



Drug and Alcohol Services South Australia Statistical Bulletin

Number 1 - June 2011

This Bulletin is the first in a series providing the most up-to-date data available on the prevalence of alcohol and other drugs, the harms associated with misuse, and alcohol and other drug treatment services in South Australia. The first issue focuses on Aboriginal people in South Australia.¹

In brief: Tobacco

In 2008, 48% of Aboriginal people surveyed in South Australia were smokers. This is slightly higher than the national prevalence (47%). There was no change in the proportion of smokers in South Australia between 2002 and 2008; in contrast, there has been a decrease nationally (from 51% to 47%). The prevalence of tobacco smoking was significantly lower among other South Australians² (20% compared with 48%).

In brief: Alcohol

In 2008, 47% of Aboriginal South Australians consumed alcohol at low risk levels for long-term harm, 19% at medium or high risk levels and 34% had never consumed alcohol, or not within the previous 12 months. Results are similar to those reported nationally, and not significantly different from data collected in 2002. Medium or high risk alcohol consumption was significantly lower among other South Australians (12% compared with 19%).

In brief: Drug-related harms

The prevalence of the hepatitis C virus among Aboriginal injecting drug users Australia-wide has been decreasing since 2005, with a significant drop between 2008 and 2010 (from 67% to 47%). The alcohol-attributable mortality rate among Aboriginal South Australians was more than double that of other South Australians in 2005 and rates of alcohol-attributable hospitalisation were four times greater in both 2007/08 and 2008/09.

In brief: Treatment

Alcohol is the most common principal drug of concern for closed treatment episodes among Aboriginal clients in South Australia, and this proportion increased significantly between 2005/06 and 2008/09 (from 34% to 57%). The proportion was also significantly higher than among other South Australian clients in 2008/09 (57% compared with 53%). The proportion of closed treatment episodes where cannabis was the principal drug of concern was also significantly higher among Aboriginal clients in 2007/08 and 2008/09 (15% compared with 10% and 14% compared with 10%, respectively).

In brief: Conclusions

These data suggest that alcohol and other drug (AOD) use among Aboriginal South Australians contributes to the greater burden of disease and injury observed when compared with other 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.



Government
of South Australia

SA Health



Tobacco

The prevalence of tobacco smoking among Aboriginal respondents in the 2002 and 2008 National Aboriginal and Torres Strait Islander Social Survey (NATSISS)³ is presented in Figures 1 and 2⁴, for South Australia and Australia. Although there are small differences in smoking rates between South Australia and Australia for both 2002 and 2008, the proportions were not statistically significant. Looking at South Australia only, smoking rates did not change significantly between 2002 and 2008, with 48% of respondents reporting they were current smokers⁵. Nationally, the prevalence of smoking decreased between 2002 and 2008 (from 51% to 47%) and the percentage of ex-smokers⁶ increased (15% compared with 20%). Differences in the two proportions were statistically significant ($p < 0.05$).

Figure 1: Smoking status of Aboriginal respondents aged 15 years and over, South Australia and Australia, 2002

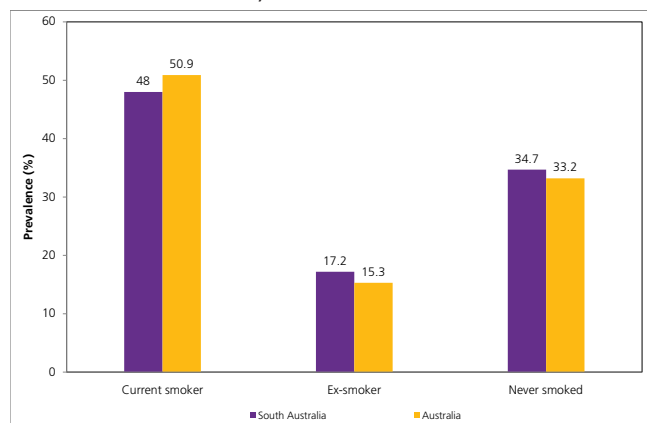


Figure 2: Smoking status of Aboriginal respondents aged 15 years and over, South Australia and Australia, 2008

