risk among non-Aboriginal South Australians remained stable between 2011-13 and 2014-15 (43%). Again, despite methodological differences, these data are similar to those reported in the 2013 NDSHS (40%) and the 2016 HOS (44%).

Figure 13: Percentage of non-Aboriginal South Australians aged 15 years and over who consumed alcohol at levels that increased their risk of disease or injury, 2007-08* to 2014-15



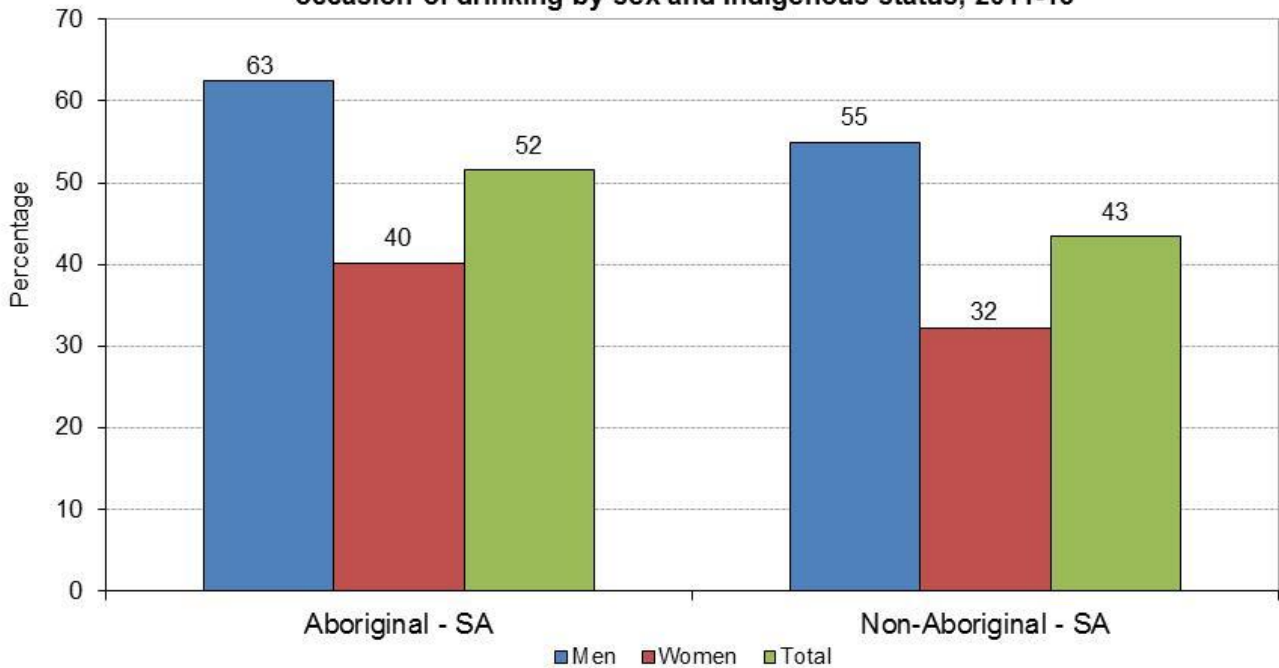
Source: National Health Survey (2007-08, 2011-13 and 2014-15), Australian Bureau of Statistics. * Data for single occasion risk (at least once in the last 12 months) were not collected in 2007-08

The proportion of Aboriginal and non-Aboriginal South Australian men and women drinking at levels that put them at risk of injury from a single occasion of drinking at least once in the last 12 months is presented in Figure 14. A higher proportion of Aboriginal South Australians drank at these levels (52% compared with 43% of non-Aboriginal South Australians); this pattern was seen for both men (63% compared with 55%) and women (40% compared with 32%). Men were much more likely to drink at these levels, as was found with lifetime risky drinking.

The proportion of Aboriginal and non-Aboriginal South Australian men and women drinking at levels that put them at risk of disease or injury over a lifetime from the 2011-13 NHS and the 2012-13 AATSIHS is presented in Figure 15¹⁵. A slightly higher proportion of Aboriginal South Australians drank at levels that increased their risk over a lifetime (20% compared with 17%), but among both groups, men were significantly more likely to drink at these levels. Notably, Aboriginal women were almost twice as likely to drink at these levels as non-Aboriginal women (15% compared with 8.2%).

