



Australian Government

Australian Institute of Health and Welfare

# 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.



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.



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



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).



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%).



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.

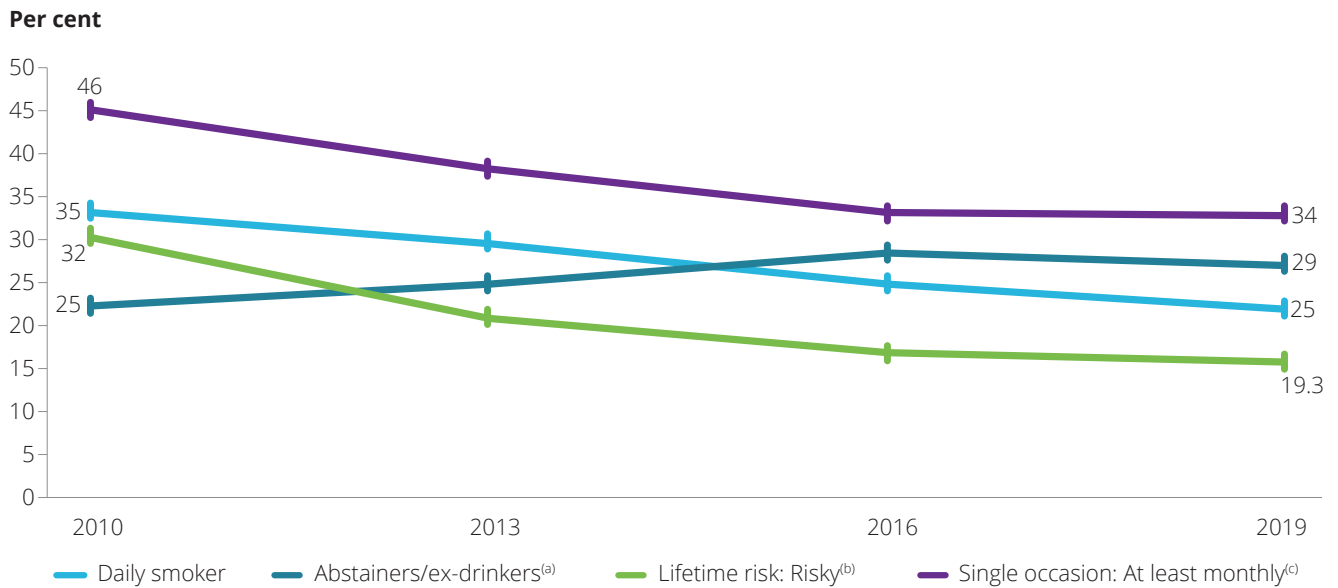
### Has drug use changed among Indigenous people?

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.