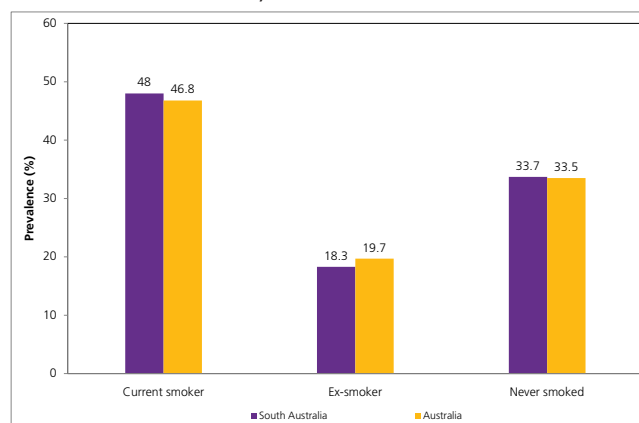


Figure 3⁴ compares the prevalence of tobacco smoking between Aboriginal and other South Australian respondents using the 2008 NATSISS and the 2007-2008 National Health Survey⁷ (NHS). There are striking differences between groups, with Aboriginal respondents more than twice as likely to be current smokers (48% compared with 20%); the difference in the two proportions was statistically significant ($p < 0.05$). This is consistent with data from the 2007 National Drug Strategy Household Survey⁸ (NDSHS), where 19% of other South Australians reported currently smoking (a small decrease from 20% in the 2004 survey). Similarly, smoking prevalence among respondents aged 15 years or more in the South Australian Annual Health Omnibus Survey (HOS)⁹ was 20.6% in 2007 (20.7% in 2010). As expected, other South Australians were significantly more likely to be ex-smokers (29% compared with 18%) or to have never smoked (51% compared with 34%). National data are not presented as they were almost identical to those reported in South Australia.

Figure 4 shows the prevalence of tobacco smoking among Aboriginal South Australians in the 2008 NATSISS according to sex, and compares it with other South Australians interviewed in the NHS. Among Aboriginal respondents, the percentage of current smokers was almost identical for males and females, and there was also no significant difference in the proportion of those who had never smoked. Males were slightly more likely to have never smoked (35% compared with 33%) but again, the difference was not significant. Among other South Australians, males were significantly more likely to be current smokers (24% compared with 17%; $p < 0.05$). Females were significantly more likely to be ex-smokers (24% compared with 33%; $p < 0.05$) and to have never smoked (43% compared with 59%; $p < 0.05$). A similar and more pronounced difference was reported in the 2010 HOS (26% of males smoked, compared with 16% of females; $p < 0.01$). In contrast, the difference in smoking prevalence between Aboriginal males and females in South Australia was not significant.

Figure 3: Smoking status of Aboriginal and other respondents aged 15 years and over, South Australia, 2008 and 2007-2008

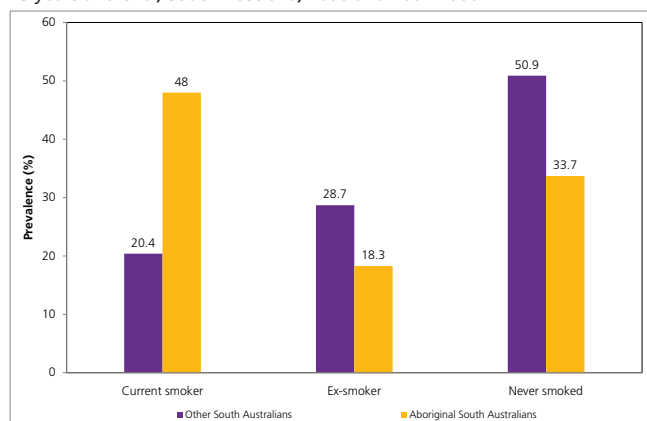


Figure 4: Smoking status of Aboriginal and other respondents aged 15 years and over by sex, South Australia, 2008 and 2007-2008

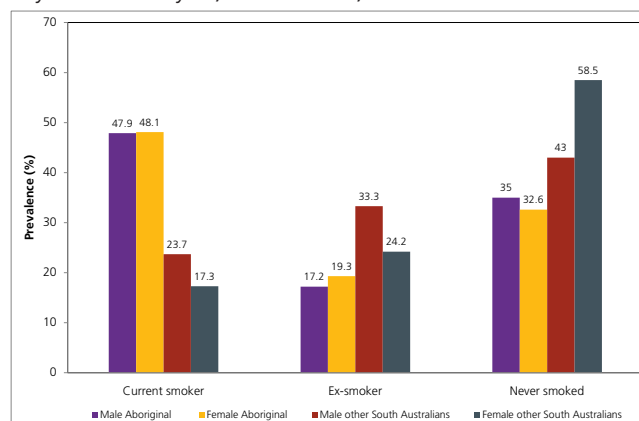


Figure 5 shows the prevalence of tobacco smoking among Aboriginal South Australians in the 2008 NATSISS according to age. Smoking rates were highest among Aboriginal respondents aged 35-44 years (59%). Forty-three percent of respondents aged 15-24 years were current smokers; this is much higher than rates reported among other South Australians (8% of 15-17 year olds and 24% of 18-24 year olds according to the South Australian component of the NHS, and 23% of 15-29 year olds according to the 2010 HOS).