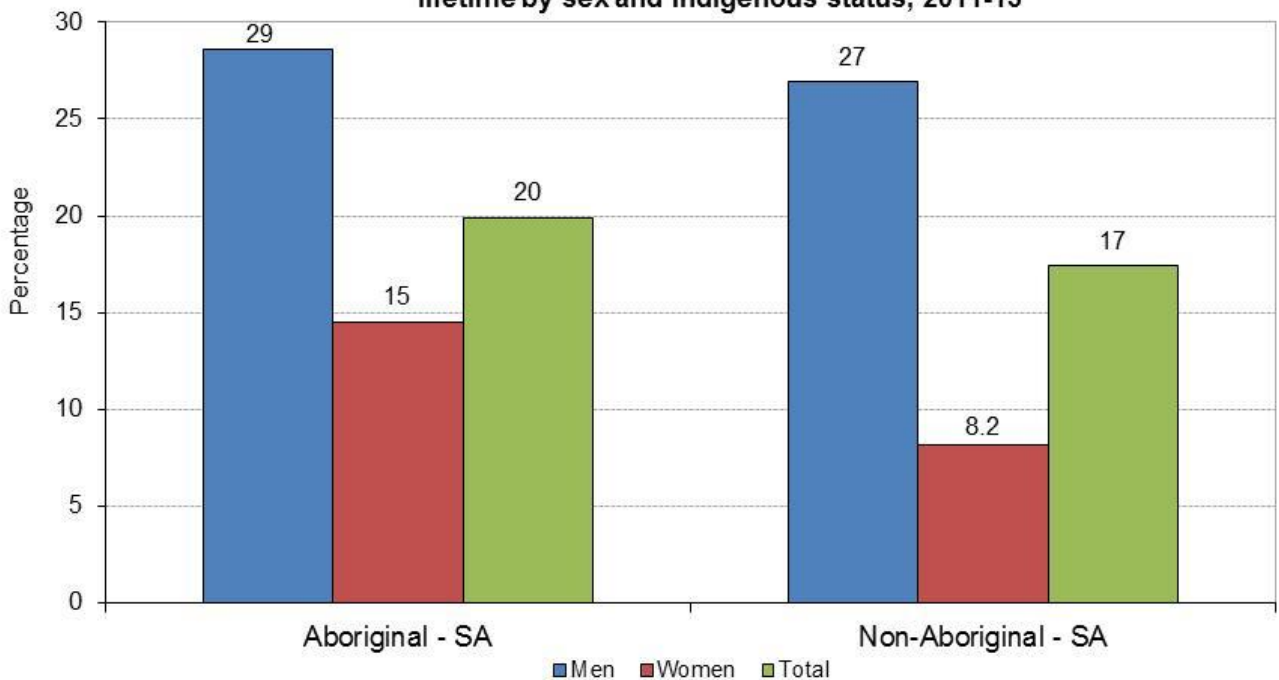
These data indicate that risky drinking is consistently higher among Aboriginal South Australians for both men and women, and as found with non-Aboriginal South Australians, rates are higher among men (1.6-1.7 times higher for lifetime risk and 1.3-1.4 times higher for single occasion risk).

Figure 14: Percentage of South Australians aged 15 years and over who consumed alcohol at levels that increased their risk injury on a single occasion of drinking by sex and Indigenous status, 2011-13



Source: National Health Survey (2011-13), Australian Aboriginal and Torres Strait Islander Health Survey (2012-13), Australian Bureau of Statistics

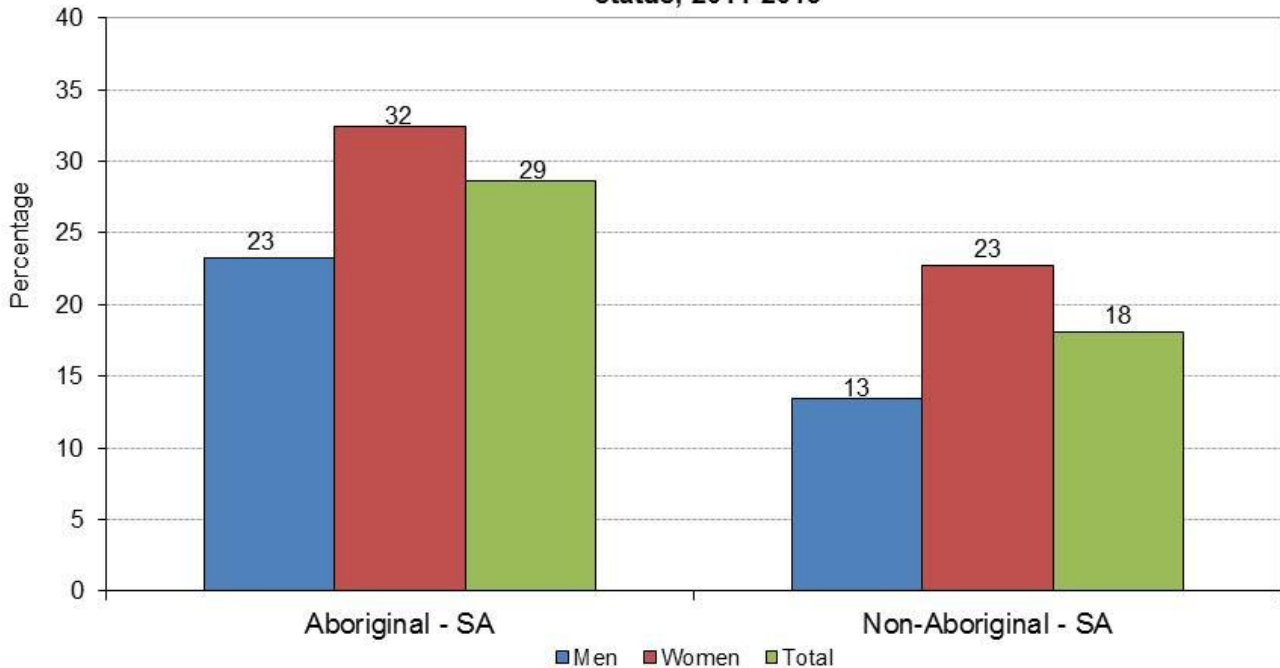
Figure 15: Percentage of South Australians aged 15 years and over who consumed alcohol at levels that increased their risk of disease or injury over a lifetime by sex and Indigenous status, 2011-13



Source: National Health Survey (2011-13), Australian Aboriginal and Torres Strait Islander Health Survey (2012-13), Australian Bureau of Statistics

Figure 16 shows the percentage of Aboriginal and non-Aboriginal South Australians who abstain from alcohol. Abstinance rates are higher among Aboriginal South Australians, with 29% reporting that they had not consumed alcohol in the last 12 months or had never consumed alcohol (23% of men and 32% of women), compared with 18% of non-Aboriginal South Australians (13% of men and 23% of women). However, this difference has decreased over time: in 2008 (NATSISS) and 2007-08 (NHS) 18% of non-Aboriginal South Australians were abstinent compared with 34% of Aboriginal South Australians. Data on abstinance were not available in 2014-15.