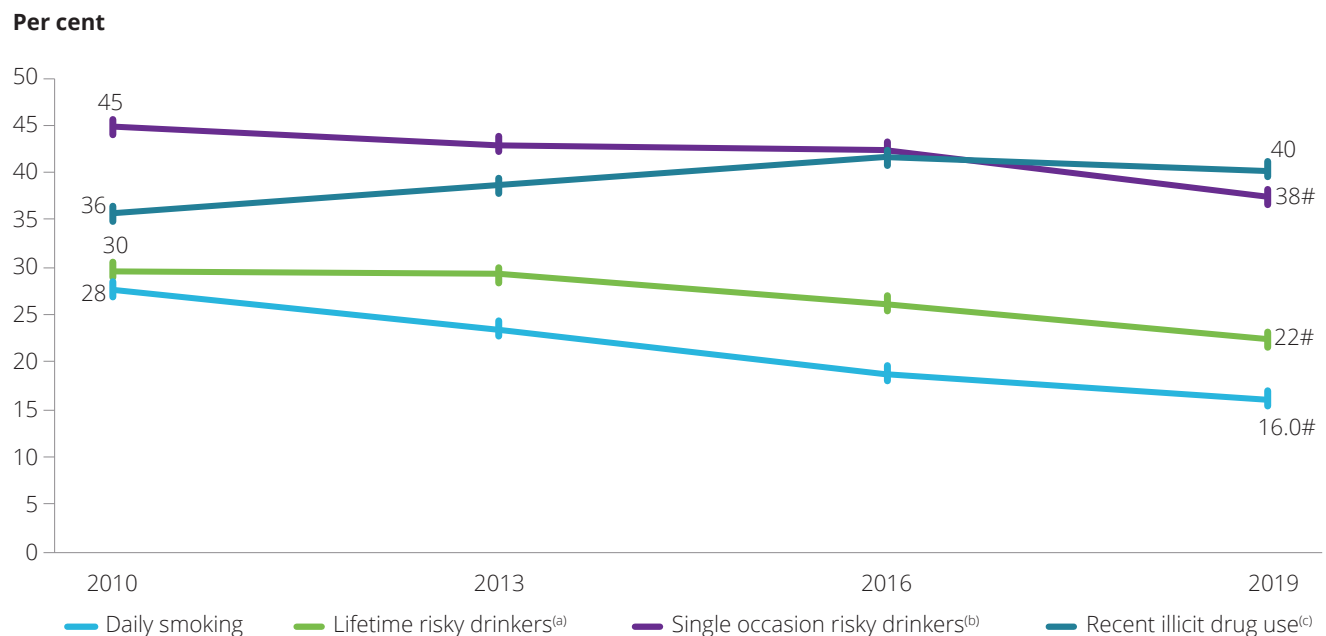


## Has drug use changed among gay, lesbian and bisexual people?

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.

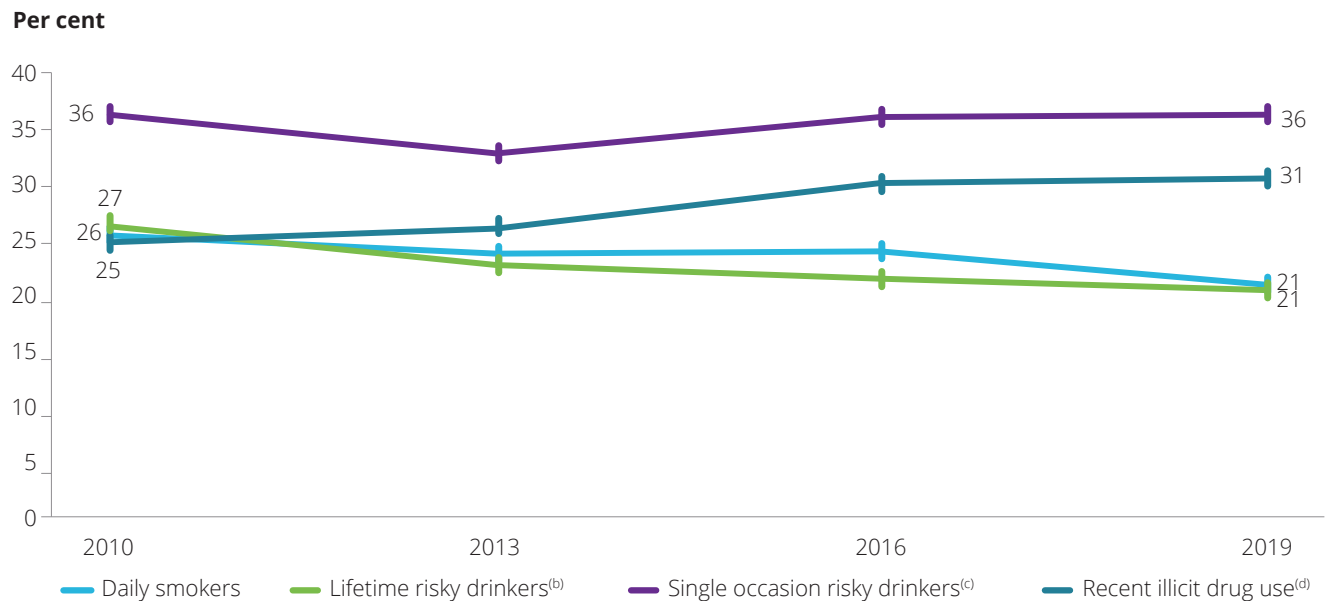
### Are levels of psychological distress increasing?