Figure 6 shows the prevalence of tobacco smoking among Aboriginal South Australians in the 2008 NATSISS according to location. A higher proportion of respondents living in remote or very remote areas were current smokers (60%) compared with those in inner or outer regional areas (49%), although the difference in the two proportions was not statistically significant. Respondents living in remote and very remote areas were significantly more likely to be current smokers than those in major cities (42%; $p < 0.05$).

Figure 5: Smoking status of Aboriginal respondents aged 15 years and over by age group, South Australia, 2008

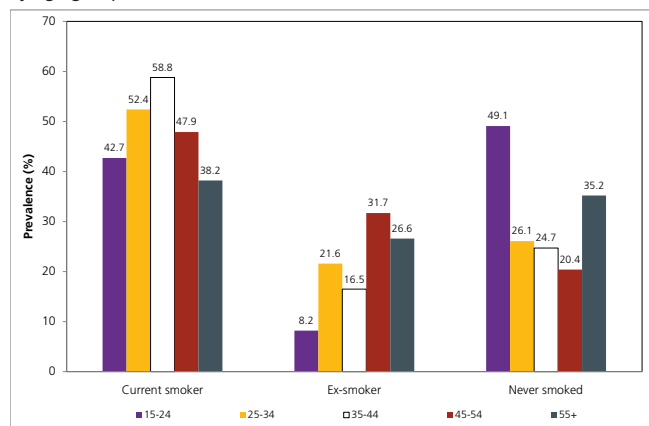
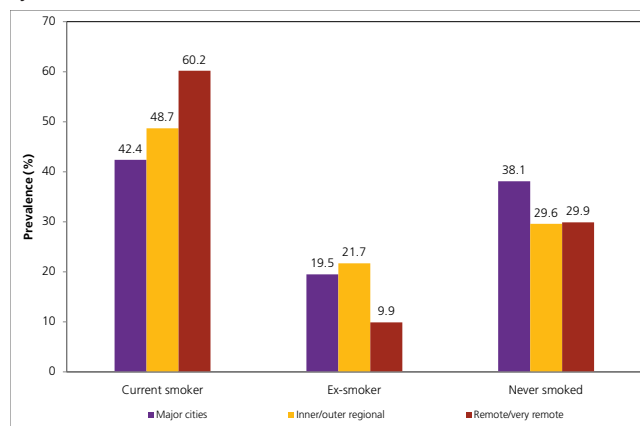


Figure 6: Smoking status of Aboriginal respondents aged 15 years and over by location, South Australia, 2008

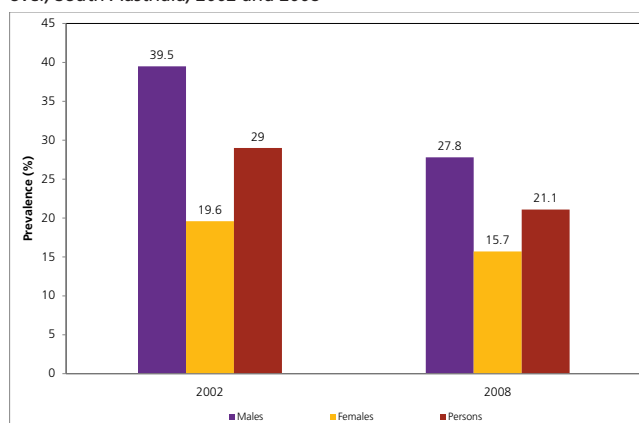


Cannabis

Figure 7 compares cannabis use among Aboriginal South Australians in the 2002 and 2008 NATSISS¹⁰. There has been a statistically significant decrease ($p < 0.05$) in cannabis use between 2002 and 2008 from 29% to 21%, primarily due to a decrease in use among males (40% to 28%).

Cannabis use by Aboriginal South Australians was higher than that reported nationally, where 20% of respondents in 2002 (25% of males and 16% of females) and 18% in 2008 (24% of males and 12% of females) reported use in the previous 12 months. Although there was a small decrease over time among Australian respondents, the difference in the two proportions was not statistically significant.

Figure 7: Cannabis use among Aboriginal respondents aged 18 years and over, South Australia, 2002 and 2008

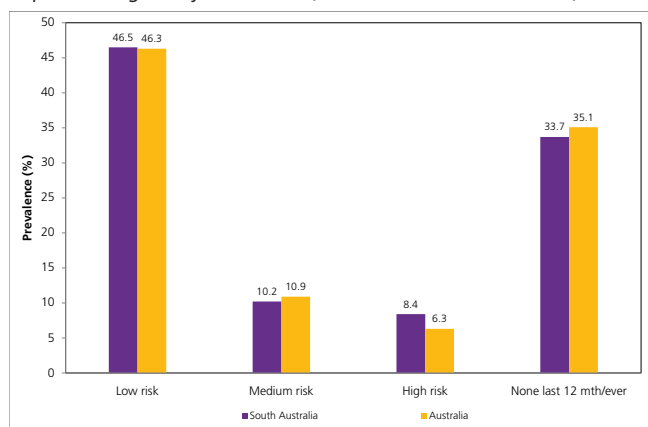


Alcohol

Long-term alcohol consumption risk¹¹ among Aboriginal respondents in the 2008 NATSISS is presented in Figure 8⁴, for South Australia and Australia. No statistically significant differences were found between South Australia and Australia for all risk categories. In addition, there were no significant differences in long-term alcohol consumption risk between the 2008 and 2002 NATSISS, for both South Australia and Australia.

