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National Drug Strategy Household Survey 2019

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Contents

Acknowledgments

Authorship

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Contributors

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Participants

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Fieldwork

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Questionnaire

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Abbreviations

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
ASSIST	Alcohol, Smoking and Substance Involvement Screening Test
CATI	Computer-assisted telephone interview
CURF	Confidentialised unit record file
IRSAD	Index of relative socioeconomic advantage and disadvantage
K10	Kessler 10 scale
NDS	National Drug Strategy
NDSHS	National Drug Strategy Household Survey
NHMRC	National Health and Medical Research Council
NSW	New South Wales
NT	Northern Territory
PHN	Primary Health Network
RSE	Relative standard error
SA1	Statistical Areas level 1
SA2	Statistical Areas level 2
SE	Standard error
WA	Western Australia

Summary

Tobacco, alcohol and illicit drug use can place a heavy burden on individuals, families and society. The health, social and economic effects are diverse and substantial, and include disease and injury, mental health conditions, road accidents, family and domestic violence, and other crime.

This report presents key results from the 2019 National Drug Strategy Household Survey. It looks at people's drug use throughout their lives and during the last 12 months, and examines how these patterns have changed over time. It also asks people for their opinions on a range of initiatives designed to reduce the harm caused by tobacco, alcohol and illicit drug use, and for the first time provides perspectives on emerging initiatives, such as the availability of pill and other drug testing for potential drug users.

Fewer Australians are smoking tobacco

In 2019, 11.0% of Australians smoked tobacco daily, down from 12.2% in 2016 and 24% in 1991. These falls were mainly driven by younger generations not taking up smoking.

Many smokers were taking steps to reduce their tobacco consumption in 2019. Around 2 in 5 (39%) said they had cut back on the amount of tobacco smoked per day over the past 12 months. In 2019, a smoker would smoke, on average, 13 cigarettes per day, down from 16 in 2010. Almost 3 in 5 (58%) smokers said the cost was motivating them to quit or cut back, up from around 1 in 2 (52%) in 2016.

Roll-your-own and e-cigarettes use is increasing

While fewer Australians were smoking in 2019, 45% of smokers used roll-your-own cigarettes, up from 36% in 2016. One-third (33%) of smokers smoked roll-your-own cigarettes in combination with manufactured cigarettes (up from 26% in 2016), and 13.9% smoked roll-your-own cigarettes exclusively (up from 10.7% in 2016).

Use of e-cigarettes is also becoming more common. Between 2016 and 2019, the proportion of people who had ever used e-cigarettes rose from 8.8% to 11.3%. While use of e-cigarettes rose across most age groups, the rise among young adults was particularly notable. Nearly 2 in 3 (64%) current smokers and 1 in 5 (20%) non-smokers aged 18–24 reported having tried e-cigarettes. Among those who had tried them, frequency of use also increased, with more people using them at least monthly (from 10.3% in 2016 to 17.9% in 2019).

More Australians are giving up or reducing their alcohol intake, driven by health concerns

Between 2016 and 2019, the proportion of ex-drinkers rose from 7.6% to 8.9%. There was also a rise in the number of people cutting back on alcohol, with 31% of people saying they had reduced the number of alcoholic drinks they consumed at any 1 time, up from 28% in 2016. The main reason people gave for reducing their intake was 'health reasons' (such as weight loss or avoiding hangovers).

Despite this, there has been little change in the proportion of people drinking at risky levels. In 2019, 1 in 4 (25%) people drank at a risky level on a single occasion at least monthly, while about 1 in 6 (16.8%) exceeded the lifetime risk guideline. While the proportion exceeding the single occasion risk and lifetime risk guidelines has remained stable in recent years, it has improved since the guidelines were introduced in 2009 (was 29% and 21% respectively in 2010).

More than 2 in 5 Australians have used an illicit drug in their lifetime, and recent cannabis use has increased

In 2019, 43% of Australians aged 14 and over had illicitly used a drug at some point in their life (including pharmaceuticals used for non-medical purposes) and 16.4% had used one in the last 12 months. This has been fairly stable since 2016, but up from 38% and 13.4% in 2007.

Cannabis was the most commonly used illicit drug in 2019, with 11.6% of Australians using it in the last 12 months. This was followed by cocaine (4.2%), ecstasy (3.0%) and non-medical use of pain-killers and opioids (2.7%). Use of cannabis, cocaine and ecstasy all rose between 2016 and 2019, as did the use of inhalants, hallucinogens, and ketamine, while the non-medical use of pain-killers and opioids fell over the same period.

While the use of cocaine and ecstasy in the previous 12 months increased between 2016 and 2019, use of meth/amphetamines remained stable (1.4% in 2016 and 1.3% in 2019). However, people who used meth/amphetamines continued to use them more frequently than people who used cocaine and ecstasy. Cannabis continued to be the most frequently used illicit drug, with 37% using it weekly or more often; this was followed by meth/amphetamine use with 17% using it at least weekly. This increased to 29% among those who used crystal/ice as their main form of meth/amphetamines. Very few people who used ecstasy or cocaine used it weekly or more often—6.7% and 4.5% respectively.

Rates of substance use are falling among younger generations

Compared with people their age in 2001, today's young people are less likely to smoke, drink and use illicit drugs. This may be due to the young people of 2001 carrying on similar habits as they age, today's young people having different habits from past generations, or a combination.

In 2001, people in their 20s were most likely to have used an illicit drug in their lifetime, but by 2019 it was people in their 40s. While rates of illicit drug use rose among older age groups over this period, rates remained stable for people in their 30s and fell for people under 30.

In 2001, people in their 20s were also the most likely to smoke daily, but in 2019 it was people in their 40s and 50s. Older people were also the most likely to drink alcohol daily in 2019, with the highest rates seen among people aged over 70 (12.6%). Just 1.2% of people aged 20–29 drank daily. Younger people are also now more likely to abstain from alcohol than they were 18 years ago. For example, the proportion of people in their 20s abstaining from alcohol increased from 8.9% in 2001 to 22% in 2019.

Cocaine use is at its highest level in almost 2 decades

In 2019, 4.2% of Australians had used cocaine in the previous 12 months. This is the highest proportion seen since 2001, and has risen from 2.5% in 2016. Increases were seen across all age groups (except 14–19 year olds), but the overall rise was mainly driven by men.

Men also drove an increase in rates of recent ecstasy use, particularly those aged in their 20s and 30s. After declining in recent years, ecstasy use was up in 2019, with 3.0% of Australians having used it in the previous 12 months (up from 2.2% in 2016). There has also been a shift in the main forms of ecstasy used, with capsules (33% in 2016 to 49% in 2019) now used more than pills/tablets (from 51% in 2016 to 34% in 2019).

Non-medical pharmaceutical use is down, driven by a fall in use of pain-killers

Between 2016 and 2019, the proportion of people using pharmaceuticals for non-medical purposes in the previous 12 months fell from 4.8% to 4.2%, falling from the second to fourth most commonly used illicit drug in Australia. This change has been driven by a reduction in the non-medical use of pain-killers and opioids, from 3.6% of Australians in 2016 to 2.7% in 2019. There has been a particularly notable fall in the proportion of people using codeine for non-medical reasons, halving from 3.0% in 2016 to 1.5% in 2019. This aligns with codeine being made a prescription-only medication in 2018.

Fewer Indigenous Australians are smoking or drinking at risky levels

Between 2010 and 2019, the proportion of Aboriginal and Torres Strait Islander people who smoked daily fell from 35% to 25%. Over the same period, the proportion who drank at a risky level on a single occasion at least monthly fell from 46% to 34%, as did the proportion who exceeded the lifetime risk guideline, from 32% to 19%.

After adjusting for differences in age, between 2010 and 2019, the proportion of Indigenous Australians who smoked daily declined from 34% to 27%; exceeded the single occasion risk guideline at least monthly declined from 39% to 35%; and exceeded the lifetime risk guideline fell from 30% to 20%.

Rates of illicit drug use remained fairly stable among Indigenous Australians, but rose for non-Indigenous Australians.

Smoking rates increase with socioeconomic disadvantage, but illicit drug use highest in the most advantaged areas

While smoking rates have fallen in all socioeconomic areas, the improvement has been greatest among people living in the most advantaged areas. In 2019, after adjusting for differences in age, the proportion of people living in the lowest socioeconomic areas who smoked daily was almost 4 times as high as the proportion of people living in the highest socioeconomic areas (18.1% compared with 5.0%).

On the other hand, compared with people in more disadvantaged areas, people living in the highest socioeconomic areas have the highest rates of recent drug use and are the least likely to have never used an illicit drug. Between 2016 and 2019, rates of recent illicit drug use rose in the highest socioeconomic areas, but remained relatively stable in the other areas.

Smoking and drinking rates are down among gay, lesbian and bisexual people

Between 2010 and 2019, the proportion of people who identified as gay, lesbian or bisexual who smoked daily fell from 28% to 16%. The proportion who drank at a risky level on a single occasion at least monthly fell from 45% to 38%, as did the proportion exceeding the lifetime risk guidelines, from 30% to 22%.

Over the same period, the proportion of gay, lesbian and bisexual people who had used an illicit drug in the previous 12 months remained similar (36% in 2010 and 40% in 2019), and the use of some drugs was much higher than among heterosexual people. After adjusting for differences in age, compared with heterosexual people gay, lesbian or bisexual people were 9 times as likely to have used inhalants in the previous 12 months, almost 4 times as likely to have used meth/amphetamines in the previous 12 months, and more than 2.5 times as likely to have used ecstasy.

Australians are increasingly supportive of cannabis use and most support pill-testing

In 2019, for the first time, more people said they supported the legalisation of cannabis than opposed it (41% compared with 37%). It was also the first time the proportion of Australians who supported cannabis being used regularly by adults was greater than the proportion that supported regular tobacco smoking (19.6% compared with 15.4%).

Almost 3 in 5 Australians (57%) supported potential drug users being able to test their pills or other drugs at designated sites. There has also been a shift towards education, rather than law enforcement, as the preferred strategy to reduce the use of illicit drugs—when asked where money should be spent, people allocated more funds to education than to law enforcement for the first time in 2019.

Between 2016 and 2019, there was also a decline in support for policies aimed at reducing the problems associated with excessive alcohol use. For example, support for reducing trading hours for pubs and clubs declined from 39% in 2016 to 31% in 2019. More people now oppose reducing trading hours for pubs and clubs than support it (40% compared with 31%).

Table 1: Recent[a] illicit drug use, alcohol use and risk, and tobacco use, people aged 14 and over, 2001 to 2019 (per cent)

Drug/Behaviour	2001	2004	2007	2010	2013	2016	2019
Tobacco							
Daily smoker	19.4	17.5	16.6	15.1	12.8	12.2	11.0#
Current smokers[b]	23.2	20.7	19.4	18.0	15.8	14.9	14.0#
Alcohol							
Recent use[c]	83.6	84.3	82.9	80.3	79.1	77.7	76.6
Lifetime risk[d]	20.9	21.1	20.8	20.5	18.6	17.2	16.8
Single occasion risk [e]	29.7	30.0	29.3	29.0	27.0	25.7	24.8
Illicit drugs (excluding pharmaceuticals)							
Marijuana/cannabis	12.9	11.3	9.1	10.3	10.2	10.4	11.6#
Ecstasy[f]	2.9	3.4	3.5	3.0	2.5	2.2	3.0#
Meth/amphetamine[g]	3.4	3.2	2.3	2.1	2.1	1.4	1.3
Cocaine	1.3	1.0	1.6	2.1	2.1	2.5	4.2#
Hallucinogens	1.1	0.7	0.6	1.4	1.3	1.0	1.6#
Inhalants	0.4	0.4	0.4	0.6	0.8	1.0	1.4#
Heroin	0.2	0.2	0.2	0.2	0.1	0.2	*<0.1
Ketamine	n.a.	0.3	0.2	0.2	0.3	0.4	0.9#
GHB	n.a.	0.1	*0.1	0.1	*<0.1	*0.1	*0.1
Synthetic Cannabinoids	n.a.	n.a.	n.a.	n.a.	1.2	0.3	0.2
New and Emerging Psychoactive Substances	n.a.	n.a.	n.a.	n.a.	0.4	0.3	*0.1#
Injected drugs	0.6	0.4	0.5	0.4	0.3	0.3	0.3
Any illicit[h] excluding pharmaceuticals	14.2	12.6	10.8	12.0	12.0	12.6	14.1#
Pharmaceuticals							
Pain-killers/pain-relievers and opioids[g,i]	n.a.	n.a.	n.a.	n.a.	n.a.	3.6	2.7#
Tranquillisers/sleeping pills[g]	1.1	1.0	1.4	1.5	1.6	1.6	1.8
Steroids[g]	0.2	*<0.1	*0.1	0.1	*0.1	*0.1	0.2
Methadone or Buprenorphine[g,j]	0.1	*<0.1	*<0.1	0.2	0.2	0.1	0.1
Non-medical use of pharmaceuticals[i]	n.a.	n.a.	n.a.	n.a.	n.a.	4.8	4.2#
Illicit use of any drug							
Any opioid[k]	n.a.	n.a.	n.a.	n.a.	n.a.	3.7	2.8#
Any illicit[l]	16.7	15.3	13.4	14.7	15.0	15.6	16.4

* Estimate has a relative standard error of 25% to 50% and should be used with caution.
# Statistically significant change between 2016 and 2019.
(a) Used the specified drug in the previous 12 months.
(b) Includes people who reported smoking daily, weekly or less than weekly.
(c) Consumed an alcoholic drink in the previous 12 months.
(d) According to 2009 NHMRC guideline 1: On average, had more than 2 standard drinks per day.
(e) Derived from 2009 NHMRC guideline 2: Had more than 4 standard drinks on one occasion at least once a month.
(f) Included 'designer drugs' before 2004.
(g) For non-medical purposes.
(h) Illicit use of at least 1 of 12 classes of drugs (excluding pharmaceuticals) in the previous 12 months in 2019. The number and type of drug used varied over time.
(i) Excludes over-the-counter medications such as paracetamol and aspirin.
(j) Did not include buprenorphine before 2007.
(k) Includes use of heroin, non-medical use of pain-killers/pain-relievers and opioids or non-medical use of methadone/buprenorphine.
(l) Used at least 1 of 16 classes of illicit drugs in the previous 12 months in 2019. The number and type of illicit drug used varied over time.
Notes
1. Smoking status in 2010 has been revised. Trend data may not match previously published results.
2. The calculation of drinking status and alcohol risk was updated for all years in 2019. Trend data may not match previously published results.
3. In 2016, pain-killer/pain-relievers and opioids sections were combined into one section and references and questions about use of non-opioid over-the-counter drugs such as paracetamol and aspirin were removed. Data are not considered comparable to previous years.
4. The NDSHS offers introductory text for each class of drug, including examples of the drugs included. Examples for hallucinogens, inhalants and New and Emerging Psychoactive Substances were changed in 2019, which may have affected trend results since 2016.

Source: Table 1.1.

1 Introduction

The National Drug Strategy Household Survey (NDSHS) collects information on alcohol and tobacco consumption, and illicit drug use among the general population in Australia. It also surveys people's attitudes and perceptions relating to tobacco, alcohol and other drug use. The 2019 NDSHS collected information from almost 23,000 people aged 14 and over across Australia.

Drug use—harms and costs to society

Understanding the extent of tobacco, alcohol and other drug use in Australia is important, as the potential harms can affect, directly and/or indirectly, not only the individual but the community more broadly. Health, social and economic harms can stem from drug use, including disease and injury, road trauma, mental health conditions, family and domestic violence, crime, and marginalisation. These harms can disproportionately affect specific population groups (DoH 2017).

The use and misuse of licit and illicit drugs imposes a heavy financial cost on the Australian community. In recent years, the separate costs of tobacco ($136.9 billion in 2015–16), opioid ($15.76 billion in 2015–16), methamphetamine (over $5 billion in 2013–14) and alcohol use ($14.35 billion in 2010) in Australia have been estimated, utilising different methodologies (Manning, Smith & Mazerolle 2013; Whetton et al. 2016; Whetton et al. 2019; Whetton et al. 2020).

Tobacco smoking continues to cause more ill health and premature death than alcohol and other drug use combined. The Australian Institute of Health and Welfare (AIHW) estimated that in 2015, 20,933 deaths were attributable to tobacco; 6,355 were attributable to alcohol; and 2,486 were attributable to illicit drugs. The number of hospital separations was also considerably higher for smoking than for alcohol and other drugs. In 2015–16, there were an estimated 1.7 million smoking-related hospital separations (Whetton et al. 2019) compared with about 136,000 alcohol and other drug related hospital separations (AIHW 2020).

Despite declines in the proportion of Australians smoking tobacco over time, tobacco continued to be the leading risk factor contributing to death and disease in Australia in 2015 and was responsible for 9.3% of the total burden of disease and injury. This includes the risks associated with past and current tobacco use, and exposure to second-hand smoke. In addition, tobacco use contributed to the burden for 8 disease groups including 41% of respiratory diseases, 22% of cancers and 12% of cardiovascular diseases. Specifically, it was estimated that 78% of the lung cancer disease burden and 72% of the chronic obstructive pulmonary disease burden were attributable to tobacco use (AIHW 2019c).

Alcohol use contributed to 4.5% of the total burden of disease in Australia in 2015 and was the leading risk factor for males aged 25–44 (11.9% compared to females 3.4%). Males experienced a greater proportion of disease burden attributable to alcohol use than females. Alcohol use was responsible for 40% of liver cancer burden, 28% of chronic liver disease burden, 22% of *Road traffic injuries—motor vehicle occupant* burden and 14% of suicide burden (AIHW 2019c).

Illicit drug use contributed to 2.7% of the total burden of disease in Australia in 2015, most of which was experienced by males and females aged 25–44. Opioid use accounted for the largest proportion (37%) of the illicit drug use burden, followed by amphetamine use (21%), cocaine (11.4%) and cannabis (8.3%). Illicit drug use was responsible for 27% of the poisoning burden as well as 75% of the acute hepatitis C burden, 37% of the acute hepatitis B burden, and 7.9% of the HIV/AIDS burden (AIHW 2019c).

The National Drug Strategy

Since 1985, the National Drug Strategy (NDS) has provided an overarching framework for a consistent and coordinated approach to dealing with licit and illicit drug use in Australia. The NDS is guided by the principle of harm minimisation. Harm minimisation encompasses 3 components (pillars): demand reduction, supply reduction and harm reduction.

The NDS 2017–2026 is the seventh iteration of the strategy. The strategy represents the agreement of the Australian, state and territory governments on the key policy priorities for the next 10 years (2017–2026). The purpose of the 2017–2026 Strategy is to provide a national framework which identifies national priorities relating to alcohol, tobacco and other drugs; guides action by governments in partnership with service providers and the community; and outlines a national commitment to harm minimisation through balanced adoption of effective demand, supply and harm reduction strategies (DoH 2017).

The Strategy recognises that drug use is a health and social issue while acknowledging the role of law enforcement to detect and deter drug crime. It provides a national framework for action that is able to accommodate new and emerging alcohol, tobacco and other drug issues when they arise, and provides a guide for jurisdictions in developing their individual responses to local alcohol, tobacco and other drug issues. In addition to providing a national framework to guide coordinated action to minimise the harms from alcohol, tobacco and other drugs, the 2017–2026 iteration includes a number of sub-strategies that were developed to give direction and context for specific issues (DoH 2017).

About the 2019 survey

The NDSHS is the leading survey of licit and illicit drug use in Australia. The 2019 survey was the 13th conducted under the auspices of the NDS. The survey was first undertaken in 1985 and has been undertaken every 3 years since 1995. The data collected through these surveys have contributed to the development of policies for Australia's response to drug-related issues.

The Australian Government Department of Health commissioned the AIHW to manage the 2019 survey, and the AIHW commissioned Roy Morgan Research to collect the data. A Technical Advisory Group comprising experts in tobacco, alcohol and other drug data collection and research (see Appendix A for Technical Advisory Group members) supported the AIHW in the management of the survey.

In 2019, 22,274 people aged 14 and over gave information on their drug use patterns, attitudes and behaviours (Table Introduction 1). The sample was based on households, so people who were homeless or institutionalised were not included in the survey (consistent with the approach in previous years). Most of the analyses are based on the population aged 14 and over (unless otherwise specified), as this allows consistent comparison with earlier survey results.

See Technical information https://www.aihw.gov.au/getmedia/07eca8ff-b4f5-46f0-ad52-21f5dd6e8d8a/aihw-phe-270-technical-information.pdf.aspx for more information on the sample, the methodology, response rate and limitations of the survey results.

Table Introduction 1: National Drug Strategy Household Survey sample sizes

Survey year	Respondents
2019	22,274
2016[(a)]	23,772
2013[(a)]	23,855
2010[(a)]	26,648
2007[(a)]	23,356
2004[(a)]	29,445
2001	26,744
1998	10,030
1995	3,850
1993	3,500

(a) Total respondents aged 12 and over.

Report structure

This report outlines the results of the 2019 NDSHS. Following this introductory chapter, chapters 2 and 3 give information on the use of tobacco and alcohol and chapters 4 and 5 cover the use of illicit drugs and pharmaceuticals used for non-medical purposes. For the first time, an emerging topics chapter—'Medicinal cannabis'—is included in Chapter 6. Chapter 7 presents data for various geographical areas, including analyses by Primary Health Network and remoteness area (see Chapter 7 or refer to glossary for explanation and definition of socioeconomic areas and remoteness classification). Chapter 8 presents data for priority population groups (for example, Indigenous people and people with a mental illness). In Chapter 9 there is a discussion of the survey results on perceptions and acceptability of drug use, as well as people's attitudes towards policy initiatives aimed at reducing harm associated with drug use.

The technical information (available online) details the survey methodology, response rates, reliability, limitations of the NDSHS and gives definitions for terminology used throughout the report. The demographic characteristics of the NDSHS sample are presented in tables TI.7 and TI.8 and are compared with the Australian Bureau of Statistics (ABS) 2016 Census data.

Each chapter has a set of supplementary (Excel) tables that support that chapter (see https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey-2019/data). Tables have been grouped into topics/categories for each chapter. For example, in the illicit drug chapter, all cannabis tables are grouped together and in the alcohol chapter, all alcohol-related harm tables are grouped together. Not all tables are referred to in the report. Tables that have been mentioned in the report have a green tab in the supplementary Excel tables; all other tables have a grey tab.

The report presents estimates derived from survey responses weighted to the appropriate Australian population. Proportions are shown as percentages rounded to 1 decimal place when less than 20% and rounded to a whole number when 20% or higher. Data presented in the body of the report have not been age-standardised (unless indicated). All increases, decreases, or changes in estimates over time mentioned in the report are statistically significant at the 95% level of confidence unless specified otherwise. Sometimes, even large apparent differences may not be statistically significant. This is particularly the case in breakdowns of small populations because the small sample size means that there is not enough power to identify even large differences as statistically significant. Conversely, with a sufficiently large sample, small changes are more likely to be statistically significant.

2 Tobacco smoking

Quick facts

Fewer Australians are smoking daily than ever before—11.0% in 2019, down from 12.2% in 2016 and 24% in 1991.

More smokers are opting for roll-your-own cigarettes, both in combination with manufactured cigarettes (up from 26% in 2016 to 33% in 2019) and exclusively roll-your-own cigarettes (up from 10.7% in 2016 to 13.9% in 2019).

People in their 40s and 50s were the most likely to smoke daily in 2019; this is different from 2001 when people in their 20s were the most likely age group to smoke daily.

Use of e-cigarettes is increasing—between 2016 and 2019, lifetime use and current e-cigarette use increased for smokers and non-smokers, as did frequency of use.

Fewer dependent children were exposed to daily tobacco smoke inside the home, declining from 19.7% in 2001 to just 2.1% in 2019 (and down from 2.8% in 2016).

3 in 10 smokers do not plan on quitting—this proportion has not changed over the last decade.

2 in 5 smokers reduced the amount of tobacco smoked per day in the last 12 months.

More smokers said the cost of smoking was motivating them to quit or cut back—58% in 2019 compared with 52% in 2016.

Current smokers are smoking fewer cigarettes—13 per day on average in 2019 compared with 16 in 2001.

Tobacco smoking is the leading cause of preventable disease and death in Australia. In 2015, it was responsible for 9.3% of the total burden of disease and injury, and more than 1 in every 10 (21,000) deaths (AIHW 2019d).

In 2015–16, tobacco smoking was estimated to cost Australian society $137 billion, comprising $19.2 billion in tangible costs (such as health care, reduced workplace productivity and caring for someone with a smoking-related disease), and $118 billion in intangible costs (such as pain and suffering caused by ill health attributed to smoking) (Whetton et al. 2019).

Public health strategies to reduce tobacco use and exposure have been in place for many decades. The National Tobacco Strategy 2012–2018, which is currently being updated, sets out the national framework to reduce tobacco-related harm in Australia. The goal of the strategy is to 'improve the health of all Australians by reducing the prevalence of smoking and its associated health, social and economic costs, and the inequalities it causes' (DoH 2012). Tobacco control will also be a key component of the Australian Government's 10-year National Preventive Health Strategy.

Unless otherwise specified, the results in this report relate to those aged 14 and over and all increases or decreases in estimates over time are statistically significant. All data presented in this chapter are available through the online tobacco tables https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey-2019/data.

How many people smoke and how has this changed?

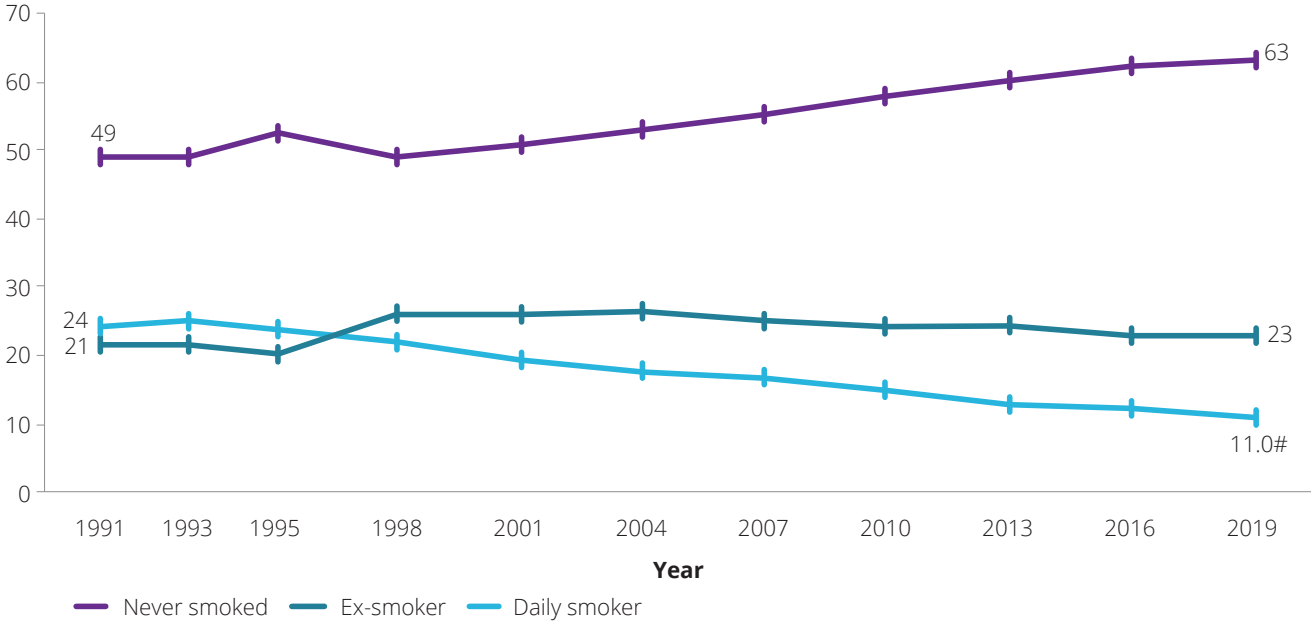
Since 1991, the proportion of daily smokers has more than halved (Figure 2.1) while the proportion never taking up smoking has increased (from 49% in 1991 to 63% in 2019). The proportion of ex-smokers has remained fairly stable over this period and did not change between 2016 and 2019 (23%).

In 2019, 11.0% of people aged 14 and over smoked daily (Table 2.1), declining from 12.2% in 2016. This equates to a reduction of about 100,000 daily smokers over the 3 years (from about 2.4 million to 2.3 million Australians; Table 2.3).

The decrease in daily smoking appears to be mainly driven by fewer people aged 14–39 taking up smoking between 2001 and 2019. For example, the proportion of young adults aged 18–24 never smoking more than 100 cigarettes in their life has increased from 58% to 80% between 2001 and 2019, while the proportion of people in their 50s increased only from 44% to 51% (Table 2.7).

Among current smokers, people smoked an average (mean) of 13 cigarettes per day in 2019—declining from 16 cigarettes per day in 2010 (Table 2.4). The proportion of pack-a-day (20 cigarettes or more) smokers also fell over this period, from 44% in 2010 to 33% in 2019 (Table 2.6).

Figure 2.1: Tobacco smoking status, people aged 14 and over, 1991–2019 (per cent)



Statistically significant change between 2016 and 2019.

Notes

1. Daily smoker: Reported smoking tobacco at least once a day (includes manufactured (packet) cigarettes, roll-your-own cigarettes, cigars or pipes). Excludes chewing tobacco, electronic cigarettes (and similar) and smoking of non-tobacco products.
2. Ex-smoker: Smoked at least 100 cigarettes or equivalent tobacco in their lifetime but report not smoking at the time of the survey.
3. Never smoker: Has never smoked more than 100 cigarettes in their lifetime.
4. In 1991, daily smoking included people who reported smoking daily, or most days.
5. In 1993, smoking status was only asked to people aged 20 years or over.

Source: Table 2.1.

Who is most likely to smoke?

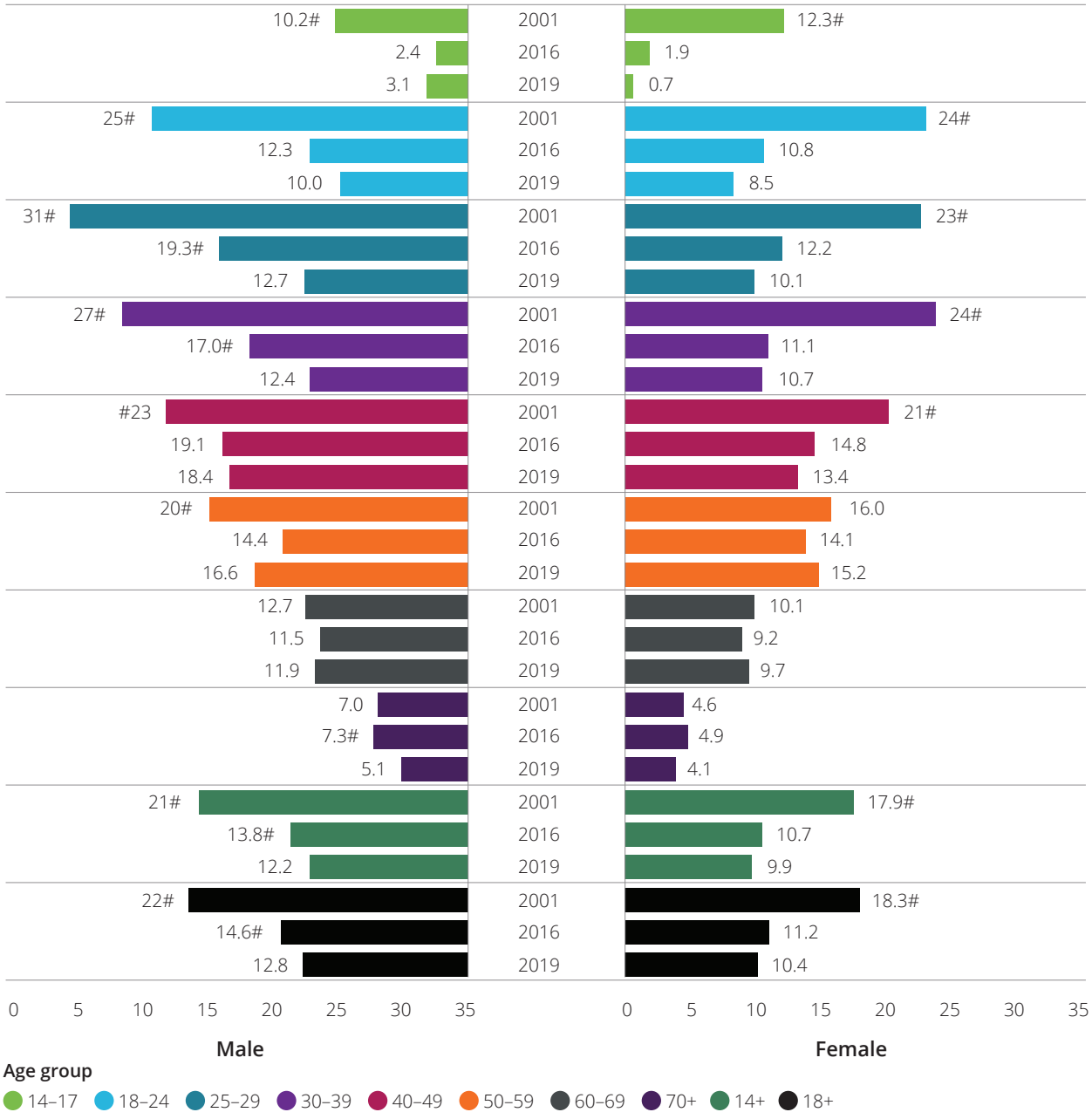
As in previous surveys, males (12.2%) were more likely to smoke daily than females (9.9%) in 2019. However, the gap has narrowed slightly since 2016 when 13.8% of males were daily smokers compared wit 10.7% of females (Table 2.2).

Between 2016 and 2019, the proportion of people who smoked daily fell for people in their 20s, 30s and those aged 70 and over, driven largely by the declining proportion of male smokers (Figure 2.2). There were no statistically significant changes in the proportion of females smoking daily across any age group between 2016 and 2019; however, the proportion of women in their 20s and 30s reporting that they had never smoked increased (from 73% to 77%, and 62% and 67%, respectively).

People in their 40s (15.8%) and 50s (15.9%) were most likely to smoke daily in 2019. Among males, people in their 40s were the most likely to smoke daily (18.4%); for females, it was those in their 50s (15.2%).

The proportion of teenagers aged 14–19 who smoked daily remained low in 2019 and has fallen by about 80% since 2001.

Figure 2.2: Proportion of daily smokers, by age and sex, 2001, 2016 and 2019 (per cent)



Statistically significant difference from 2019 estimate.

Source: Table 2.7.

People are older when they try their first cigarette

Most people first try smoking tobacco during adolescence, however, the age at which they first smoked a full cigarette has been increasing over time. The average (mean) age people aged 14 and over smoked their first full cigarette rose from 16.4 years in 2016 to 16.6 years in 2019 (Table 2.10). This was due to an increase in the age in which males first smoked a full cigarette—from 16.1 to 16.4 years. The age of initiation for females was similar in 2016 and 2019 (16.7 years and 16.8 years respectively).