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<sup>(a)</sup>, 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.

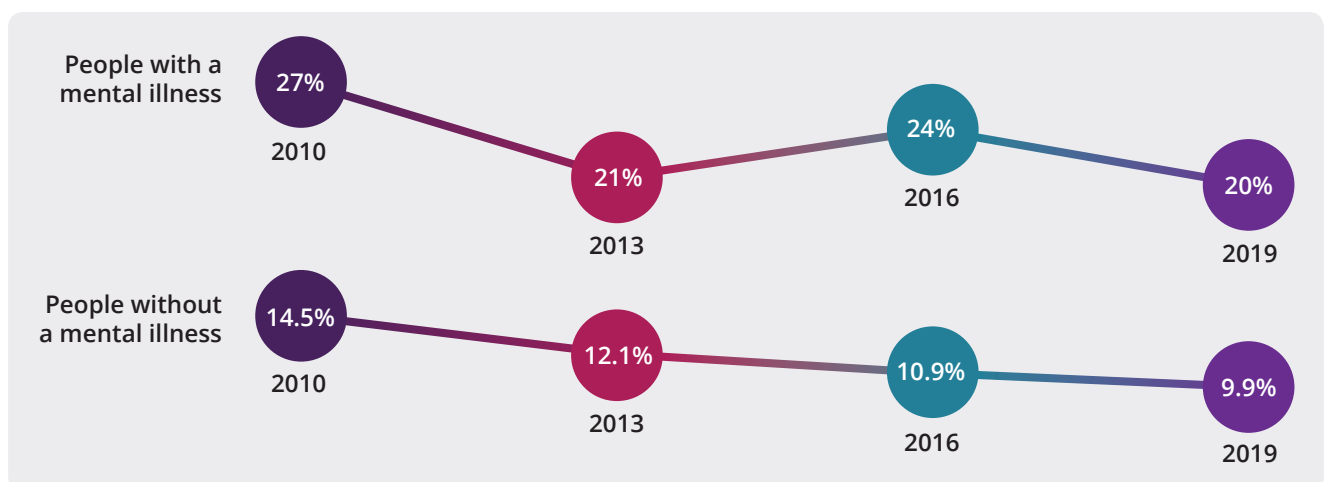
(d) Used at least 1 illicit substance in previous 12 months.

Source: Table 8.7.

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

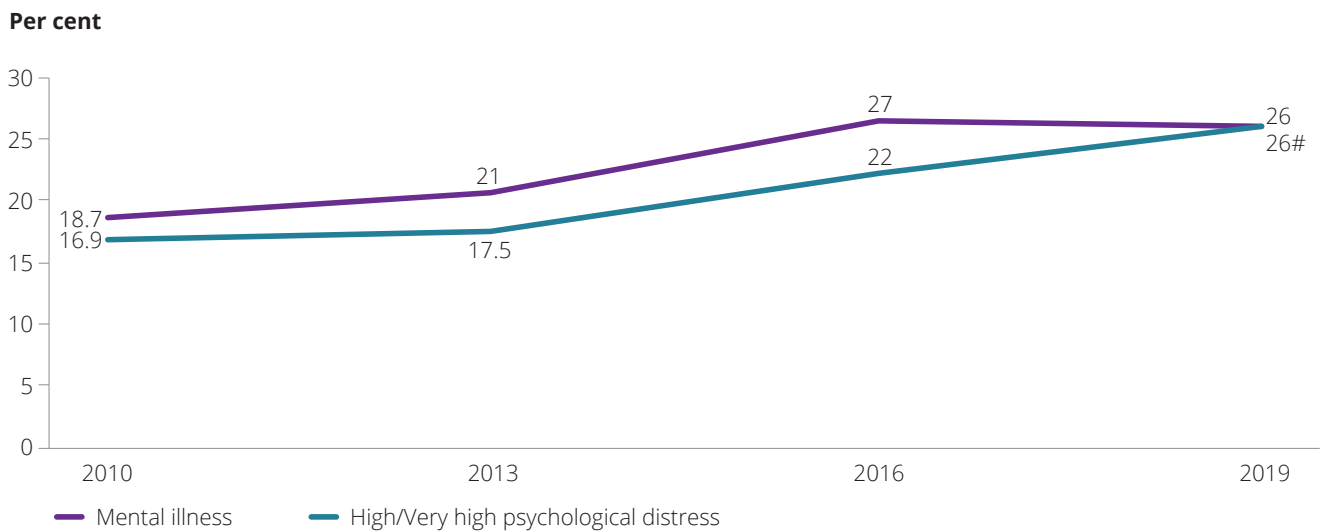
Among people who recently used illicit drugs aged 18 and over, the proportion who had been diagnosed with or treated for a mental health condition in the previous 12 months remained stable over the most recent 3-year period at 26%, but has increased since 2010 (from 18.7%; Figure 8.4).