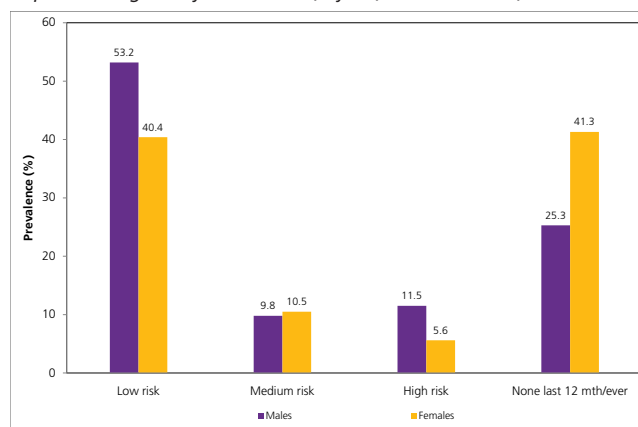
Figure 9 shows alcohol consumption risk in the long-term among Aboriginal South Australians in the 2008 NATSISS according to sex. Females were significantly more likely to have not consumed alcohol in the previous 12 months or ever (41% compared with 25%; $p < 0.05$); males were significantly more likely to have consumed alcohol at high-risk (12% compared with 6%; $p < 0.05$) or low-risk levels (53% compared with 40%; $p < 0.05$).

Figure 8: Alcohol consumption risk* in the long-term for Aboriginal respondents aged 15 years and over, South Australia and Australia, 2008



* Alcohol consumption reported in the previous 12 months

Figure 9: Alcohol consumption risk* in the long-term for Aboriginal respondents aged 15 years and over, by sex, South Australia, 2008



* Alcohol consumption reported in the previous 12 months

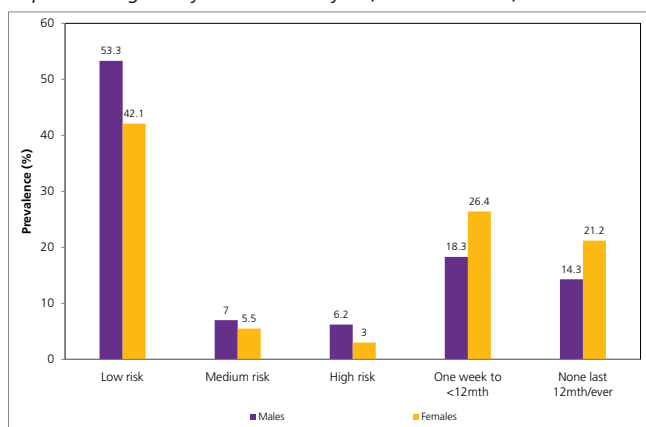
Figure 10 shows long-term alcohol consumption risk among other South Australians in the NHS according to sex. Males were significantly more likely to drink alcohol at low risk levels (53% compared with 42%, $p < 0.05$). Males were also significantly more likely to consume alcohol at high risk levels (6% compared with 3%; $p < 0.05$). Conversely, females were significantly more likely to have not consumed alcohol between one week and 12 months prior to the survey (26% compared with 14%; $p < 0.05$) or ever/within the last 12 months (21% compared with 14%; $p < 0.05$).

Figure 11 compares long-term alcohol consumption risk between Aboriginal South Australians and other South Australians using the 2008 NATSISS and the 2007-2008 NHS. Note that 22% of other South Australians reported last consuming alcohol between one week and less than 12 months ago; as this category was not reported separately in the NATSISS comparisons were only made between alcohol consumption risk categories.

Aboriginal South Australians in the NATSISS were significantly more likely to consume alcohol at medium or high-risk levels compared with other South Australians in the NHS ($p < 0.05$). National data are not presented as they showed a similar trend to that observed in South Australia.