Among younger females aged 14–24, the age at which they first smoked a full cigarette rose from 16.0 years in 2016 to 16.6 years in 2019. The mean age for males remained stable at 16.6 years (Table 2.11).

What tobacco products do people use and how has this changed?

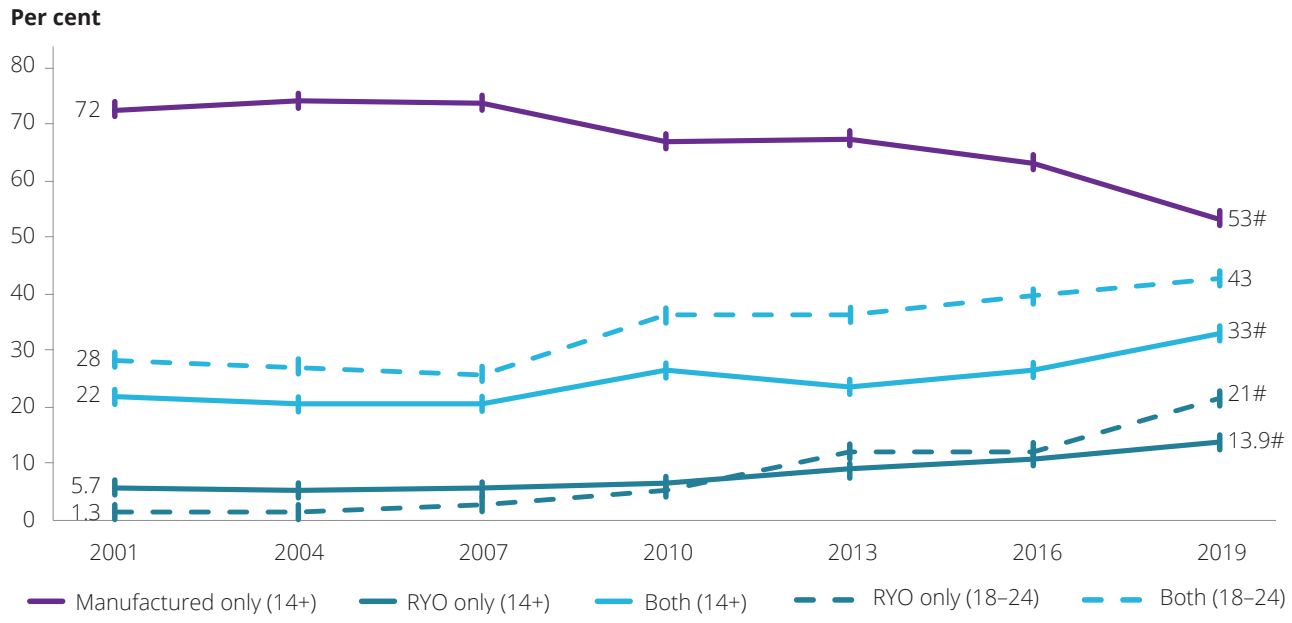
Tobacco smokers choose to smoke a variety of tobacco products including cigarettes, cigars and cigarillos (short, narrow cigars) (tables 2.14 and 2.15).

In 2019, among smokers in the last 12 months:

- **84%** smoked manufactured cigarettes
- **45%** smoked roll-your-own cigarettes
- **1 in 10** had smoked cigarillos (10.6%)
- **1 in 10** smoked e-cigarettes (9.7%)
- **5.4%** had smoked cigars
- Fewer than **1 in 20** used water pipe tobacco and pipe tobacco

More smokers are opting for roll-your-own cigarettes, either in combination with manufactured cigarettes or exclusively roll-your-own cigarettes—overall use rose from 26% in 2007 to 36% in 2016 and 45% in 2019 (Table 2.16). The rise was greatest among young adult smokers aged 18–24 (up from 28% in 2007 to 63% in 2019), the age group most likely to smoke these cigarettes (Figure 2.3).

Figure 2.3: Use of manufactured cigarettes and roll-your-own cigarettes, current smokers, 2001–2019 (per cent)



Statistically significant change between 2016 and 2019.

Note: Base is current smokers.

RYO: Roll-your-own.

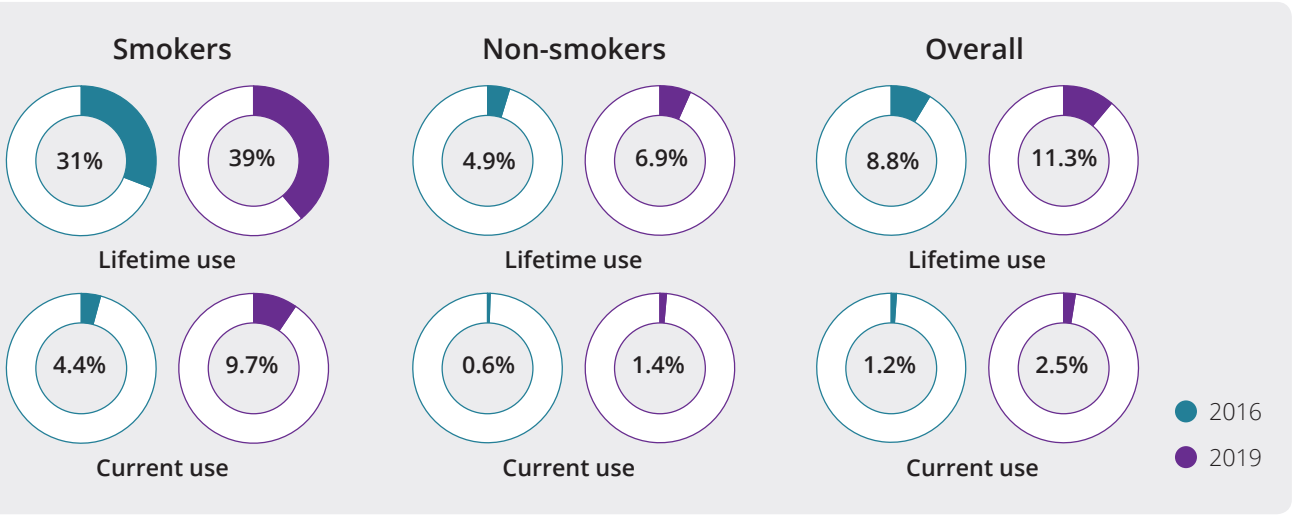
Source: Tables 2.17 and 2.18.

The overall changes in the use of these products were largely driven by people using a combination of manufactured and roll-your own cigarettes, which increased from 26% in 2016 to 33% in 2019 (Table 2.18). There was also an increase in the proportion of people using exclusively roll-your-own cigarettes, from 10.7% in 2016 to 13.9% in 2019. The increase among young adult smokers aged 18–24, however, was driven by an increase in people smoking only roll-your-own cigarettes (from 12.0% in 2016 to 21% in 2019) (Table 2.18).

The increase in use of roll-your-own cigarettes is likely to be partly due to cost— roll-your-own cigarettes may be cheaper (for example, due to the availability of smaller pouch sizes) than manufactured cigarettes. Smokers of roll-your-own cigarettes can also control the amount of tobacco per cigarette and roll smaller cigarettes to reduce their costs (Young et al. 2012).

More people are using electronic cigarettes

Between 2016 and 2019, lifetime and current use of e-cigarettes (see Box 2.1) increased among smokers and non-smokers, and across most age groups:



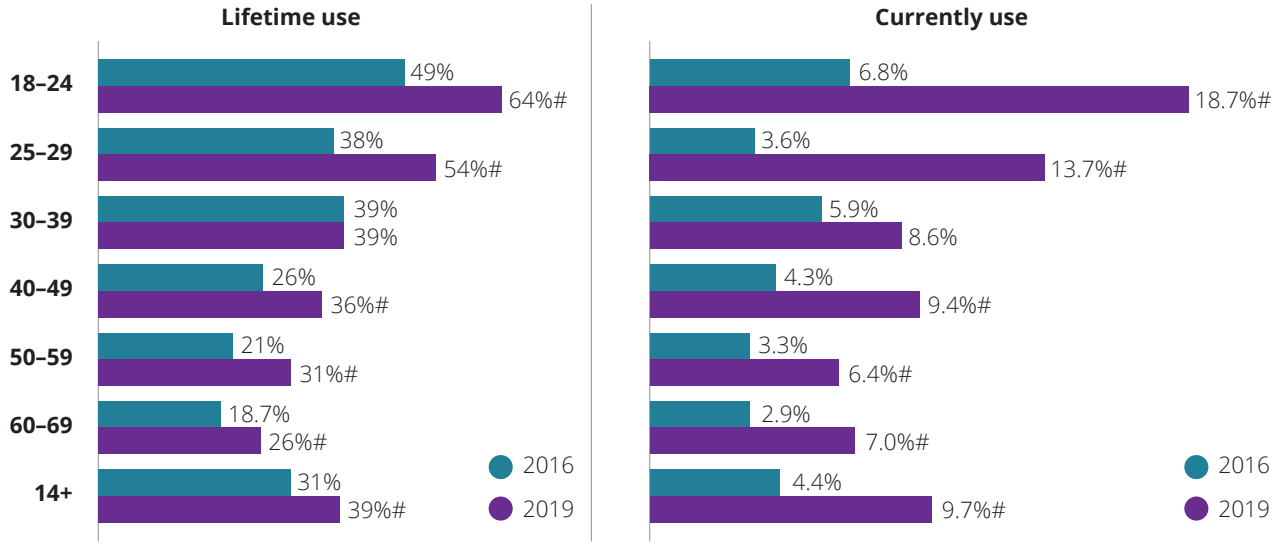
Young adults were most likely to be attracted to these products— nearly two-thirds of current smokers and 1 in 5 non-smokers aged 18–24 reported having tried e-cigarettes (see Figure 2.4). Frequency of use also rose among smokers between 2016 and 2019—daily use rose from 1.5% to 3.2%, and at least monthly use increased from 3.4% to 7.8% (Table 2.22).

Box 2.1: Electronic cigarettes

Electronic cigarettes (also known as e-cigarettes, e-cigs, electronic nicotine delivery systems, electronic non-nicotine delivery systems, alternative nicotine delivery systems, personal vaporisers, e-hookahs, vape pens or vapes) are devices designed to deliver nicotine and/or other chemicals via an aerosol vapour that the user inhales (Greenhalgh & Scollo 2018). Most e-cigarettes contain a battery, a liquid cartridge and a vaporisation system and are used in a manner that simulates smoking (ACT Health 2019). The liquid solution used in e-cigarettes can contain nicotine, but also flavourings and other chemicals. In Australia, it is illegal to sell e-cigarettes and e-liquids that contain nicotine in any form (Cancer Council 2017), however, it may be lawful for people to import up to 3 months' personal supply of nicotine for personal therapeutic use in e-cigarettes with a written authorisation from a doctor, subject to state and territory laws (TGA 2019).

Australian governments have taken a precautionary approach to the marketing and use of e-cigarettes in view of the risks these products pose to tobacco control and population health. This approach is underpinned by the current state of evidence regarding: the direct harms e-cigarettes pose to human health; their impacts on smoking initiation and cessation; uptake among youth; and dual use with conventional tobacco products (Byrne et al. 2018; Gotts et al. 2019; Kennedy et al. 2019).

Figure 2.4: Lifetime and current use of e-cigarettes, smokers aged 14 and over, 2016 and 2019 (per cent)



Statistically significant change between 2016 and 2019.

Source: tables 2.20 and 2.24.

Although more than two-thirds (69%) of electronic cigarette users were smokers when they first tried an e-cigarette, nearly 1 in 4 considered themselves to be a 'never smoker' at the time (Table 2.26). Younger users were far more likely to report being a never smoker than older users— 39% of 18–24 year olds compared with less than 10% of people aged 40 and over (Table 2.27).

Why do people use e-cigarettes?

More than half of people (54%) tried e-cigarettes out of curiosity (Table 2.31). This was especially the case for never smokers (85%) and young adults aged 18–24 (72%). Other reasons included:

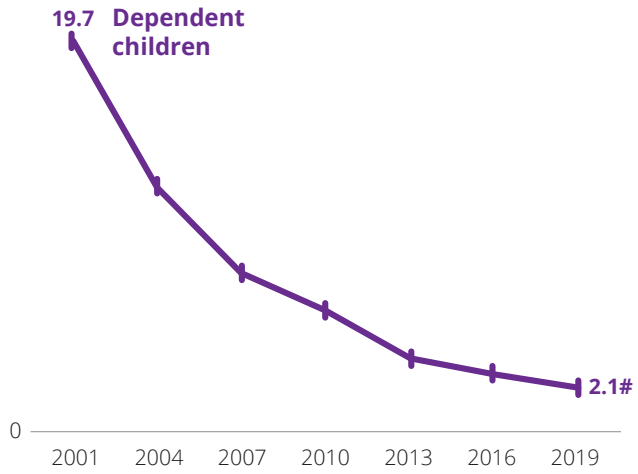
- to help me quit smoking (32% in 2019, similar proportion to 2016, 31%)
- I think they are less harmful than regular cigarettes (23%, up from 19.2%)
- to try to cut down on the number of cigarettes smoke/smoked (22%, up from 18.7%)
- to try to stop me going back to smoking regular cigarettes (17.8%, up from 14.5%)
- they are cheaper than regular cigarettes (17.7%, up from 10.5%)
- I think they taste better than regular cigarettes (16.1%, up from 10.0%).

How many people are exposed to tobacco smoke at home?

Fewer people in the general population are smoking and this is reflected in the proportion of children and adults exposed to tobacco smoke at home regularly (Figure 2.5). Very few households with dependent children had a household member who smoked daily inside the home in 2019, falling from 2.8% in 2016 to just 2.1%.This was much lower than in 2001 when it was 1 in 5 households (Table 2.36).

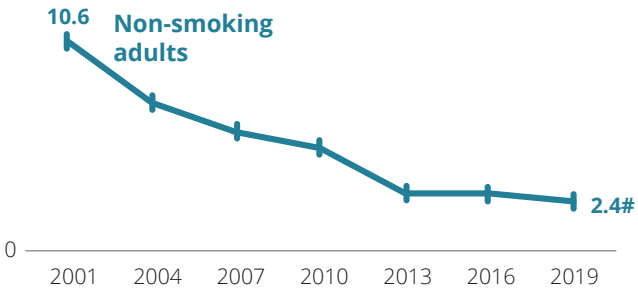
The proportion of adult non-smokers being exposed to tobacco inside the home has also fallen considerably over this period and continued to decline in 2019—from 2.9% in 2016 to 2.4% in 2019 (Table 2.38).

Figure 2.5: Households with dependent children exposed to tobacco smoke inside the home daily, 2001–2019 (per cent)



Statistically significant change between 2016 and 2019.
Source: Table 2.36.

Figure 2.6: Non-smoking adults exposed to tobacco smoke inside the home daily, 2001–2019 (per cent)



Statistically significant change between 2016 and 2019.
Source: Tables 2.38.

How many smokers try to quit or reduce their smoking?

Questions about quitting and reducing smoking are asked only of smokers who reported smoking in the previous 12 months. In 2019, 3 in 10 (31%) smokers tried to quit but were not successful (Table 2.39), 2 in 10 (21%) were able to quit for more than a month (up from 17.2% in 2016) and 4 in 10 (39%) reduced the amount of tobacco smoked in a day in the previous 12 months. More smokers said the cost of smoking was motivating them to quit or cut back—58% in 2019 compared with 52% in 2016—and nearly half (45%) were motivated to try quitting due to the effect smoking was having on their health or fitness (Table 2.41).

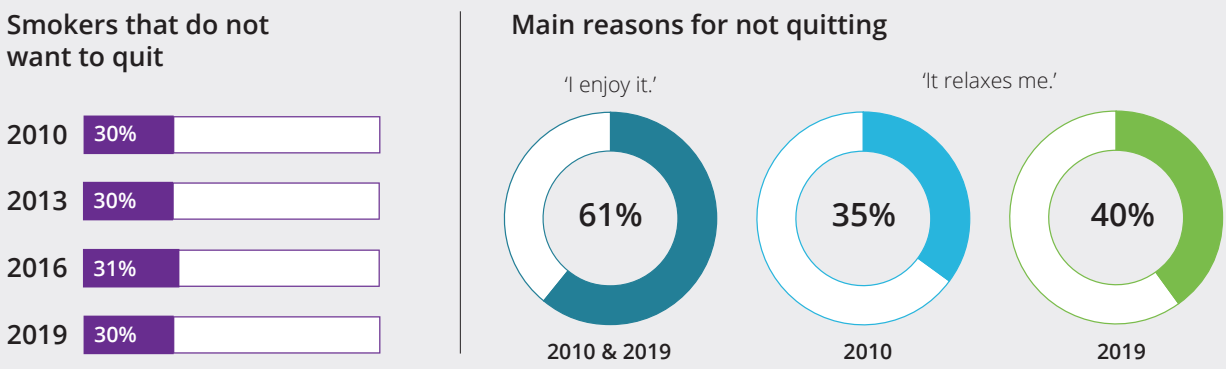
The majority (61%) of smokers tried to undertake at least 1 activity to help quit smoking in 2019 (Table 2.44), including:

- by going 'cold turkey' (that is, they just stopped smoking (23%))
- discussing smoking and health at home (22%)
- using nicotine gum, nicotine patch, inhaler or spray (16.8%)
- asking their doctor for help to quit (10.2%).

Why don't smokers quit?

While the majority of smokers (63%) would like to quit smoking and intend to, some may have no interest in giving up smoking. In 2019, 3 in 10 smokers said they did not intend to quit and this proportion has not changed over the last decade (Table 2.45).

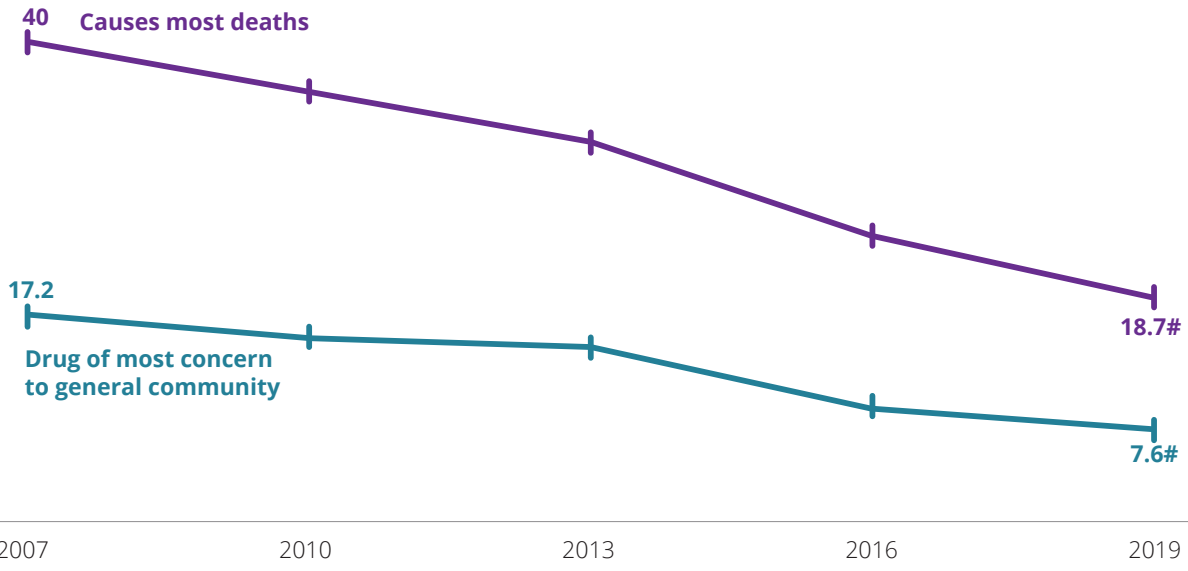
The reasons for not intending to quit have remained similar over time:



Do people think smoking tobacco is harmful?

Tobacco contributes to more drug-related deaths in Australia than alcohol and illicit drug use combined. But the proportion of people who perceive tobacco as the drug that causes the most deaths continues to fall, as does the proportion who perceive tobacco to be the drug of most concern (Figure 2.7). This trend is most likely driven by the substantial shift in people's attitudes towards meth/amphetamines (the proportion of people nominating it as causing most deaths or as being of most concern to the community more than doubled since 2013) and increasing concern about the use of opioids (see 'Chapter 9 Perceptions and policy support').

Figure 2.7: Perceptions of tobacco, people aged 14 and over, 2007–2019 (per cent)



Statistically significant change between 2016 and 2019.

Source: Tables 9.3 and 9.5.

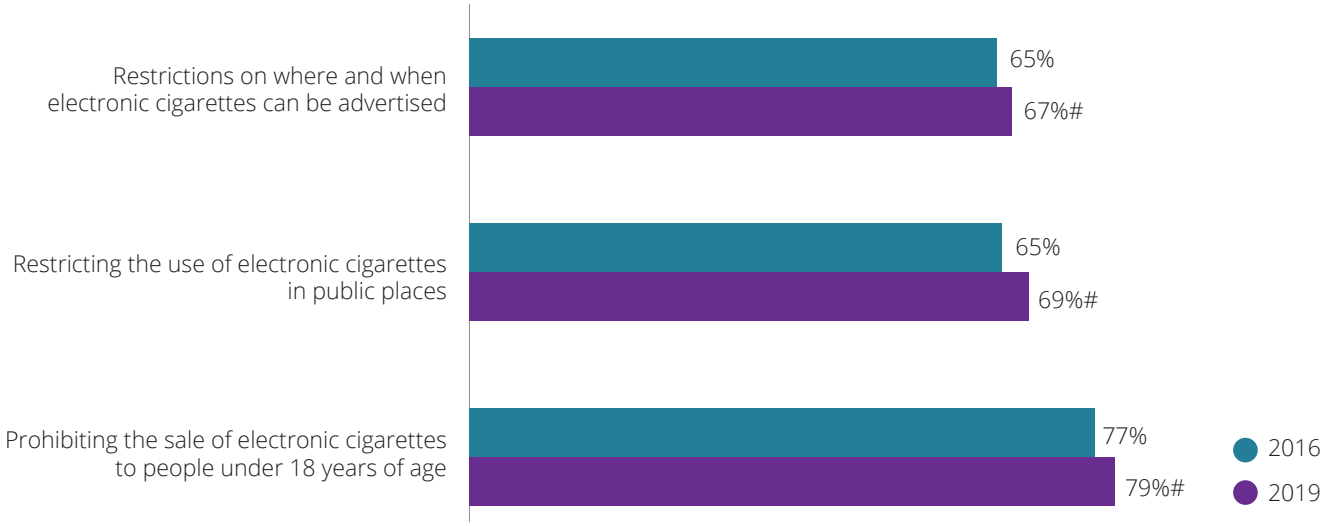
Does the community support tobacco policies?

Although more than 6 in 10 people supported government policies to reduce tobacco-related harm in 2019 (Table 2.52), the level of support has fallen since 2016 (with 7 out of 9 policies receiving less support). This includes declines in support for:

- increasing tax on tobacco products to pay for health education (from 69% in 2016 to 65% in 2019)
- increasing tax on tobacco products to discourage smoking (from 67% to 64%)
- increasing tax on tobacco products to contribute to treatment programs (from 70% to 67%)
- making it harder to buy tobacco in shops (from 64% to 61%).

By contrast, support for measures related to restrictions on the use and sale of e-cigarettes has grown, perhaps due to an increase in use or awareness of these products. In 2019, two-thirds of the population supported restrictions on where e-cigarettes could be advertised and used in public, and 8 in 10 supported prohibiting their sale to people under 18 (Figure 2.8).

Figure 2.8: Support for measures to reduce the problems associated with e-cigarette use, people aged 14 and over, 2016 and 2019 (per cent)



Statistically significant change between 2016 and 2019.

Source: Table 2.52.

Where can I get more information?

To explore the data and view additional analyses, see the supplementary tobacco smoking data tables. These include data on:

- awareness and use of illicit branded and unbranded tobacco
- where people buy their regular cigarettes and electronic cigarettes
- tobacco smoking by social/demographic characteristics (including by education and sexual orientation) and health status (including mental health and other health conditions).

3 Alcohol

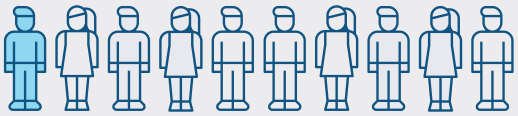
Quick facts

More Australians are giving up alcohol; between 2016 and 2019, the proportion of people who were ex-drinkers increased from 7.6% to 8.9%.

The proportion of people drinking at risky levels on a single occasion (25%) and exceeding the lifetime risk guidelines (16.8%) remained stable since 2016, although both have seen reductions since the National Health and Medical Research Council (NHMRC) guidelines were introduced in 2009.

Reductions in risky drinking have been driven by younger age groups, with levels remaining stable or increasing among older Australians since 2001.

The proportion of adults aged 18 and over consuming 11 or more standard drinks on a single occasion at least once a month declined between 2016 and 2019 (from 7.4% to 6.7%).



1 in 10 recent drinkers (9.9%) are likely to meet the criteria for alcohol dependence.

In comparison to 2016 and earlier years, more Australians are taking action to reduce their drinking—52% undertook an action in 2019, up from 48%.

Support for almost all policies aimed at reducing the problems associated with excessive alcohol use declined since 2016, and opposition increased.

Alcohol is the most used drug in Australia and, although many people drink responsibly, it is a significant source of harm to the Australian community. Alcohol has consistently remained the most common drug of concern among people who have accessed specialist treatment services (AIHW 2019a), and many people continue to drink at levels that are hazardous to their health. It also contributes to other sources of harm, including road deaths and injuries, family and domestic violence and Fetal Alcohol Spectrum Disorder (DoH 2019). This chapter provides information on alcohol consumption patterns in Australia, and how many people might have experienced harms due to their own or other people's use of alcohol.

Unless otherwise specified, the results in this report relate to people aged 14 and over and all increases or decreases in estimates over time are statistically significant. All data presented in this chapter are available through the online alcohol tables https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey-2019/data.

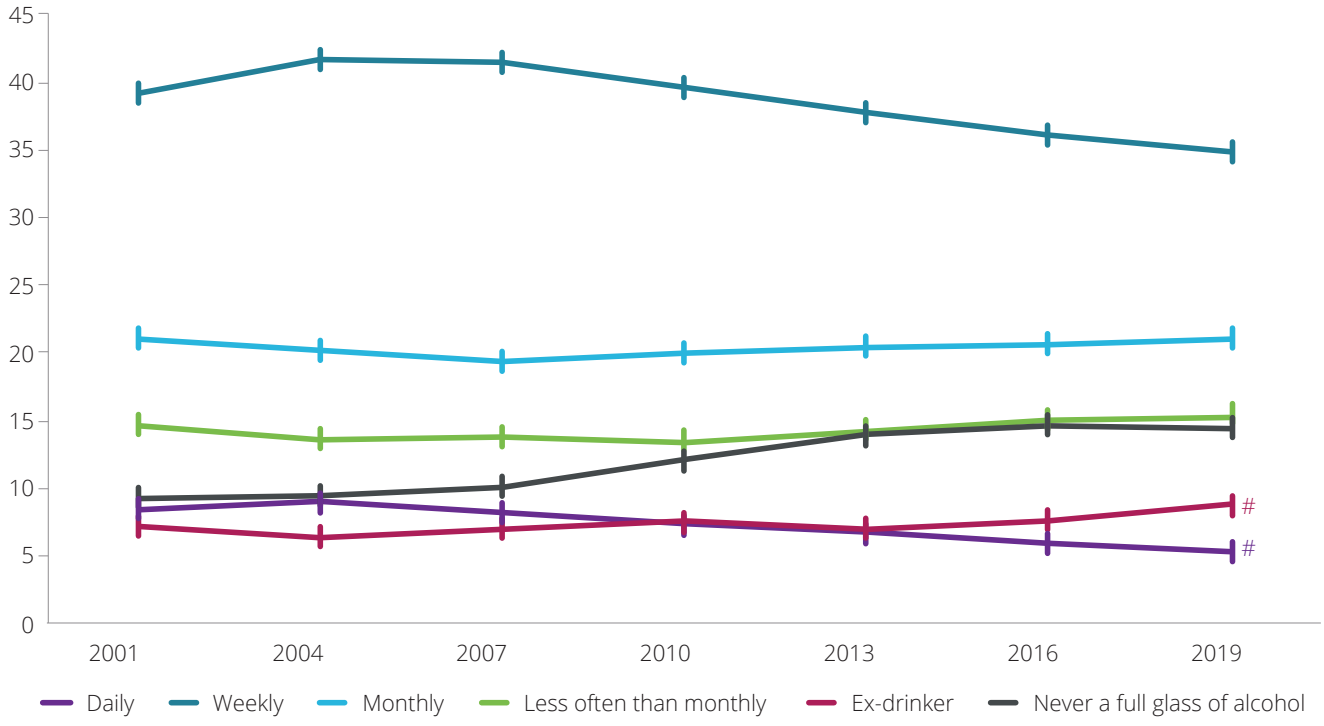
How often do Australians drink?

More people are giving up drinking

The proportion of ex-drinkers increased between 2016 and 2019, from 7.6% to 8.9% (Table 3.2), or approximately 1.5 million to 1.9 million Australians (Table 3.3). The proportion of ex-drinkers has fluctuated since 2001 but 2019 recorded the highest proportion of ex-drinkers over this period (Figure 3.1).

Among males, this corresponded with a significant drop in daily drinkers, declining from 7.7% in 2016 to 6.9% in 2019. Females were significantly less likely to drink weekly than in 2016, down from 31% to 29% in 2019. The proportions of people drinking daily and weekly have been falling since 2004, and are now at the lowest point since 2001 (Table 3.2).

Figure 3.1: Drinking frequency among people aged 14 and older, 2001–2019 (per cent)



Statistically significant change between 2016 and 2019.

Source: Table 3.2.

Older people more likely to drink daily

Consistent with previous survey waves, the proportion of adults drinking daily increased with age. People aged 70 and over were the most likely to drink daily at 12.6%, while only 1.2% of people aged 20–29 did so (Table 3.4). This trend was the same for both males and females, although males were much more likely to drink every day (6.9%) than females (3.9%).

More young adults abstaining from alcohol

In 2019, the proportion of people aged 18 and over abstaining from alcohol increased, from 19.5% to 21% (Table 3.16). Younger age groups drove this increase, in particular those aged 25–29 (from 19.0% in 2016 to 24% in 2019) and 30–39 (16.6% to 22%).

Over the longer term, the proportion of young adults (aged 18–29) who abstained from alcohol has more than doubled. Between 2001 and 2019, the proportion abstaining rose from 9.7% to 21% for 18–24 year olds and from 8.8% to 24% for 25–29 year olds. However, for people aged 70 and over, the proportion abstaining declined (from 32% in 2001 to 28% in 2019).

What do typical drinking occasions look like?

Drinking frequency offers insights into how often people consume alcohol, but the impact that the alcohol consumption may have on a person's health also depends on the amount that they drink. For the first time, the 2019 survey asked people who had consumed alcohol in the previous week to describe their latest drinking occasion in more detail, including when it occurred, how much they had to drink and the types of drinks they had.

Among people who had consumed alcohol in the previous week, the last drinking occasion was most likely to have occurred on a Friday (20%) or Saturday (23%), with only between 9.1% and 12.0% of people having last consumed alcohol between Monday and Thursday (Table 3.9). The day the survey was completed is unlikely to be responsible for these differences as survey completion was fairly evenly distributed across the days of the week, ranging from 12.9% on a Friday to 15.3% on a Monday (Table 3.9a).

The average (mean) number of standard drinks consumed was also higher on Friday and Saturday, with drinkers reporting 3.8 standard drinks on Fridays and 4.0 on Saturdays (Table 3.10) compared with 2.8 standard drinks on Mondays, Tuesdays and Wednesdays.

Regardless of the day that the drinking occurred, males consumed more alcohol on average than females (4.0 standard drinks compared with 2.7). The amount consumed also decreased with age, from an average of 4.5 standard drinks among people aged 14–29 to 2.8 among people aged 50 and over (Table 3.10).

These effects of age, gender and day of the week combine to give particularly notable results among some groups of people. For example, males aged 14–29 drinking on a Friday night consumed an average (mean) of 5.8 standard drinks; this was 2 standard drinks higher than the average for all drinkers (aged 14 and over) on a Friday night (3.8 standard drinks).

Males

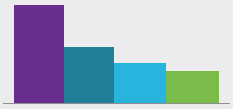
Age: 14–29

Wednesday
9.5% last drank on a Wednesday, and they consumed 3.5 standard drinks on average

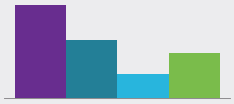
Saturday
21% last drank on a Saturday, and they consumed 6.7 standard drinks on average

Age: 30–49

Wednesday
8.4% last drank on a Wednesday, and they consumed 3.7 standard drinks on average



Saturday
27% last drank on a Saturday, and they consumed 4.8 standard drinks on average



Age: 50+

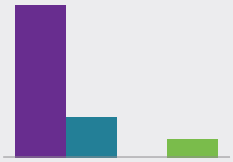
Wednesday
12.3% last drank on a Wednesday, and they consumed 3.2 standard drinks on average

Saturday
21% last drank on a Saturday, and they consumed 3.7 standard drinks on average

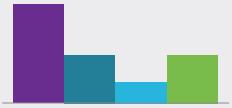
Females

Age: 14–29

Wednesday
8.4% last drank on a Wednesday, and they consumed 2.5 standard drinks on average

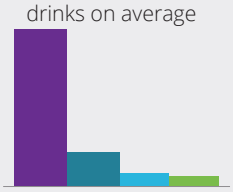


Saturday
28% last drank on a Saturday, and they consumed 4.3 standard drinks on average

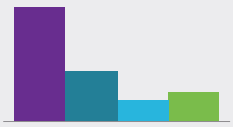


Age: 30–49

Wednesday
8.8% last drank on a Wednesday, and they consumed 2.4 standard drinks on average

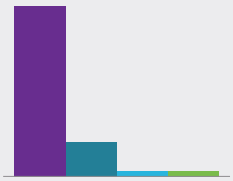


Saturday
26% last drank on a Saturday, and they consumed 3.4 standard drinks on average

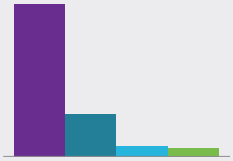


Age: 50+

Wednesday
12.6% last drank on a Wednesday, and they consumed 1.9 standard drinks on average



Saturday
21% last drank on a Saturday, and they consumed 2.2 standard drinks on average



Standard drinks

The amount some people drink puts their health at risk

Box 3.1 How is risky drinking defined?

The NHMRC publishes the Australian Guidelines to Reduce Health Risks from Drinking Alcohol (NHMRC 2009). The data for alcohol risks in this report are measured against the following guidelines:

- Guideline 1 (lifetime risk): For healthy men and women, drinking no more than 2 standard drinks on any day reduces the lifetime risk of harm from alcohol-related disease or injury.
- Guideline 2 (single occasion risk): For healthy men and women, drinking no more than 4 standard drinks on a single occasion reduces the risk of alcohol-related injury arising from that occasion.
- Guideline 3 (children and young people): For children and young people under 18 years of age, not drinking alcohol is the safest option.