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<sup>(a)</sup> and people diagnosed or treated for a mental illness<sup>(b)</sup> who used any illicit drug<sup>(c)</sup> 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.

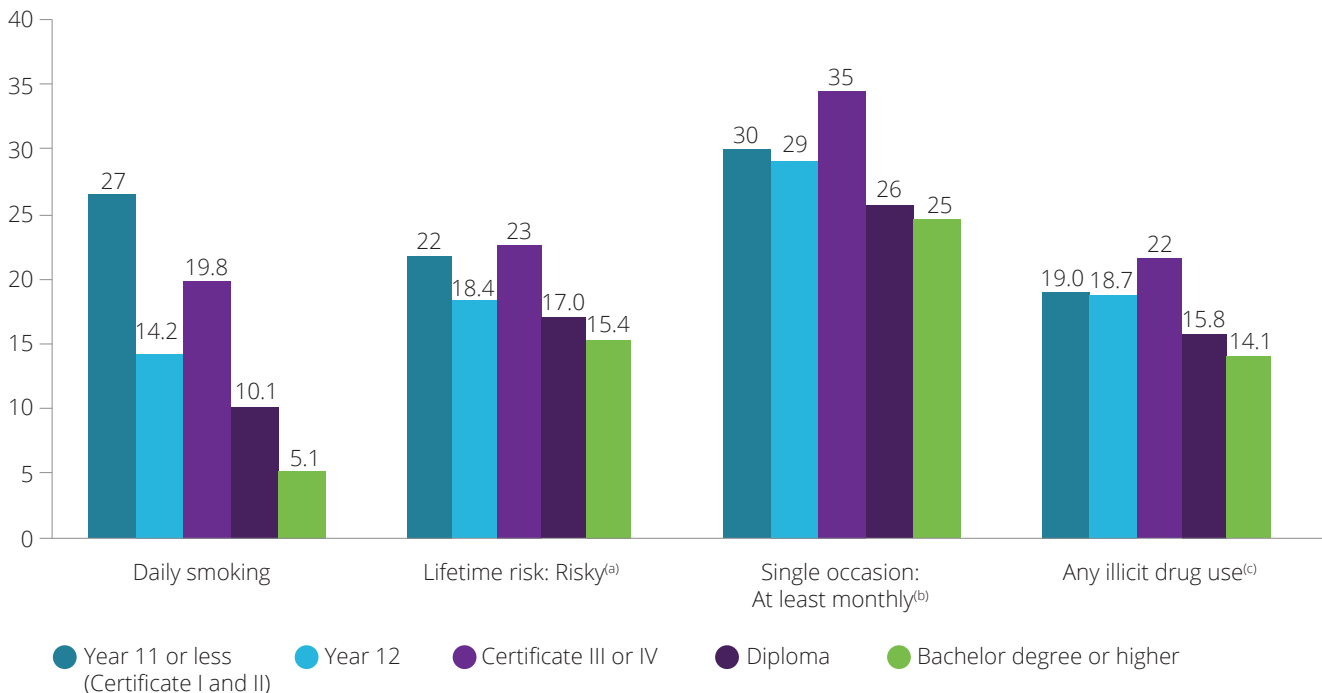


## How does drug use vary by a person's educational level?

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)**

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.