Figure 16: Percentage of South Australians aged 15 years and over who had not consumed alcohol in the last 12 months or ever by sex and Indigenous status, 2011-2013



Source: National Health Survey (2011-13), Australian Aboriginal and Torres Strait Islander Health Survey (2012-13), Australian Bureau of Statistics

Remoteness

South Australian data on risky alcohol consumption and remoteness were not available in 2014-15.

Illicit Drugs

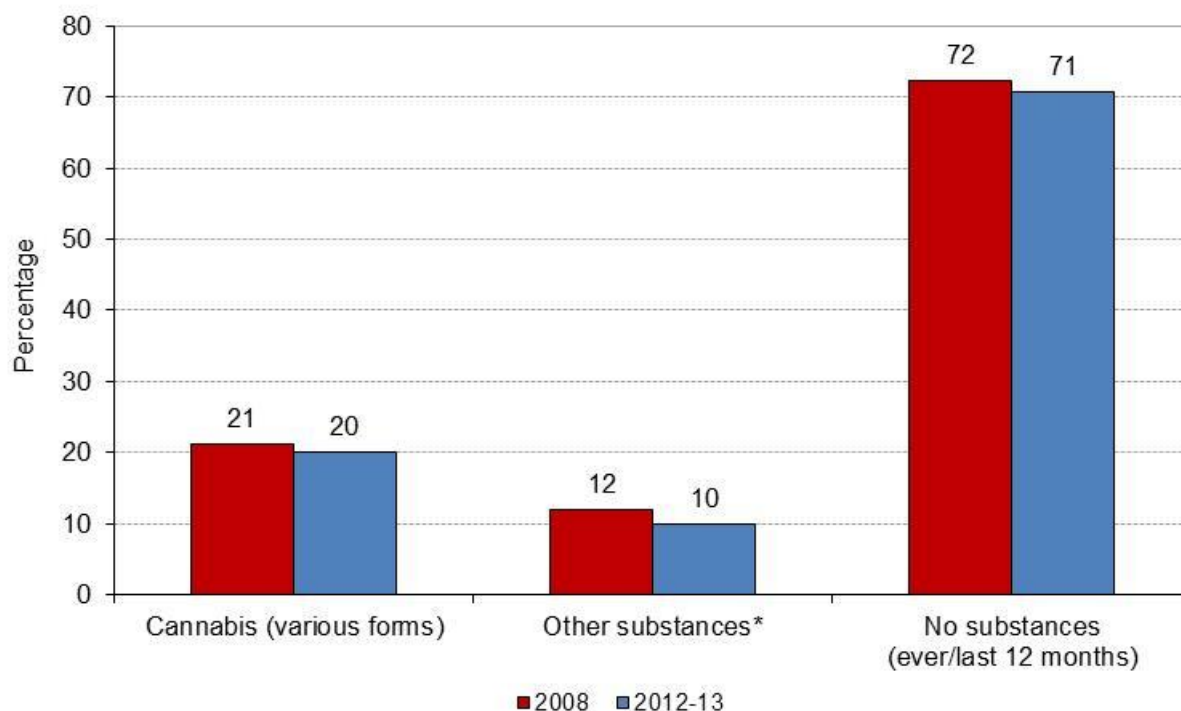
The 2008 NATSISS and the 2012-13 AATSIHS have been used to estimate illicit drug use among the Aboriginal population. In 2008, 21% of Aboriginal South Australians aged 18 years and older had used cannabis in the last 12 months (see Figure 17); 28% of men and 16% of women. This is only slightly higher than among Aboriginal Australians aged 18 years and over, where 18% had used cannabis in the last 12 months. A further 12% of men and women had used other substances (11% nationally).

There was no change in the proportion of Aboriginal South Australians using illicit drugs in the last 12 months in 2012-13 compared with 2008, with 20% using cannabis (27% of men and 14% of women) and 10% using other substances. This is comparable with national figures where 19% of Aboriginal Australians had used cannabis in the last 12 months (24% of men and 14% of women) and 10% had used other substances.

Cannabis use in 2012-13 was highest among 25-34 year old Aboriginal South Australians (26%), followed by 23% for those aged 15-24, 35-44 and 45-54 years. Use was low among those aged 55 years and over (3.3%). There was no difference in use in remote (20%) and non-remote (19%) areas. Methamphetamine¹⁶ use in the last 12 months was reported by 3.3% of Aboriginal South Australians (4% of men and 3.6% of women), with no use in non-remote areas (4.1% in remote areas). Use was also higher among those aged 25-34 (6.4%) and 35-44 years (5%).

Comparable data on illicit drug use among non-Aboriginal South Australians were not available.

Figure 17: Prevalence of illicit drug use among Aboriginal South Australians in the last 12 months, 2008 and 2012-13



* 'Other substances' include: heroin, cocaine, petrol, LSD/synthetic hallucinogens, naturally occurring hallucinogens, ecstasy/designer drugs, methadone and other inhalants. Excludes refusals.

Source: National Aboriginal and Torres Strait Islander Health Social Survey (NATSISS) 2008; Australian Aboriginal & Torres Strait Islander Health Survey (AATSIHS) 2012-13, Australian Bureau of Statistics. Note that data from the AATSIHS were extracted from TableBuilder by Population Research & Outcomes Studies (PROS), Discipline of Medicine, School of Medicine, Faculty of Health Sciences, The University of Adelaide.