Guideline 2 references drinking on only a single occasion, so people can exceed the recommended amount of alcohol multiple times on different occasions. The supplementary alcohol tables include results for a variety of frequencies (for example, the proportion that drank more than the recommended amount at least once in a year, or the proportion that did so at least once a week). The NDSHS report focuses on the proportion of people who drank more than the single occasion guideline at least once a month on average.

The NHMRC released revised draft guidelines in December 2019 which are expected to be finalised in the fourth quarter of 2020. The 2009 alcohol guidelines were the current advice at the time of data collection in 2019, and remain NHMRC's current advice until the review of the guidelines is finalised.

As this is the last survey under the 2009 alcohol guidelines, the results from 2010 to 2019 show how drinking behaviours have changed over the life of the guidelines.

How many people are drinking at levels that may be dangerous to their health?

The number of people drinking at levels that put their health at risk has remained stable since 2016. In the case of lifetime risk, 17.2% of people in 2016, and 16.8% of people in 2019 drank more than 2 drinks per day on average (Table 3.13), corresponding to 3.4 million people in 2016 and 3.5 million in 2019 (Table 3.14).

The trend for single occasion risk was similar. The proportion of people drinking more than 4 drinks in 1 sitting at least monthly was about 1 in 4 in 2016 and 2019 (Table 3.13), representing around 5.1 million people in 2016 and 5.2 million in 2019 (Table 3.14).

However, the results in 2019 continue a trend of declining risky drinking since the alcohol guidelines were introduced in 2009 (Figure 3.2). From 2001 to 2010, people drinking at levels that exceeded the lifetime risk guidelines did not change substantially (21% both years). Since 2010, the proportion has declined to 16.8%.

Single occasion risk (at least monthly) follows a similar trend, dropping by only 1 percentage point between 2001 and 2010 (30–29%), but declining to 25% by 2019.

Figure 3.2: Proportion of abstainers and people exceeding the 2009 NHMRC alcohol guidelines, people aged 14 and over, 2001–2019 (per cent)

Source: Table 3.13.

However, these declines do not mean that fewer people are at risk of injury or illness, due to the population increasing over the same time frame. In 2001, approximately 3.3 million Australians had consumed alcohol at levels that exceeded the lifetime risk guideline, while in 2019, 3.5 million people had done so. The number of people exceeding the single occasion risk at least once a month has increased substantially since 2001, from 4.6 million to 5.2 million. In the same period, the number of people abstaining from alcohol has almost doubled, from 2.6 million to 5.0 million (Figure 3.3).

Figure 3.3: Number of abstainers and people exceeding the 2009 NHMRC alcohol guidelines, people aged 14 and over, 2001–2019

Source: Table 3.14.

Are people aware of the amount of alcohol that can cause harm?

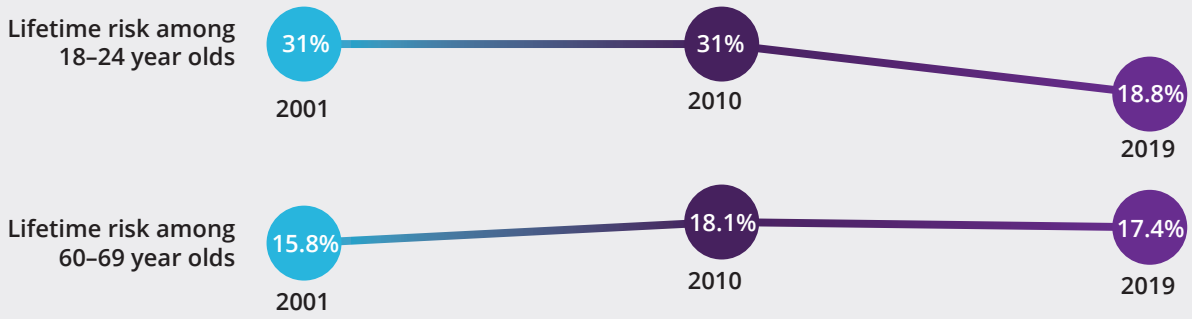
People were asked how many drinks they believed a person could consume on a single occasion and every day for many years, without putting their health at risk. Since the guidelines were introduced in 2009, people have become less likely to indicate amounts greater than the guideline recommendations. Despite these declines, a substantial number of people still report 'safe amounts' of alcohol that would put their health at risk, with males more likely to do so than females.

Who is more likely to drink at harmful levels?

Lifetime risky drinking remains common among older Australians

Despite people aged 70 and over being the most likely to drink alcohol daily, people in their 40s and 50s were the most likely to exceed the lifetime risk, both at 21% (Table 3.15). The only statistically significant change since 2016 was an increase among females aged 70 and over, although this remained the adult age group least likely to exceed the lifetime risky drinking guideline (4.0% in 2016, increasing to 5.9% in 2019).

The proportion of people exceeding the lifetime risk guidelines has remained stable for older age groups since 2001, while for younger age groups, it declined.

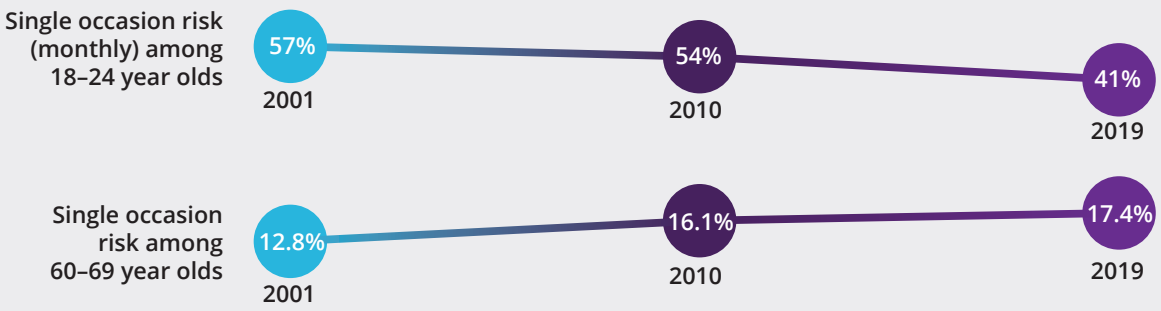


Single occasion risky drinking becoming more common among older people

Consistent with 2016, single occasion risk was most likely to be exceeded at least monthly by people aged 18–24 (41%, compared with 42% in 2016) and 25–29 (36%, the same as 2016) (Table 3.15). People in their 30s were less likely to have done so in 2019 (28%) than in 2016 (31%).

However, 27% of people in their 50s exceeded the single occasion guideline at least monthly, an increase from 25% in 2016. The proportion of people aged 70 and over drinking this amount also increased, from 7.2% to 8.8% (Table 3.15).

Trends in single occasion risky drinking since 2001 have followed a similar pattern to lifetime risk, with risky drinking declining among younger age groups but increasing among older age groups.



Risky drinking also changes depending on where people live

People living in *Remote and Very remote* areas were more likely to be risky drinkers than those living in *Major cities*. Further information about regional differences in risky drinking can be found in the geography chapter (see 'Chapter 7 Drug use by geographic areas').

People who were employed were more likely to be risky drinkers (both single occasion and lifetime risk) than people who were unemployed. Further information on employment status, and other personal factors, can be found in the population groups chapter (see 'Chapter 8 Priority population groups').

At what age do people start drinking?

The NHMRC guidelines recommend that people under 18 do not drink alcohol, and should delay their initiation as long as possible. In 2019, 2 in 3 (66%) 14–17 year olds had never consumed a full standard drink (Table 3.30).

The average (mean) age that 14–24 year olds first consumed their full serve of alcohol in 2019 was 16.2 years. While this was not a significant change since 2016, it does continue an increasing trend seen since 2001, when the mean age of initiation was 14.7 (Table 3.31). Among females aged 14–24, the mean age at which they consumed their first drink increased since 2016, from 16.0 to 16.3.

What proportion of people have consumed 11 or more drinks on a single occasion?

In addition to reporting against the NHMRC guidelines, it is important to examine other drinking patterns among people who exceed the guidelines, including those people who drink well in excess of the guidelines—those consuming 11 or more drinks on a single occasion.

In 2019, there was a decline among the adult population drinking 11 or more drinks in a single session at least once a month, from 7.4% in 2016 to 6.7% in 2019. There was also a slight but non-significant decline among people aged 14 and over (from 7.1% in 2016 to 6.5% in 2019) (Table 3.19).

People drinking at these levels at least yearly did not change over the latest 3-year period, but has declined since 2010 from 17.4% to 15.1% in 2019.

As with single occasion risk, young adults (aged 18–24) continued to be the most likely age group to drink 11 or more drinks on a single occasion in 2019, with 30% having done so in the past year, and 14.6% doing so at least monthly (Table 3.19).

1 in 10 people who drink may be experiencing alcohol dependence

The NHMRC alcohol guidelines were developed to provide an indication of how people's alcohol consumption may have an impact on their health, either through chronic health conditions or by increasing their risk of injury while affected by alcohol. However, it is also important to consider how many people may be dependent on alcohol (Box 3.2). Alcohol dependence is a different form of harm that is likely to require specialised alcohol treatment services, rather than presentation to a doctor or an emergency room to treat alcohol-related health issues.

Box 3.2: The ASSIST: a measure of harmful use

The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) was developed by the World Health Organization to identify people whose substance use may be causing them harm. The ASSIST screens for harmful use of alcohol and tobacco, as well as illicit drugs and pharmaceuticals.

ASSIST scores are categorised as 'low risk', 'moderate risk' or 'high risk'. High risk scores are likely to indicate a substance dependence issue, while moderate risk scores indicate substance use that may be hazardous or harmful to the person's health.

The ASSIST-Lite is an abridged version of the ASSIST, consisting of 3 to 4 questions for each substance (Ali et al. 2013). It was incorporated into the NDSHS in 2019 to estimate how many people who use substances show signs of substance dependence, or a pattern of use that may be hazardous to their health. Results also have implications for alcohol and other drug treatment services in Australia: people who receive a high risk score are likely to require specialist assessment and treatment for their substance use, while people who receive a moderate risk score are likely to benefit from a brief intervention or education of some kind.

Of everyone who had an alcoholic drink in the previous 12 months, 9.9% were likely to meet the criteria for alcohol dependence (Table 3.26). Males (13.5%) were more likely than females (6.3%) to receive this score. The ASSIST-Lite scores indicated that a further 29% of this population were using alcohol to a hazardous or harmful extent, and again males (36%) were much more likely to meet this threshold than females (22%).

Among the total Australian population aged 14 and over, this equates to 7.5% who may be experiencing some form of alcohol dependence and would benefit from specialist treatment, and a further 22% who are likely to be using alcohol in a harmful way (Table 3.26).

Of the people identified as being at high risk (likely to have some extent of alcohol dependence):

- 74% had never participated in any form of tobacco, alcohol or other drug treatment program (such as a telephone helpline, counselling, or medications to help with their drinking), and only 12.5% had done so in the previous 12 months
- 27% had been diagnosed or treated for a mental illness in the previous 12 months, much higher than the 16.7% proportion of the general population (Table 3.29).

Of the people identified as being at moderate risk (likely to be negatively affected by their alcohol use):

- 89% had never participated in any form of tobacco, alcohol or other drug treatment program, and only 3.9% had done so in the previous 12 months
- 17.8% had been diagnosed or treated for a mental illness in the previous 12 months (Table 3.29).

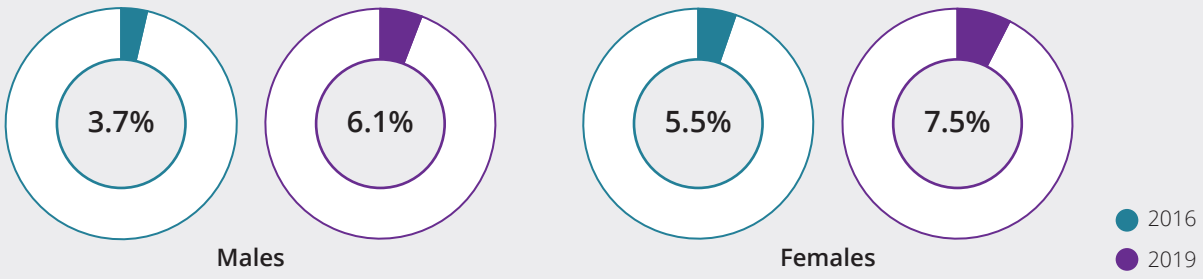
People are modifying their drinking to protect their health

The proportion of drinkers taking action to reduce their alcohol consumption was highest in 2019 (Table 3.38). While the number of people drinking at risky levels did not substantially change between 2016 and 2019, more people reduced their alcohol intake by:

- reducing the amount of alcohol consumed at any 1 time (up from 28% to 31%)
- reducing the number of drinking occasions (from 29% to 31%)
- switching to drinking more low-alcohol drinks (from 5.2% to 6.1%)
- stopping drinking alcohol (6.6% to 7.8%).

When asked why they had done so, most people said that it was for health reasons. This was the most common reason selected in 2016 and 2019 but it increased from 50% to 54% (Table 3.39). These changes may be because people were more aware that alcohol causes health risks.

Proportion of people who said drinking any amount of alcohol can put an adult's health at risk



More people were motivated to change their drinking habits due to drink-driving regulations, increasing from 11.4% in 2016 to 12.9% in 2019 (Table 3.39). This was primarily due to an increase among people aged 60–69 (from 16.3% to 21%), and those aged 70 and over (increasing from 21% to 26%).

How many people were harmed by other people's alcohol use?

A person's alcohol consumption can harm others, not just themselves. The NDSHS contains several questions about whether the respondent has experienced harm from another person who was under the influence of alcohol. Specifically, people were asked whether they were verbally or physically abused, or put in fear by another person who was under the influence of alcohol.

More than 1 in 5 people (21%) had been verbally or physically abused, or put in fear by someone under the influence of alcohol in the previous 12 months (Table 3.46), corresponding to 4.5 million Australians—little change from 2016 (Table 3.47).

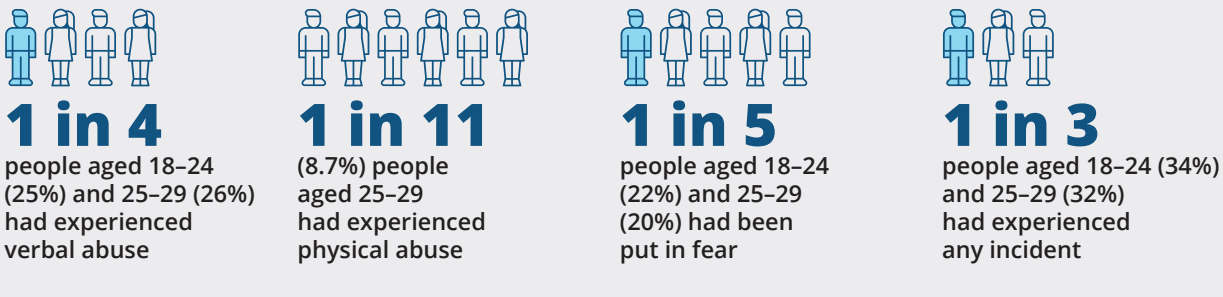
The proportion of males who had experienced physical abuse from someone under the influence of alcohol in the previous 12 months decreased since 2016, from 6.8% to 5.6% in 2019, representing a decline from 700,000 to 600,000 males (tables 3.46 and 3.47).

The proportion of females who experienced physical abuse also decreased from 5.0% to 4.0% (or 500,000 to 400,000). In the same time frame, verbal abuse decreased, from 17.2% to 15.9%, but the number remained unchanged at 1.7 million.

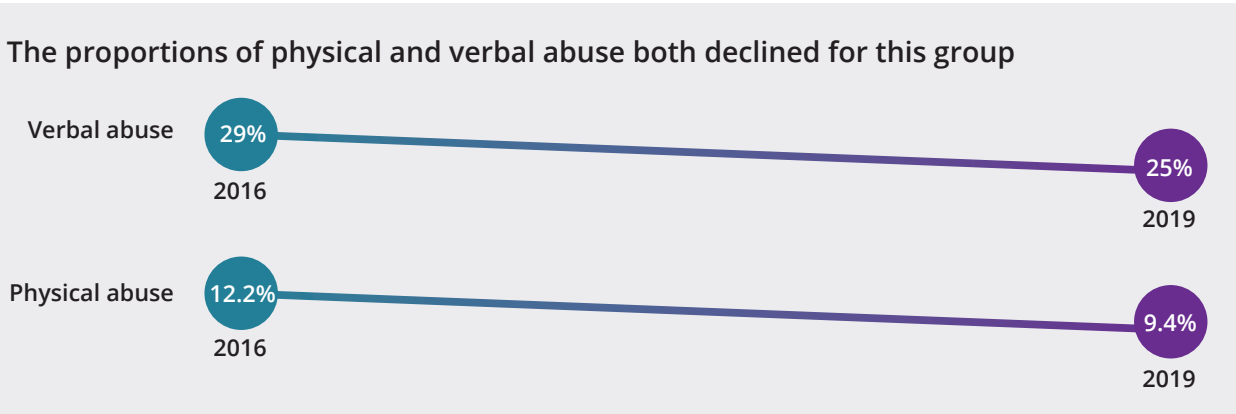
Of all incidents of physical abuse, 10.6% were serious enough to require admission to hospital (Table 3.51).

Some people are more likely to experience harms than others

Younger adults were disproportionately abused and put in fear by people under the influence of alcohol:



The proportion of incidents is also much higher among people who exceed the single occasion drinking guideline.



Who are the perpetrators of alcohol-related harms?

Despite similar proportions of males and females having experienced harms in the previous 12 months, the people responsible for those harms are different. Females were more likely than males to report their abuser being their current or former spouse or partner, while males were more likely to report their abuser being a stranger. (Table Alcohol1).

Table Alcohol1: Relationship of perpetrators to victims of alcohol-related incidents, victims aged 14 and over, by sex, 2019 (per cent)

	Verbal abuse		Physical abuse		Put in fear	
	Males	Females	Males	Females	Males	Females
Current or ex-spouse or partner	9.3	27	9.5	32	4.4	18.1
Other relative	9.4	16.8	9.5	14.5	8.2	13.5
Friend	9.2	7.9	*5.9	6.2	6.5	6.9
Other person known to me	20	16.3	21	16.0	15.4	18.5
Someone not known to me	72	49.1	65	41	78	61

* Estimate has a relative standard error of 25% to 50% and should be used with caution.

This indicates that the types of abuse being experienced by females and males are likely to take different forms and may occur in different places, so different strategies are required to reduce the number of people experiencing abuse or fear from people who are under the influence of alcohol.

How do people feel about policies aimed at reducing excessive alcohol use?

The survey asks respondents to give their level of support for various policies intended to reduce problems associated with excessive alcohol use. People could support, oppose or neither support nor oppose any given policy measure. They could also abstain from answering if they did not know enough about the policy to make a decision.

New policy questions

Two new policy suggestions questions were added to the survey in 2019. The first asked people whether they would support displaying health warnings on all alcohol containers. Responses were positive, with 65% of people supporting and only 9.3% opposing the idea (Table 3.54).

The second new policy measure asked about was the introduction of minimum unit pricing (or minimum floor pricing) for alcoholic drinks, which proposes a minimum price for drinks based on how much alcohol they contain. Opinions on this measure were varied. More people supported it (39%) than opposed it (27%), but it had one of the highest proportions of people saying they neither supported nor opposed it at 33% (Table 3.54).

Support down across most alcohol policies

Public support declined for more than two-thirds of policies asked about in the survey, and opposition increased (Table 3.54). This continues a trend seen since 2013 of declining support across a majority of measures to reduce the harms from alcohol.

Three measures saw drops in support larger than 5 percentage points, all relating to late night alcohol activity. For example, support for the strict monitoring of late night premises dropped from 73% to 67%, and support for restricting late night trading of alcohol declined from 57% to 49%.

The largest reduction in support was seen for reducing the trading hours for pubs and clubs, declining from 39% in 2016 to 31% in 2019 (Table 3.54). It also saw the largest increase in opposition, from 34% to 40%, making this the first time more people have opposed the policy measure than supported it since 2004 (when 32% supported and 40% opposed).

Despite the declines seen in policy support, two-thirds of the policies were supported by a majority of Australians. Measures that received the highest support involved enforcement of existing alcohol-related laws:

84%
More severe legal penalties for drink-driving

79%
Stricter enforcement of the law against supplying minors

78%
Stricter enforcement of the law against supplying customers who are drunk

Measures that received the strongest opposition involved making it harder or more costly for everyone to obtain alcohol:

47%
Increasing the price of alcohol

40%
Reducing trading hours for pubs and clubs

36%
Reducing the number of outlets that sell alcohol

Where can I get more information?

To explore the data and view additional analyses, see the supplementary alcohol data tables. These include data on:

- where people usually obtain their alcohol
- actions taken to reduce harm while drinking
- days of work or school missed due to illness, injury or alcohol use.

4 Illicit use of drugs

Quick facts

In 2019, an increase in recent use was reported for a number of illicit drugs, including cannabis, cocaine, ecstasy, hallucinogens, inhalants and ketamine.

Use of pain-killers and opioids for non-medical purposes and use of emerging psychoactive substances decreased between 2016 and 2019.

For the first time since 2001, males in their 20s reported an increase in recent illicit drug use (excluding pharmaceuticals) (from 29% in 2016 to 34% in 2019), largely driven by increases in cocaine and ecstasy.

Use of illicit drugs continued to increase among older age groups, driven by the highest levels of cannabis use since 2001.

Meth/amphetamine use has been declining since it peaked at 3.4% in 2001 and stabilised in 2019 (1.4% in 2016 and 1.3% in 2019) but crystal/ice continues to be the main form used and was used more frequently than drugs such as cocaine and ecstasy.

The average (mean) age 14–29 year olds first tried an illicit drug increased between 2016 and 2019 for cannabis, ecstasy, inhalants, pain-killers/opioids and tranquillisers.

Most people first try illicit drugs out of curiosity (69%) and of those who continue using illicit drugs, they do so because they enjoy it (71%).

More people were victims of an illicit drug-related incident in 2019 with the proportion of people reporting that they were verbally abused, physically abused or put in fear all increasing since 2016—*any incident* increased from 9.2% to 10.5%.

Among people who used hallucinogens in the previous 12 months, frequency of use increased between 2016 and 2019—at least monthly use (from 3.0% to 10.3%) and use every few months increased (from 21% to 34%).

People using cocaine in the previous 12 months has been increasing since 2004, from 1.0% to 4.2% in 2019, and is at its highest level over the last 18 years for all adult groups.

Harms from illicit drugs affect all Australian communities, families and individuals, either directly or indirectly. These include illnesses and injuries, mental health and trauma, and health care and other financial costs (DoH 2017).

In 2015, illicit drug use contributed to 2.7% of the total burden of disease and injury (AIHW 2019c). In 2018, 1,740 deaths were directly attributable to drug use, and opioids were present in nearly two-thirds of these deaths (64.5% or 1,123 deaths).

The first part of the chapter focuses on illicit use of at least 1 drug (including non-medical use of pharmaceuticals) and the second part focuses on use of selected illegal drugs excluding pharmaceuticals (see Chapter 5 for more detailed information on pharmaceuticals used for non-medical purposes).

What is meant by 'illicit drug use'?

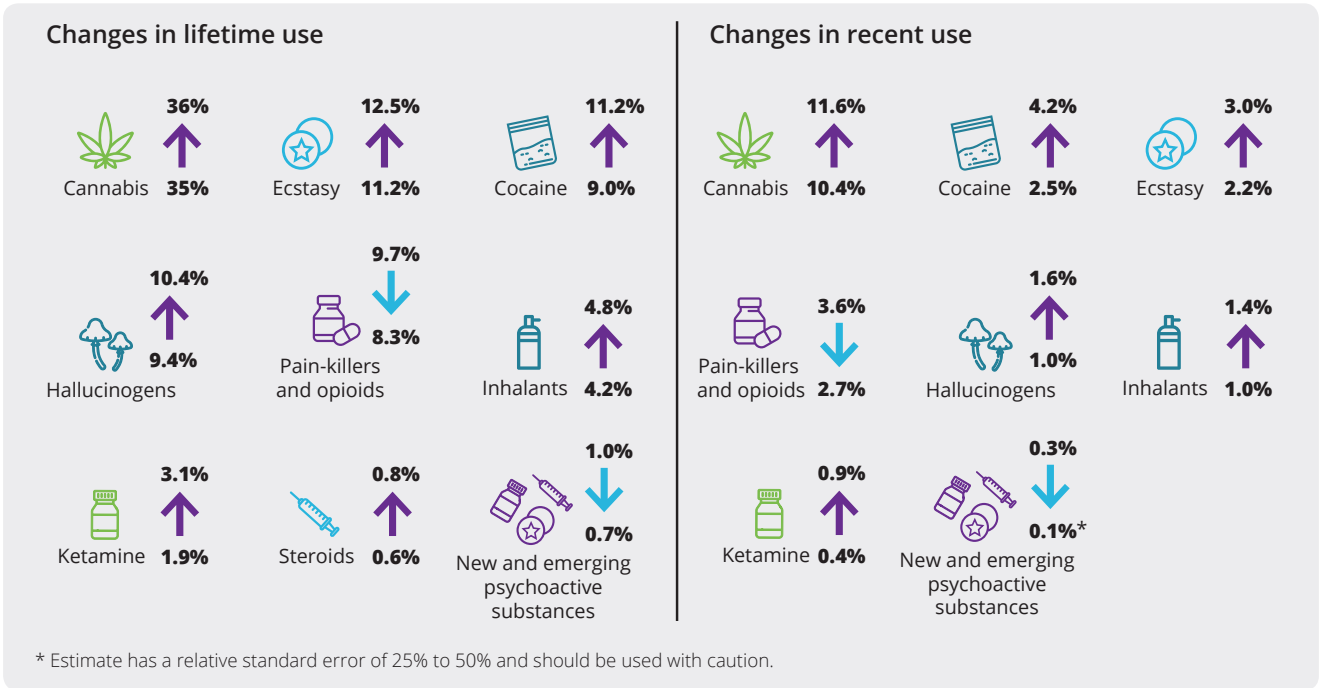
- use of illegal drugs (such as meth/amphetamines and cocaine)
- use of pharmaceuticals for non-medical purposes (for example, using oxycodone or benzodiazepines without a prescription, or in a quantity or for a purpose for which it is not intended)
- volatile substances used inappropriately (for example, inhalants such as petrol or glue).

Unless otherwise specified, the results in this report relate to those aged 14 and over and all increases or decreases in estimates over time are statistically significant. All data presented in this chapter are available through the online illicit drug tables https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey-2019/data.

How many people use illicit drugs and how has this changed?

In 2019, 9.0 million (or 43%) people aged 14 and over in Australia had illicitly used a drug at some point in their lifetime (including pharmaceuticals used for non-medical purposes) and 3.4 million (or 16.4%) had used one in the last 12 months (tables 4.1, 4.3, 4.7, and 5.5). This was similar to the proportions in 2016 but has increased since 2007 (38% and 13.4% respectively).

There were a number of changes in lifetime and recent use of specific drugs between 2016 and 2019 (Tables 4.2 and 4.6).

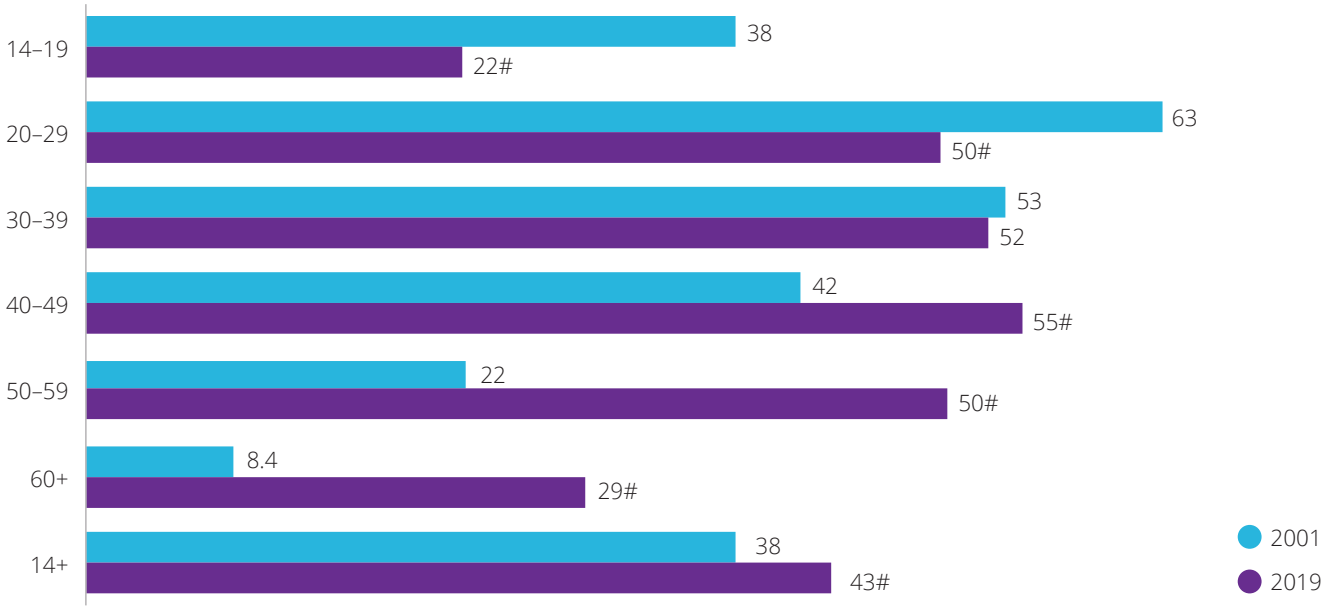


* Estimate has a relative standard error of 25% to 50% and should be used with caution.

How has illicit drug use changed across age groups?

In 2001, use of an illicit drug in a person's lifetime was highest among people in their 20s (Figure 4.1). By 2019, it was people in their 40s who were the most likely to have ever used an illicit drug. Over the last 18 years, both lifetime and recent use have risen among older age groups, remained stable for people in their 30s and generally declined among people aged under 30 (14–29 years; tables 4.4 and 4.6).

Figure 4.1 Lifetime[(a)] use of an illicit drug (including pharmaceuticals), by age, 2001 and 2019 (per cent)



Statistically significant change between 2001 and 2019.

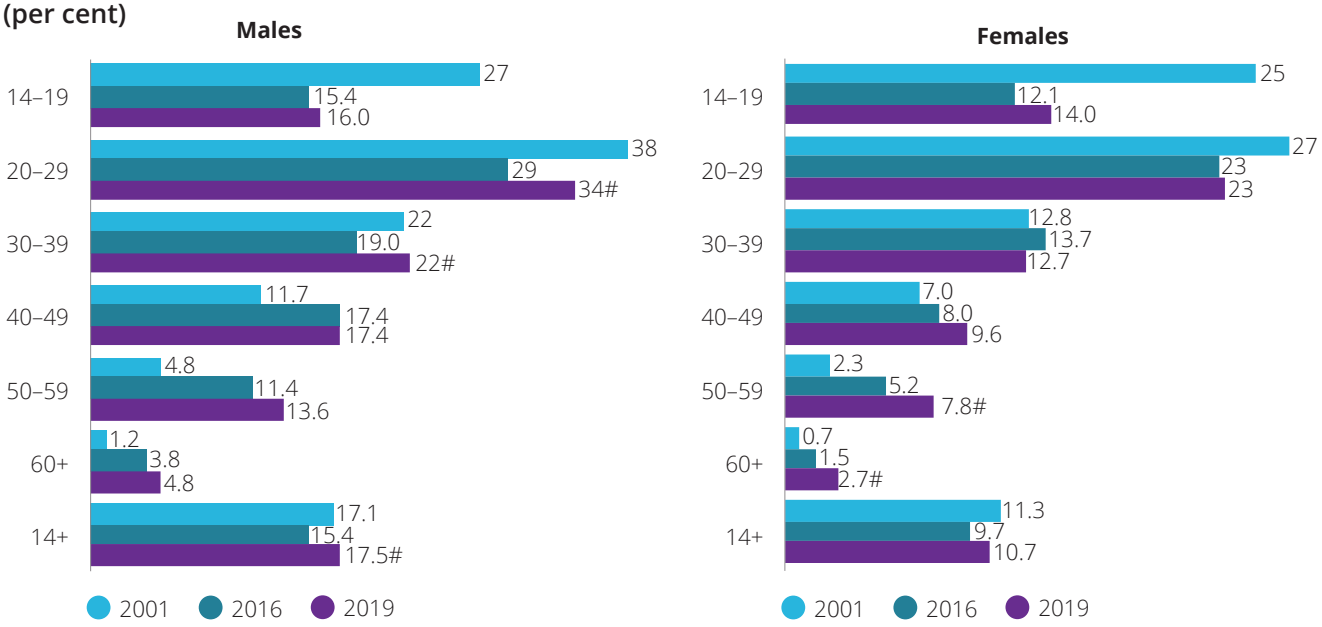
(a) Used at least 1 of 16 illicit drugs in 2019—the number and type of drug used varied between 2001 and 2019.

Source: Table 4.4.

Over the most recent 3-year period, the proportion of people aged 60 and over who had ever used an illicit drug increased. This pattern was seen for both males and females (Table 4.4). This could be due in part to people who used illicit drugs ageing. Trends in drug use can also result from generational differences in drug use and changes in the composition of the population over time, such as the ageing of a particular generation of people (McKetin et al. 2010).

When looking at illicit drug use excluding pharmaceuticals (Figure 4.2), males in their 20s and 30s reported increases in recent use between 2016 and 2019. Females in their 50s and those aged 60 and over reported small increases in recent use.

Figure 4.2: Recent[(a)] illicit drug use excluding pharmaceuticals, by age and sex, 2001, 2016 and 2019 (per cent)



Statistically significant change between 2016 and 2019.

(a) Used at least 1 of 12 illegal drugs in 2019—the number and type of drug used varied between 2001 and 2019.

Source: Table 4.11.

The average age at which some people use drugs has risen

Although no statistically significant changes were detected in the median age of people who used drugs between 2016 and 2019, the median age of people who use drugs for most illicit drugs has risen since 2001 (Table 4.19a). For example:

- the median age of people who used cannabis was 26 in 2001 and increased to 31 in 2019
- the median age of people who used cocaine was 25 in 2001 and rose to 28 in 2019
- people who used meth/amphetamine are nearly a decade older, on average, than they were in 2001—increasing from 23 years old in 2001, to 32 by 2019.

People using ecstasy and hallucinogens in the past 12 months were generally younger than people using cannabis and meth/amphetamines (mid-20s compared with early 30s).

At what age do people start using illicit drugs?

Of people aged 14 and over who have used illicit drugs in their lifetime, most first tried them in their 20s, with some drugs tried earlier than others (Table 4.17). The age at which people first tried drugs was similar in 2016 and 2019 but in comparison to 2001, people were generally older.

