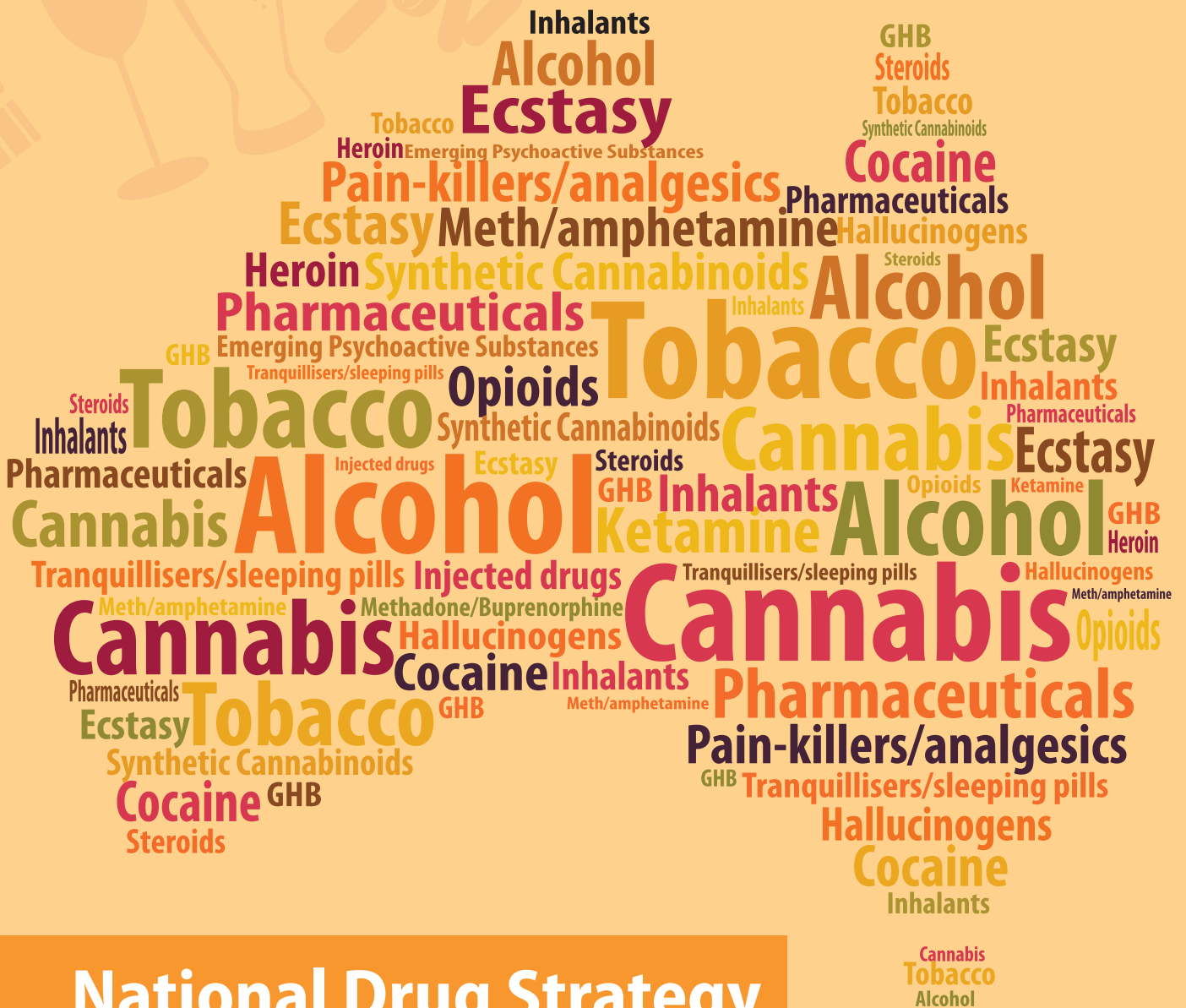




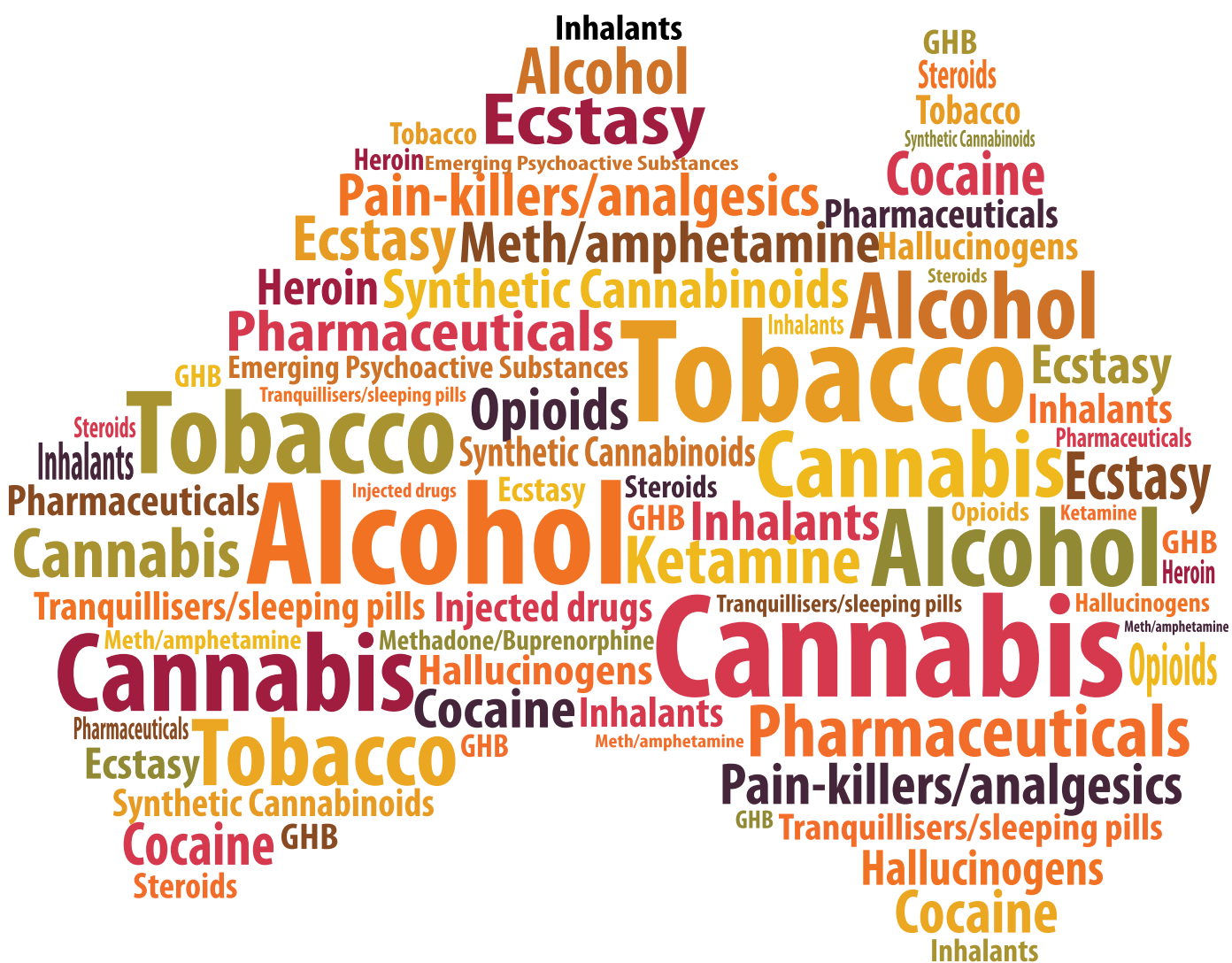
Australian Government

Australian Institute of Health and Welfare



# National Drug Strategy Household Survey detailed report


# 2013



National Drug Strategy  
Household Survey  
detailed report

2013

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## Participants

The AIHW would like to very gratefully acknowledge the 23,855 people across Australia who volunteered their time to complete the 2013 survey.