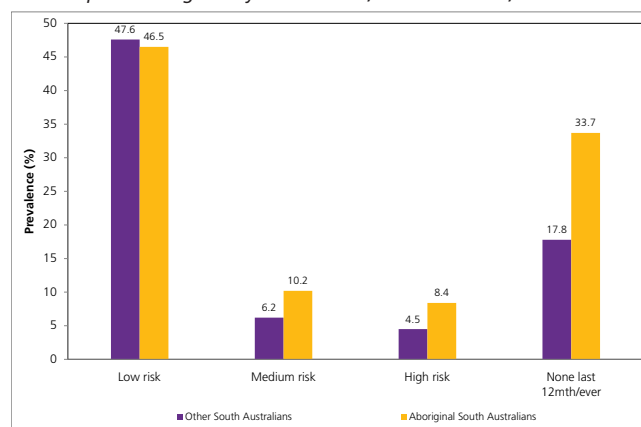
Long-term alcohol consumption risk among other South Australians and Australians in the NHS was also examined, with no significant differences found. Results were very similar, with 47-48% of respondents reporting low risk alcohol consumption. A further 12-13% had consumed alcohol at medium or high risk levels, 22% had not consumed alcohol for at least one week but within the last 12 months, and the remaining 18% had not consumed alcohol in the previous 12 months, or ever.

Figure 10: Alcohol consumption risk* in the long-term for other respondents aged 15 years and over by sex, South Australia, 2007-2008



* Alcohol consumption reported in the previous 12 months

Figure 11: Alcohol consumption risk* in the long-term for Aboriginal and other respondents aged 15 years and over, South Australia, 2008 & 2007-10



* Alcohol consumption reported in the previous 12 months

Drug-related harms

Prevalence of hepatitis C among injecting drug users

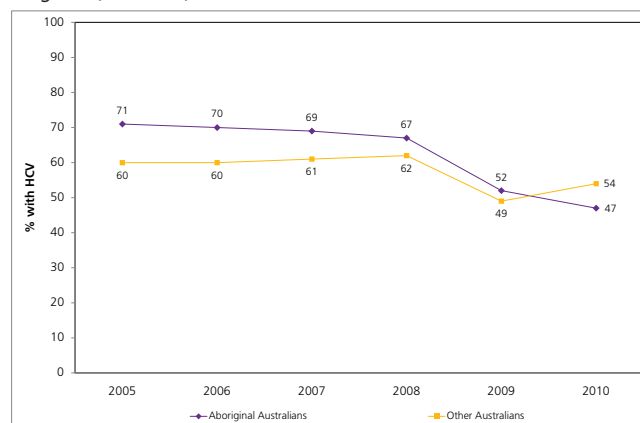
Figure 12 presents data on the prevalence of the hepatitis C virus (HCV) among Aboriginal and other injecting drug users in Australia between 2005 and 2010 (Australian Needle & Syringe Program Survey; ANSPS)¹². South Australian data are not included here as Aboriginal respondents only comprised between 16 and 31 people (7% to 13%) of the sample.

For Aboriginal injecting drug users, the prevalence of HCV was significantly higher than for other injecting drug users from 2005-2007 (around 10 percentage points). In 2008 and 2009, the prevalence of HCV remained higher among Aboriginal injecting drug users but the difference was not statistically significant (67% compared with 62%, and 52% compared with 49%, respectively). However, in 2010 the prevalence of HCV was significantly lower among Aboriginal injecting drug users (47% compared with 54%; $p < 0.05$). In addition, HCV prevalence has decreased steadily among Aboriginal injecting drug users since 2005; the drop between 2008 and 2009 from 67% to 52% was statistically significant ($p < 0.05$), and this decrease was sustained in 2010. Looking at gender

differences, male Aboriginal Australians had a higher prevalence of HCV than other male Australians from 2005-2009, but this was only statistically significant in 2007 (71% compared with 60%; $p < 0.05$) and the gap has been narrowing over time. In 2010, the prevalence of HCV was lower among male Aboriginal injecting drug users (49% compared with 54%), although this was not statistically significant. Similar results were found for females, with a significantly higher prevalence of HCV in both 2005 and 2006 (78% compared with 60%, and 78% compared with 61%, respectively; $p < 0.01$). However, the percentage of female respondents with HCV in 2009 was identical between groups (52%) and in 2010, the prevalence of HCV was lower among female Aboriginal injecting drug users (45% compared with 54%), although again, the difference was not statistically significant.

It can be seen that for other injecting drug users, the prevalence of HCV remained fairly consistent between 2005 and 2008, ranging from 60% to 62%. There was a statistically significant drop between 2008 and 2009 from 62% to 49% ($p < 0.05$), followed by a non-significant increase to 54% in 2010.

Figure 12: HCV antibody prevalence among Aboriginal and other injecting drug users, Australia, 2005-2010



Mortality¹³

Table 1 shows that alcohol consumption accounted for 578 South Australian deaths in 2005 and 540 in 2006¹⁴. Although the number of Aboriginal deaths in South Australia attributable to alcohol was much lower than that of other South Australians (21 compared with 539 in 2005 and 11 compared with 522 in 2006), the alcohol-attributable mortality rate was more than double that of other South Australians in 2005. In 2006, the disparity between groups was less pronounced, but mortality rates were still higher among the Aboriginal population.