Table Illicit1: Mean age of initiation, people who have used selected illicit drugs at least once in their lifetime, aged 14 and over

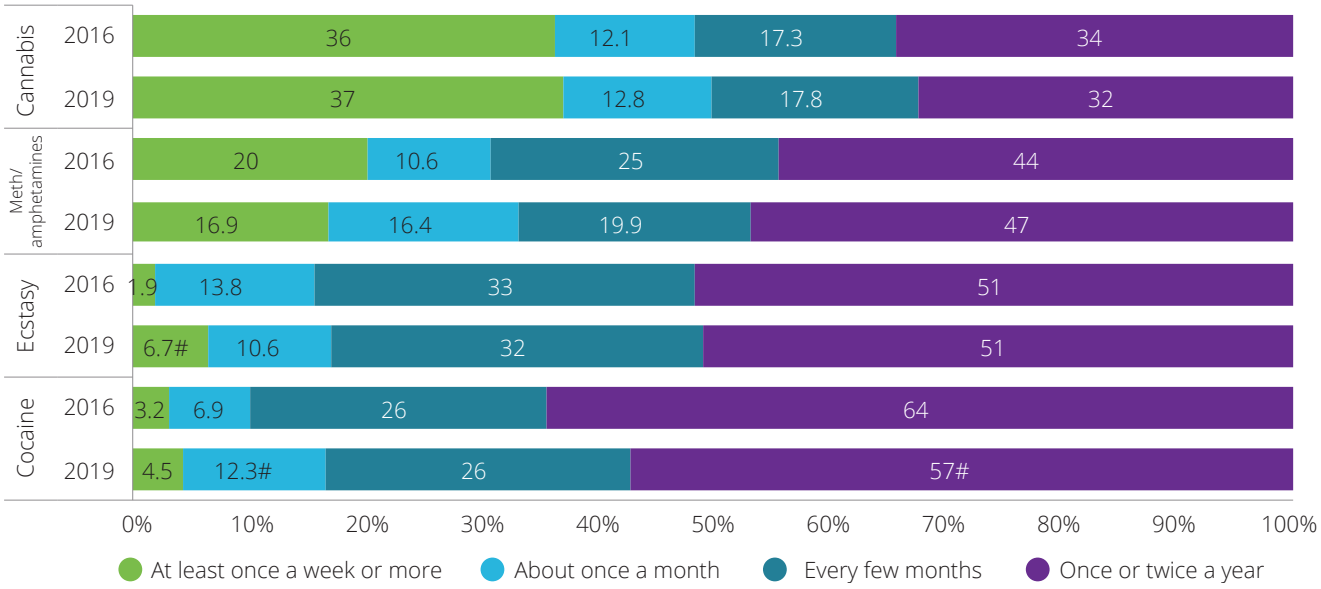
Drugs tried in late teens	Cannabis
Drugs tried in early 20s	Ecstasy; Meth/amphetamines; Hallucinogens; Inhalants; Heroin; Injected drugs
Drugs tried in mid-20s	Cocaine; GHB; Ketamine; Pain-killers/opioids
Drugs tried in late 20s or later	Tranquillisers; Steroids

Among people aged 14–29, the mean age of initiation of illicit drug use rose from 16.7 years in 2016 to 17.3 years in 2019 (Table 4.18). This was due to 14–29 year olds delaying their uptake of cannabis, ecstasy, inhalants, pain-killers and opioids, and tranquillisers.

Which illicit drugs are used most frequently?

Some drugs are used much more often than others, and the health risks of illicit drug use vary with the frequency, type and quantity of drugs used (Degenhardt et al. 2013). The NDSHS results show that cannabis and meth/amphetamines are used much more frequently than cocaine and ecstasy (Figure 4.3). In 2019, people who used cannabis or meth/amphetamines were much more likely to use the drug regularly, with 37% and 17% respectively using as often as weekly or more compared with those who used ecstasy or cocaine (6.7% and 4.5% respectively). However, there were more people using ecstasy at least weekly in 2019 than in 2016, and more people were using cocaine about once a month, but fewer using it once or twice a year.

Figure 4.3: Frequency of illicit drug use, by specific illicit drug, people aged 14 and over, 2016 and 2019 (per cent)



Statistically significant change between 2016 and 2019.

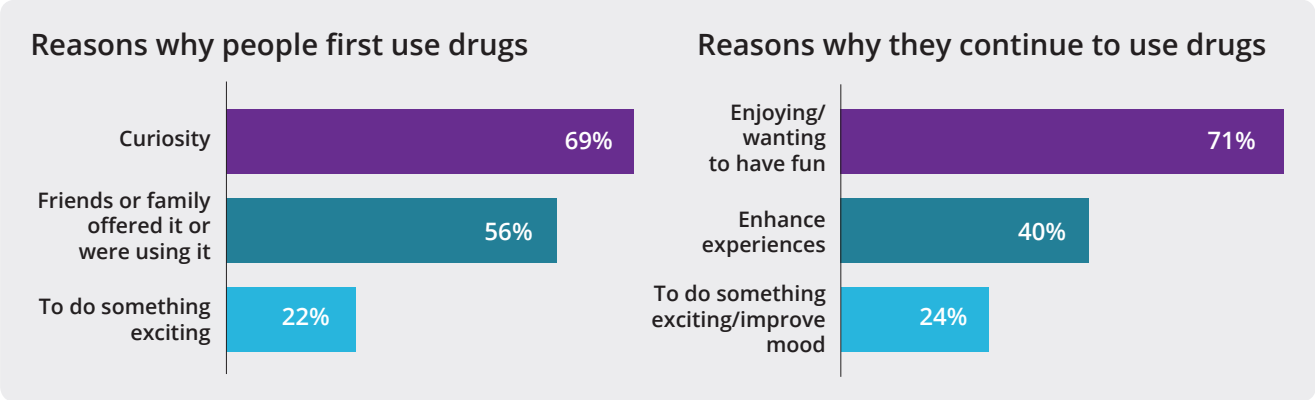
Note: The 2016 estimate for at least weekly ecstasy use and at least once a week or more cocaine use has a relative standard error between 25% and 50%.

Source: Table 4.20.

Why do people decide to use illicit drugs?

The decision to use drugs for the first time and to continue using them is influenced by a number of factors. There are different categories of drug use including experimental use (trying it once or twice out of curiosity), recreational use (for enjoyment, to enhance a mood or social occasion), situational use (to cope with the demands of a situation) and dependent use (needing it consistently to feel normal or avoid withdrawals) (ADF 2017). It can be difficult for a person to identify the reasons they may take drugs, or they may answer in a way they deem to be more socially acceptable.

In 2019, people were asked why they first decided to use drugs, and if they continue to use them, the reasons that they do.

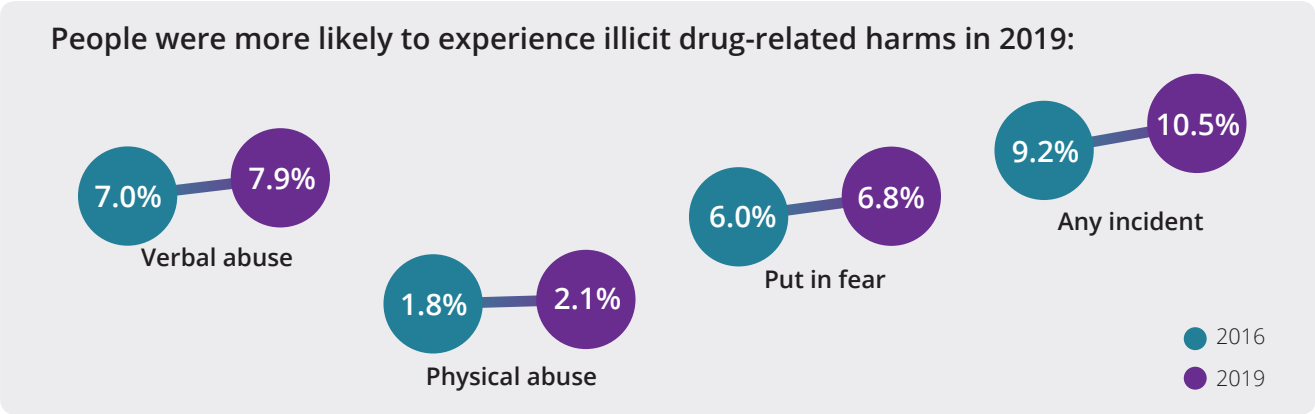


Most people who have not tried illicit drugs are not interested

In 2019, around 3 in 4 (73%) people who had never used illicit drugs had not tried them because they were not interested and this has not changed since 2010 (Table 4.27). A further 44% said they had never tried them as they were concerned about their health or becoming addicted and about 1 in 3 (32%) were worried about the legal consequences and did not want to break the law.

More people experienced drug-related harm

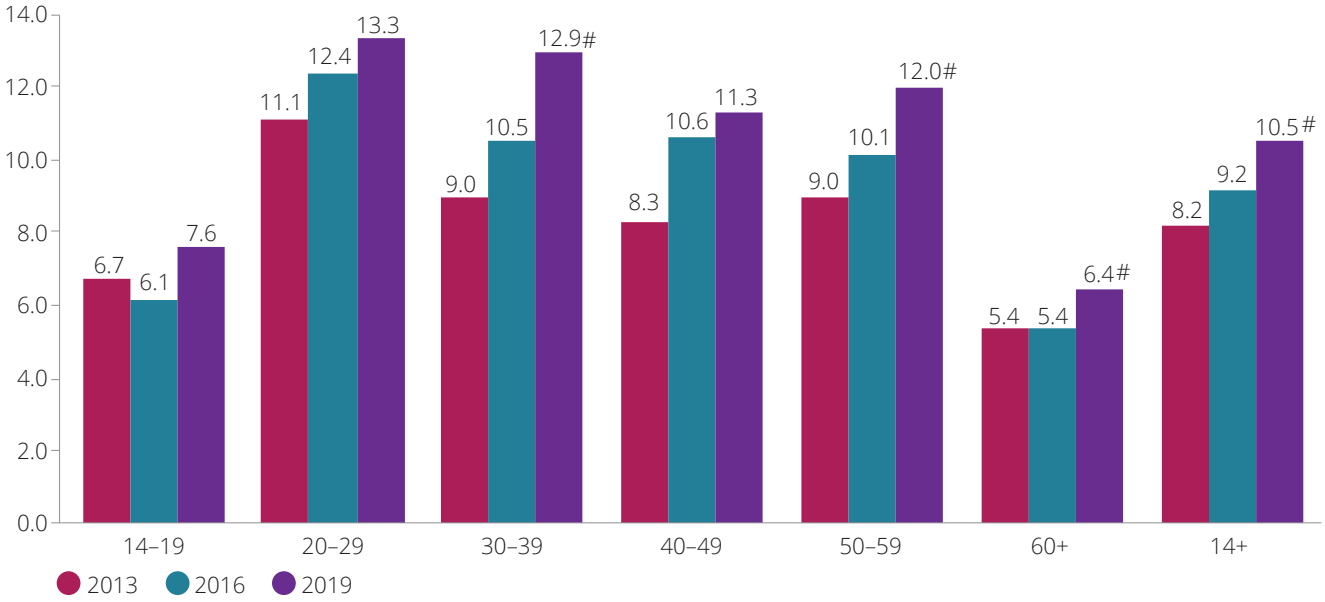
The survey asks people if they have experienced verbal abuse, physical abuse or have been put in fear by someone they suspect is under the influence of illicit drugs. In 2019, more people were victims of an incident related to illicit drugs in the previous 12 months than in 2016—the proportions of people experiencing verbal abuse, physical abuse and being put in fear all increased, driven by increases among males and people in their 30s, 50s, and aged 60 and over (Figure 4.4).



The number of people reporting that they had been a victim of an illicit drug-related incident increased from about 1.8 million in 2016 to 2.2 million in 2019 (Table 4.29).

Figure 4.4: Victims of illicit drug-related incidents, 2013–2019 (per cent)

Per cent



Statistically significant change between 2016 and 2019.

Source: Table 4.30.

Use of selected illicit drugs

Cannabis

Before 2016, Australian law generally considered cannabis an illegal narcotic. However, in February 2016 the *Narcotics Drug Act 1967* was amended (see Box 6.1. in the medicinal cannabis chapter) and medicinal cannabis products are available for specific patient groups under strict medical supervision.

In the 2019 NDSHS, 2 new questions were included regarding medical use of cannabis:

- Have you used marijuana/cannabis for medical purposes in the last 12 months?
- Was the medical marijuana/cannabis prescribed by a doctor?

If a person indicated that they used cannabis only for medical purposes and always had it prescribed by a doctor, then they were removed from recent use of cannabis as the NDSHS focuses on illicit use. Refer to the medicinal cannabis chapter for further information on people who said they used cannabis for medical purposes.

Snapshot of cannabis use in 2019

Among people aged 14 and over:	
Lifetime use	36% (7.6 million)
Recent use (last 12 months)	11.6% (2.4 million)
Change since 2016	↑ Lifetime use (35%) ↑ Recent use (10.4%)
Change since 2001	↑ Lifetime use (33%) ↓ Recent use (12.9%)
Offered/ Opportunity to use in last 12 months	23%

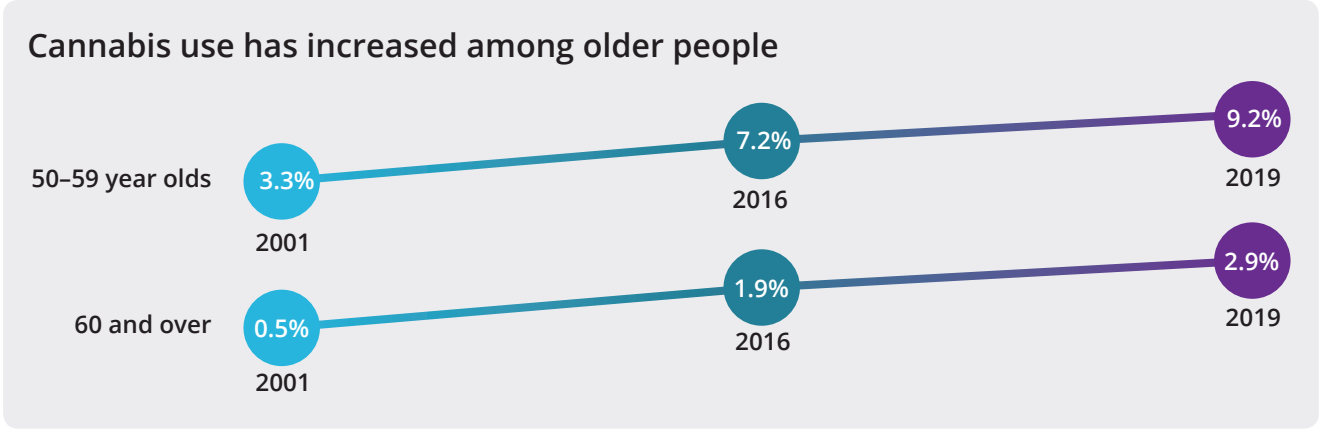
Among people who used cannabis:	
Average age of first use (years)	18.9 (mean) 17.2 (median)
Age group most likely to use (% recent use)	20–29 (24%)
Median age of people who use cannabis (years)	31
Used weekly or more often	37%
Main methods used	Joints (83%) Bongs/pipe (72%)
Diagnosed or treated for a mental illness	27%
High or very high psychological distress	28%

Are more people using cannabis?

Both lifetime and recent use of cannabis increased between 2016 and 2019. In 2019, 36% had used it in their lifetime (up from 35% in 2016) and 11.6% had used it in the last 12 months (up from 10.4%). In addition, more people reported using it in the month before the survey (from 5.8% to 6.6%) but there was no change in the frequency of use—about half of those who used cannabis did so monthly or more often (tables 4.16 and 4.20).

The increase in lifetime use was due mainly to an increase among people aged 60 and over (from 13.8% to 18.9%) (Table 4.41). This could be due to an ageing cohort of people who had used cannabis, an increase in people deciding to try it, or to more people being willing to report their use.

Between 2016 and 2019, recent use of cannabis increased among older people (Table 4.43). Recent use among those aged 50–59 and 60 and over is at the highest level since 2001. These age groups were also the most likely to use cannabis regularly, with almost half using it once a week or more.



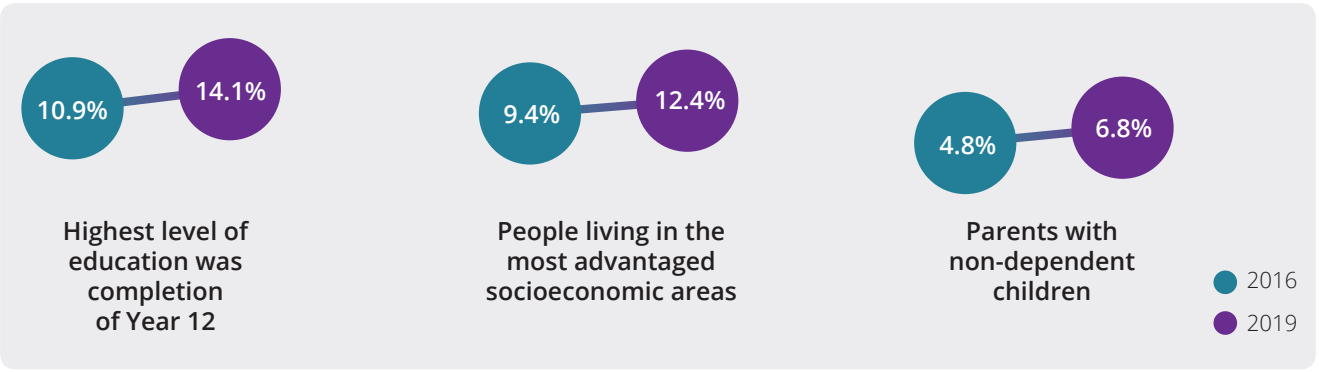
Who is most likely to use cannabis?

Males continue to be more likely to have recently used cannabis than females (14.7% compared with 8.6%), the greatest difference (almost twice as likely among males as females) occurring among those aged in their 30s and 40s (Table 4.43).

Compared with those in other age groups, people in their 20s continued to be the most likely to use cannabis but this declined over the longer term—from 29% in 2001 to 24% in 2019.

How does use of cannabis vary by population group?

As in previous years, people who identified as gay, lesbian or bisexual, and unemployed people, were the groups most likely to use cannabis—31% and 19.8% respectively, compared with 11.6% among all Australians (Table 4.47). While these 2 groups did not report any statistically significant changes in recent use between 2016 and 2019, recent use rose for a number of other population groups in this period.



About 1 in 4 people (27%) who used cannabis in the previous 12 months reported they had been diagnosed with or treated for mental illness (Table 4.48), no change from 2016 but higher than in 2010 (18.7%). A similar proportion had experienced high or very high levels of psychological distress (in the 4 weeks before completing the survey), and this increased from 24% in 2016 to 28% in 2019 (see 'Chapter 8 Priority population groups' for more information).

How many people who use cannabis may be at risk of problem drug use?

A number of questions from the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST-Lite) were added to the 2019 NDSHS questionnaire to better understand what proportion of the population may be at risk of problem drug use and in need of intervention (see alcohol chapter and Technical notes for more information about the ASSIST-Lite). ASSIST-Lite scores are categorised as 'low risk', 'moderate risk' or 'high risk'. High risk scores may indicate a substance dependence problem, while moderate risk scores indicate substance use that may be hazardous or harmful (Ali et al. 2013). People with a high risk score are likely to require specialist assessment and treatment for their substance use; people with a moderate risk score are likely to benefit from a brief intervention or education.

Among people who had used cannabis in the last 12 months:

- 2.9% were at high risk and could be dependent or experiencing severe problems and in need of referral for specialist assessment and treatment
- 14.6% were at moderate risk and would be likely to benefit from a brief intervention
- 82% were categorised as low risk (Table 4.50).

Cocaine

Snapshot of cocaine use in 2019

Among people aged 14 and over:	
Lifetime use	11.2% (2.3 million)
Recent use (last 12 months)	4.2% (900,000)
Change since 2016	↑ Lifetime use (9.0%) ↑ Recent use (2.5%)
Change since 2001	↑ Lifetime use (4.4%) ↑ Recent use (1.3%)
Offered/ Opportunity to use in last 12 months	8.5%

Among people who used cocaine:	
Average age of first use (years)	24 (mean) 22 (median)
Age group most likely to use (% recent use)	20–29 (12.0%)
Median age of people who use cocaine (years)	28
Used monthly or more often	16.8%
Main form used	Powder (99%)
Diagnosed or treated for a mental illness	22%
High or very high psychological distress	25%

Lifetime and recent use of cocaine continues to increase

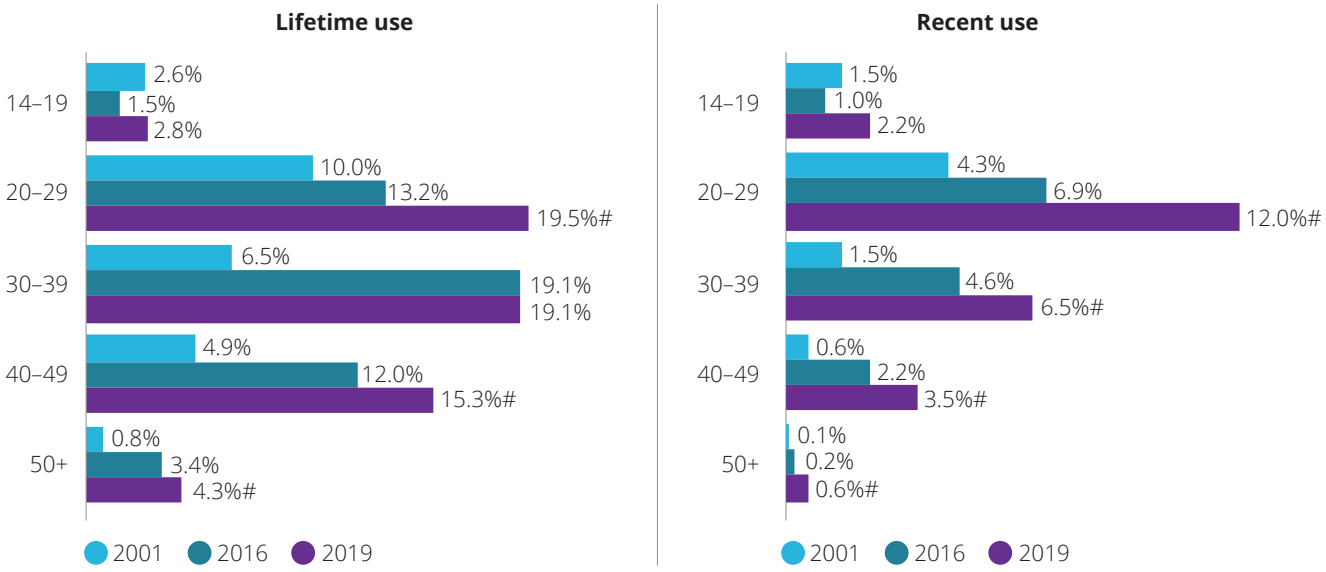
Compared with 2016, more people aged 14 and over reported they had used cocaine in their lifetime, previous 12 months, previous month and previous week (tables 4.15 and 4.16). Lifetime use of cocaine increased for both males and females, following an increasing trend that started in 2004. This was driven mainly by more people in their 20s, 40s and those aged 50 and over reporting in 2019 that they had used cocaine in their lifetime (Figure 4.5).

Between 2016 and 2019, recent cocaine use increased across all age groups (except 14–19 year olds) and is at the highest proportion seen since 2001. The increase in recent use was driven mainly by the males in these age groups, but use among females in their 20s also increased. The proportion of males in their 20s using cocaine in the 12 months before the survey almost doubled (from 7.3% to 14.4%).

People are using cocaine more frequently

Lifetime and recent use of cocaine increased in 2019 and people who used cocaine also used it more often—at least monthly use increased from 10.1% to 16.8% between 2016 and 2019 (Figure 4.5).

Figure 4.5: Lifetime and recent[(a)] use of cocaine, by age, 2001, 2016 and 2019 (per cent)



Statistically significant change between 2016 and 2019.

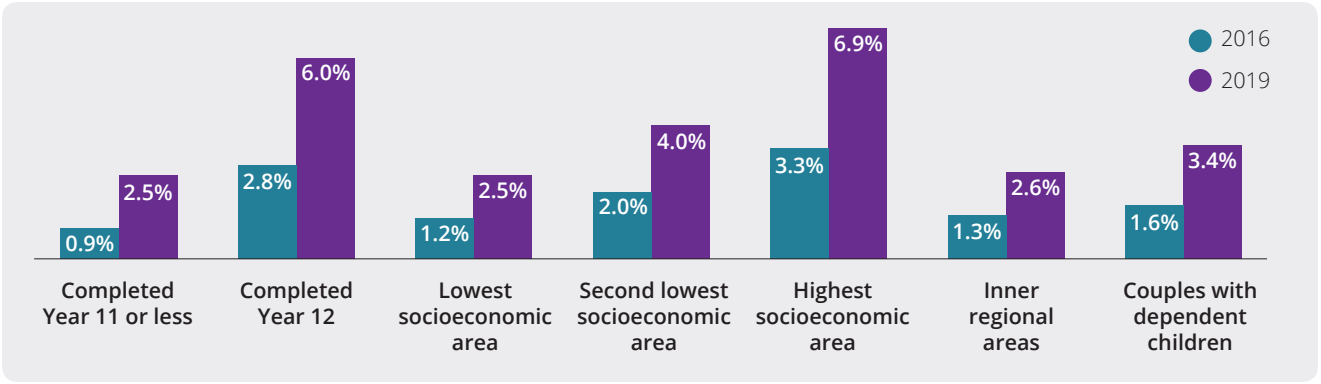
(a) Used in the last 12 months.

Note: The 2016 and 2019 estimates for 14–19 year olds have a relative standard error between 25% and 50%, as does the 2016 estimate for people aged 50 and over.

Source: tables 4.54 and 4.56.

Recent cocaine use more than doubled in some groups

Between 2016 and 2019, recent use of cocaine more than doubled in the following groups:



See Table 4.58 or 'Chapter 8 Priority population groups' for more information. See 'Chapter 7 Drug use by geographic areas' for explanation and definition of socioeconomic areas and remoteness classification.

People's perception of cocaine has changed

There was a small increase in the proportion of people who thought cocaine should be legalised (from 7.0% in 2016 to 8.0% in 2019) and a decrease in support for increasing the penalties for the sale or supply of cocaine (from 80% to 77%). There was also a small increase in the proportion of people who approve the regular adult use of cocaine between 2016 and 2019 (see 'Perceptions and policy support' chapter for more information).

Ecstasy

Snapshot of ecstasy use in 2019

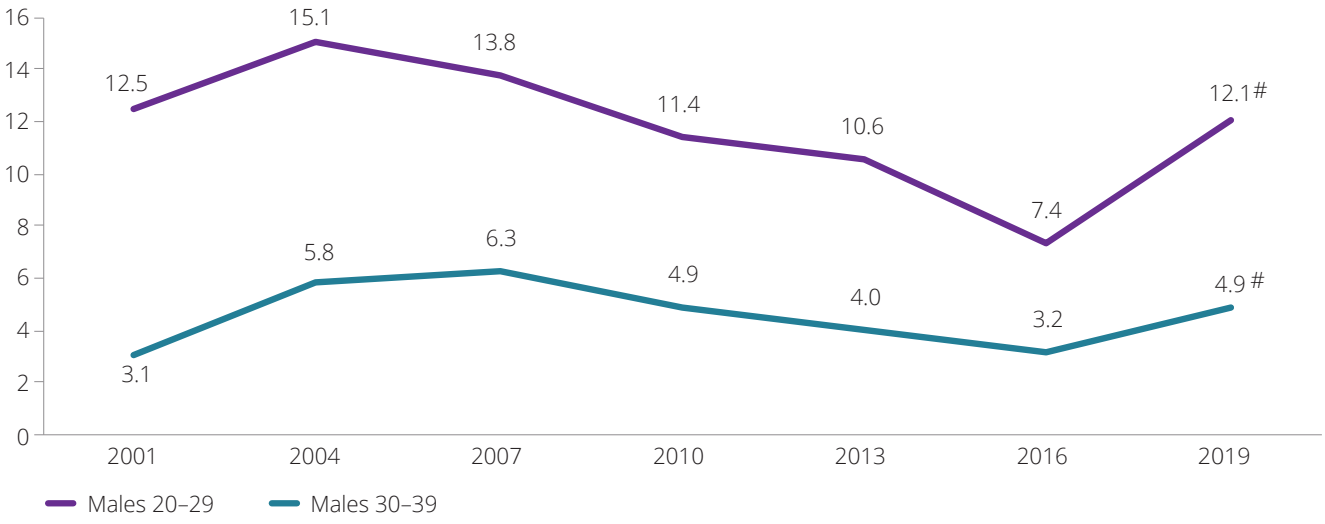
Among people aged 14 and over:	
Lifetime use	12.5% (2.6 million)
Recent use (last 12 months)	3.0% (600,000)
Change since 2016	↑ Lifetime use (11.2%) ↑ Recent use (2.2%)
Change since 2001	↑ Lifetime use (6.1%) ~Recent use (2.9%)
Offered to use in last 12 months	7.0%

Among people who used ecstasy:	
Average age of first use (years)	22 (mean) 20 (median)
Age group most likely to use (% recent use)	20–29 (9.8%)
Median age of people who use ecstasy (years)	25
Used monthly or more often	17.3%
Main form used	Capsules (49%) Pills (34%)
Diagnosed or treated for a mental illness	22%
High or very high psychological distress	28%

More people using ecstasy

Compared with 2016, more people aged 14 and over reported they had used ecstasy in their lifetime, in the previous 12 months and in the previous month, in 2019 (Table 4.15). The increase in lifetime use, from 11.2% in 2016 to 12.5% in 2019, was due mainly to the increase among people in their 40s, from 14.8% to 19.4% (Table 4.61). This group has continually reported increases in lifetime use since 2004. Recent ecstasy use had been declining since 2010 but increased between 2016 and 2019, returning to the 2010 level of 3.0% (Table 4.63). There were no statistically significant changes among females, but males in their 20s and 30s both reported increases, with use returning to levels similar to those reported in 2010 (Figure 4.6).

Figure 4.6: Use of ecstasy in the previous 12 months, by males aged 20–39, 2001–2019 (per cent)



Statistically significant change between 2016 and 2019.

Source: Table 4.63.

People in their 20s had been reporting declines in use since 2007 but in 2019 reported an increase for the first time in over a decade (from 7.0% in 2016 to 9.8% in 2019).

People in the highest socioeconomic areas are most likely to use ecstasy

Between 2016 and 2019, use of ecstasy in the previous 12 months increased for people living in the lowest and highest socioeconomic areas but people in the highest areas continued to be more than twice as likely as those in the lowest areas to use ecstasy. Recent use also increased among people who were employed; completed Year 12; and those who had a bachelor degree or other post-graduate qualification (Table 4.66).

There was a shift in the main forms of ecstasy used

In the 2016 survey, people were asked for the first time what forms of ecstasy they had used. In 2016, pills/tablets were the main form used but this declined in 2019, from 51% to 34%, while the use of capsules increased from 33% to 49% (Table 4.65). Forms ever used also reported similar changes with pill/tablet form declining (from 90% to 83%) and capsules increasing (from 69% to 83%). There was also an increase in the use of crystal/rock over this period (from 42% to 51%).

The age of people who use ecstasy has an impact on the forms used. Teenagers and people in their 20s were more likely to use capsules while people aged 30 and over were more likely to use pill/tablets (Table 4.68).

Meth/amphetamines

Snapshot of meth/amphetamines use in 2019

Among people aged 14 and over:	
Lifetime use	5.8% (1.2 million)
Recent use (last 12 months)	1.3% (300,000)
Change since 2016	~Lifetime use (6.3%) ~Recent use (1.4%)
Change since 2001	↓ Lifetime use (8.9%) ↓ Recent use (3.4%)
Offered/ Opportunity to use in last 12 months	4.4%

Among people who used meth/amphetamines:	
Average age of first use (years)	22 (mean) 20 (median)
Age group most likely to use (% recent use)	20–29 (2.4%)
Median age of people who use meth/amphetamines (years)	32
Used weekly or more often	16.9%
Main form used	Crystal/ice (50%) Powder/speed (19.9%)
Diagnosed or treated for a mental illness	31%
High or very high psychological distress	36%

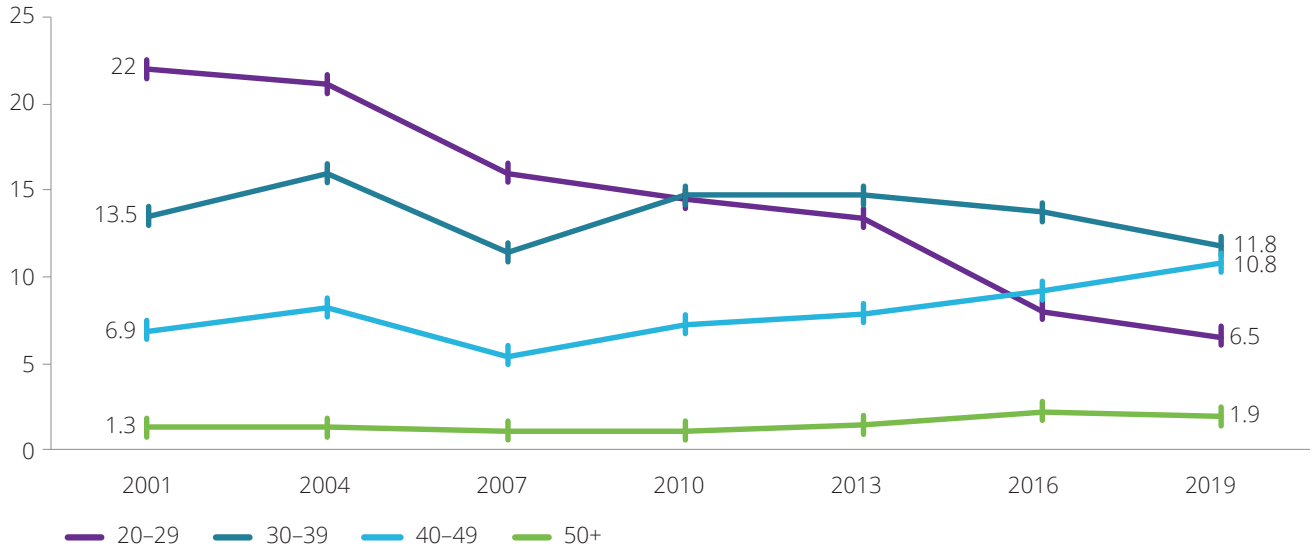
Meth/amphetamine use declining among younger people

Meth/amphetamine use has been declining since it peaked at 3.4% in 2001 (Table 4.72), and stabilised in 2019 (1.4% in 2016 and 1.3% in 2019). While no statistically significant changes by age or sex were detected between 2016 and 2019, use has been declining among younger age groups since 2001 but increasing or remaining stable among older age groups (40 and over) (Figure 4.7).