## Fieldwork

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## Questionnaire

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# Abbreviations

ABS	Australian Bureau of Statistics
ADA	Australian Data Archive
AIHW	Australian Institute of Health and Welfare
ANPHA	Australian National Preventive Health Agency
ANZSCO	Australian and New Zealand Standard Classification of Occupations
ANZSIC	Australian and New Zealand Standard Industry Classification
ASGS	Australian Statistical Geographic Standard
CATI	computer-assisted telephone interview
CCD	Census Collection District
COAG	Council of Australian Governments
CURF	confidentialised unit record file
EPS	emerging psychoactive substances
GHB	gamma hydroxybutyrate
GLBTI	Gay, lesbian, bisexual, transgender and intersex
GST	Goods and Services Tax
IGCD	Intergovernmental Committee on Drugs
K10	Kessler 10 scale
MCDS	Ministerial Council on Drug Strategy
MDPV	methylenedioxypropylone
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NCPIC	National Cannabis Prevention and Information Centre
NDS	National Drug Strategy
NDSHS	National Drug Strategy Household Survey
NHMRC	National Health and Medical Research Council
NIDAC	National Indigenous Drug and Alcohol Committee
NTS	National Tobacco Strategy
PBS	Pharmaceutical Benefits Scheme
RSE	relative standard error
SDO	serious drug offences
SE	standard error
SES	socioeconomic status
UNODC	United Nations Office on Drugs and Crime



# Symbols

- nil or rounded to zero
- .. not applicable
- n.a. not available
- n.p. not publishable because of small numbers, confidentiality or other concerns about the quality of the data
- <0.1 non-zero estimate less than 0.1%
- \* relative standard error between 25% and 50%
- \*\* relative standard error greater than 50
- # statistically significant change between 2010 and 2013

# Summary

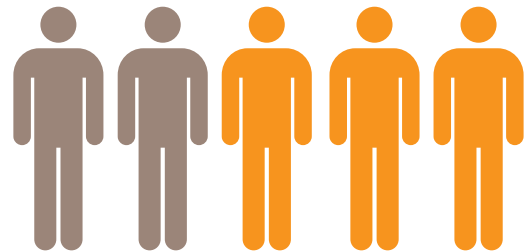
The 2013 National Drug Strategy Household Survey collected information from almost 24,000 people across Australia on their tobacco, alcohol and illicit drug use, attitudes and opinions.

In July 2014, the AIHW released key national findings from the survey which showed:

- **Smoking**—a significant decline in daily smoking between 2010 and 2013 (from 15.1% to 12.8%); younger people are delaying the take up of smoking; and smokers reduced the average number of cigarettes smoked per week.
- **Alcohol**—fewer people in Australia drank alcohol in harmful quantities in 2013; the proportion of young people abstaining from alcohol rose; and there was a decline in alcohol-related victimisation.
- **Illicit use of drugs**—declines in use of some illegal drugs in 2013, including ecstasy, heroin and GHB; while meth/amphetamine use did not increase, there was a change in the main form used with ice (or crystal methamphetamine) replacing powder; and there was a **rise in the misuse of pharmaceuticals**.

This report builds on the key findings and presents more detailed analysis including comparisons between states and territories and for other population groups.

2 in 5 people in Australia smoked tobacco, drank alcohol at risky levels or used an illicit drug



In 2013, just over 40% of Australians either smoked daily, drank alcohol in ways that put them at risk of harm or used an illicit drug in the previous 12 months; 3.1% engaged in all 3 of these behaviours.



People living in *Remote* and *Very remote* areas were twice as likely as people in *Major cities* to smoke daily, drink alcohol in risky quantities, and use meth/amphetamines in the previous 12 months

Certain groups disproportionately experience some drug-related risks. People in the lowest socioeconomic status group, the unemployed, people who live in *Remote* and *Very remote areas*, and Indigenous Australians continue to be more likely to smoke daily than other population groups. Meth/amphetamine use was highest among people in *Remote* and *Very remote areas* and those people were twice as likely to have used meth/amphetamines as people in non-remote areas. Use of illicit drugs in the last 12 months was far more common among people who identified as being homosexual or bisexual, although as a group their drug-taking behaviour did not change between 2010 and 2013.

**The drug-use patterns in states and territories generally reflect national trends**



Declines in daily tobacco smoking were statistically significant in New South Wales, Victoria and Western Australia. The proportion of daily smokers in the Northern Territory (22%) was more than double the proportion in the Australian Capital Territory (9.9%).