Hospital Admissions

It has been estimated that 11,537 and 12,076 people were hospitalised in South Australia in the 2007/08 and 2008/09 financial years, respectively, as a result of drinking¹⁴. Details are provided in Table 2.

In 2007/08, a total of 795 Aboriginal South Australians were hospitalised as a result of drinking, compared with 10,262 other South Australians. That is, Aboriginal South Australians comprised 7% of drinking-related hospitalisations in 2007/08.

In 2008/09, 880 Aboriginal South Australians were hospitalised compared with 10,607 other South Australians, (8% of drinking-related hospitalisations in 2008/09). Importantly, Aboriginal South Australians were hospitalised at more than four times the rate seen in other South Australians. This rate was higher for Aboriginal males than Aboriginal females. Aboriginal South Australians were also nearly twice as likely to be hospitalised as a result of events that were not attributed to alcohol.

Table 1: Estimated number of lives lost due to drinking in 2005 and 2006, based on 2001 NHMRC drinking guidelines, South Australia

Indigenous status	Lives lost							
	Alcohol-attributable				Non-alcohol attributable			
	2005		2006		2005		2006	
	N	CR	N	CR	N	CR	N	CR
Other South Australians	539	3.5	522	3.4	5167	33.8	5488	35.5
Aboriginal South Australians	20	7.3	11	4.0	71	25.5	62	21.9
Unknown	19	-	6	-	83	-	38	-
Total	578	3.7	540	3.4	5321	34.2	5588	35.5

Note: totals may not add up as they are based on actual estimates (including all decimal values) and not the rounded values given in this table.
CR = Crude rates per 10,000 population.

Table 2: Estimated number of hospitalisations caused by drinking in 2007-08 to 2008-09, based on 2001 NHMRC drinking guidelines, South Australia

Indigenous status	Hospitalisations caused							
	Alcohol-attributable				Non-alcohol attributable			
	2007-08		2008-09		2007-08		2008-09	
	N	CR	N	CR	N	CR	N	CR
Other South Australians	10262	65.2	10607	66.4	486300	3089.2	497764	3118.4
Aboriginal South Australians	795	272.5	880	295.3	15416	5281.4	16279	5465.5
Unknown	479	-	589	-	22554	-	26444	-
Total	11537	72.0	12076	74.3	524270	3269.8	540487	3324.0

Note: totals may not add up as they are based on actual estimates (including all decimal values) and not the rounded values given in this table.
CR = Crude rates per 10,000 population.

Treatment data

The proportion of closed treatment episodes in Australia where the client identified as Aboriginal increased slightly between 2005-06 and 2008-09, from 10% to 12%. In South Australia, the proportion of closed episodes where clients identified as Aboriginal fluctuated between 2005-06 and 2008-09 and overall, was lower than the national percentages (7.4% in 2005/06, increasing to 9.4% in 2006/07, followed by a decrease to 6.8% in 2007/08 and rising again in 2008/09 to 8.5%). These data have been taken from the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS).¹⁵

Figures 13 and 14 show the proportion of closed treatment episodes for Aboriginal and other South Australian clients according to principal drug of concern from 2005-06 to 2008-09. For both groups, alcohol was the most common principal drug of concern.

The proportion of closed treatment episodes where alcohol was the principal drug of concern increased steadily among Aboriginal clients between 2005/06 and 2008/09 (from 34% to 57%). The proportion of closed treatment episodes for cannabis decreased over time among other South Australian clients, from 15% in 2005/06 to 10% in 2008/09. Among Aboriginal clients, closed treatment episodes for cannabis remained fairly stable at around 14%, although there was a decrease to 10% in 2006/07.

The proportion of closed treatment episodes where the principal drug of concern was meth/amphetamine was slightly lower among Aboriginal clients, and proportions have fluctuated over time. The proportion of closed treatment episodes where meth/amphetamine was the principal drug of concern for other South Australian clients has shown an overall decreasing trend over time. For heroin, there has been a decrease in the proportion of closed treatment episodes among Aboriginal clients, from 13% in 2005/06 to 7% in 2008-/09. Among other South Australian clients, the proportion has fluctuated between 8% and 9%, with an increase in 2008/09 to 11%.

In 2005/06 and 2008/09, differences between the proportions of closed treatment episodes for Aboriginal and other South Australian clients were statistically significant for alcohol ($p < 0.01$ and $p < 0.05$, respectively). In 2005/06, Aboriginal clients had a significantly lower proportion of closed treatment episodes for alcohol, but in 2008/09 the reverse was found, with 57% of closed treatment episodes having alcohol as the principal drug of concern, compared with 53% among other South Australian clients.