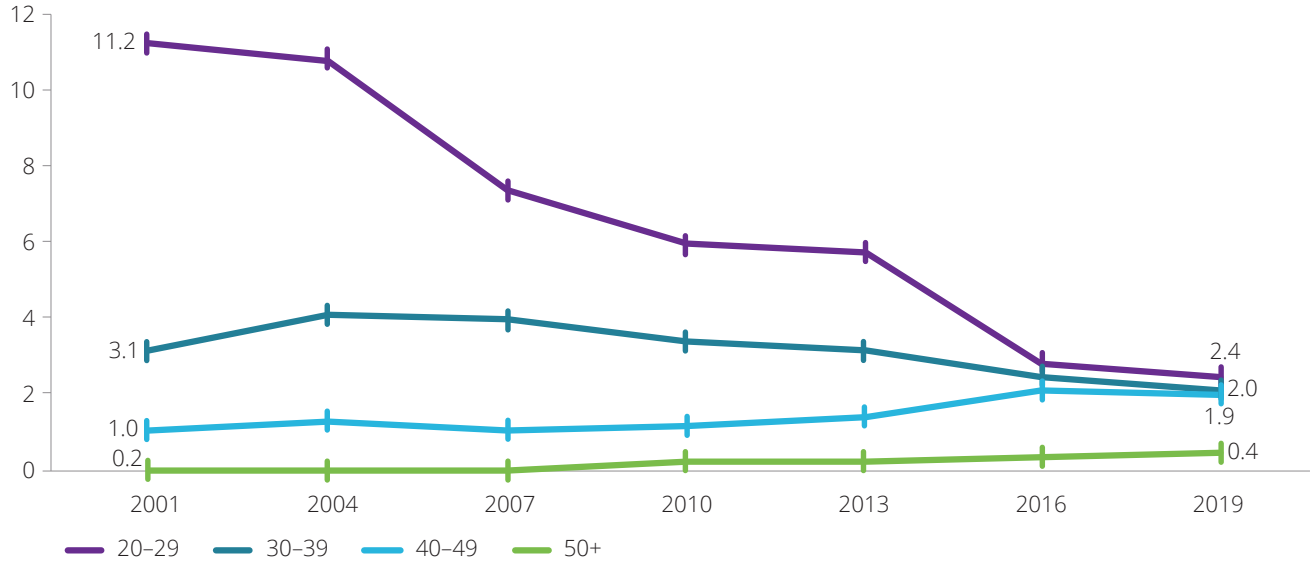
In 2001, people in their 20s were 11 times as likely to use meth/amphetamines in the previous 12 months as people in their 40s (11.2% compared with 1.0%) but meth/amphetamines no longer appears to be the drug of choice among this demographic. In 2019, people in their 20s were only 1.3 times as likely to use it as people in their 40s (2.4% compared with 1.9%).

Figure 4.7: Lifetime and recent[(a)] use of meth/amphetamines, by age, 2001–2019 (per cent)

Lifetime use (per cent)



Recent use (per cent)



(a) Used in the last 12 months.

Note: Recent use of meth/amphetamines among people aged 50 and over was low (<0.5%) and data were unreliable for some years.

Source: tables 4.70 and 4.72.

Crystal/ice still the main form of meth/amphetamine used

Meth/amphetamine comes in many forms including powder/pills (speed), crystal methamphetamine (crystal meth or ice) and a sticky paste (base). Crystal/ice is usually the most pure form, followed by base then speed. The 'high' experienced from ice and base is much more intense, and with intense reactions come powerful responses including comedown, the potential for dependence (addiction) and chronic physical and mental health problems (DoH 2008).

In 2013, there was a change in the main form of meth/amphetamine used, with crystal/ice replacing powder as the preferred form. In 2019, this trend continued, with 50% of people who used meth/amphetamine reporting that crystal/ice was the main form used in the previous 12 months. This has remained stable since 2013 but increased from 22% in 2010. Over the same period, use of powder decreased from 51% in 2010 to 29% in 2013 and to 20% in 2019 (Table 4.74).

Form of meth/amphetamine used affects frequency of use

People who used crystal/ice as their main form of meth/amphetamine were far more likely to use it monthly or more often than people who used mainly powder/speed—47% compared with 15.4%—a similar trend reported since 2010 (Table 4.75). Daily and weekly use among people who reported using mainly crystal/ice has doubled since 2010, from 12.4% to 29% in 2019.

How many people who use meth/amphetamines may be at risk of problem drug use?

A number of questions from the ASSIST-Lite were added to the 2019 NDSHS questionnaire to better understand what proportion of the population may be at risk of problem drug use and in need of intervention (see Box 2.1 in alcohol chapter/Technical notes for more information about the ASSIST-Lite).

Among people who had used meth/amphetamines in the last 12 months:

- 7.5% were at high risk of harm and could be dependent or experiencing severe problems and in need of referral for specialist assessment and treatment
- 56% were at moderate risk of developing problems related to their substance use and should be offered brief intervention by a health professional
- 36% were categorised as low risk (Table 4.82).

Use of hallucinogens may be increasing

Hallucinogen are a class of psychoactive substances that produce changes in perception, mood and cognitive processes. Some are naturally occurring, such as magic mushrooms/psilocybin, and some are synthetic, such as acid/LSD. Both lifetime and recent use increased since 2016 and were at the highest proportions since 2001 (Table 4.86). However, the increase could be due to questionnaire changes as the list of drug examples was updated in 2019 and included DMT, mescaline and peyote, which were not specifically mentioned in previous surveys. A question on forms of hallucinogens used in the previous 12 months was also added.

Key findings from 2019 include:

- Between 2016 and 2019, lifetime use increased from 9.4% to 10.4% and recent use increased from 1.0% to 1.6%.
- People in their 20s and those aged 40 and over drove the increase in lifetime use; recent use also increased among people in their 20s.
- One in 20 (5.0%) people in their 20s had used a hallucinogenic drug in the previous 12 months, which is higher than recent use of meth/amphetamines.
- Most people who used hallucinogens had used LSD/acid/tabs (73%) and magic mushrooms/psilocybin (61%) in the previous 12 months (Table 4.87).
- Frequency of use between 2016 and 2019 increased—at least monthly use (from 3.0% to 10.3%) and every few months increased (from 21% to 34%) while once or twice a year use decreased (76% to 56%) (Table 4.92).

More people reported use of inhalants

Use of inhalants in the previous 12 months has been gradually increasing—from 0.4% in 2001 to 1.0% in 2016 and 1.7% in 2019 (Table 4.90). Examples of inhalants include chroming, sniffing, solvents, aerosols, glue, petrol, laughing gas, whippets, nitrous, snappers, poppers, pearlers, rushamines, locker room, bolt, bullet, rush, climax, red gold, amyl and bulbs. Inhalants do not include nasal sprays, inhalers or puffers used for asthma and similar conditions.

People who used inhalants used them quite frequently (compared to drugs such as ecstasy and cocaine), with 33% reporting at least monthly use. The most common forms of inhalants used in 2019 were nitrous oxide (for example, laughing/happy gas) and amyl nitrate and other nitrates (for example, poppers), used by at least 6 in 10 people who had used inhalants in the previous 12 months.

Other illicit drug use remained low

Other illicit drugs, such as heroin, ketamine, GHB and emerging psychoactive substances are uncommon in Australia. However, the use of some of these drugs has increased in recent years and there are serious risks associated with some of the behaviours undertaken when using these drugs, such as injecting drug use.

Use of ketamine in the previous 12 months increased from 0.4% in 2016 to 0.9% in 2019, mainly due to recent use doubling among people in their 20s over this period (1.2% to 3.9%) (Table 4.94).

Heroin and injecting drug use was low among the general population

The proportion aged 14 and over who had used heroin (a drug that is commonly injected) or injected illicit drugs in the previous 12 months was low over the period 2001–2019. Injecting drug use remained stable at 0.3% and less than 0.1% had used heroin in 2019.

More people are using multiple drugs at the same time

Mixing drugs or taking one drug when under the influence of another drug is known as polydrug use. Using a single drug can be dangerous; using more than 1 significantly increases the risks of addiction, overdose and medical problems such as heart attacks and liver failure (Druginfo 2017).

In 2019, among people who used drugs, there appeared to be an increase in the proportion who took multiple drugs at the same time. Alcohol is the most common substance used at the same time. At least 8 in 10 people who had used cannabis, cocaine, ecstasy or meth/amphetamines used alcohol at the same time. Among people who had recently used cannabis, the proportions of people using alcohol, tranquillisers, hallucinogens, cocaine, or ecstasy at the same time all increased (Table 4.52). There was also an increase in the proportion of people who used ecstasy and meth/amphetamines reporting they had used cocaine at the same time (tables 4.69 and 4.85).

Where can I get more information?

To explore the data and view additional analyses, see the supplementary illicit use of drugs data tables. These include data on:

- people who are unable to stop or reduce use
- where people obtained drugs and where they used them
- people who missed work due to illicit drug use
- participation in drug treatment programs
- whether people were offered or had the opportunity to use illicit drugs and whether their friends and acquaintances used illicit drugs
- illicit drug use by social characteristics and health status.

5 Non-medical use of pharmaceuticals

Quick facts

Non-medical use of pharmaceuticals declined between 2016 and 2019 from 4.8% to 4.2%.

This change has been driven by a reduction in the non-medical use of pain-killers and opioids, from 3.6% in 2016 to 2.7% in 2019.

The proportion of people using codeine for non-medical purposes has halved since 2016, from 3.0% to 1.5% in 2019. Codeine was made a prescription-only medication in 2018.

People who used pain-killers and opioids for non-medical purposes also used them less frequently, with the proportion using them at least weekly declining from 29% in 2016 to 19.5% in 2019.

Among people who did use pain-killers and opioids for non-medical purposes, 31% said they could not reduce their use even though they wanted to.

Pharmaceuticals are drugs that can be legally purchased from a pharmacy or chemist, usually with a prescription. The NDSHS includes questions about the use of pain-killers/pain relievers and opioids, tranquillisers/sleeping pills (including benzodiazepines) and steroids, as well as opioid replacement medications such as methadone and buprenorphine. Pharmaceutical cannabis preparations are not included in this chapter; see Chapter 6 for results about medical use of cannabis.

This chapter discusses the non-medical use of pharmaceuticals, rather than general medication use. Non-medical use in the survey is defined as any drugs that were used:

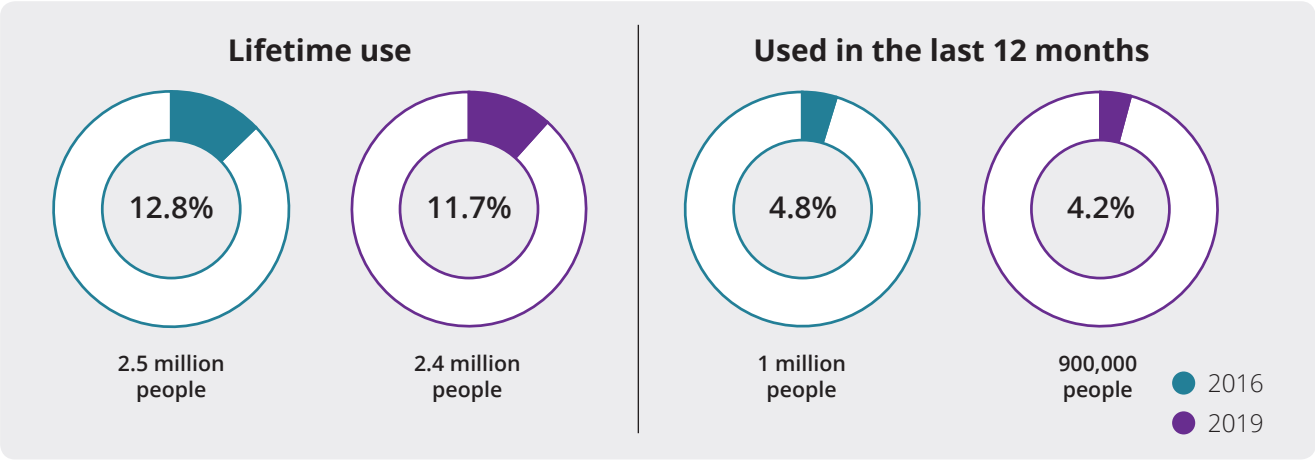
- to induce a drug experience or feeling
- in combination with other drugs to enhance a drug experience
- for performance enhancement
- for cosmetic purposes, such as for body shaping.

Regardless of the purpose of their use, many pharmaceuticals come with substantial risk of harm. In Australia in 2018, a majority of drug-induced deaths (excluding alcohol and tobacco) involved opioids, and three-fifths (60%) of those deaths were attributed to prescription drugs only (Man et al. 2019). Many pharmaceuticals also have a high potential for addiction. Due to these risks, and the prevalence of non-medical use in Australia, pharmaceuticals used for non-medical purposes are a priority substance in Australia's National Drug Strategy 2017–2026 (DoH 2017).

Unless otherwise specified, the results in this report are for people aged 14 and over and all increases or decreases in estimates over time are statistically significant. All data presented in this chapter are available through the online pharmaceuticals and illicit drugs tables https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey-2019/data.

How many people have used pharmaceuticals for non-medical purposes?

Between 2016 and 2019, non-medical use of pharmaceuticals declined. The proportion of people reporting non-medical use of pharmaceuticals in their lifetime dropped, as did use in the last 12 months.



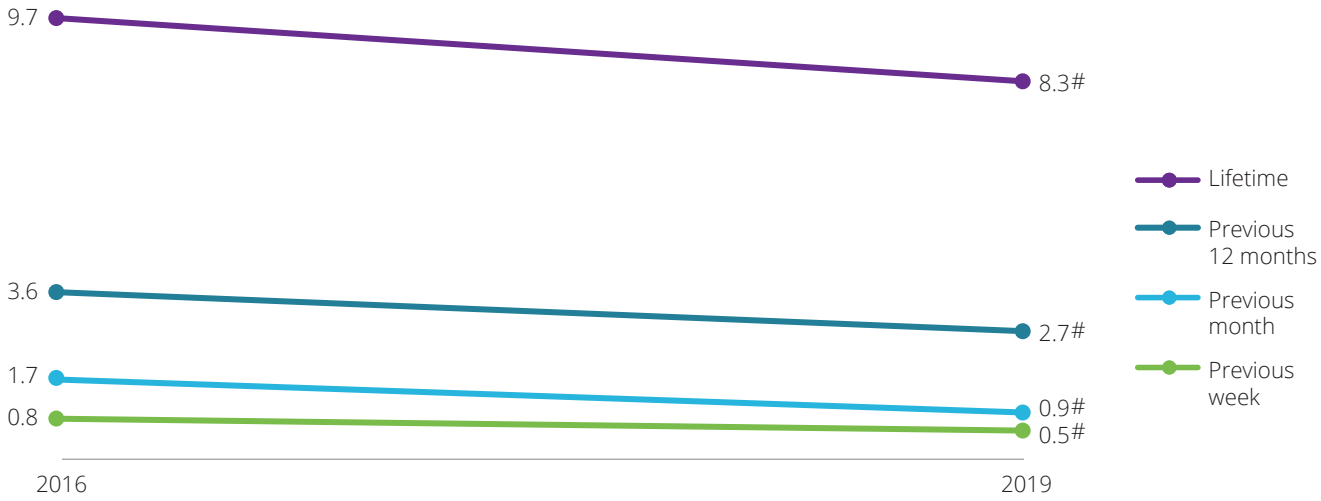
This trend was largely driven by the decrease in non-medical use of pain-killers/pain relievers and opioids, which have made up the majority of non-medical use of pharmaceuticals since 2001.

More people are using illicit drugs than pain-killers and opioids

In 2016, the non-medical use of pain-killers/pain-relievers and opioids (referred to as pain-killers and opioids) were the second most common illicitly used drug in the previous 12 months, behind cannabis. However, in 2019, they were the fourth most common, after cannabis, cocaine and ecstasy (Table 4.6).

From 2016 to 2019, the proportion of people using pain-killers and opioids non-medically in the previous week, month, 12 months and in their lifetime declined (Figure 5.1).

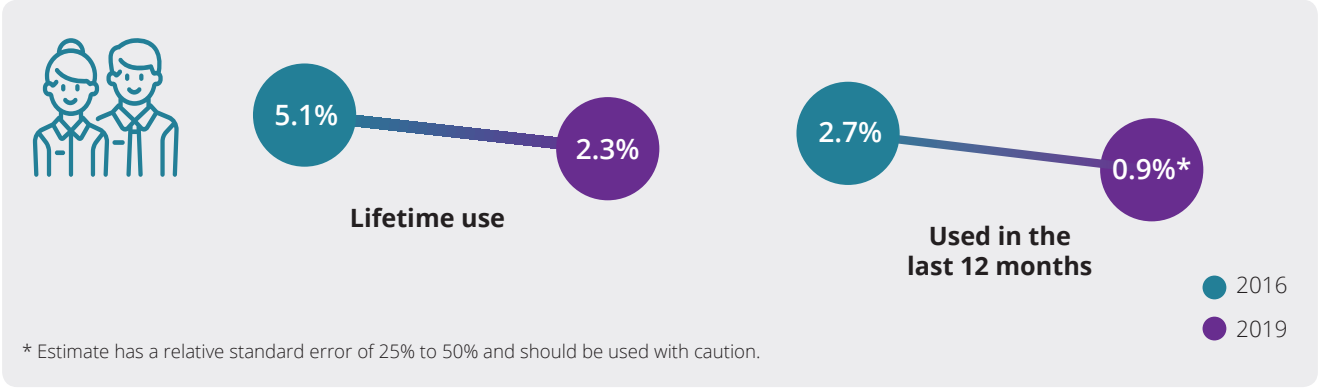
Figure 5.1: Non-medical use of pain-killers/pain-relievers and opioids within the last week, month, year and in their lifetime, persons aged 14 and over, 2016–2019 (per cent)



Statistically significant change between 2016 and 2019.

Source: Table 5.8.

Use remained stable or declined across all age groups between 2016 and 2019. The decline was most pronounced among young people aged 14–19, who in 2019 were half as likely to have used pain-killers and opioids non-medically in their lifetime as 14–19 year olds in 2016, and only a third as likely to have done so in the previous 12 months (tables 5.4 and 5.5).



* Estimate has a relative standard error of 25% to 50% and should be used with caution.

People who did use pain-killers and opioids for non-medical purposes did so less often

Among people who did use pain-killers and opioids for non-medical purposes, those who used them at least weekly declined from 29% in 2016 to 19.5% in 2019, while the proportion who used them only once or twice a year increased from 28% to 43% (Table 5.10).

Despite this reduction, many people still struggled to cut down on their non-medical use of pain-killers and opioids. Of all people who had used them in the previous 12 months, 31% said they could not cut down on their non-medical use, even though they had wanted to or attempted to stop (Table 4.35a).

Box 5.1: Changes to codeine scheduling

In February 2018, medications containing codeine were reclassified to schedule 4 drugs, meaning they could no longer be purchased from a pharmacy or chemist without a prescription. The scheduling change may account for some of the reductions in the non-medical use of pain-killers and opioids since 2016.

This was clearly reflected in the types of pain-killers and opioids used by respondents in the NDSHS. Among people who had used them in the previous 12 months, codeine continued to be the most common type used, but had declined since 2016 (88% to 61%). In contrast, non-medical use of oxycodone, tramadol, gabapentinoids, fentanyl and other prescription pain-killers/opioids all increased (Table 5.12).

However, these increases do not indicate that people are substituting other medicines for codeine as the reduction in overall non-medical use needs to be taken into account. Among the general population aged 14 and over, the only statistically significant differences seen were a reduction in the non-medical use of codeine (from 3.0% in 2016 to 1.5% in 2019), and an increase in the number of people using 'other prescription pain-killers/pain relievers and opioids' for non-medical purposes (from 0.5% to 0.9%). Non-medical use of morphine, fentanyl, tramadol, oxycodone and gabapentinoids did not change substantially (Table 5.13).

The scheduling change also affected how people obtained these drugs. In 2016, people were most likely to purchase them from a pharmacy or chemist (52%), while in 2019 they were most commonly obtained with a prescription for a medical condition (45%).

Older Australians are using pain-killers and opioids non-medically

Illicit drug use is often more common among younger people. Use of cannabis, cocaine, ecstasy and meth/amphetamines in the previous 12 months is highest among people in their 20s, with levels of use decreasing in older age groups. However, this trend was less pronounced among people who had used pain-killers and opioids. Non-medical use was still highest among people aged 20–29 at 3.8%, but use among older age groups ranged from 2.4% to 3.2% (Table 5.5).

The median age of people who had recently used pain-killers/pain relievers and opioids for non-medical purposes was also higher than for all other drugs, at 41.9 years. The median age of people who had used illicit drugs excluding pharmaceuticals was 30.7 years (Table 4.19a).

Has the non-medical use of other pharmaceuticals also declined?

The proportion of Australians who reported using tranquillisers/sleeping pills and methadone or buprenorphine, either in their lifetime or in the previous 12 months, has not changed substantially since 2016.

Despite the overall number being small, there has been a growing trend in non-medical steroid use in the previous decade. Only 0.3% of people had done so in their lifetime from 2001 to 2007, but the proportion rose to 0.6% by 2016 and increased again to 0.8% in 2019 (Table 5.1). However, only 0.2% of people had used steroids for non-medical purposes in the previous 12 months (Table 5.2).

Where can I get more information?

To explore the data and view additional analyses, the use of pharmaceuticals for non-medical purposes is included in the supplementary pharmaceuticals tables, as well as the illicit drugs tables. These include data on:

- use of other drugs at the same time as pain-killers and opioids
- non-medical use of pharmaceuticals disaggregated by age and sex
- days of work missed due to illness, injury or drug use among people who used pharmaceuticals for non-medical purposes.

6 Emerging topic: Medicinal cannabis

Quick facts

6.8% of people who used cannabis only used it for medical purposes.

3.9% of those who used cannabis for medical purposes obtained it by prescription.

Older people were more likely than younger people to use cannabis only for medical purposes.

About 1 in 2 people who used cannabis for medical purposes had chronic pain.

People who did not use cannabis for medical purposes were twice as likely to use another illicit drug than a person who only used cannabis for medical purposes.

There has been increasing interest over the last few years in the use of cannabis for medical purposes. The main psychoactive component of the cannabis plant is delta-9-tetrahydrocannabinol (THC). The highest concentration of THC is in the flowering tops and leaves of the plant. Other than THC, cannabis has more than 70 unique chemicals that are collectively referred to as cannabinoids (ACIC 2018). The potential benefits of cannabinoids for symptom relief in cancer patients have been subject to a number of government reviews and public debate in recent years. Governments at Commonwealth, state and territory levels have made legislative and policy changes to progress access to the use of cannabis in the treatment of various medical conditions (Cancer Council 2020).

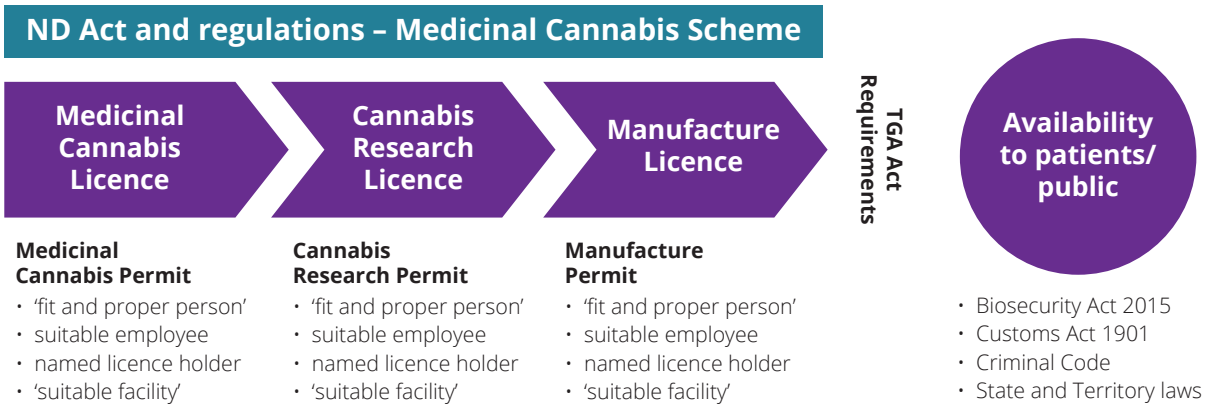
Previous surveys (until 2016) measured the public's support for the use of cannabis as a medicine and the greater majority were in favour of it. In the 2016 NDSHS, 87% of those surveyed supported 'a clinical trial for people to use marijuana to treat medical conditions' and 85% supported a permanent legislative provision in the form of a 'change in legislation permitting the use of marijuana for medical purposes'.

What is the current law in Australia?

Before 2016, Australian law generally considered cannabis an illegal narcotic. However, in February 2016, the *Narcotics Drug Act 1967* was amended (see Box 6.1 for the current legislative overview of medicinal cannabis) and medicinal cannabis products are available for specific patient groups under strict medical supervision.

Box 6.1: Australian legislative overview of medicinal cannabis

The *Narcotic Drugs Amendment Act 2016* established a national licensing and permit scheme for the cultivation, production and manufacture of cannabis for medicinal and scientific research purposes. There are other existing commonwealth, state and territory laws that contribute to the regulatory landscape dealing with cannabis which goes beyond the medicinal cannabis scheme.



Source: Young 2020.

How was use of medicinal cannabis collected in the survey?

In the 2019 survey, 2 new questions were included regarding medical use of cannabis:

- Have you used Marijuana/Cannabis for medical purposes in the last 12 months?
- Was the medical Marijuana/Cannabis prescribed by a doctor?

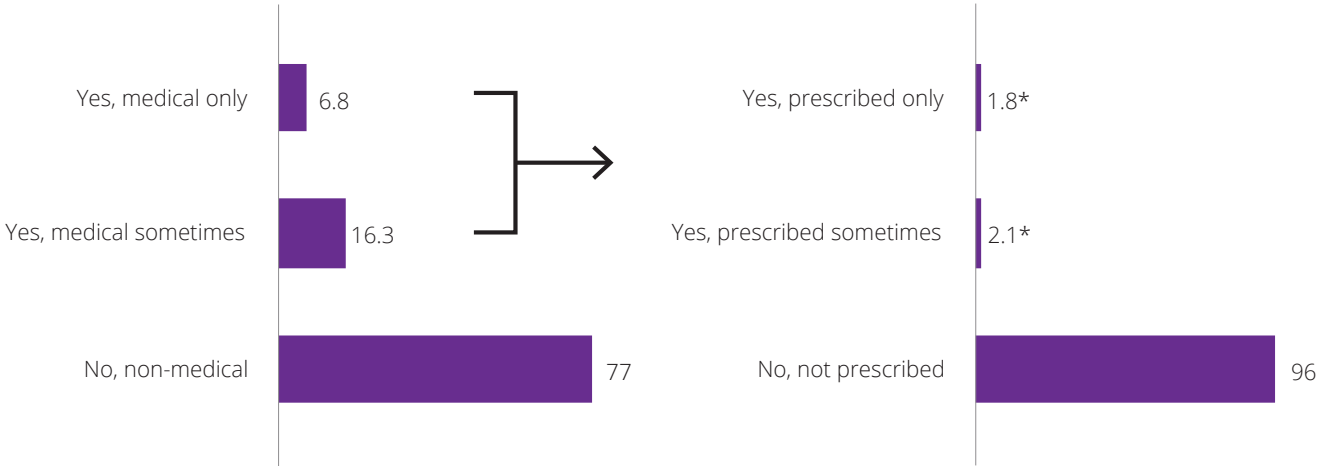
If a person indicated that they used cannabis only for medical purposes and always had it prescribed by a doctor, then they were removed from recent use of cannabis results as the NDSHS focuses on illicit use. This chapter focuses on people who reported that their cannabis was used only for medical purposes and those who sometimes used it for medical purposes and sometimes for other reasons, regardless of whether they said a doctor prescribed it.

How many people use cannabis and how many use it for medical purposes?

In 2019, 11.7% of people (or about 2.5 million Australians) aged 14 and over had used cannabis in the previous 12 months, including use for medical purposes that was prescribed by a doctor (tables 6.1 and 6.2). Of people who used cannabis in the previous 12 months, 6.8% said they used it only for medical purposes and 16.3% said they sometimes used it for medical purposes and sometimes for other reasons (Table 6.1). This equates to 2.7% in the total Australian population (or about 600,000 people) using cannabis for medical purposes, either always or sometimes (tables 6.1 and 6.2).

However, when asked if their medical cannabis was prescribed by a doctor, only 3.9% of those who said they used cannabis for medical purposes obtained it by prescription—1.8% always had it prescribed and 2.1% sometimes had it prescribed (Figure 6.1).

Figure 6.1: Proportion using cannabis for medical purposes and proportion that had it prescribed by a doctor, 2019 (per cent)



*Estimate has a relative standard error of 25% to 50% and should be used with caution.

Source: tables 6.1 and 6.3.

Due to the small number of people whose medicinal cannabis was prescribed by a doctor, the remaining discussion in this chapter focuses on people who said they used cannabis for medical purposes even though cannabis might not have been prescribed.

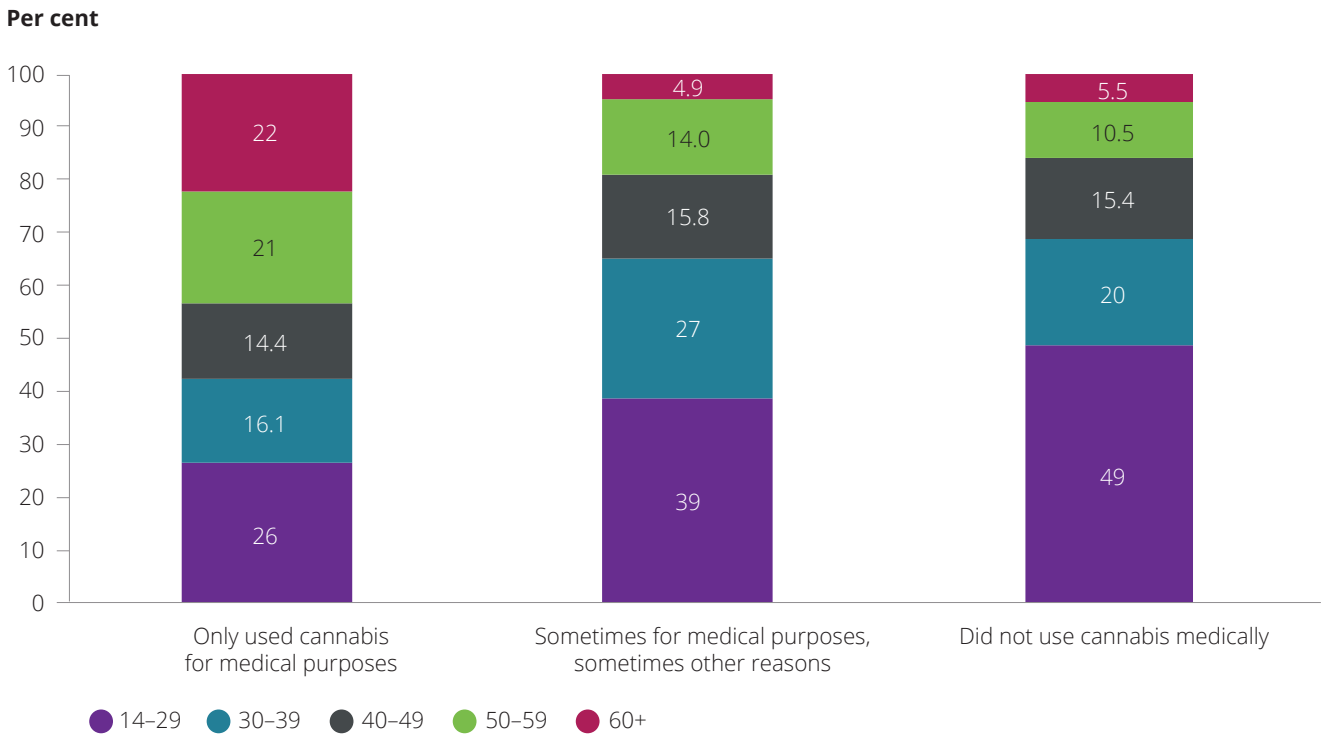
Who is most likely to use cannabis for medical purposes?

Older people, particularly those aged 60 and over, were most likely to use cannabis only for medicinal purposes, while people in their 20s were least likely to use it for medicinal purposes (Table 6.4).

Of people who used cannabis medically only, 43% were aged 50 and over (Figure 6.2). By comparison, among those who did not use cannabis for medical purposes (non-medically or illicitly), only 16% were aged 50 and over and 49% were aged 14–29.

People who used cannabis for medical purposes, either always or sometimes, were more likely than those who did not use cannabis for medical purposes to live in the lowest socioeconomic areas (29% compared with 20%) and *Inner regional* areas (22% compared with 17.0%) (Table 6.6).

Figure 6.2: Age distribution of people who used cannabis, by medical use status, 2019 (per cent)



Source: Table 6.5.

People who used cannabis medicinally were more likely to have a health condition

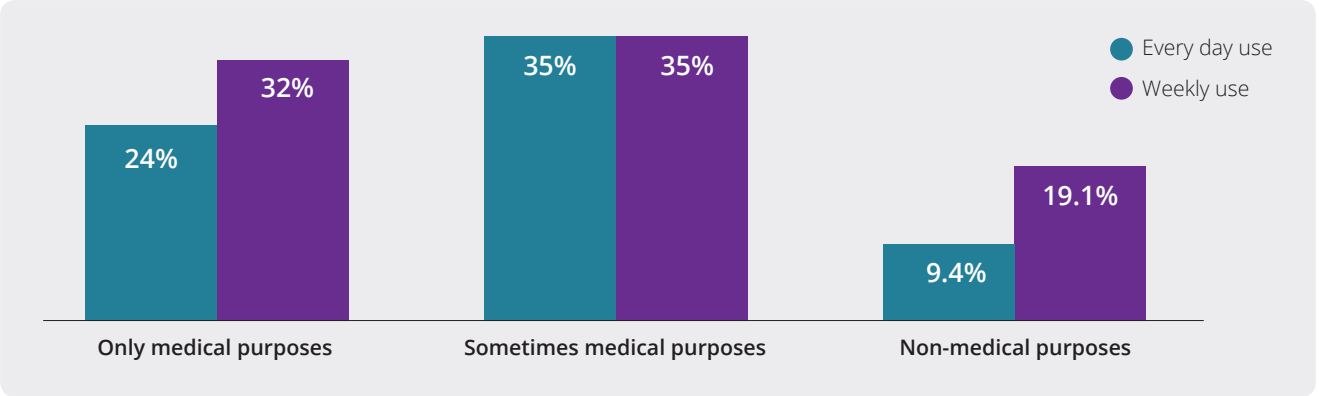
Compared with people who used cannabis for non-medical purposes, people who used cannabis only for medical purposes were far more likely to have:

- chronic pain (7.7 times as likely)
- a mental illness (2.4 times as likely)
- very high levels of psychological distress (2.8 times as likely)
- hypertension (3.2 times as likely)
- poor or fair health (3.2 times as likely) (Table 6.7).