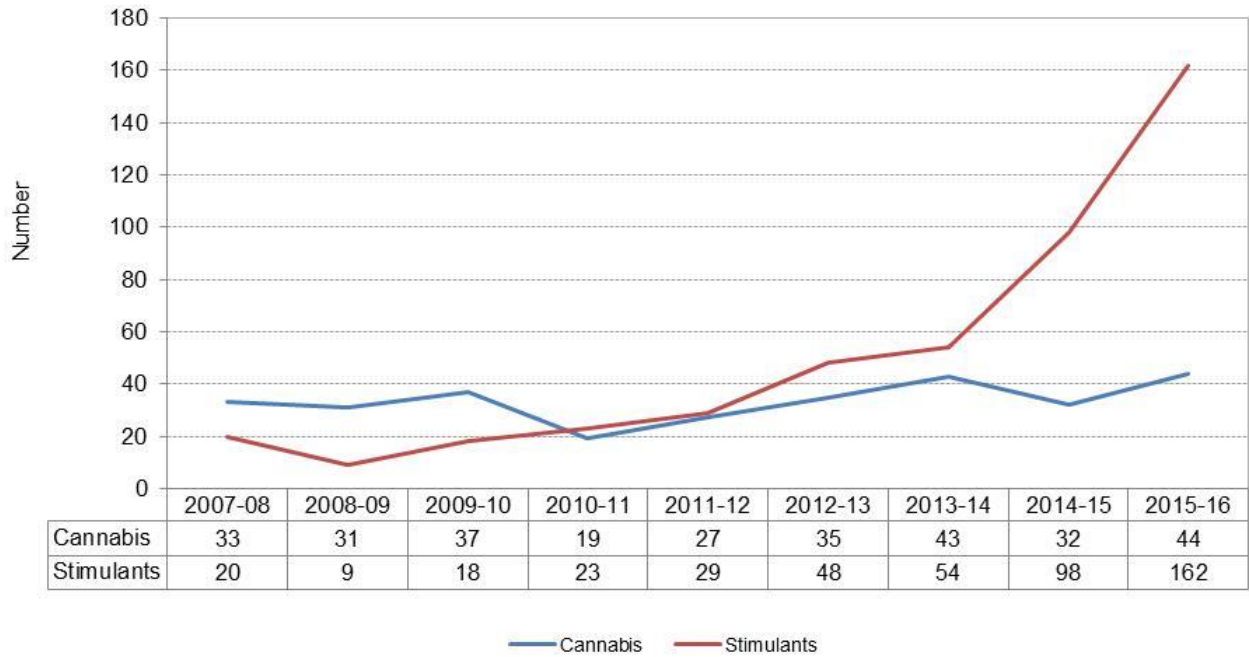
Hospitalisations

The following graphs show the number of hospitalisations¹⁷ for heroin, cannabis, stimulants¹⁸ and alcohol, by Indigenous status, from 2007-08 to 2015-16.

Although numbers are small, there has been an eight-fold increase in hospitalisations among Aboriginal patients for stimulants over the reporting period, from 20 in 2007-08 to 162 in 2015-16 (Figure 18a). The rate per 10,000 Aboriginal population has also increased seven-fold, from 6.9 in 2007-08 to 47.2 in 2015-16. The number and rate for heroin¹⁹ and cannabinoids remained relatively stable (in 2015-16, 1.7 per 10,000 Aboriginal population for heroin and 12.8 for cannabinoids).

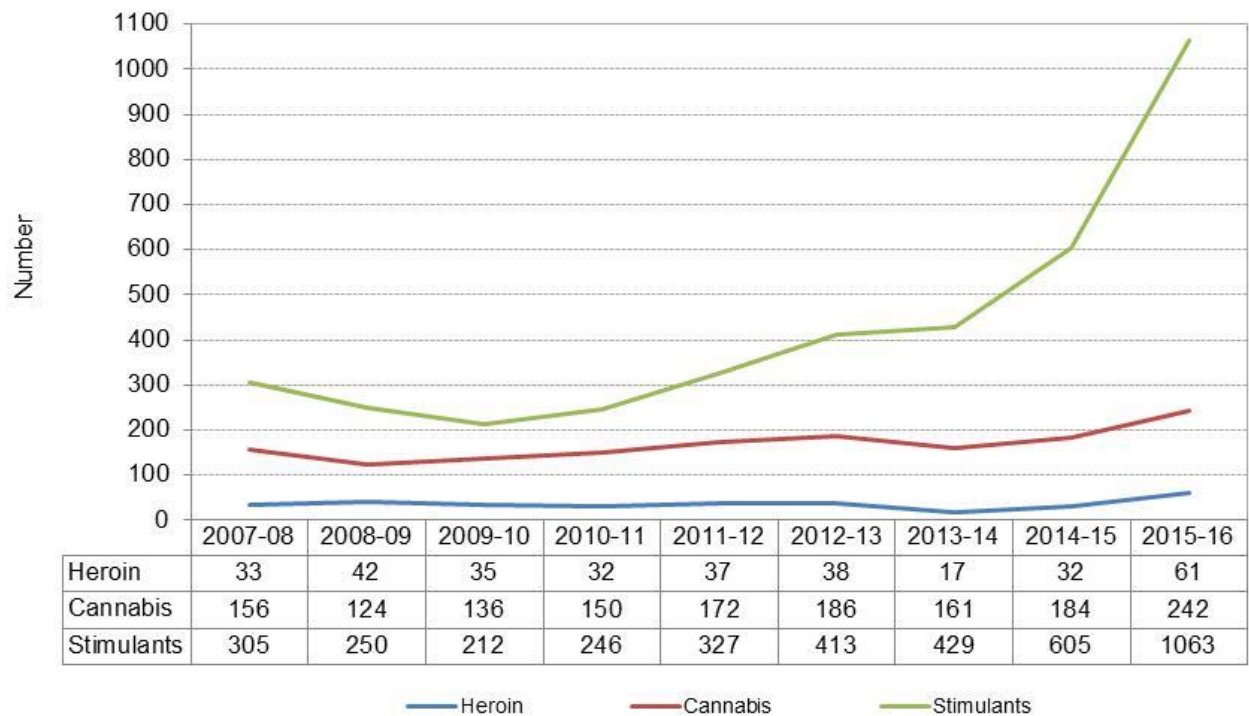
Figure 18b presents the same information for non-Aboriginal patients. The number of hospitalisations has increased for all three drug types, particularly for stimulants where it more than tripled between 2007-08 (305) and 2015-16 (1063). As was found for Aboriginal patients, the rate per 10,000 population for stimulants has also increased, from 1.9 in 2007-08 to 6.4 in 2015-16. The rate for heroin (0.4) and cannabis (1.4) is much lower than that found among Aboriginal patients.