For cannabis, statistically significant differences between Aboriginal and other South Australian closed treatment episodes proportions exist for 2007/08 and 2008/09. At each time-point, the proportion of closed treatment episodes with cannabis as the principal drug of concern was significantly higher among Aboriginal clients (15% compared with 10% and 14% compared with 10%, respectively; $p < 0.01$).

Conversely, the proportion of treatment episodes with meth/amphetamine as the principal drug of concern was significantly lower among Aboriginal clients in 2006/07 and 2008/09 (11% compared with 20% and 9% compared with 14%, respectively; $p < 0.01$).

Figure 13: Closed treatment episodes by principal drug of concern among other clients, South Australia, 2005-2009

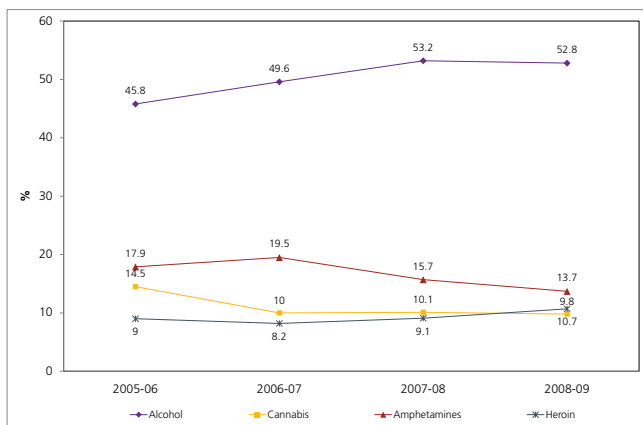
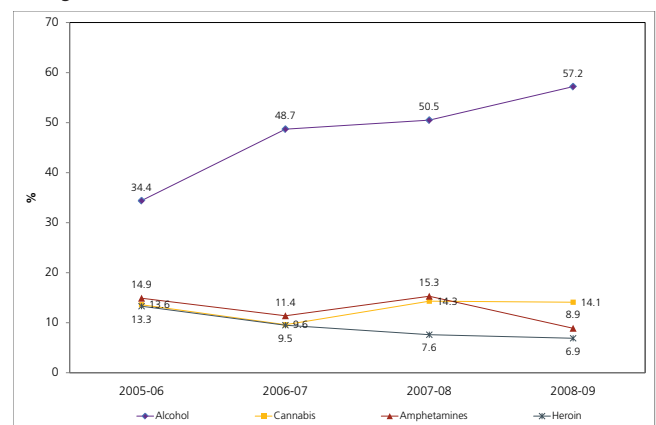


Figure 14: Closed treatment episodes by principal drug of concern among Aboriginal clients, South Australia, 2005-2009