CHRONIC PAIN	MENTAL ILLNESS	PSYCHOLOGICAL DISTRESS	HYPERTENSION	POOR OR FAIR HEALTH
53% compared with 6.9%	**53%** compared with 22%	**27%** compared with 9.7%	**20%** compared with 7.9%	**33%** compared with 10.4%

However, these results should be interpreted with caution and are likely to be influenced by age. As noted in the previous section, people who used cannabis for medical purposes are more likely to be older than those who used for non-medical purposes.

Frequency of use also varied among people who used cannabis for medical and non-medical purposes, with people using for medical purposes much more likely to use it every day or weekly than those who used for non-medical purposes (Table 6.8).



What forms of cannabis are most often used?

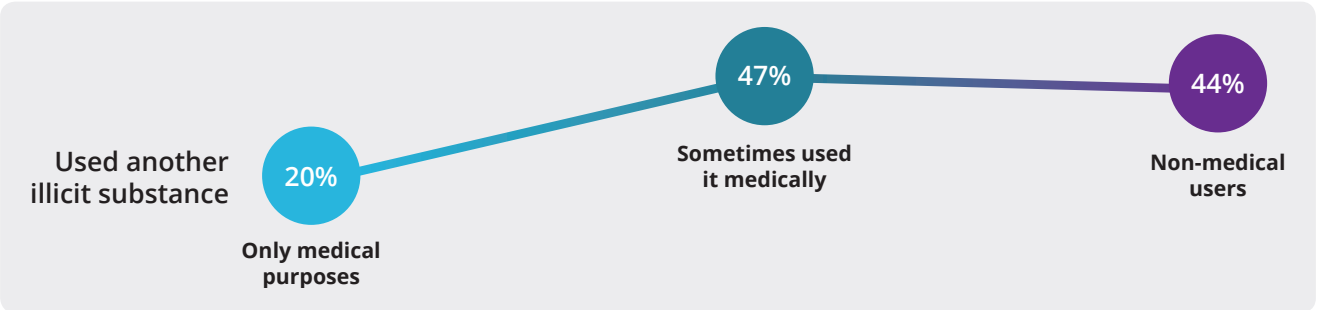
Not only did people who used cannabis for medical purposes differ in their demographics and health conditions, they also used different forms of cannabis. Cannabis comes in 3 main forms:

- herbal cannabis (also referred to as marijuana)—the dried leaves and flowers of the cannabis plant (the weakest form)
- cannabis resin (hashish)—the dried resin from the cannabis plant
- cannabis oil (hashish oil)—the oil extracted from the resin (the strongest form) (ACIC 2019; NSW Ministry of Health 2017).

Compared with people who used cannabis for non-medical purposes, people who used cannabis only for medical purposes were more likely to use cannabis oil (23% compared with 4.5%) and less likely to use leaf (27% compared with 51%) (Table 6.9).

Use of other drugs varied by status of medicinal cannabis use

People who used cannabis for non-medical purposes and people who sometimes used cannabis for medical purposes were twice as likely to have used another illicit substance as those who used it only for medical purposes.



People who use cannabis are far more likely to smoke tobacco than the general population (43% compared with 14%), and smoking tobacco was highest among people who used cannabis for medical purposes. Half (51%) of those who only used cannabis for medical purposes and 57% of those who used it sometimes for medical purposes smoked tobacco, compared with 39% of people who used it for non-medical purposes (Table 6.10).

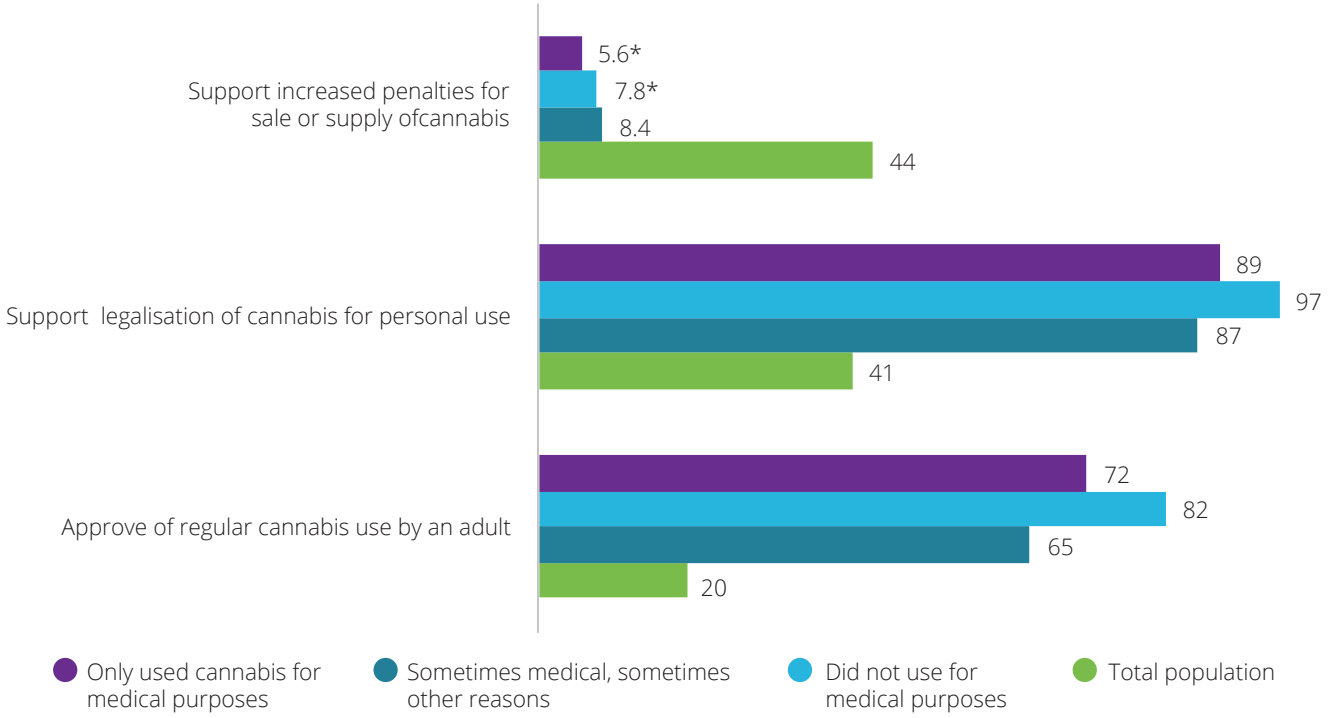
Where do people who used medicinal cannabis get it from?

People who used cannabis for medical purposes (either always or sometimes), usually obtained it from a friend (51%), but 22% purchased it from a dealer; 7.3% grew it themselves and 2.2% had a prescription for a medical condition (this last result should be interpreted with caution due to high sampling error) (Table 6.11).

What are people's attitudes towards cannabis?

People who use drugs are more likely to support legalisation and less likely to support negative consequences for supplying or using drugs. This was no different among people who used cannabis for medical purposes and was in fact often higher among people who used cannabis for medicinal purposes, particularly those who sometimes used cannabis for medical purposes (Figure 6.3).

Figure 6.3: Attitudes towards cannabis use, by medicinal cannabis status, people aged 14 and over, 2019 (per cent)



*Estimate has a relative standard error of 25% to 50% and should be used with caution.

Source: Table 6.12.

7 Drug use by geographic areas

Quick facts

While most jurisdictions reported a decline in daily smoking between 2016 and 2019, the decline was statistically significant in New South Wales (10.1%, down from 12.0% in 2016) and Victoria (10.6%, down from 12.3% in 2016).

Recent use of cocaine increased from 2016 to 2019 in New South Wales (from 3.4% in 2016 to 5.0% in 2019), Victoria (from 2.5% to 5.2%) and Queensland (from 2.1% to 3.6%).

People in *Remote and very remote* areas were twice as likely as those in *Major cities* to smoke daily (19.2% compared with 9.8%).

People in *Remote and very remote* areas were about 1.6 times as likely as those in *Major cities* to consume alcohol at levels that exceeded both the lifetime risk guideline and the single occasion risk guideline.

People living in the lowest socioeconomic areas were about 3.7 times as likely as those in the highest socioeconomic areas to smoke daily (19.0% compared with 5.1%).

Compared with 2016, cocaine use in the past 12 months increased in the lowest (1.2% to 2.5%) and highest socioeconomic areas (3.3% to 6.9%).

The proportion of people smoking daily in Primary Health Network areas was as low as 3.3% in Northern Sydney and as high as 17.4% in Northern Queensland.

The harm caused by tobacco, alcohol and other drug use does not affect all communities equally. Some areas often experience worse outcomes due to factors such as higher levels of unemployment, lower educational attainment, and poorer access to, and use of, health services. For example, in 2015 the burden of disease and injury attributable to alcohol use was highest in *Remote* and *Very remote* areas compared with *Major cities* (2.1 and 2.7 times as high respectively) (AIHW 2019c). As a result, it is important to understand patterns of tobacco, alcohol and other drug use across different geographical areas to inform effective policy development and provide support and services where they are needed most.

Unless otherwise specified, the results are for those aged 14 and over and all increases or decreases in estimates over time are statistically significant. All data presented in this chapter are available through the online geography tables https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey-2019/data.

How does drug use vary across states and territories?

The consumption of alcohol, tobacco and other drugs is a major cause of preventable disease and illness in Australia and varies by region. Understanding data at the jurisdictional level enables state and territory governments to be aware of where services and support are required.

This section summarises information on tobacco, alcohol and other drug use by jurisdiction, with more detailed information available in their respective fact sheets. Increases and decreases in estimates over time that are statistically significant are difficult to detect in smaller jurisdictions due to a smaller sample size. Sometimes, even large apparent differences may not be statistically significant. This is particularly the case in breakdowns of small populations because the small sample size means that there is not enough power to identify even large differences as statistically significant. Comparisons to state and territories prevalence estimates should be considered only using age-standardised results, available through the supplementary tables.

Were there any changes in drug use by jurisdiction?

Smoking down in New South Wales and Victoria

Most jurisdictions reported declines in the proportion smoking daily between 2016 and 2019, continuing the trend observed since 2001, with the changes for New South Wales and Victoria statistically significant—decreasing from 12.0% in 2016 to 10.1% in 2019 and from 12.3% to 10.6%, respectively. Since 2001, the proportion of adults smoking in each jurisdiction has declined (Table 7.1).

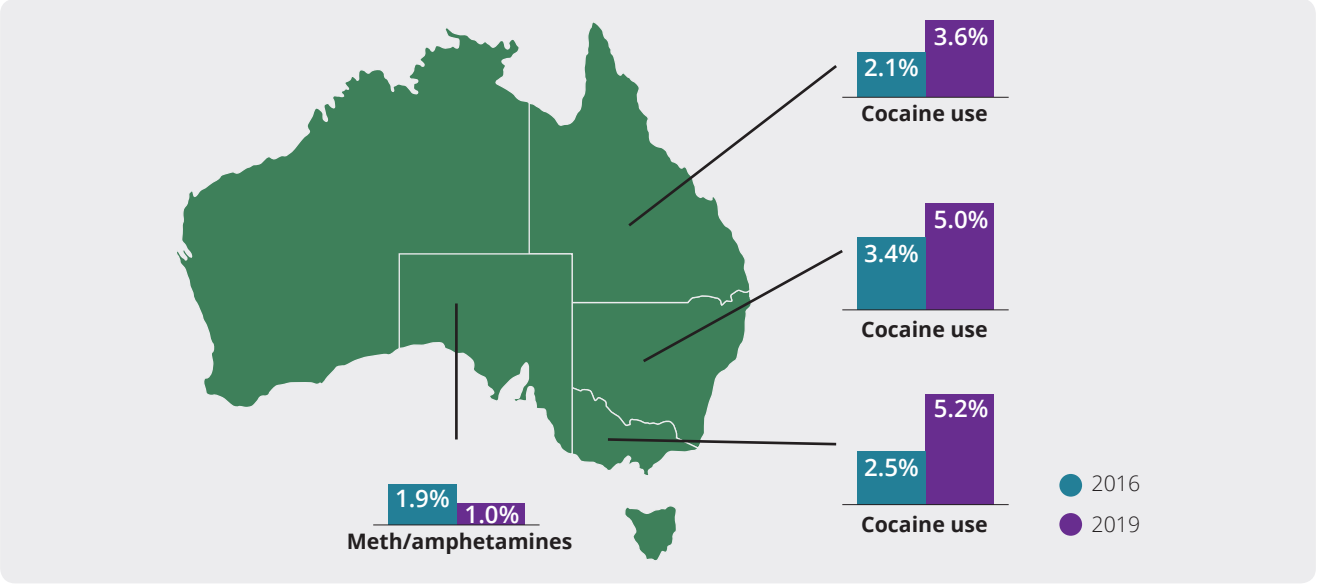
Alcohol consumption declining in most jurisdictions

Consistent with the national trend, between 2016 and 2019 the proportion drinking in excess of the lifetime risk and single occasion guidelines remained fairly stable across most jurisdictions (tables 7.7 and 7.9). However since 2007, there has generally been a decline in the proportion of people who drank in excess of the alcohol risk guidelines (tables 7.7 and 7.9), with the exception of the proportion exceeding the lifetime risk guideline in Queensland and South Australia.

Cocaine use up in 3 jurisdictions

In 2019, Victoria reported an increase in recent use of any illicit drug (from 15.0% in 2016 to 17.1%), a change evident for Victorian males only (Table 7.13). For most jurisdictions, the proportion using illicit drugs in the last 12 months has generally increased since 2010 (Table 7.11). But declines were reported in the recent use of an illicit drug between 2001 and 2019 for the Northern Territory (from 29% in 2001 to 19.6% in 2019) and Western Australia (from 22% to 15.6%).

By drug type there were clear changes in drug use in New South Wales, Victoria, Queensland and South Australia from 2016 to 2019 (Table 7.14). Most notably, these include increases in the recent use of cocaine in New South Wales, Victoria and Queensland, while there was a decline in meth/amphetamine use in South Australia.



How did drug use vary between jurisdictions?

There were clear differences in drug use between jurisdictions, with the greatest variation occurring in smaller jurisdictions (tables 7.2, 7.8, 7.10 and 7.12). After adjusting for differences in age, across all jurisdictions:

- the Australian Capital Territory had the lowest proportions of adult daily smokers (8.6%), lifetime risky drinking (13.8%), single occasion risky drinking at least monthly (21%) and recent illicit drug use (14.3%)
- the Northern Territory had the highest proportion of adult daily smoking (15.4%), lifetime risky drinking (24%), single occasion risky drinking at least monthly (34%) and recent illicit drug use (19.0%).

How does drug use vary by remoteness area?

Tobacco, alcohol and other drug use are major health issues in Australia and are associated with a number of harms, both physical and social. Australians living in remote areas often have worse health outcomes than people living in metropolitan areas (AIHW 2019b).

Were there any changes in drug use by remoteness area?

Daily smoking remains stable but has declined since 2010

There were small but non-significant declines in daily smoking across all remoteness areas between 2016 and 2019 (Table 7.15). However, since 2010 there was a decline in the proportion who smoked daily in *Major cities* (from 13.7% in 2010 to 9.7% in 2019), *Inner regional* areas (from 17.4% to 13.4%) and *Remote and very remote* areas (from 26% to 19.6%).

Similar proportions continue to drink at levels above the recommended guidelines

There were no statistically significant changes in the proportion exceeding the lifetime risk guideline and the single occasion risk guideline (at least monthly) between 2016 and 2019 in any remoteness area. Since 2010, the proportion of people who drank in excess of alcohol risk guidelines in *Major cities* and *Inner regional* areas has declined. While there were no statistically significant declines in risky alcohol consumption in *Outer regional* and *Remote and very remote* areas, levels of risky drinking have generally trended downward since 2010 (Table 7.15).

Level of recent drug use steady but changes in type of drug used

The proportion of people using at least 1 illicit drug in the last 12 months did not change significantly for any remoteness area from 2016 to 2019 (Table 7.15). In *Outer regional* and *Remote and very* remote areas there appeared to be substantial (but not significant) change in recent drug use; however this was a return to levels similar to 2013. In *Major cities*, recent illicit drug use has increased since 2010 (from 14.8% in 2010 to 16.7% in 2019).

Between 2016 and 2019, there were a number of changes by drug type (Table 7.15):

- In *Major cities* there were increases in the level of recent use of cannabis (from 10.4% in 2016 to 11.7% in 2019), ecstasy (from 2.5% to 3.3%) and cocaine (from 3.2% to 5.0%) , while the use of pain-killers and opioids decreased (from 3.3% in 2016 to 2.6% in 2019).
- In *Inner regional* areas there was a rise in the use of cocaine (from 1.3% in 2016 to 2.6% in 2019) and a decline in pain-killers and opioids (from 3.6% to 2.5%).
- Changes in the use of low-prevalent drugs are difficult to detect for smaller areas.

Daily smoking and risky drinking increase with remoteness

After adjusting for age, the proportion of people who smoked daily and drank at risky levels increased with remoteness (Figure 7.1). In 2019, people in *Remote and very remote* areas were:

- 2 times as likely as those in *Major cities* to smoke daily
- 1.6 times as likely as those in *Major cities* to consume alcohol at levels that exceeded both the lifetime risk guideline (25% compared with 15.5%) and the single occasion risk guideline (38% compared with 24%).

People in *Remote and very remote* areas had a slightly higher level of illicit drug use in the past 12 months compared with people in *Major cities* (18.6% compared with 16.7%) (Figure 7.1).

Figure 7.1: Daily smoking, lifetime risky drinkers, single occasion risky drinkers (monthly), and recent illicit drug use in Australia, people aged 14 and over, by remoteness area, 2019 (age-standardised per cent)

Notes

(a) According to NHMRC guideline 1: On average, had more than 2 standard drinks per day.

(b) Derived from 2009 NHMRC guideline 2: Had more than 4 standard drinks on 1 occasion at least once a month.

(c) Used at least 1 of 16 classes of illicit drugs in 2019. The number and type of illicit drug used varied over time.

Source: Table 7.16.

How does drug use vary by socioeconomic area?

Although the average overall level of health and wellbeing of the Australian population is high when compared with the populations of other countries, there are substantial differences in the health of specific groups within the population.

Social and economic factors shape risk behaviour and the health of people who used drugs. They affect health indirectly by shaping individual drug-use behaviour, and directly by affecting the availability of resources, access to social welfare systems, marginalisation and compliance with medication. In this report, the Index of Relative Socio-economic Advantage and Disadvantage (IRSAD) is used to classify individuals according to the socioeconomic characteristic of the area in which they live. It scores each area by summarising attributes of the population, such as income, educational attainment, unemployment rate and jobs in skilled or unskilled occupations.

The areas are grouped into quintiles, and the 20% of the areas with the greatest overall level of disadvantage is described as the 'lowest socioeconomic area'. The 20% of the areas with the greatest overall level of advantage—the top fifth—is described as the 'highest socioeconomic area'.

Note that the IRSAD reflects the overall or average level of advantage and disadvantage of the population of an area; it does not show how individuals living in the same area differ from each other in their socioeconomic position.

Declines in daily smoking in highest socioeconomic areas

Compared with 2016, there were declines in the proportion of people who smoked daily who lived in the second highest (10.1% compared with 7.9% in 2019) and highest socioeconomic areas (6.5% compared with 5.0%). Since 2010, there were declines in daily smoking across all socioeconomic areas (Table 7.18).

Levels of risky drinking steady across socioeconomic areas

Between 2016 and 2019, there were no statistically significant changes in the proportion of people who consumed alcohol in excess of the lifetime risk guideline and single occasion risk guideline, at least monthly, across socioeconomic areas (Table 7.18). However, since 2010 there were decreases in the proportion of people drinking in excess of alcohol risk guidelines, except among people living in the highest socioeconomic areas where there was little change in those exceeding the single occasion risk guideline.

Illicit drug use increases in highest socioeconomic areas

Levels of recent illicit drug use increased in areas of highest socioeconomic advantage (from 14.1% in 2016 to 18.1% in 2019). This change has been driven by a rise in the use of cannabis (from 9.4% to 12.4%), ecstasy (from 2.7% to 4.8%) and cocaine (from 3.3% to 6.9%). Conversely there was a decline in the use of painkillers/pain-relievers and opioids (2.6% in 2016 compared with 1.8% in 2019) (Table 7.18).

In the lowest socioeconomic areas there were a number of changes in the type of drug recently used, including:

- an increase in ecstasy (from 1.2% in 2016 to 2.0% in 2019) and cocaine (1.2% to 2.5%)
- a decrease in painkillers/pain-relievers and opioids (from 4.8% in 2016 to 3.0% in 2019) (Table 7.18).

How did drug use vary between socioeconomic areas?

Daily smoking highest in lowest socioeconomic areas

After adjusting for age, daily smoking was about 3.7 times higher among people living in the lowest socioeconomic areas than people living in the highest socioeconomic areas (19.0% compared with 5.1%; Figure 7.2).

People in highest socioeconomic areas less likely to abstain from alcohol

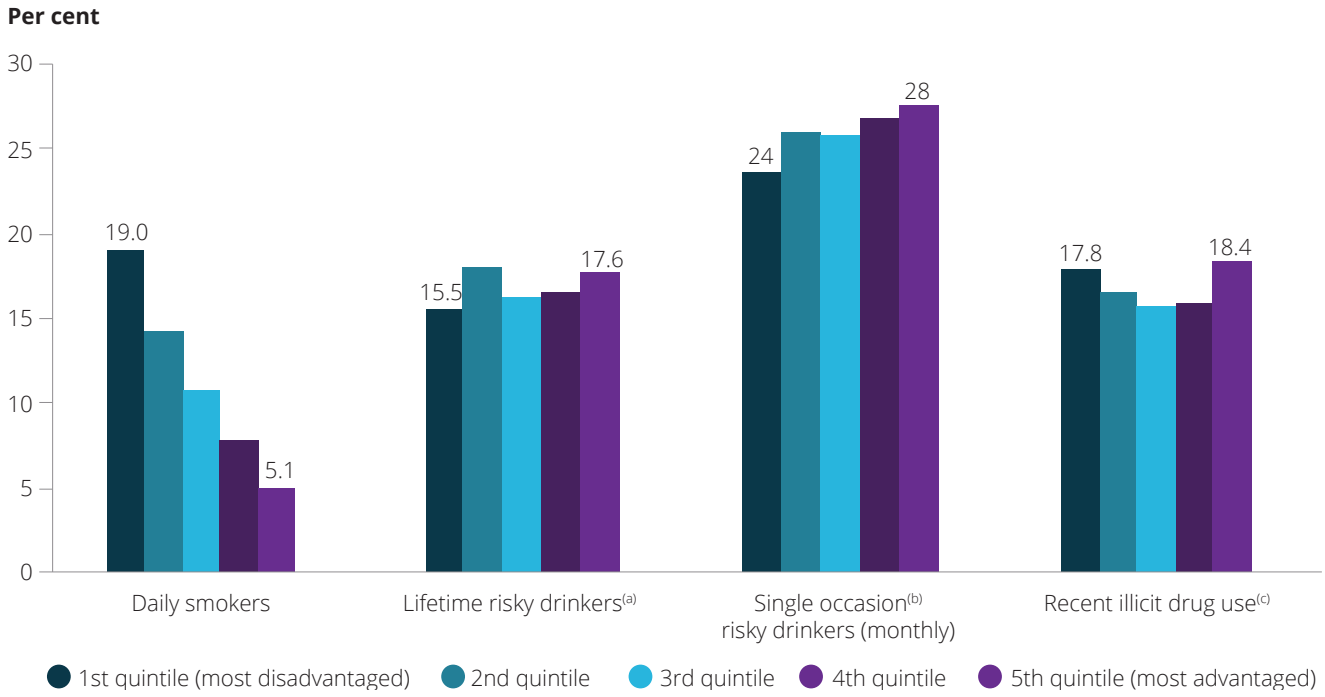
People living in the highest socioeconomic areas were more likely to drink alcohol than those living in the lowest socioeconomic areas and were more likely to exceed the single occasion risk guidelines, monthly or more often (28% compared with 24%). After adjusting for age, people living in the lowest socioeconomic areas were about 1.5 times as likely as those in the highest socioeconomic areas to abstain from alcohol in 2019 (31% compared with 21%) (Table 7.19).

Greater cocaine and ecstasy use in highest socioeconomic areas

After adjusting for age, levels of use of any illicit drug in the last 12 months were similar in the lowest socioeconomic areas and the highest (17.8% compared with 18.4%), but the type of drug used varied. People living in the highest socioeconomic areas were:

- more likely to have recently used ecstasy (4.8% compared with 2.1%) and cocaine (7.1% compared with 2.6%)
- less likely to have used pain-killers and opioids in the last 12 months (1.8% compared with 3.0%), than people living in the lowest socioeconomic areas.

Figure 7.2: Daily smoking, lifetime risky drinkers, single occasion risky drinkers (monthly), and recent illicit drug use, people aged 14 and over, by socioeconomic area, 2019 (age-standardised per cent)



Notes

(a) According to NHMRC guideline 1: On average, had more than 2 standard drinks per day.

(b) Derived from 2009 NHMRC guideline 2: Had more than 4 standard drinks on 1 occasion at least once a month.

(c) Used at least 1 of 16 classes of illicit drugs in 2019. The number and type of illicit drug used varied over time.

Source: Table 7.19.

How does drug use vary across Primary Health Network areas?

Primary Health Networks (PHNs) are organisations that connect health services over local geographic areas according to boundaries defined by the Department of Health. There are 31 PHNs in Australia.

Across PHNs there was wide variation in the use of tobacco, alcohol and illicit drugs in 2019 (tables 7.20 and 7.21), including:

- Daily smoking proportions were as low as 3.3% in Northern Sydney and as high as 17.4% in Northern Queensland.
  - After adjusting for differences in age, Northern Sydney continued to have the lowest daily smoking rate at 3.3% and Gippsland had the highest at 20%.
- South Western Sydney (8.5% and 14.3%) and Western Sydney (7.6% and 15.4%) had the lowest proportions of both lifetime risk and single occasion risk (at least monthly) drinkers; Murrumbidgee had the highest lifetime risky drinkers (25%); and the Northern Territory had the highest proportion of single occasion risky drinkers (35%).
  - After adjusting for differences in age, North Coast and Country Western Australia had the highest proportion of lifetime risky drinkers (24%) and Western Victoria had the highest proportion of single occasion risky drinkers (38%).
- Northern Sydney (11.0%) had the lowest proportion of people who used illicit drugs in previous 12 months while North Coast (NSW) had the highest (23%) (Table Geography1).
  - After adjusting for differences in age, North Coast continued to have the highest proportion of people who used illicit drugs (26%) and Western Sydney had the lowest (9.5%).

Table Geography1 provides the highest 5 and lowest 5 Primary Health Networks for daily smoking, lifetime risky drinkers, single occasion risky drinkers (monthly) and recent illicit drug use in 2019.

Table Geography1: Primary Health Networks with highest and lowest daily smoking, lifetime risky drinkers, single occasion risky drinkers (monthly), and recent illicit drug use, people aged 14 and over, 2019

Daily smoking			
Highest 5		**Lowest 5**	
Northern Queensland	17.4	Western Sydney	8.7
Country WA	17.3	ACT	8.2
Gippsland	17.1	Eastern Melbourne	8.0
Darling Downs and West Moreton	15.6	Central and Eastern Sydney	6.6
Central Queensland, Wide Bay, Sunshine Coast	15.3	Northern Sydney	3.3
Australia	*11.0*		
Exceeded lifetime risk guideline			
Highest 5		**Lowest 5**	
Murrumbidgee	25.0	ACT	14.1
Northern Territory	23.9	Eastern Melbourne	12.6
Gold Coast	23.5	North Western Melbourne	12.4
Country WA	22.9	South Western Sydney	8.5
Central Queensland, Wide Bay, Sunshine Coast	22.6	Western Sydney	7.6
Australia	*16.8*		
Exceeded single occasion risk guideline (at least monthly)			
Highest 5		**Lowest 5**	
Northern Territory	35.4	Nepean Blue Mountains	22.1
Gold Coast	34.8	Eastern Melbourne	22.1
Western Victoria	33.7	ACT	20.7
Brisbane North	31.8	Western Sydney	15.4
Northern Queensland	30.0	South Western Sydney	14.3
Australia	*24.8*		
Recent illicit drug use			
Highest 5		**Lowest 5**	
North Coast	23.0	Gippsland	12.9
Gold Coast	22.7	Darling Downs and West Moreton	12.5
Western Victoria	21.6	South Western Sydney	12.2
Northern Territory	19.6	Western Sydney	11.7
Central and Eastern Sydney	19.4	Northern Sydney	11.0
Australia	*16.4*		

The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) was developed to identify people whose substance use may be causing them harm (Ali et al. 2013). ASSIST-Lite scores are categorised as 'low risk', 'moderate risk' or 'high risk'. High risk scores are likely to indicate a substance dependence issue, while moderate risk scores indicate substance use that may be hazardous or harmful to the person's health (see Box 3.2 in the alcohol chapter for more details).

These results may have implications for alcohol and other drug treatment services in Australia as people who receive a high risk score are likely to require specialist assessment and treatment for their substance use, while people who receive a moderate risk score are likely to benefit from a brief intervention or education of some kind.

In a number of PHNs, over 10% of people were estimated to have a high risk score and may require referral to specialist treatment services for assessment of their alcohol use (Table 7.22):

- Country WA (12.5%)
- Gippsland (*10.7%; this estimate has a relative standard error (RSE) between 25 and 50 and should be used with caution)
- South Eastern NSW (10.3%)
- Brisbane North (10.1%).

The ASSIST scores for cannabis, meth/amphetamines and opioids by PHN are unreliable and therefore not reported.

Where can I get more information?

For information on each state and territory please see the online data visualisations and respective factsheets https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey-2019/contents/fact-sheets. To explore the data and view additional analyses on tobacco, alcohol and other drug use by geographical area, refer to the supplementary data tables. These include data on:

- sex and age breakdowns for each jurisdiction
- age-standardised analysis
- SA4 analysis.

8 Priority population groups

Quick facts

Between 2010 and 2019, the proportion of Aboriginal and Torres Strait Islander people aged 14 and over smoking daily or exceeding the lifetime risk or single occasion risk alcohol guidelines declined.

Compared to 2010, gay, lesbian and bisexual people were smoking and drinking less in 2019 but a similar proportion continued to use illicit drugs.

More adults who had used an illicit drug in the previous 12 months reported high or very high levels of psychological distress in 2019 than in 2016 (26% compared with 22%).

People with lower education levels often have higher levels of tobacco, alcohol and illicit drug consumption than those with higher levels of education. For example, among people aged 25–64, 26% of people who completed Year 11 or below smoked daily in 2019 compared with 5.1% for people with a bachelor degree or higher.

For unemployed people, between 2010 and 2019, the proportion drinking at risky levels has declined, but a similar proportion used an illicit drug in the previous 12 months (about 1 in 4).

Nearly two-thirds (65%) of women are abstaining from alcohol while pregnant, up from 56% in 2016 and 40% in 2007.

The harm from tobacco, alcohol and other drug use can disproportionately affect specific population groups including Aboriginal and Torres Strait Islander people, people with mental health conditions, and people identifying as gay, lesbian, bisexual, transgender or intersex (DoH 2017). It is important to understand patterns of tobacco, alcohol and other drug use among specific population groups to inform effective policy development and ensure that efforts will benefit those most at risk of harm, marginalisation and disadvantage.

Drug use is associated with social health determinants such as unemployment, educational attainment, homelessness, poverty and family breakdown. Approaches that seek to build protective factors and address issues underpinning social determinants of health, in order to prevent the initial uptake of drugs, can also enhance community health and wellbeing and reduce health inequalities among population groups who experience disproportionate risk of harm from alcohol, tobacco and other drugs (DoH 2017).

There is scope to highlight many population groups in Australia but this chapter focuses on 4 groups and 2 socioeconomic/ sociodemographic characteristics that affect population groups differently:

- 3 priority population groups as identified in the *National Drug Strategy 2017–2026*: Aboriginal and Torres Strait Islander people; people identifying as gay, lesbian or bisexual, and people with a mental illness
- women who were pregnant or breastfeeding, in whom the consequences of drug use can have significant negative outcomes
- 2 socioeconomic/ sociodemographic characteristics which are known to have a differential impact on both drug use and its consequences—employment status and educational attainment.

The results for some of the groups presented in this chapter are based on a relatively small sample of respondents and therefore should be interpreted with caution, particularly those for illicit drug use. It is also difficult to detect changes in use over time for smaller population groups. Therefore, comparisons in this section are often made to the longer-term trends rather than focusing on changes since 2016, which are difficult to detect among groups with a small sample size.

All data presented in this chapter are available through the online Specific population groups tables https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey-2019/data.

Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people (Indigenous Australians) living in non-remote Indigenous communities constitute only 2.4 per cent of the 2019 NDSHS (unweighted) sample (or 533 respondents). This is a small proportion of the NDSHS sample and the results are subject to high sampling error. Therefore the results must be interpreted with caution, particularly those for illicit drug use.

For the first time in the 2019 NDSHS, remote Indigenous communities were surveyed. All remote Indigenous communities selected were located in the Northern Territory. While this has improved the representation of Indigenous Australians in the NDSHS, the methodology and data collection mode were different from the rest of the sample. Data from respondents in these communities are therefore not comparable with the data from the remaining Indigenous sample. Further details on the methodology and the results from remote Indigenous communities will be provided in the special topics remote Indigenous communities paper which will be released separately at a later date.

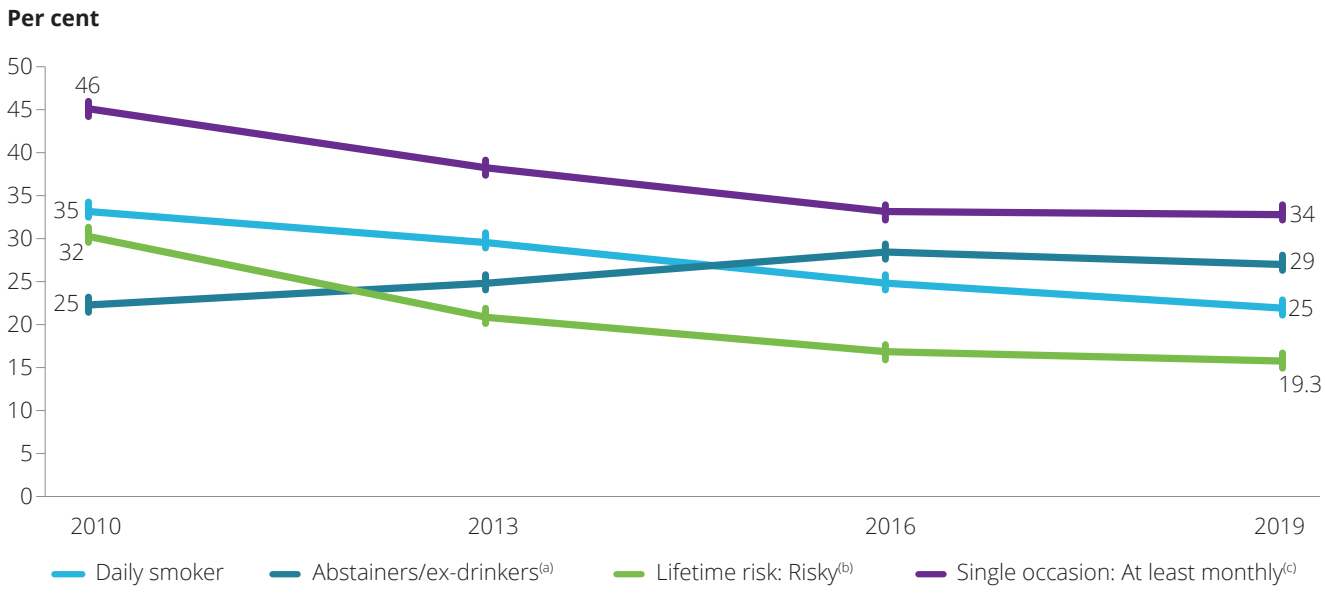
This section of the report focuses on the data collected from Indigenous people living in non-remote communities.