Figure 18a: Number of hospitalisations by drug type for patients identifying as Aboriginal, 2007-08 to 2015-16



Source: Integrated South Australian Activity Collection (ISAAC), South Australian Health Department.

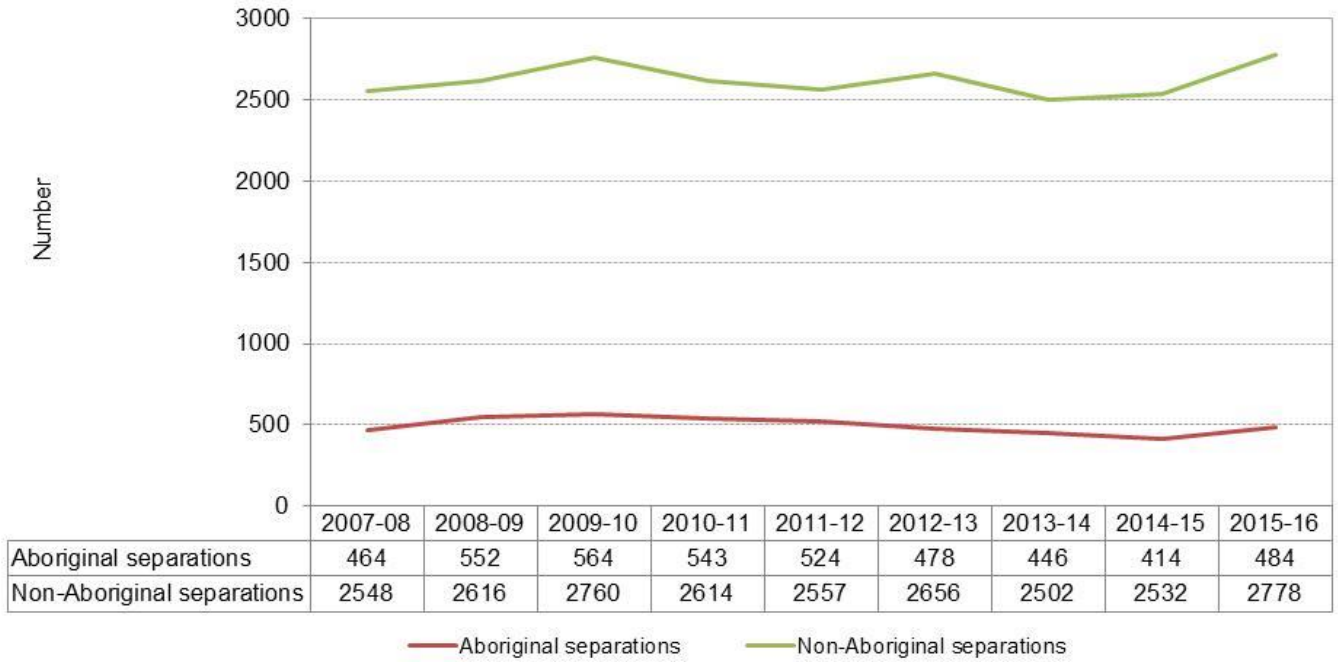
Figure 18b: Number of hospitalisations by drug type for patients identifying as non-Aboriginal, 2007-08 to 2015-16



Source: Integrated South Australian Activity Collection (ISAAC), South Australian Health Department.

Figure 18c presents the number of hospitalisations for alcohol by Indigenous status. Numbers have remained relatively stable, with a small increase over time for both Aboriginal and non-Aboriginal patients. The rate was much higher among Aboriginal patients, ranging from 123 to 186 separations per 10,000 population (141 in 2015-16), compared with a range of 15 to 17 separations per 10,000 population among non-Aboriginal patients (17 in 2015-16).