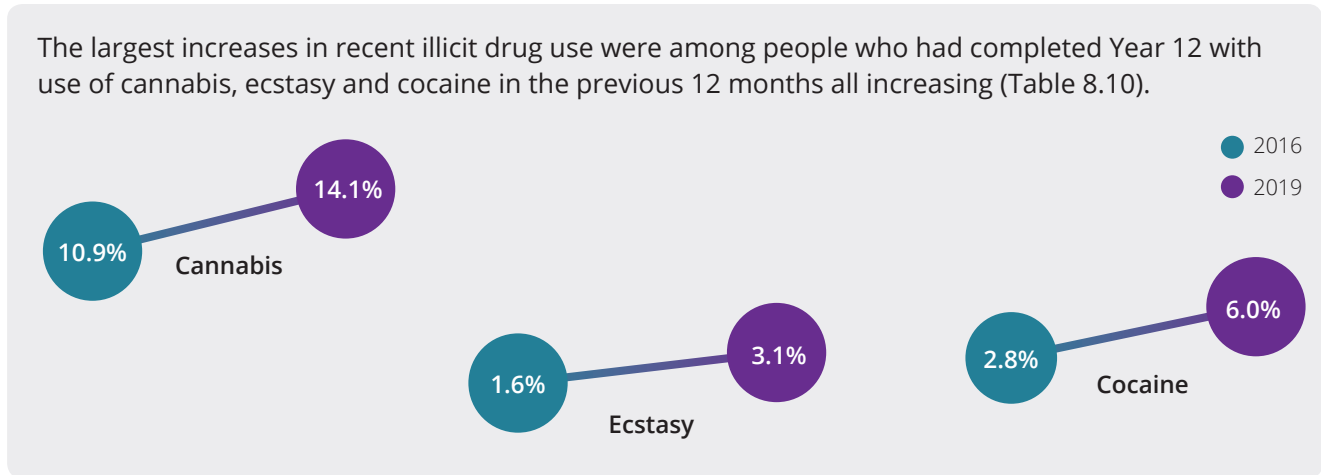
People with a diploma or bachelor degree and higher were slightly less likely to exceed the guidelines for reducing the harm due to alcohol (both lifetime risk and single occasion risk guidelines), while people with a Certificate III or IV were generally the most likely group to consume alcohol in risky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



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%).

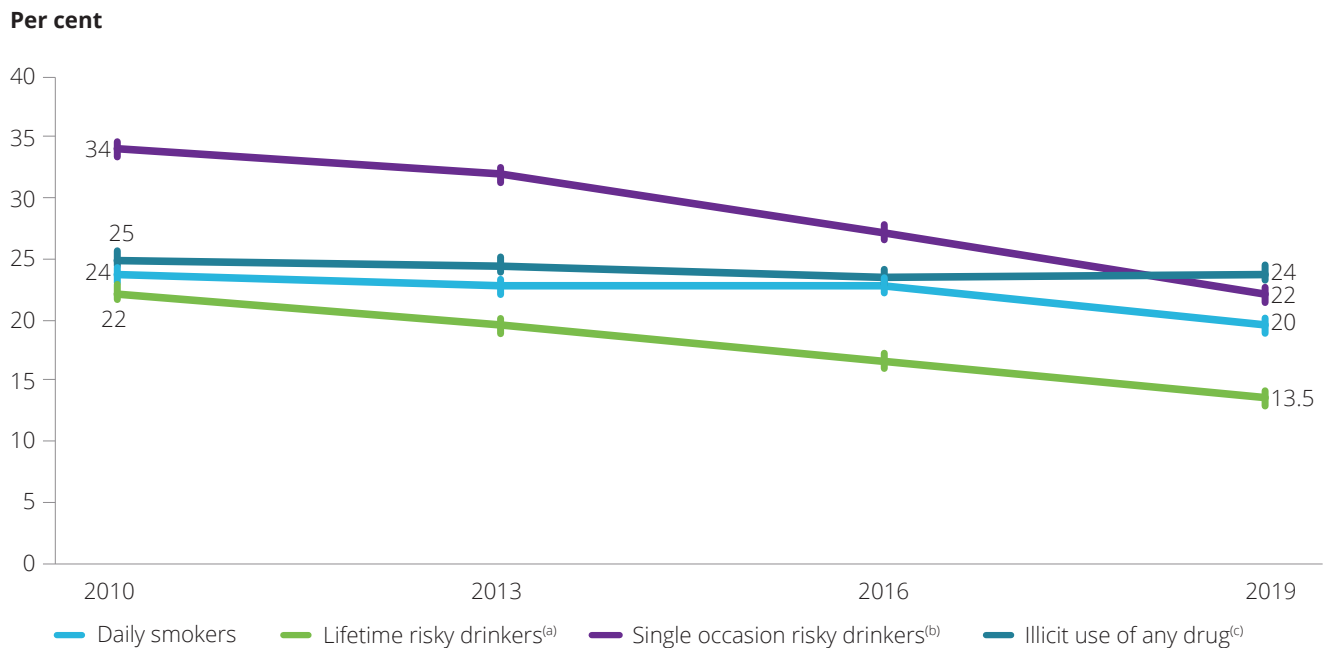
### Were there any changes in drug use by employment status?