Has drug use changed among Indigenous people?

Since 2010, smoking and alcohol consumption have generally declined while illicit drug use has remained stable. The proportion of Indigenous Australians aged 14 and over smoking daily has been declining since 2010, from 35% in 2010 to 25% in 2019 (Table 8.1).

The proportion of abstainers has gradually increased over the last decade and the proportion drinking alcohol in risky quantities—exceeding either the lifetime risk or single occasion risk guidelines—has declined since 2010 (Figure 8.1).

Figure 8.1: Daily smoking and risky alcohol consumption by Indigenous Australians, aged 14 and over, 2010–2019 (per cent)



(a) Not consumed alcohol in the previous 12 months.

(b) According to NHMRC guideline 1: On average, had more than 2 standard drinks per day.

(c) Derived from 2009 NHMRC guideline 2: Had more than 4 standard drinks on 1 occasion at least once a month.

Source: Table 8.1.

Between 2016 and 2019, there was a considerable decrease (from 28% to 17.7%) in Indigenous Australians drinking in excess of the recommended guidelines, and consuming 11 or more standard drinks on 1 occasion (Table 8.1). Prior to 2019, the proportion had not changed since 2010.

Between 2016 and 2019, there were non-statistically significant declines in the recent use of cannabis (from 19.4% to 16.0%) and pharmaceuticals used for non-medical purposes (10.6% to 7.0%) (Table 8.1).

After adjusting for differences in age, Indigenous Australians were 2.5 times as likely as non-Indigenous Australians to smoke daily (27% compared with 10.8%). As in previous years, Indigenous Australians are slightly more likely to abstain from alcohol than non-Indigenous Australians, but among those who do drink, a higher proportion drink at risky levels. However, the gap between Indigenous Australian and non-Indigenous Australians exceeding the lifetime risk guidelines has narrowed, from 1.5 times as high in 2010 to 1.2 in 2019 (Table 8.2).

People identifying as gay, lesbian or bisexual

In 2019, the proportion of people aged 14 and over who identified as gay, lesbian or bisexual in the NDSHS was higher than in 2016 (3.8% compared with 3.2%) (Table 8.3). This section only presents findings on people who identified as gay, lesbian or bisexual as the survey does not capture information on people who are transgender or intersex.

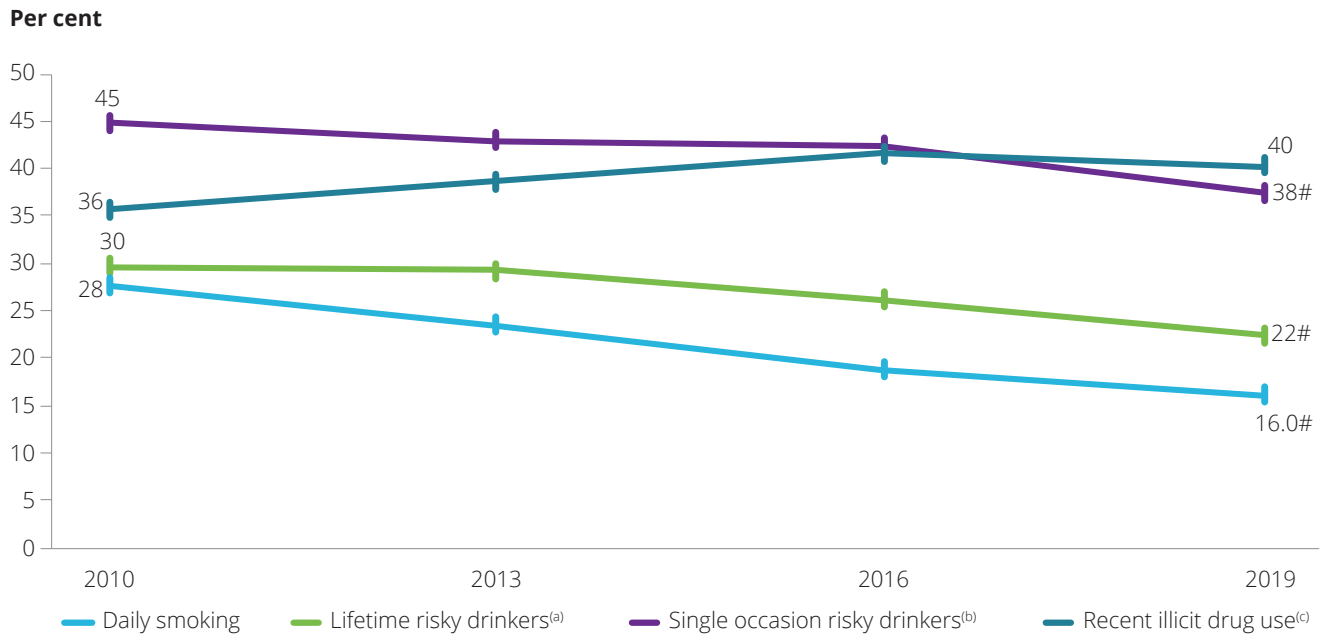
Findings for people who identify as gay, lesbian and bisexual are grouped together for data quality purposes as the sample size is small but it is important to note that there are differences in substance use between these 2 groups; for example, 18.0% of bisexual people smoke daily compared with 12.9% of gay or lesbian people.

Has drug use changed among gay, lesbian and bisexual people?

Between 2016 and 2019, there were no statistically significant changes in daily smoking, risky drinking and recent use of any illicit drug but there was a decline in the non-medical use of pharmaceuticals (from 12.0% to 7.5%), mainly due to a decline in the use of pain-killers and opioids (from 7.6% to 4.3%) (Table 8.3). Conversely, there was an increase in the proportion using inhalants in the previous 12 months, from 6.5% in 2016 to 10.3% 2019.

Compared with 2010, gay, lesbian and bisexual people were smoking and drinking less but a similar proportion continued to use illicit drugs (Figure 8.2). While no statistically significant changes were detected in the illicit use of most drugs over this period, use of cocaine in the previous 12 months increased, from 4.4% in 2010 to 10.5% in 2019, a change that was also reported among heterosexual people (increasing from 2.1% in 2010 to 4.1% in 2019).

Figure 8.2: Daily smoking, risky alcohol consumption and illicit drug use by people who identified as gay, lesbian or bisexual, aged 14 and over, 2010–2019 (per cent)



Statistically significant change between 2010 and 2019.

(a) According to NHMRC guideline 1: On average, had more than 2 standard drinks per day.

(b) Derived from 2009 NHMRC guideline 2: Had more than 4 standard drinks on 1 occasion at least once a month.

(c) Used at least 1 illicit substance in previous 12 months.

Source: Table 8.3.

How does drug use compare with heterosexual people?

Since 2010, for people aged 14 and over who identified as being gay, lesbian or bisexual, the proportions for substance use have consistently been higher than for heterosexual people (Table 8.4). This is more pronounced for illicit drug use than for drinking and smoking. In 2019, after adjusting for differences in age, in comparison to heterosexual people, gay, lesbian or bisexual people were:

- 1.5 times as likely to smoke daily
- 1.5 times as likely to exceed the lifetime risk guideline to reduce the harm from drinking alcohol
- 9.0 times as likely to have used inhalants in the previous 12 months
- 3.9 times as likely to have used meth/amphetamines in the previous 12 months
- 2.6 times as likely to have used ecstasy in the previous 12 months.

The types of illicit drugs people had used in the last 12 months also varied by a person's sexual orientation. For example, after adjusting for differences in age, inhalants were the second most commonly used illicit drug in the previous 12 months among people who identified as gay, lesbian or bisexual. However, for heterosexual people inhalants did not feature in the top 5 illicit drugs used in the previous 12 months (Table 8.4).

Drug use and mental illness

A mental illness may make a person more likely to use drugs—for example, for short-term relief from their symptoms—while other people may have drug problems that trigger the first symptoms of mental illness. Some drugs cause drug-induced psychosis, which usually passes after a few days. However, if someone has a predisposition to a psychotic illness such as schizophrenia, the use of illicit drugs may trigger the first episode in what can be a lifelong mental illness (Sane Australia 2017). The use of drugs can interact with mental illness in ways that create serious adverse effects on many areas of functioning, including work, relationships, health and safety.

It is important to note that, by themselves, these findings do not establish a causal link between mental illness and drug use—the mental illness may have preceded the drug use or vice versa (AIHW 2010).

In addition to asking people if they have been diagnosed or treated for a mental illness in the previous 12 months, the survey also includes the Kessler 10 scale (K10), which was developed for screening populations for psychological distress (refer to Glossary for more information).

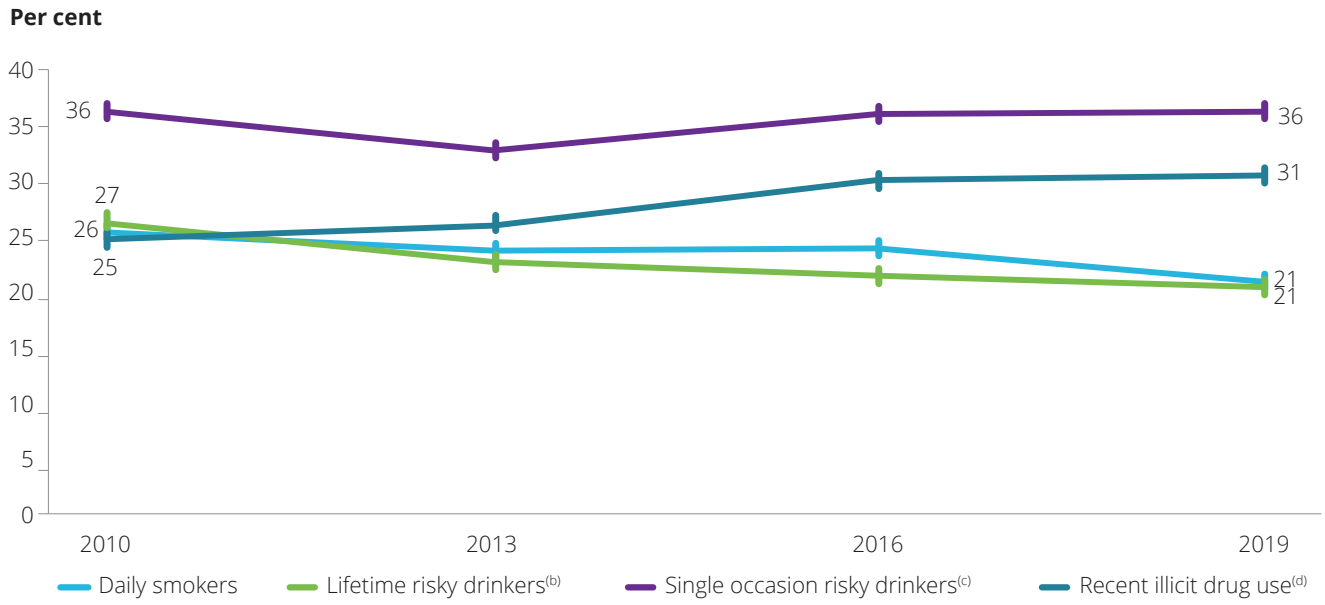
Since the 2010 survey, the proportion of adults who had been diagnosed with or treated for a mental health condition in the previous 12 months has been increasing and increased again between 2016 and 2019 (from 12.0% in 2010 to 15.9% in 2016 and to 16.9% in 2019) (Table 8.5). Increasing literacy and awareness around mental illness in Australia may partially explain these reported increases (National Mental Health Commission of NSW 2015), however, there are likely to be other factors involved including changing trends and patterns in the use of alcohol and other drugs.

Are levels of psychological distress increasing?

In 2019, the proportion of adults who reported high or very high levels of psychological distress increased (11.7% in 2016 compared with 14.0% in 2019) (Table 8.5). This increase occurred among adults who had used an illicit drug in the previous 12 months (22% in 2016 compared with 26% in 2019) and those who had not used an illicit drug (9.7% compared with 11.7%) (Table 8.6). The increase in high or very high psychological distress levels was most noticeable among people who had used cannabis in the last 12 months (24% in 2016 compared with 28% in 2019).

Among adults with high or very high levels of psychological distress, the proportion smoking daily was stable between 2010 and 2016 but declined in the most recent 3-year period (from 24% to 21%) (Table 8.7). Since 2010, the proportion exceeding the lifetime risk guideline to reduce the harm from alcohol has declined (from 27% to 21%) but the proportion exceeding the single occasion risk guideline was similar between 2010 and 2019 (Figure 8.3). The proportion who had used any illicit drug in the previous 12 months increased (from 25% in 2010 to 31% in 2019).

Figure 8.3: Drug use among people with high or very high psychological distress[a], aged 18 and over, 2010–2019 (per cent)



(a) K10 score: (High 22–29 or Very high: 30–50).

(b) According to NHMRC guideline 1: On average, had more than 2 standard drinks per day.

(c) Derived from 2009 NHMRC guideline 2: Had more than 4 standard drinks on 1 occasion at least once a month.

(d) Used at least 1 illicit substance in previous 12 months.

Source: Table 8.7.

Drug use among people diagnosed or treated for a mental health condition

Among people who recently used illicit drugs aged 18 and over, the proportion who had been diagnosed with or treated for a mental health condition in the previous 12 months remained stable over the most recent 3-year period at 26%, but has increased since 2010 (from 18.7%; Figure 8.4).

Although the proportion smoking daily declined between 2016 and 2019, no clear trend since 2010 is evident. However, the proportion is consistently higher than for people who have not been diagnosed or treated for a mental illness (Table 8.9).

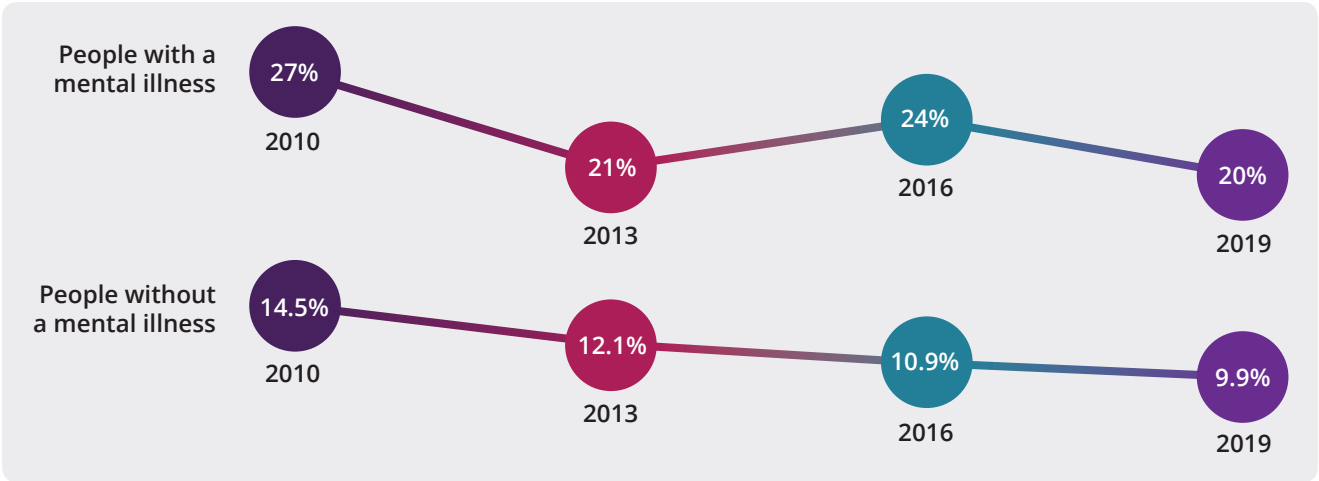
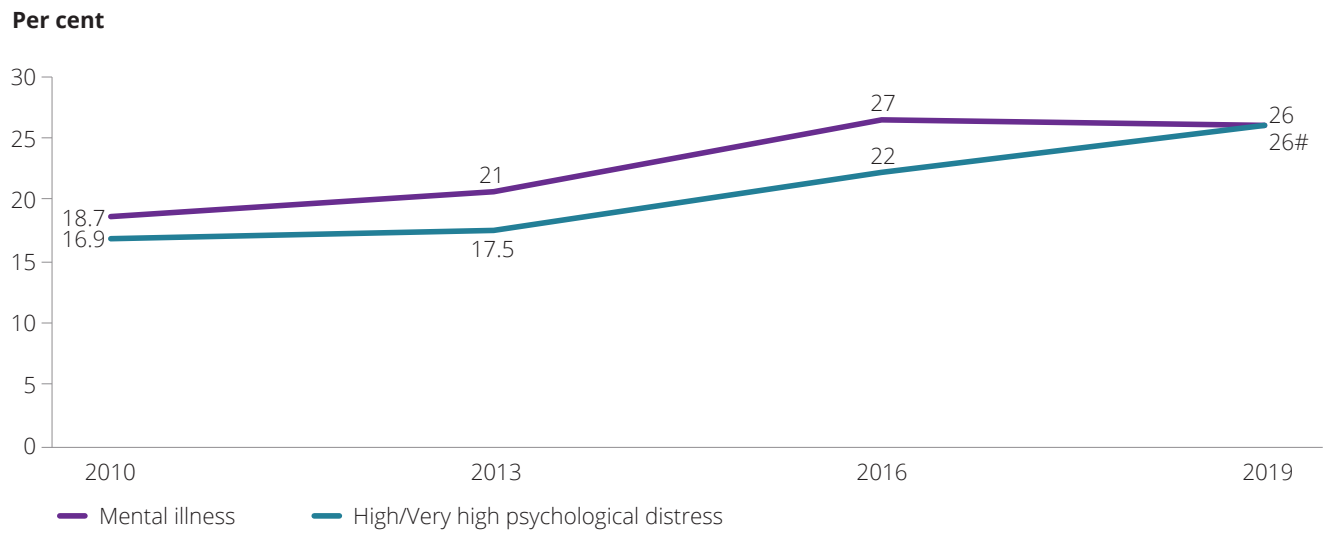


Figure 8.4: Psychological distress[a] and people diagnosed or treated for a mental illness[b] who used any illicit drug[c] in the past 12 months, aged 18 and over, 2010–2019 (per cent)



Statistically significant change between 2016 and 2019.

(a) Low: K10 score 10–15, Moderate: 16–21, High: 22–29, Very high: 30–50.

(b) Includes depression, anxiety disorder, schizophrenia, bipolar disorder, an eating disorder and other form of psychosis.

(c) Used at least 1 of 16 classes of illicit drugs in 2019 The number and type of illicit drug used varied over time.

Source: tables 8.6 and 8.8.

Drug use still higher among people with a mental illness or high psychological distress

Since 2010, people who had used an illicit drug in the previous 12 months have been at least twice as likely as people who have not used an illicit drug to experience high or very high levels of psychological distress in the 4 weeks before completing the survey (Table 8.6). High levels of psychological distress is consistently greater among people who report meth/amphetamine use in the previous 12 months.

In 2019, compared with people who had not been diagnosed or treated for a mental health condition in the previous 12 months, people with a mental health condition were:

- twice as likely to smoke daily (20% compared with 9.9%)
- about 1.2 times as likely to drink alcohol at levels that exceed the lifetime risk (21% compared with 17.1%) and single occasion risk guidelines (at least monthly) (31% compared with 25%)
- 1.7 times as likely to have recently used any illicit drug (26% compared with 15.2%)
- about 2.2 times as likely to have used meth/amphetamine (2.6% compared with 1.2%)
- 2.1 times as likely to use pharmaceuticals for non-medical purposes (7.6% compared with 3.6%) (Table 8.9).

Education and Employment

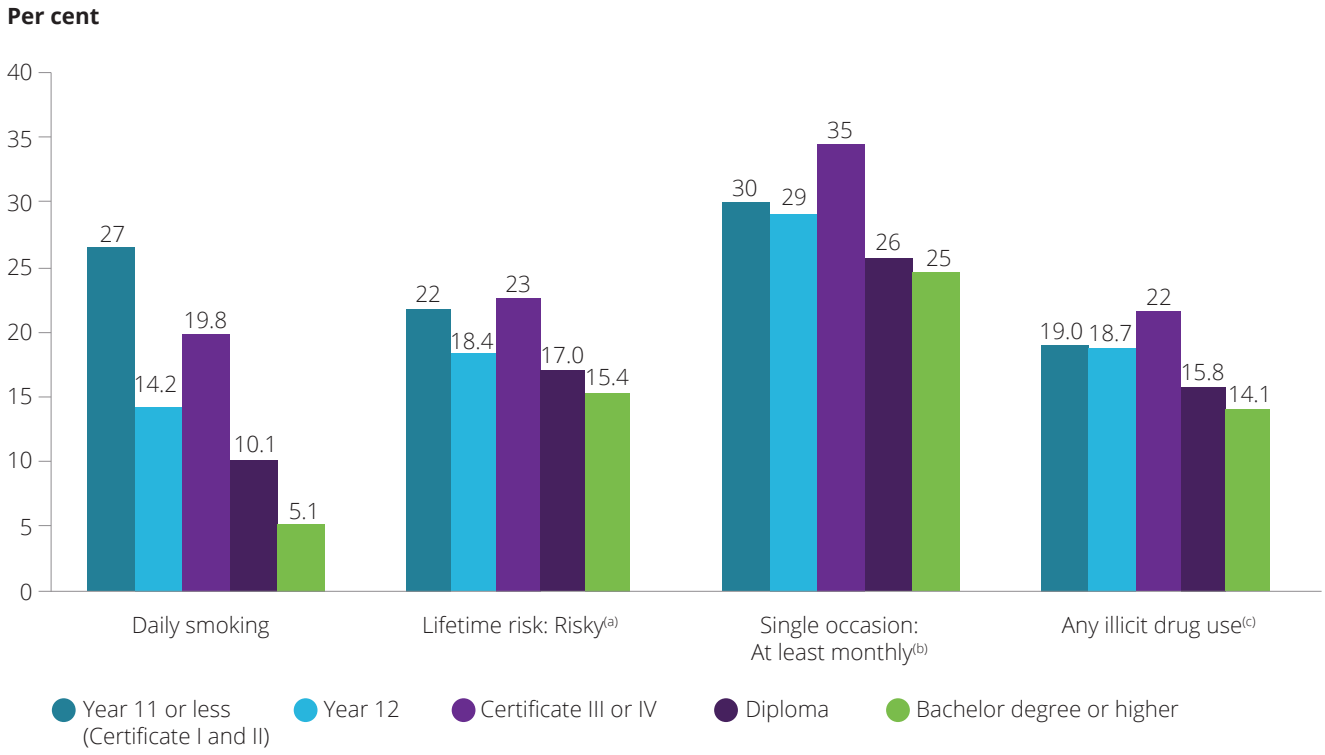
An individual's social context might influence their socioeconomic characteristics, such as education and income, which might influence their health behaviours, such as drug use.

People living in low socioeconomic areas often do not have educational qualifications, have low income, and are unemployed or in unskilled or semi-skilled occupations. Data from the NDSHS show an association with these determinants/factors, but it is not possible to determine the individual contribution of specific factors to the drug taking behaviour.

How does drug use vary by a person's educational level?

In Australia, there appears to be a relationship between a person's education level and substance use, with people with lower education levels (completed Year 11 or below) more likely to smoke daily, consume alcohol at risky levels and use illicit drugs in the previous 12 months (see Figure 8.5).

Figure 8.5: Daily smoking, risky drinking and any recent illicit drug use, by educational attainment, people aged 25–64, 2019 (per cent)



(a) According to NHMRC guideline 1: On average, had more than 2 standard drinks per day.

(b) Derived from 2009 NHMRC guideline 2: Had more than 4 standard drinks on 1 occasion at least once a month.

(c) Used at least 1 of 16 classes of illicit drugs in 2019.

Source: Table 8.10.

Strong relationship between smoking status and educational attainment

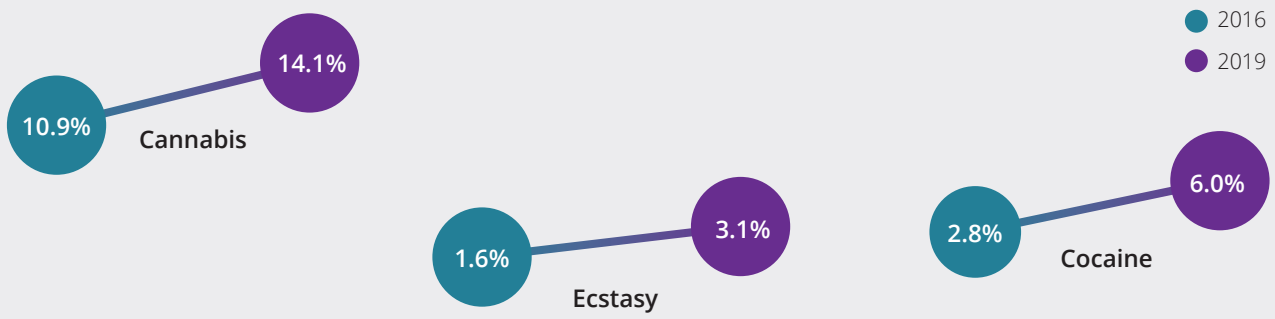
People who have a bachelor degree or higher consistently have the lowest smoking levels and people with a diploma have made the greatest improvement over time. Conversely, people who had completed Year 11 or below and people with a Certificate III or IV made the least improvement over time and have the highest smoking levels (Table 8.10). For example, among people aged 25–64, 26% of people who completed Year 11 or below smoked daily in 2019, compared with 5.1% for people with a bachelor degree or higher.

People with a diploma or bachelor degree and higher were slightly less likely to exceed the guidelines for reducing the harm due to alcohol (both lifetime risk and single occasion risk guidelines), while people with a Certificate III or IV were generally the most likely group to consume alcohol in risky quantities (Table 8.10).

Has drug use changed among people with different education qualifications?

Between 2016 and 2019, there were increases and declines for a number of drug types across the spectrum of educational attainment.

The largest increases in recent illicit drug use were among people who had completed Year 12 with use of cannabis, ecstasy and cocaine in the previous 12 months all increasing (Table 8.10).



Until 2016, recent cocaine use was typically more likely to be among people who had completed a bachelor degree or higher than people who had completed Year 12. However, in 2019, recent cocaine use increased among people who had completed Year 12, thereby making their use higher than people with a bachelor degree (6.0% compared with 4.6%). Cocaine use also increased among people who completed Year 11 or below and those who completed a Certificate III or IV between 2016 and 2019 (Table 8.10).

Employment status has an impact on which drugs are more commonly used

Employment status, and unemployment in particular, is strongly related to health status. Use of some drugs is consistently higher among people who are unemployed than people who are employed (Table 8.13), including:

- daily smoking (19.9% compared with 11.0%)
- use of cannabis in the last 12 months (19.8% compared with 13.5%)
- recent use of meth/amphetamine (3.4% compared with 1.5%).

Similar patterns were evident between people unable to work and employed people, with the greatest disparity in daily smoking (29% compared with 11.0%) (Table 8.13).

However, some substances were more likely to be used among employed people (Table 8.13). For example, employed people were more likely than unemployed people to:

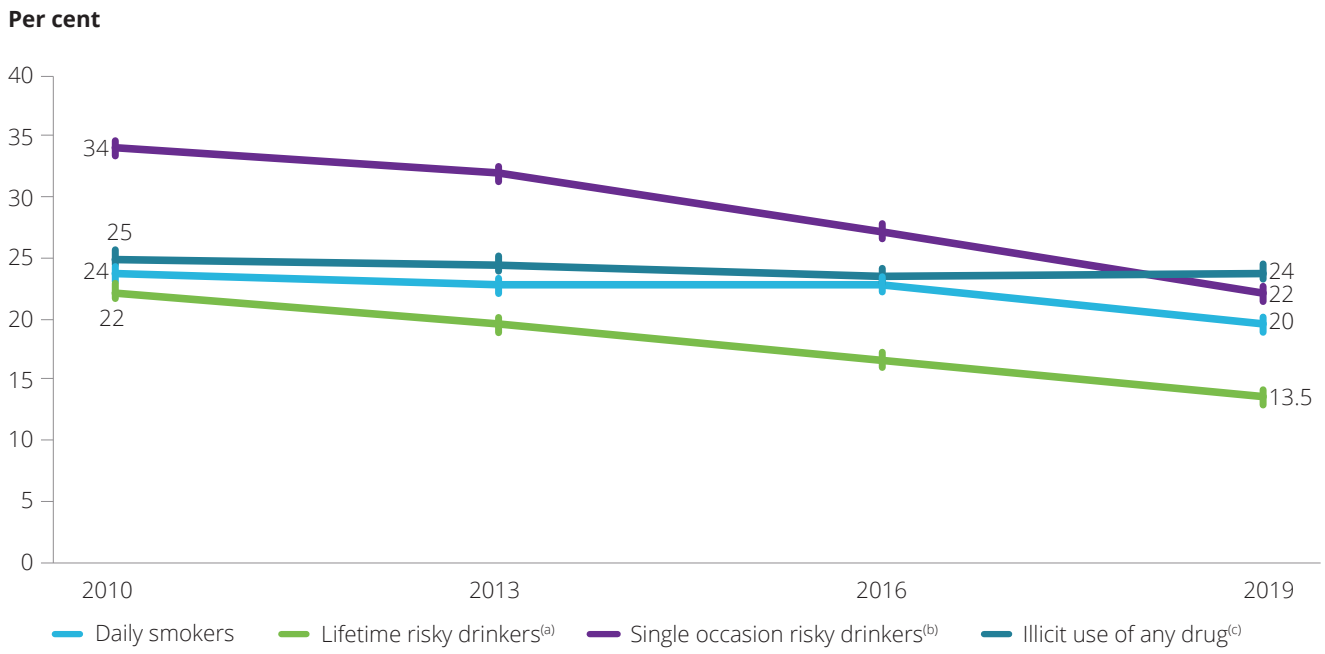
- drink in excess of lifetime risk guidelines (21% compared with 13.5%)
- drink in excess of the single occasion risk guideline, at least monthly (32% compared with 22%)
- use cocaine in the last 12 months (6.2% compared with 3.7%).

Were there any changes in drug use by employment status?

While the proportion smoking daily continued to decline for employed people, there were a number of increases in illicit drug use between 2016 and 2019, with recent use of cannabis (from 12.2% to 13.5%), cocaine (from 3.8% to 6.2%) and ecstasy (from 2.9% to 3.8%) all increasing (Table 8.13).

For unemployed people, there was a decline in the proportion of people consuming alcohol in excess of the single occasion risk guideline (at least monthly; decreased from 27% in 2016 to 22% in 2019). There has been little change in the illicit use of drugs among unemployed people since 2010 (Figure 8.6).

Figure 8.6: Daily smoking, risky drinking and any recent illicit drug use, people who were unemployed aged 14 and over, 2010–2019 (per cent)



(a) According to NHMRC guideline 1: On average, had no more than 2 standard drinks per day.

(b) According to NHMRC guideline 1: On average, had more than 2 standard drinks per day.

(c) Used at least 1 of 16 classes of illicit drugs in 2019.

Source: Table 8.13.

Pregnant women

Substance use among pregnant women is a particular concern as drugs can cross into the placenta and lead to a range of health problems, including abnormal foetal growth and development.

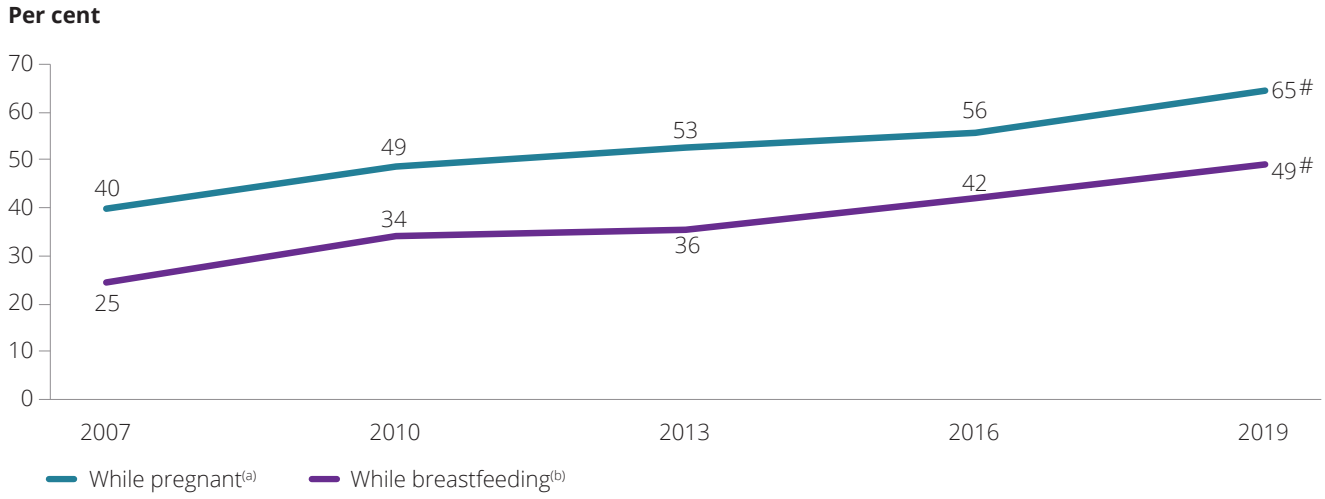
The NHMRC notes the evidence is that there is no safe amount of alcohol that pregnant women and breastfeeding mothers can drink. Therefore the council recommends that pregnant women and breastfeeding mothers do not consume alcohol (NHMRC 2009).

The questions on drug use during pregnancy were updated in 2013 to provide a more accurate picture of drinking during pregnancy—see Technical notes for further information and how these changes have an impact on the interpretation of these data.

More pregnant women abstaining from alcohol

In 2019, nearly two-thirds (65%) of women abstained from alcohol while pregnant, up from 56% in 2016 and 40% in 2007 (Figure 8.7). This trend was also evident for breastfeeding, where twice as many women abstain from alcohol compared to 2007 (49% compared with 25%).

Figure 8.7: Proportion of pregnant/breastfeeding women abstaining from alcohol, aged 14–49, 2007–2019 (per cent)



Statistically significant change between 2016 and 2019.

(a) Base is only pregnant women or women pregnant and breastfeeding.

(b) Base is women who were only breastfeeding or pregnant and breastfeeding.

Source: Table 8.14.

How much alcohol was consumed?