Figure 18c: Number of hospitalisations for alcohol by Indigenous status, 2007-08 to 2015-16

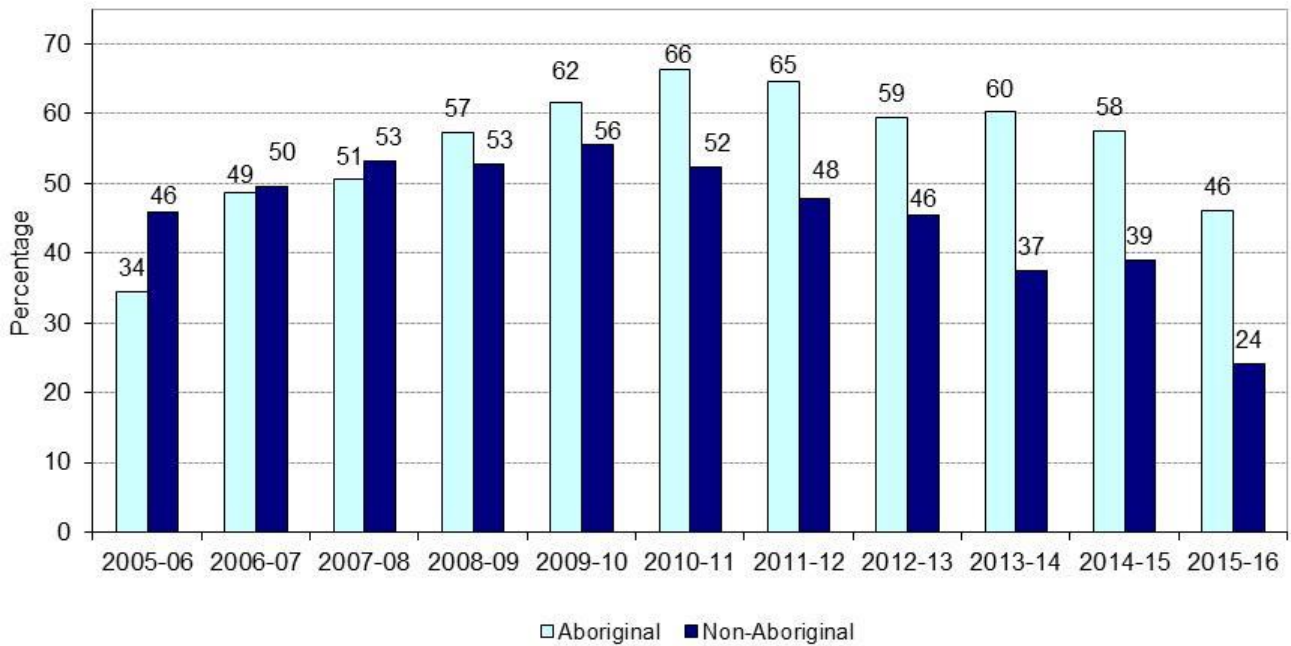


Source: Integrated South Australian Activity Collection (ISAAC), South Australian Health Department.

Drug Service Treatment Data

Figure 19 shows the proportion of closed treatment episodes²⁰ separately for Aboriginal and non-Aboriginal clients in South Australia where alcohol was the principal drug of concern, from 2005-06 to 2015-16. For Aboriginal South Australians, this proportion has increased from 34% in 2005-06 to 66% in 2010-11, followed by a substantial decrease to 46% in 2015-16. For non-Aboriginal South Australians, there was an increase in the proportion of closed treatment episodes for which alcohol was the principal drug of concern between 2005-06 and 2009-10, after which time it has decreased, falling to 24% in 2015-16.

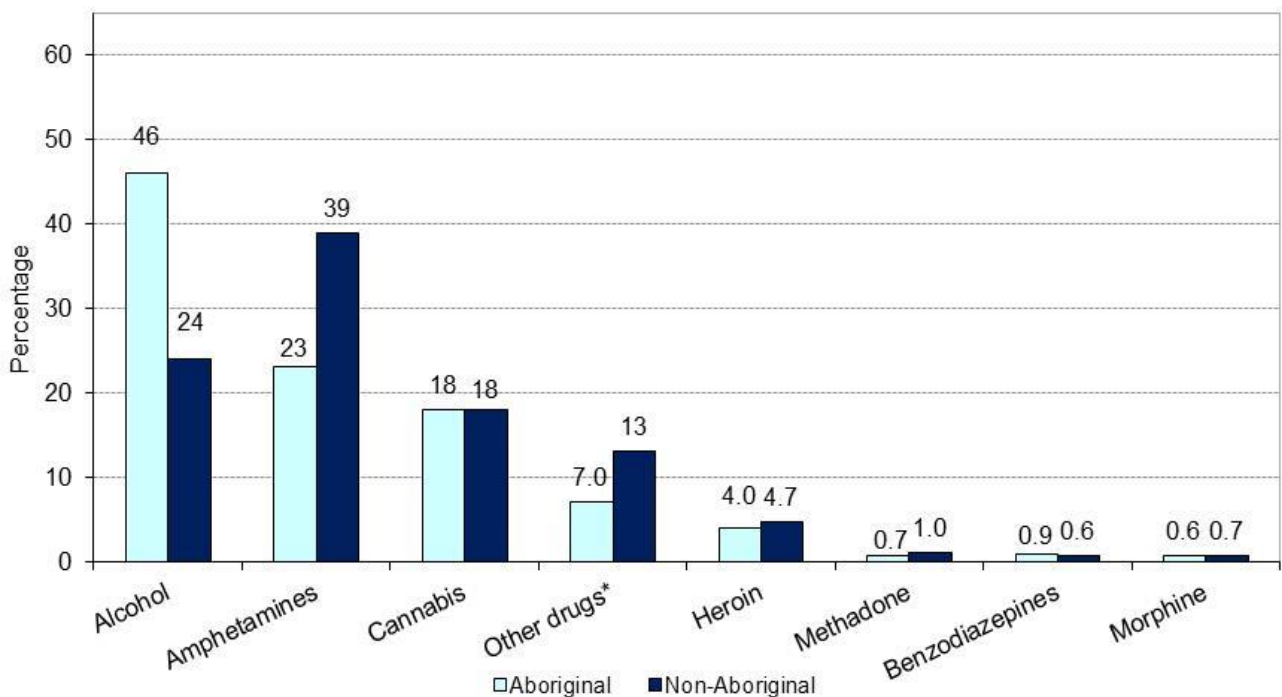
Figure 19: Percentage of closed treatment episodes among Aboriginal and non-Aboriginal clients where the principal drug of concern was alcohol, 2005-06 to 2015-16



Source: Australian Institute of Health and Welfare, Alcohol and Other Drug Treatment Services National Minimum Data Set, unpublished data. Excludes treatment episodes for clients seeking treatment for the drug use of others.