Endnotes

1. In this document, Aboriginal includes both Aboriginal and Torres Strait Islander people. Note that Torres Strait Islander people make up a very small proportion of the South Australian population.
2. Throughout this bulletin, 'other South Australians/Australians', 'other respondents/patients/clients/injecting drug users' refer to people who do not identify as Aboriginal or Torres Strait Islander. This terminology is taken from the SA Health Corporate Style Guide, February 2008.
3. The 2002 and 2008 NATSISS was conducted by the Australian Bureau of Statistics (ABS) from August 2002 to April 2003 and from August 2008 to April 2009, respectively. Information was collected from 9,359 Indigenous Australians in 2002 and 13,307 in 2008, 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 and 1,291 in 2008. Reference: National Aboriginal and Torres Strait Islander Social Survey 2008. Australian Bureau of Statistics Catalogue No. 4714.0. Canberra: Australian Bureau of Statistics, 2009.
4. Figures 1-3 and 8 have been taken from Issue 2 (2010) of Pulsecheck, a newsletter produced by the Drug and Alcohol Office in Western Australia, and adapted to include South Australian data.
5. Defined as either regular/daily smokers (at least one cigarette per day) or occasional smokers (less than one cigarette per week, or at least one cigarette per week, but not daily). The majority of current smokers were daily smokers.
6. Respondents who reported that they did not currently smoke, but had regularly smoked daily, or had smoked at least 100 cigarettes, or smoked pipes, cigars, etc at least 20 times in their lifetime.
7. The 2007–2008 National Health Survey was conducted from August 2007 to July 2008. It is the fifth in a series designed to obtain national benchmark information on a range of health-related issues and to enable the monitoring of health trends over time. A total of 20,788 persons participated; 3,171 in South Australia. References: National Health Survey: Summary of Results; State Tables, 2007-2008. Australian Bureau of Statistics Catalogue No. 4362.0. Canberra: Australian Bureau of Statistics, 2009. National Health Survey: Summary of Results, 2007-2008. Australian Bureau of Statistics Catalogue No. 4364.0. Canberra: Australian Bureau of Statistics, 2009.
8. The NDSHS has been conducted triennially since 1985. In 2007, 23,356 Australians aged 12 years or older were surveyed, and provided information on drug use patterns, attitudes and behaviours. The sample included 372 Indigenous respondents (1.6%). In South Australia, 1,947 people were surveyed. References: Australian Institute of Health and Welfare. 2007 National Drug Strategy Household Survey: detailed findings. Drug statistics series no. 22. Cat. no. PHE 107. Canberra: AIHW, 2008. Australian Institute of Health and Welfare. 2007 National Drug Strategy Household Survey: State and territory supplement. Drug statistics series no. 21. Cat. no. PHE 102. Canberra: AIHW, 2008.
9. TCRE. Progress against the 'South Australian Tobacco Control Strategy 2005-2010'. Adelaide: Tobacco Control Research and Evaluation, Cancer Council SA, March 2011. The Health Omnibus Survey is an annual survey that has been running since 1990, and aims to interview 3,000 respondents each year. In 2010, 3,046 face-to-face interviews were conducted, and the sample is weighted to reflect the South Australian population using sex, age and geographic area. Current smokers were defined as those who smoked daily, weekly and less than weekly. The majority of current smokers were daily smokers.
10. Data are based on respondents living in non-remote areas only and only include those who accepted the substance use form. In 2002, 12.2% of respondents in South Australia refused the form, compared with 9.7% in 2008. In the Australian sample as a whole, 7.4% refused the form in 2002 and 9.3% in 2008.
11. Long-term risk is based on respondents' self-reported usual daily consumption of alcohol and the frequency of consumption in the previous 12 months; risk was determined using the 2001 NH&MRC Australian Drinking Guidelines, where low risk is defined as drinking less than four drinks per day for men and two for women; medium risk as 5-6 drinks per day for men and 3-4 for women; and high risk as 7+ per day for men and 5+ for women. Reference: National Health & Medical Research Council. Australian Guidelines to Reduce Health Risks from Drinking Alcohol. Canberra: National Health & Medical Research Council, 2009.
12. The ANSPS is an annual survey that monitors human immunodeficiency virus (HIV) and hepatitis C (HCV) antibody prevalence among people who inject drugs in Australia. All clients attending participating Needle & Syringe Program services during the designated survey period were invited to complete a brief, anonymous questionnaire and to provide a capillary blood sample for HIV and HCV antibody testing. Reference: Iversen J, Topp L, Maher L. Australian NSP Survey National Data Report 1995-2010. The Kirby Institute, The University of New South Wales, Sydney, 2011.
13. Data are taken from Evans M, Pascal R, Chikritzhs T. Development of South Australian Specific Aetiological Fractions and Estimates of Alcohol Attributable Morbidity and Mortalities. Western Australia: National Drug Research Institute, Curtin University, 2010.
14. Data differ from those published elsewhere (National Alcohol Indicators Project. Trends in estimated alcohol attributable deaths and hospitalisations in Australia, 1996-2005. Bulletin No. 12, September 2009) as they are based on all levels of risk rather than just deaths or hospitalisations attributable to risky/high risk alcohol consumption. Data presented here are also based on SA-specific aetiological fractions.
15. Information regarding the utilisation of alcohol and other drug treatment services is sourced from the AODTS-NMDS. The unit of measurement used is a 'closed treatment episode', which 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 AODTS-NMDS does not equate to the number of individuals who have received treatment in any one year. Note that clients receiving services that are funded solely by the Office for Aboriginal and Torres Strait Islander Health (OATSIH) as Indigenous Substance Use Services, Aboriginal primary health care services, Aboriginal medical services and community controlled health services are not included in the AODTS-NMDS. Reference: Australian Institute of Health and Welfare. Alcohol and other drug treatment services in Australia 2008–09: report on the National Minimum Data Set. Drug treatment series no. 10. Cat. no. HSE 92. Canberra: AIHW, 2010.



For more information

This Bulletin was prepared by Marie Longo and Richard Cooke, Population Health Monitoring Unit, Drug and Alcohol Services South Australia.

For more information, please contact:

Population Health Monitoring Unit
Telephone: 08 8274 3385
Email: richard.cooke@health.sa.gov.au

Drug and Alcohol Services South Australia acknowledges the contribution of the Australian Institute of Health and Welfare and the Australian Bureau of Statistics.

Drug and Alcohol Services SA
161 Greenhill Road, Parkside SA 5063
Telephone: 08 8274 3333
www.dassa.sa.gov.au

Alcohol and Drug Information Service (ADIS)
Telephone: 1300 13 1340
(24-hour confidential counselling and information service)



<http://www.gilf.gov.au/>

© Department of Health, Government of South Australia. All rights reserved. July 2011.



Government
of South Australia

SA Health