Of those women who consumed any alcohol while pregnant in 2019 (35%), most:

- usually consumed 1–2 standard drinks (96%) on a typical day they drank
- drank monthly or less (90%) (Table 8.15).

Does behaviour change once aware of pregnancy?

Pregnant women were asked about their drug-taking behaviours before they became aware they were pregnant. Of pregnant women who were unaware of their pregnancy in 2019 (Table 8.16):

- about 1 in 2 (55%) consumed alcohol before they knew they were pregnant, and this declined to 14.5% once they knew they were pregnant (down from 25% in 2016)
- the proportion of women who smoked tobacco halved once they found out they were pregnant (from 22% to 10.8%)
- 5.4% used cannabis and 1.8% used other illicit drugs before they knew they were pregnant. However, this should be interpreted with caution due to the high sampling error.

Among all pregnant women, there were no statistically significant changes in their drug taking behaviours between 2016 and 2019.

Where can I get more information?

To explore the data and view additional analyses, refer to the supplementary populations data tables. These include data on drug use by:

- self-assessed health status
- household type
- country of birth and main language
- marital status.

9 Perceptions and policy support

Quick facts

More Australians had a negative perception of pain-killers/ pain-relievers and opioids in 2019 than in 2016.

Almost 3 in 5 (57%) Australians supported 'allowing potential drug users to test their pills/drugs at designated sites'.

Tobacco has dropped to third most common drug that people thought caused the most deaths (behind alcohol and meth/amphetamine).

The most common action supported for people in possession of selected drugs was for 'referral to treatment or an education program' except for cannabis where a 'caution/warning' was the most common action supported.

For the first time, cannabis had a higher level of personal approval of regular use by an adult than tobacco (19.6% compared with 15.4%).

For the first time, from a theoretical $100 to spend on reducing illicit drug use, people allocated more money to education than law enforcement ($36.00 compared with $34.80).

Community tolerance has increase for cannabis use—more people supported legalisation while possession of cannabis being a criminal offence and penalties for sale and supply received less support. 2019 was the first time more people supported the legalisation of cannabis than opposed it (41% compared with 37%).

Understanding Australians' perceptions of drug use and policy support is an important part of policy planning and development. However, public perception does not always align with the available evidence. For example, a higher proportion of people nominated meth/amphetamine over tobacco as the drug that caused the most deaths. However, in 2015 the number of deaths attributable to tobacco was more than 8 times the number attributable to all illicit drugs (AIHW 2019c). These differences may be due to a variety of factors affecting public perception of drug use and their related harms, including the legal status of the drug, personal experience, media, culture and family attitudes, peer relationships, advertising and public health and safety campaigns.

This section presents findings on the perceptions and attitudes of people in Australia towards drug use and the level of support given to different measures that aim to reduce problems associated with the use of alcohol, tobacco, cannabis and heroin.

Unless otherwise specified, the results are for those aged 14 and over and all increases or decreases in estimates over time are statistically significant. All data presented in this chapter are available through the online policy and attitudes tables https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey-2019/data.

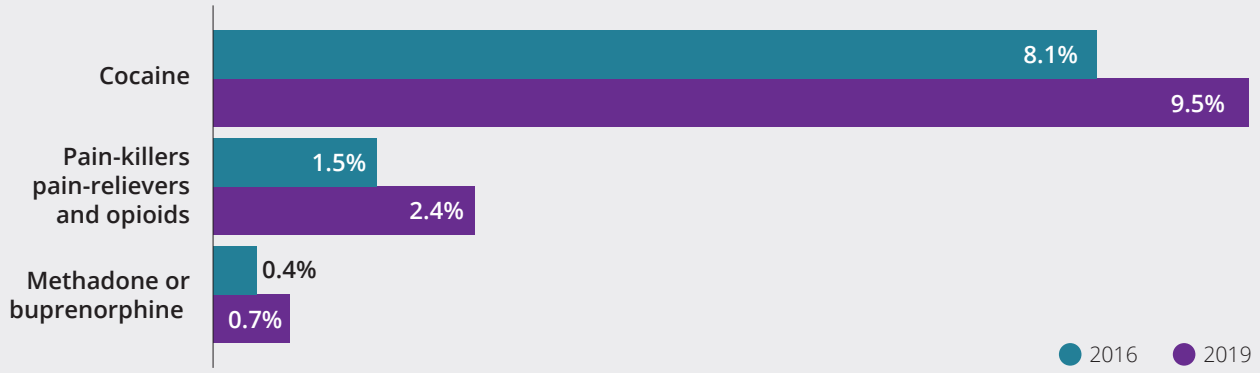
Perceptions of drugs

A range of factors, including media coverage and personal experience, are likely to influence people's perceptions of drug use. Three questions in the NDSHS are designed to monitor people's perceptions of drugs—which drugs they perceive to be a problem, associated with mortality and of greatest concern to the community.

Meth/amphetamine continues to be the drug people associate with a 'drug problem'

In 2019, almost half of people (49%) nominated meth/amphetamine to be the drug most likely to be associated with a 'drug problem', up from 46% in 2016 (Table 9.1).

There were small increases in the proportion of people who first thought of the following drugs as a 'drug problem' between 2016 and 2019 (Table 9.1).



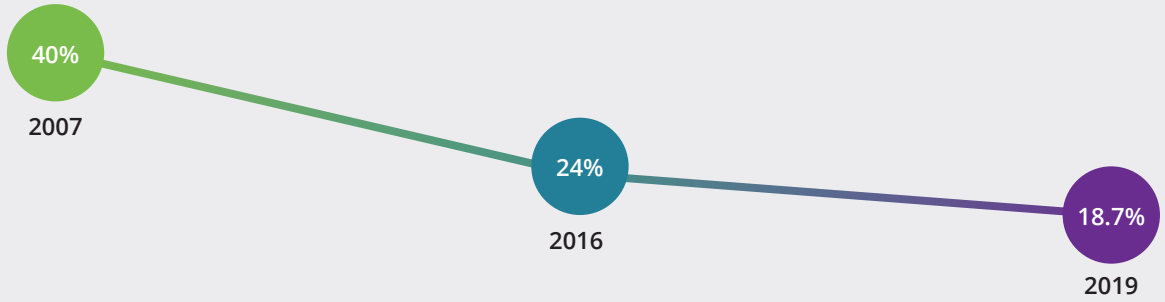
These shifts mean that there were some declines in the proportion nominating the following drugs as a 'drug problem':

- marijuana/cannabis (from 14.6% in 2016 to 12.4% in 2019)
- heroin (from 14.0% to 12.1%)
- ecstasy (from 3.1% to 2.1%) (Table 9.1).

Tobacco continues to decline as a drug thought to cause the most deaths

Tobacco contributes to more deaths in Australia than alcohol and illicit drug use combined. In 2015, it was estimated 20,933 deaths were attributable to tobacco; 6,355 to alcohol use; and 2,486 to illicit drug use (AIHW 2019c).

The proportion of people who nominated tobacco as the drug they thought caused the most deaths declined from 2016 to 2019, continuing a steady decline since 2007 (Table 9.3).



Young people aged 14–17, who had the lowest levels of daily smoking by age group, were less likely to nominate tobacco as the drug most likely to cause deaths than people in their 60s (60–69) (12.9% compared with 24%) (Table 9.4).

Alcohol remained the drug most commonly identified as causing deaths (34%) (Figure 9.1). Meth/amphetamine overtook smoking as the second most commonly identified drug (20%, up from 19.2% in 2016) (Table 9.4).

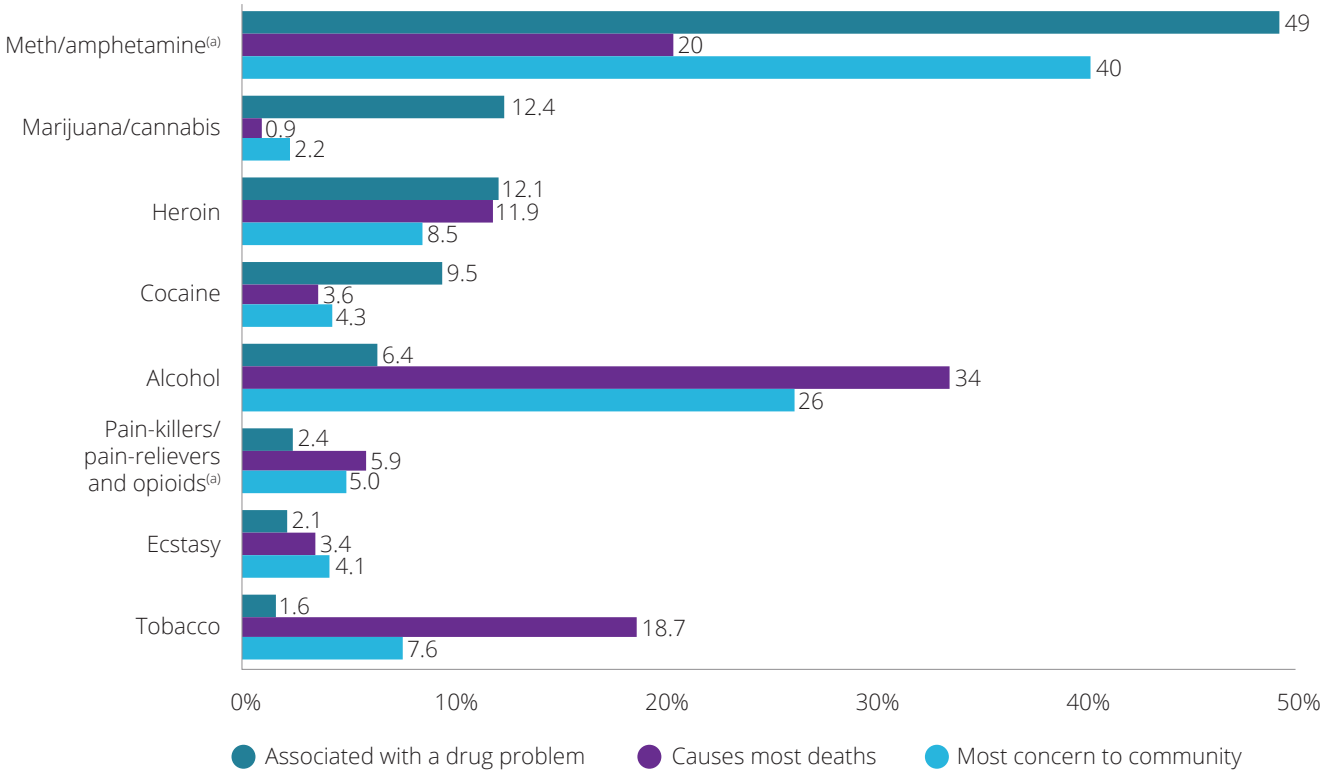
In 2019, respondents expressed more concern about opioids, with increases in the proportion nominating heroin (from 10.6% in 2016 to 11.9% in 2019) and pain killers/pain-relievers and opioids (from 1.9% to 5.9%) as the drug they thought caused the most deaths in Australia (Table 9.3).

More people thought opioids were the drug of most concern for the general community

In 2019, heroin (8.5%; up from 7.5% in 2016) and pain killers/pain-relievers and opioids (5.0%; up from 2.0% in 2016) increased as drugs of most concern for the general community. There was also increased concern about cocaine (from 3.3% in 2016 up to 4.3% in 2019). In addition:

- meth/amphetamine continues to be the drug thought to be of most concern for the general community (40%) (Table 9.5)
- excessive drinking continues to decline as a drug of most concern (from 28% in 2016 to 26% in 2019), as does tobacco smoking (from 9.4% to 7.6%)
- there was a decline in the proportion who nominated ecstasy as the drug of most concern (from 5.0% to 4.1%) (Table 9.5).

Figure 9.1: Perceptions of selected drugs, people aged 14 and over, 2019 (per cent)



(a) For non-medical purposes.

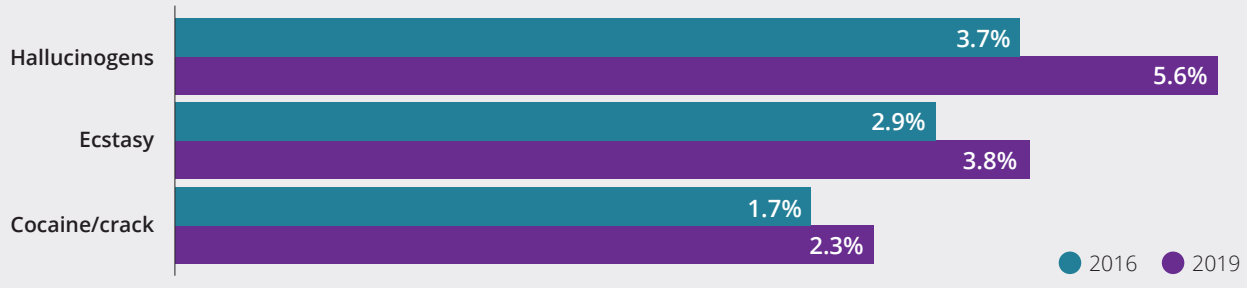
Source: tables 9.1, 9.3, 9.5.

How many people approve of regular adult drug use?

Respondents were asked about what they thought of regular adult use of drugs. Results are presented for those respondents who 'approve' (said 'strongly approve' or 'approve'), 'neither' (neither approve nor disapprove) and 'disapprove (said 'strongly disapprove' or 'disapprove'). Responses from those who indicated they did not know enough to give or withhold approval were excluded from the analysis.

In 2019, alcohol (45%) continued to have the highest level of personal approval of regular adult use than any other drug. For the first time, cannabis had a higher level of approval than tobacco (19.6% compared with 15.4%). The level of approval for cannabis has continued to increase since 2007 (6.6%) (Table 9.7).

The level of approval of regular adult drug use increased for:



Alcohol was the only drug for which the level of approval of regular use by an adult was higher than disapproval (45% compared with 21%). Alcohol, cannabis (54%) and tobacco (61%) had the lowest levels of disapproval, while heroin (96%), inhalants (95%) and meth/amphetamine (95%) had the highest levels of disapproval (Table 9.10).

Personal approval of regular drug use was consistently higher among individuals who had used that particular drug recently than among those who had not used the drug in the preceding year or their lifetime. Levels of personal approval varied by drug type, with people who recently used marijuana/cannabis (68%), hallucinogens (65%), GHB (55%) and alcohol (52%) reporting higher levels of approval. On the other hand, people who used methadone or buprenorphine, meth/amphetamine, heroin and inhalants had lower levels of approval (less than 20%) (Table 9.9).

Policy support

Australia has had a coordinated national policy for dealing with tobacco, alcohol and other drugs since 1985 when the National Campaign Against Drug Abuse (later renamed the National Drug Strategy) was developed. This section presents findings on the level of support given to different measures that aim to reduce drug use or drug-related harm.

Respondents were asked to indicate how strongly they would support or oppose specific policies, using a 5-point scale. Only responses of 'support' or 'strongly support' are taken as support for specific policies. Responses from those who indicated they did not know enough about the policy to give or withhold support were excluded from the analysis.

Support for measures to reduce problems associated with tobacco and alcohol

In 2019, support for measures aimed at reducing tobacco-related harm generally remained high. Support for measures related to the use of e-cigarettes has grown, while there were declines in support for measures related to increasing tax on tobacco (see Chapter 2 for more detail).

Support for measures aimed at reducing alcohol-related harm continued to decline in 2019, with support for 12 out of 18 measures falling since 2016 (see Chapter 3 for more detail).

People's attitudes towards cannabis continue to change

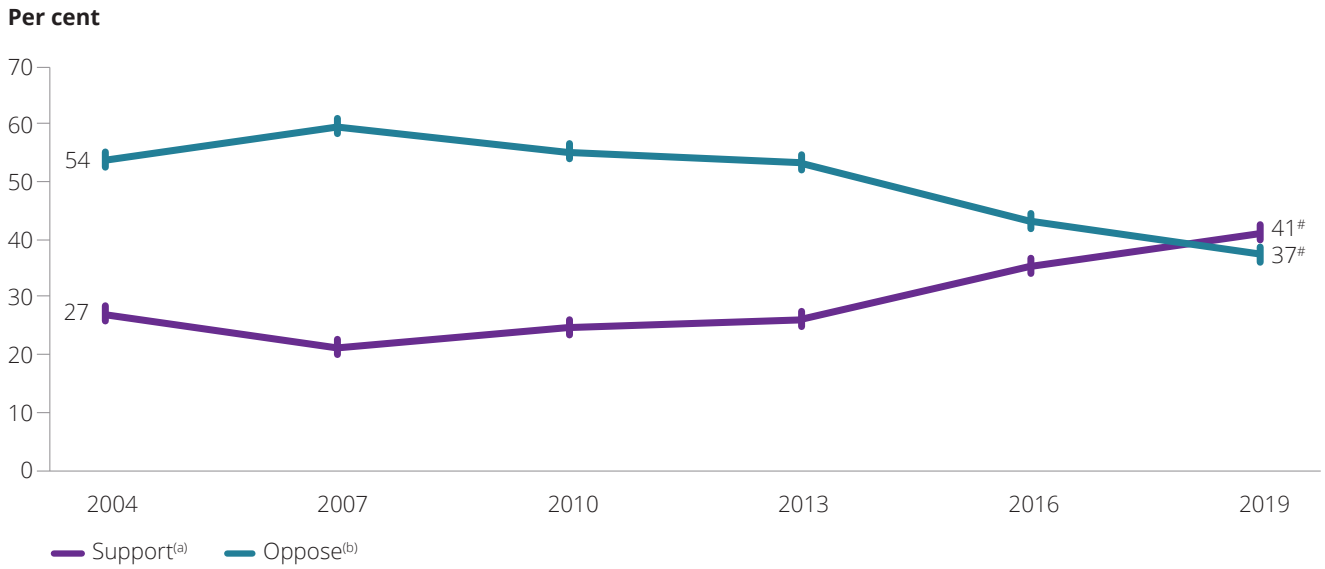
Respondents were asked about their support for legalisation, penalties and actions taken against people involved with cannabis.

Support for the legalisation of cannabis continued to grow in 2019 (41%; up from 35% in 2016), reaching almost double the level of support in 2007 (21%) (Table 9.23). For the first time in 2019, more people supported the legalisation of cannabis than opposed it (41% compared with 37%), with opposition declining since 2007 (59%) (Figure 9.2). There was also an increase in the recent use of cannabis from 2016 to 2019 (see Chapter 4 for more detail).

Fewer people thought that possession of cannabis should be a criminal offence (down from 26% in 2016 to 22% in 2019) or that penalties should be increased for the sale or supply of cannabis (down from 50% to 44%) (tables 9.15 and 9.29).

If cannabis were to be legalised, nearly 4 in 5 (78%) people claimed they would still not use it. However, there was an increase from 2016 to 2019 in the proportion of people who said they would 'try it' (7.4% to 9.5%) and 'use it more often than you do now' (1.8% to 2.9%) (Table 9.17).

Figure 9.2: Levels of support and opposition for the legalisation of cannabis, people aged 14 and over, 2004–2019 (per cent)



Statistically significant change between 2016 and 2019.

(a) Support or strongly support (calculations based on those respondents who were informed enough to indicate their level of support).

(b) Oppose or strongly oppose (calculations based on those respondents who were informed enough to indicate their level of support).

Note: The proportion of those who neither support nor oppose is not included in this figure.

Source: Table 9.26.

Support for measures to reduce problems associated with injecting

In 2019, most people supported measures to reduce problems associated with injecting drugs. The most commonly supported measures were:

- rapid detoxification therapy (69%)
- methadone/buprenorphine maintenance programs (67%)
- treatment with drugs other than methadone (66%) (Table 9.19).

There were small declines in the level of support for 'needle and syringe programs' (from 67% in 2016 to 64% in 2019) and a 'trial of prescribed heroin' (from 35% to 33%) (Table 9.19). A 'trial of prescribed heroin' was the only measure where opposition was higher than support (45% compared with 33%) (Table 9.22).

People who had recently injected drugs expressed higher levels of support than people who had never injected drugs for all measures, including (Table 9.21):

90%
needle and syringle programs (compared with 64%)

83%
the availability of take-home Naloxone (compared with 56%)

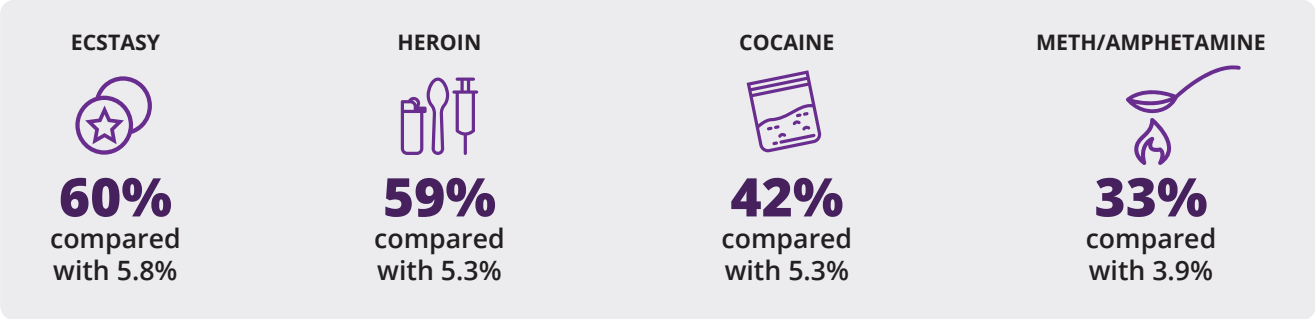
79%
regulated injecting rooms (compared with 54%)

60%
trial of prescribed heroin (compared with 32%)

Support for other illicit drug measures

Support for the legalisation of drugs remained low in 2019. However, there were increases in support for legalisation of cocaine (from 7.0% in 2016 to 8.0% in 2019) and ecstasy (from 8.2% to 9.5%); recent use of cocaine and ecstasy also increased from 2016 to 2019 (see Chapter 4 for more detail). Support for the legalisation of heroin (5.6%) and meth/amphetamines (4.6%) was stable in 2019. Males were more likely to support the legalisation of these drugs than females (Table 9.23).

People who recently used each drug type had substantially higher levels of support for legalisation than those who had never used the drug (Table 9.25):



In 2019, there was increased support of legalisation by people who had recently used cocaine (from 30% in 2016 to 42% in 2019) (Table 9.25).

There were slight declines in the support for increased penalties for the sale or supply of cocaine (from 80% in 2016 to 77% in 2019) and ecstasy (from 79% to 76%). The support for increased penalties for meth/amphetamine (84%) and heroin (83%) remained stable in 2019 (Table 9.27).

Box 9.1: Majority of people support pill testing but fewer supported supervised drug consumption rooms

For the first time in 2019, respondents were asked about the following measures:

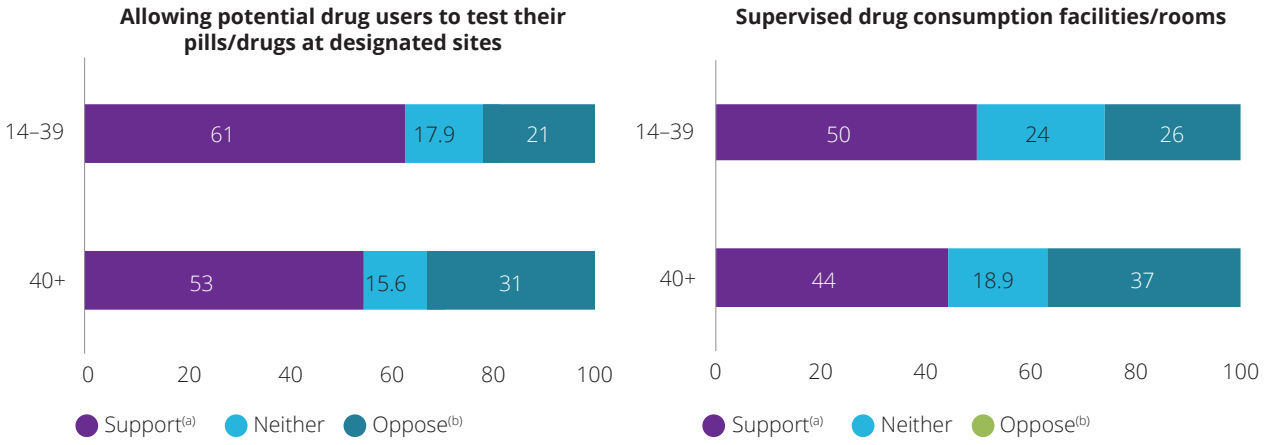
- Allowing potential drug users to test their pills/drugs at designated sites. The test will inform them of the purity and the substances the drug contains.
- Supervised drug consumption facilities/rooms.

These measures were generally well supported in comparison to the legalisation of drugs and a 'trial of prescribed heroin' but remained slightly below support for other measures associated with injecting drugs.

Overall, almost 3 in 5 (57%) Australians supported 'allowing potential drug users to test their pills/drugs at designated sites'; only 1 in 4 opposed this measure (27%) (Table 9.13). Support was higher among people aged 14–39 (61%) than those aged 40 and over (53%) (Table 9.14). People who recently used drugs were substantially more likely to support this measure compared with those who had never used drugs (78% compared with 47%) (Table 9.12).

Slightly less than half (47%) supported 'supervised drug consumption facilities/rooms', while about 1 in 3 (32%) opposed this measure (Table 9.13). Support was higher among people aged 14–39 (50%) than those aged 40 and over (44%) (Table 9.14). People who had recently used drugs were substantially more likely to support this measure than those who had never used drugs (65% compared with 39%) (Table 9.12).

Support for measures relating to the use of illicit drugs and harm minimisation, people aged 14 and over, by age groups, 2019 (per cent)



(a) Support or strongly support.

(b) Oppose or strongly oppose.

Note: Base is people who were informed enough to indicate their level of approval.

Source: Table 9.14.

What actions against people in possession of drugs are supported?

Across each drug type the action people most supported was for 'referral to treatment or an education program': heroin (51%), meth/amphetamines (49%), hallucinogens (46%) and ecstasy (40%). Cannabis was the only exception to this, where 'a caution/warning or no action' was the main action supported (54% compared with 24% for 'referral to treatment or an education program'). In addition, between 2016 and 2019:

- for all drugs there was a decline in the proportion who supported a 'prison sentence'
- a higher proportion supported 'a caution/warning or no action' for cannabis, ecstasy and hallucinogens (Table 9.32).

Spending on education preferred to spending on law enforcement

People's priorities (aligning conceptually with the 3 pillars of the NDS) were explored by looking at how a hypothetical $100 should be split between education, treatment or law enforcement to reduce the harm of alcohol, tobacco and illicit drugs.

Overall, education continued to receive the greatest proportion of the allotted $100 for tobacco ($45.00), alcohol ($41.20) and illicit drugs ($36.00). There was a decrease in the allotted dollars for law enforcement for alcohol (from $27.60 in 2016 to $26.70 in 2019) and illicit drugs (from $36.00 to $34.80); this resulted in the allotted dollars for illicit drugs being higher for education than for law enforcement for the first time since the question was introduced in 2004 (Table 9.33).

Where can I get more information?

For more information on support for alcohol and tobacco policy measures please see the respective chapters. To explore the data and view additional analyses on the information presented in this chapter, refer to the supplementary policy and attitudes data tables. These include data on:

- social characteristics, perceptions and attitudes towards drugs
- sex and age breakdowns for perceptions and policy support measures.

Appendix A: Technical Advisory Group

Members of the 2019 National Drug Strategy Household Survey Technical Advisory Group included:

Name	Organisation
Dr Gabrielle Phillips (Chair) Matthew James (former chair)	Australian Institute of Health and Welfare (AIHW)
Moira Hewitt	AIHW
Cathy Claydon	AIHW
Josh Sweeney	AIHW
Parker Blakey	AIHW
Elise Kennedy	Australian Bureau of Statistics (ABS)
Amber Migus	Australian Criminal Intelligence Commission
Professor Paul Dietze	Burnet Institute
Professor Melanie Wakefield	Cancer Council of Victoria
Professor Toni Makkai	Centre for Social Research and Methods, Australian National University
Debra Reid	Chair ABS Round Table on Aboriginal and Torres Strait Islander Statistics
Allison Jones	Department of Health
Jenny Trudinger	Department of Health
Alessandro Oliveira	Department of Health
Dr Michael Livingston	Centre for Alcohol Policy and Research, Latrobe University
Dr Tina Lam	Monash Addiction Research Centre, Monash University
Dr Janine Chapman	National Centre for Education and Training on Addiction (NCETA)
Professor Louisa Degenhardt	National Drug and Alcohol Research Centre (NDARC)

Glossary

Aboriginal or Torres Strait Islander: A person of Aboriginal and/or Torres Strait Islander descent who identifies as an Aboriginal and/or Torres Strait Islander.

abstainer (alcohol): a person who has not consumed alcohol in the previous 12 months.

Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): The ASSIST was developed to identify people whose substance use may be causing them harm. ASSIST-Lite scores are categorised as 'low risk', 'moderate risk' or 'high risk'. High risk scores are likely to indicate a substance dependence issue, while moderate risk scores indicate substance use that may be hazardous or harmful to the person's health.

Australian Statistical Geography Standard (ASGS) Remoteness Area: The ABS ASGS Remoteness Area classification allocates 1 of 5 remoteness categories to areas, depending on their distance from 5 types of population centre. These classifications reflect the level of remoteness at the time of the 2016 Census. Areas are classified as *Major cities, Inner regional, Outer regional, Remote* and *Very remote*. For the NDSHS analysis, *Remote and very remote* were grouped together.

alcohol-induced deaths: Deaths that can be directly attributable to alcohol use, as determined by toxicology and pathology reports.

branded illicit tobacco: Tobacco products that are smuggled into Australia without payment of the applicable customs duty.

burden of disease and injury: A term referring to the quantified impact of a disease or injury on an individual or population, using the disability-adjusted life year (DALY) measure.

current smoker: Reported smoking daily, weekly or less than weekly at the time of the survey.

current use of e-cigarettes: Reported smoking electronic cigarettes daily, weekly, monthly or less than monthly.

daily smoker: Reported smoking tobacco at least once a day (includes manufactured (packet) cigarettes, roll-your-own cigarettes, cigars or pipes). Excludes chewing tobacco, electronic cigarettes (and similar) and smoking of non-tobacco products.

drug-induced deaths: Drug-induced deaths are defined as those that can be directly attributable to drug use, as determined by toxicology and pathology reports. They are classified due to their intent—accidental, intentional (including assault and suicide), undetermined intent or other. Further, they include deaths from illicit drugs (for example, heroin, amphetamines and cocaine) and licit drugs (for example, benzodiazepines and anti-depressants). Deaths solely attributable to alcohol and tobacco are excluded.

electronic cigarette (e-cigarette): Devices designed to produce a vapour that the user inhales. Usually contain a battery, a liquid cartridge and a vaporisation system and are used in a manner that simulates smoking.

emerging psychoactive substances: Are drugs that often mimic the effects of more established illegal drugs. These are sometimes referred to as research chemicals, analogues, or bath salts. Some of the more well-known substances include Mephedrone, NBOMe, Methylone, Flakka, MDPV, 2C-I, BZP, Carfentanyl and Krokodil.

ever use: Used at least once in lifetime.

ex-drinker: A person who has consumed a full serve of alcohol in his or her lifetime, but not in the previous 12 months.

ex-smoker: A person who has smoked at least 100 cigarettes or equivalent tobacco in his or her lifetime, but does not smoke at all now.

ex-user: A person who has used a substance in his or her lifetime, but not in the previous 12 months.

hospital separation: The term used to refer to the episode of care, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation).

illicit drugs: Illegal drugs, drugs and volatile substances used illicitly, and pharmaceuticals used for non-medical purposes. The survey included questions on the following illicit drugs:

- pain-killers/pain-relievers and opioids^
- tranquillisers/sleeping pills^
- Steroids^
- meth/amphetamines^
- cannabis
- heroin
- methadone or buprenorphine^
- cocaine
- hallucinogens
- ecstasy
- ketamine
- GHB
- synthetic cannabinoids
- emerging psychoactive substances
- inhalants
- (any) injected drug.

Note

^ used for non-medical purposes

Non-medical and non-maintenance use is noted in the report.

Excludes the use of cannabis for medical purposes that was prescribed by a doctor only.

injected drugs: The injection of drugs that were not medically prescribed to inject.

Kessler Psychological Distress Scale (K10): A survey device that is used for screening populations on psychological distress. The scale consists of 10 questions on non-specific psychological distress, and relates to the level of anxiety and depressive symptoms a person may have felt in the preceding 4-week period. It is used only for people aged 18 and over.

lifetime risk (alcohol): The accumulated risk from drinking either on many drinking occasions, or regularly (for example, daily) over a lifetime. The lifetime risk of harm from alcohol-related disease or injury increases with the amount consumed.

medicinal cannabis: Cannabis that has been prescribed for use by a doctor.

never drinker: A person who has never consumed a full serve of alcohol in their lifetime.

never smoker: A person who does not smoke now and has smoked fewer than 100 cigarettes or the equivalent tobacco in his or her lifetime.

non-medical use: Use of drugs either alone or with other drugs to induce or enhance a drug experience, for performance enhancement or for cosmetic purposes. In this report, this includes pain-killers/analgesics, tranquilisers/sleeping pills, steroids, methadone or buprenorphine and meth/amphetamines and other opioids such as morphine or pethidine.

non-smoker: Never smoked or an ex-smoker.

over-the-counter (OTC) drugs: Medicine that you can buy without a prescription from a pharmacy or retail outlet.

recent: In the previous 12 months.

roll-your-own tobacco/cigarettes: Cigarettes made from loose tobacco and rolling paper.

single occasion risk (alcohol): A single occasion is defined as a sequence of drinks taken without the blood alcohol concentration reaching zero in between. The risk of an alcohol-related injury arising from a single occasion of drinking increases with the amount consumed.

smoker: A person who reported currently smoking daily, weekly or less often than weekly.

socioeconomic status and the Index of Relative Socio-Economic Advantage and Disadvantage: The Index of Relative Socio-Economic Advantage and Disadvantage (IRSAD) is 1 of 4 Socio-Economic Indexes for Areas (SEIFA) compiled by the ABS after each Census of Population and Housing. The IRSAD compiled by the ABS was used to derive fifths. In this report, the 20% of the areas with the greatest overall level of disadvantage is described as the 'lowest socioeconomic area'. The 20% of the areas with the greatest overall level of advantage—the top fifth—is described as the 'highest socioeconomic area'.

standard drink: Containing 10 grams of alcohol (equivalent to 12.5 millilitres of alcohol); also referred to as a full serve.

unbranded tobacco: Finely cut, unprocessed loose tobacco that has been grown, distributed and sold without government intervention or taxation.

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List of tables

List of figures

The 2019 National Drug Strategy Household Survey report showed that:

- fewer Australians are smoking tobacco daily, while the use of e-cigarettes is increasing
- more Australians are giving up or reducing their alcohol intake, driven by health concerns
- rates of substance use are falling among younger generations (less likely to smoke, drink and use illicit drugs)
- non-medical pharmaceutical use is down, driven by a fall in the use of pain-killers.

AIHW

Stronger evidence,
better decisions,
improved health and welfare