Figure 20 shows all major drugs nominated as the principal drug of concern in 2015-16, by Indigenous status. Alcohol (46%), amphetamines (23%) and cannabis (18%) were the most common among Aboriginal clients, with amphetamines (39%), alcohol (24%) and then cannabis (18%) among non-Aboriginal clients.

Figure 20: Principal drug of concern for closed treatment episodes among Aboriginal and non-Aboriginal South Australians, 2015-16

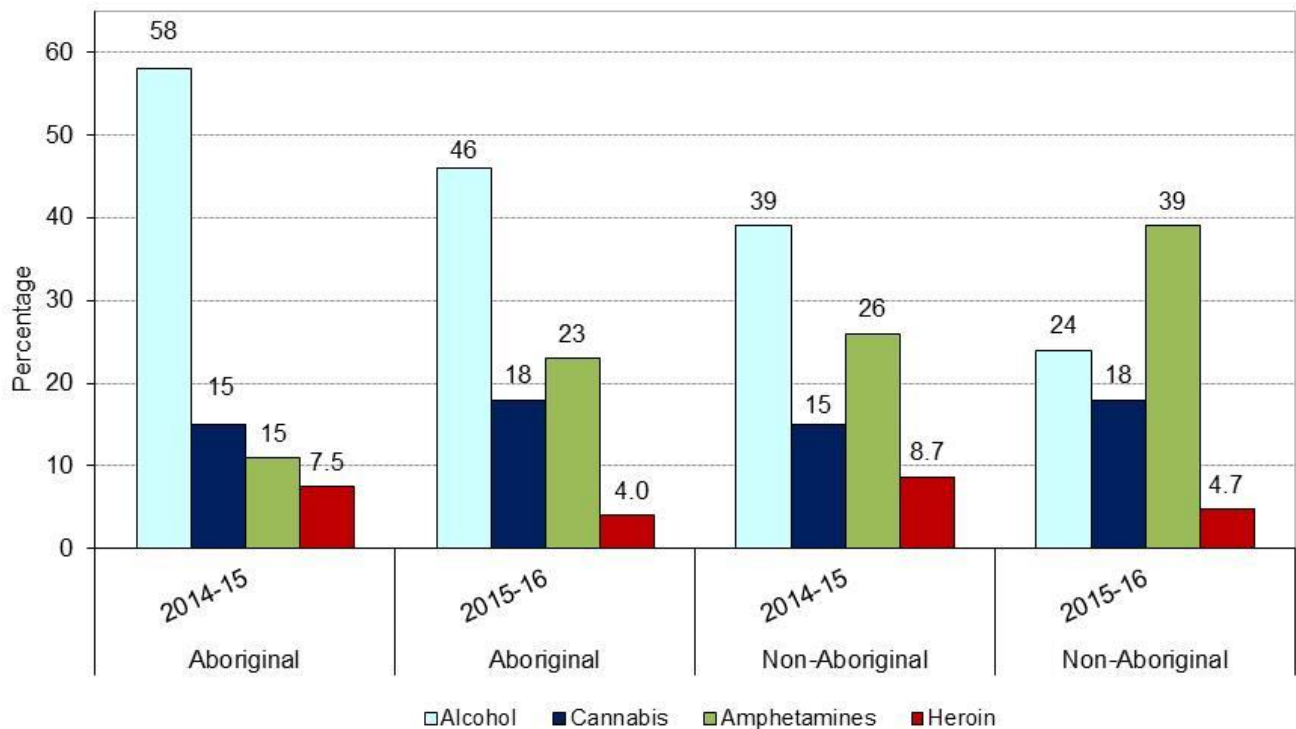


Source: Australian Institute of Health and Welfare, Alcohol and Other Drug Treatment Services National Minimum Data Set, unpublished data. Excludes treatment episodes for clients seeking treatment for others' drug use. Totals exceed 100% due to rounding counts.

* Includes ecstasy, nicotine, cocaine, miscellaneous other drugs.

These data indicate a change from previous years: in 2014-15, alcohol was nominated as the principal drug of concern among both Aboriginal (58%) and non-Aboriginal (39%) clients, followed by amphetamines among non-Aboriginal clients (26%) and cannabis among Aboriginal clients (15%). Changes between 2014-15 and 2015-16 are presented in Figure 21, and may reflect an increase in harms and therefore in treatment seeking among those who use methamphetamine, particularly among non-Aboriginal clients²¹.

Figure 21: Principal drug of concern for closed treatment episodes among Aboriginal and non-Aboriginal South Australians, 2014-15 and 2015-16



Source: Australian Institute of Health and Welfare, Alcohol and Other Drug Treatment Services National Minimum Data Set, unpublished data. Excludes treatment episodes for clients seeking treatment for others' drug use.

For more information

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Drug and Alcohol Services South Australia acknowledges the contribution of the Australian Institute of Health and Welfare, the Australian Bureau of Statistics and Population Research & Outcomes Studies (PROS), The University of Adelaide.