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).

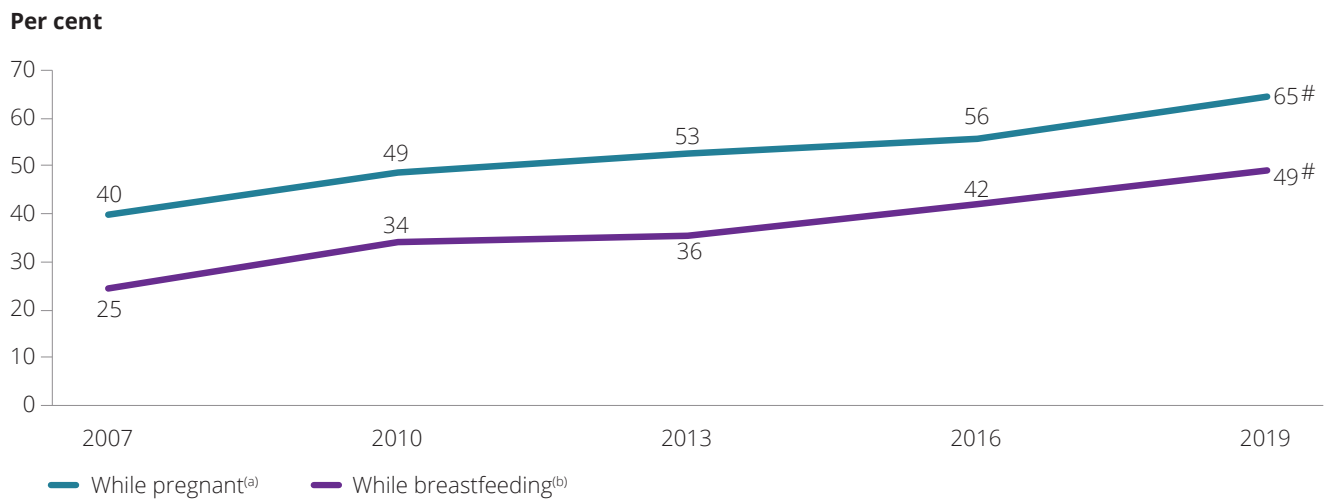
The questions on drug use during pregnancy were updated in 2013 to provide a more accurate picture of drinking during pregnancy—see Technical notes for further information and how these changes have an impact on the interpretation of these data.

### 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%)
- none of them reported that they continued to use cannabis or other illicit drugs once they found out they were pregnant—this compares with 5.4% and 1.8%, respectively, who reported consuming them before they knew they were pregnant. However, this data 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.

For references and terminology used in this chapter please see the [main report](#) or refer to the [technical information](#) for more information on the sample, the methodology, response rate and limitations of the survey results.