1 In this document, Aboriginal includes people who identify as either Aboriginal, or Torres Strait Islander, or both. Note that Torres Strait Islander people make up a very small proportion of the South Australian population

2 <http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/resources/statistical+bulletin+number+1+-+june+2011>

3 http://www.nhmrc.gov.au/files_nhmrc/publications/attachments/ds10-alcohol.pdf

4 The NATSISS was conducted by the Australian Bureau of Statistics (ABS) in 2002 (N=9,359), 2008 (N=13,307) and 2014-15 (11,178). Information was collected from Indigenous Australians living in private dwellings in remote and non-remote areas, including discrete communities. The NATSISS provides information on a range of demographic, social, environmental and economic indicators. The number of respondents in South Australia was 1,010 in 2002, 1,291 in 2008 and 1,077 in 2014-15. For more information visit www.abs.gov.au

5 The AATSIHS was conducted by the Australian Bureau of Statistics (ABS) in 2004-05 (N=10,439), and 2012-13 (N=9,300), with methodology very similar to the NATSISS. The number of respondents in South Australia was 1,106 in 2004-05 and 979 in 2012-13. For more information visit www.abs.gov.au

6 The National Health Survey (NHS), also known as the Australian Health Survey (AHS) has been conducted by the Australian Bureau of Statistics (ABS) every three to five years since 1989-90. Data in this bulletin are from 2007-08 (N=20,788), 2011-13 (N=20,426) and 2014-15 (19,259). The NHS is designed to obtain national benchmark information on a range of health-related issues and to enable the monitoring of health trends over time. The number of respondents in South Australia was 3,171 in 2007-08, 2,508 in 2011-13 and 2,434 in 2014-15. As this is a representative sample of the Australian population, the number of Aboriginal and Torres Strait Islanders is very small, and in some iterations there was a separate survey conducted specifically looking at Aboriginal and Torres Strait Islander Australians. Thus the NHS/AHS can be used to measure health-related indicators among non-Aboriginal Australians. For more information visit www.abs.gov.au

7 Includes publicly funded government and non-government agencies that provide one or more specialist alcohol and/or other drug treatment services.

8 <http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/resources/dassa+statistical+bulletin+number+10+-+may+2016>

9 Another source on smoking among Aboriginal Australians is the Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS). The most recent data are from 2012-13, with the previous iteration (known as the National Aboriginal and Torres Strait Islander Health Survey, NATSIHS) occurring in 2004-05. Due to the eight-year gap between surveys, and the lack of consistency in data collected on daily smoking (15 years and over in 2012-13 but 18 years and over in 2004-05, and 2004-05 data include all smokers), trends over time are not presented here.

10 Data from 2007-08 were excluded as data on daily use were not available among those aged 15 years and over, nor were data on smoking by sex.

11 <http://www.aihw.gov.au/alcohol-and-other-drugs/data-sources/ndshs-2013/>; http://www.nhmrc.gov.au/files_nhmrc/publications/attachments/ds10-alcohol.pdf

12 AATSIHS lifetime risk: respondents who reported having a drink in the last two weeks were then asked about the day they consumed the most alcohol, followed by the last three drinking days in the last week. For each of the drinking days, brands, types and quantities of drinks consumed were recorded. From this, average daily alcohol consumption was calculated. Published data on lifetime risk are compiled using average consumption over the three days x number of days consumed alcohol x seven. AATSIHS single occasion risk: respondents were asked the number of times they had a range of standard drinks in a day in the last 12 months. The number of drinks per day was then used to calculate whether alcohol had been consumed at a risky level at least once in the last 12 months. NATSISS lifetime risk: based on respondents' reported usual daily consumption of alcohol and the frequency of consumption in the last 12 months. NATSISS single occasion risk: assessed based on the largest quantity of alcohol consumed in a single day during the two weeks prior to interview. NHS: Alcohol consumption questions are conceptually identical to those in the AATSIHS, although lifetime risk was measured by asking respondents about whether they had consumed alcohol in the last week. All information obtained from the users' guides that can be found at www.abs.gov.au

13 http://www.aihw.gov.au/alcohol-and-other-drugs/data-sources/ndshs-2013/ch7/#7_3

14 <http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/health+and+medical+research/dassa+research+publications>

15 Due to differences between the NATSISS and AATSIHS/NHS surveys in how risky drinking was calculated, comparisons by Indigenous status are made using the AATSIHS and NHS only. Risky drinking was higher in the AATSIHS than in the NATSISS, reflective of differences in how risk was calculated.

16 Relative standard error (RSE) values are between 25% and 50% and should be used with caution.

17 Based on primary diagnosis; and include mental and behavioural disorders attributed to alcohol or other drugs (intoxication, dependence or psychosis). Patients for whom Indigenous status was not stated were excluded.

18 Includes methamphetamine, MDMA and unspecified/unknown.

19 Numbers for heroin were less than 10 in all of the years (and less than five in three of the years) so have been omitted from the graph to ensure confidentiality.

20 A closed treatment episode refers to a contact period between a client and a service provider that has a defined start and end date. A client may be involved in more than one type of treatment episode at any one time (or may have more than one treatment episode of the same treatment type within the counting period) therefore the number of closed treatment episodes counted by the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS) does not equate to the number of individuals who have received treatment in any one year.

21 An important reason why South Australia has a high proportion of episodes of treatment where amphetamines are the principal drug of concern and assessment only is the main treatment type is that data include assessment under the Police Drug Diversion Initiative. This program is legislated in South Australia, unlike other jurisdictions, and therefore results in a much higher percentage of assessment only services and a very high rate of engagement with amphetamine users. In addition, due to the Cannabis Expiation Notice legislation in South Australia, adult simple cannabis offences are not diverted to treatment and so are excluded from the data.