Patterns of risky drinking varied across jurisdictions, for example, people in the Northern Territory and Western Australia were more likely to consume alcohol in quantities that placed them at risk of an alcohol-related disease, illness or injury.

Similar to the national trend, there were no significant changes in illicit drug use for any jurisdiction.

one

# Introduction





## Background

Drug use is a serious and complex problem, which contributes to thousands of deaths, substantial illness, disease and injury, social and family disruption, workplace concerns, violence, crime and community safety issues (MCDS 2011). The use and misuse of licit and illicit drugs is widely recognised in Australia as a major health problem, and one that has wider social and economic costs. Tobacco smoking, alcohol and illicit drug use imposes a heavy financial burden on the Australian community. Collins & Lapsley (2008) estimated that the economic costs associated with licit and illicit drug use in 2004–05 amounted to \$56.1 billion, comprising \$31.5 billion due to tobacco, \$15.3 billion to alcohol and \$8.2 billion to illicit drugs. Tobacco smoking is the single most preventable cause of ill health and death, being a major risk factor for coronary heart disease, stroke, peripheral vascular disease, cancer and various other diseases and conditions. It is responsible for more drug-related hospitalisations and deaths than alcohol and illicit drugs combined (AIHW 2010).

Excessive alcohol intake is also a major risk factor for morbidity and mortality. Short episodes of heavy alcohol consumption are a major cause of road and other accidents, domestic and public violence, and crime. Long-term heavy drinking also has a major link with chronic disease, including liver disease and brain damage (MCDS 2011).

Similarly, illicit drug use is a major risk factor for ill health and death, being linked with HIV/AIDS, hepatitis C, low birthweight, malnutrition, infective endocarditis (leading to damage to the heart valves), poisoning, mental illness, suicide, self-inflicted injury and overdose (AIHW 2010).

Estimates of the burden of disease provide an insight into the loss of health and wellbeing of Australians due to premature mortality, disability and other non-fatal events. The most recent global estimates come from the Global Burden of Disease Study 2010. To enable global comparability for a large range of causes and risk factors, this study needed to use innovative methods to help overcome global data limitations in producing country-level estimates. Estimates presented here are for the Australasian region (that is Australia and New Zealand) rather than for Australia.

In 2010, it was estimated that tobacco smoking was responsible for 8.3% of the burden of disease in Australasia, 2.7% was attributable to alcohol use and a further 2.6% was attributable to the use of illicit drugs (IHME 2014).

The last national burden of disease analysis that provided estimates for the Australian and Aboriginal and Torres Strait Islander populations was published in 2007, based on 2003 data. The Australian Institute of Health and Welfare is updating these estimates using the 2010 global burden of disease method where possible, with some enhancements to better suit the Australian and Indigenous contexts, and using more recent and detailed Australian data. The revised estimates are expected to be finalised in 2015.



## The National Drug Strategy

The National Drug Strategy (NDS) 2010–2015 is the sixth iteration of a national policy for alcohol, tobacco and other drugs, which started in 1985 as the National Campaign Against Drug Abuse. The NDS is regularly updated to ensure it remains current and relevant to contemporary Australia and provides a framework for a coordinated, integrated approach to drug issues in the Australian community.

Its mission is to build safe and healthy communities by minimising alcohol, tobacco and other drug-related health, social and economic harm among individuals, families and communities. At the heart of the framework are the 3 pillars of demand reduction, supply reduction and harm reduction, which are applied together to minimise harm. Prevention is an integral theme across the pillars.

The Intergovernmental Committee on Drugs (IGCD) manages the ongoing work of the NDS and is responsible for enacting policies and programs under the framework. The IGCD is an Australian, state and territory government forum of senior officers who represent health and law enforcement agencies in each Australian jurisdiction.

## About the 2013 survey

The National Drug Strategy Household Survey (NDSHS) is the leading survey of licit and illicit drug use in Australia. The 2013 survey was the 11th conducted under the auspices of the NDS. Previous surveys were conducted in 1985, 1988, 1991, 1993, 1995, 1998, 2001, 2004, 2007 and 2010. 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 2013 survey, and the AIHW commissioned Roy Morgan Research to undertake the data collection. A Technical Advisory Group comprising experts in tobacco, alcohol and other drug data collection and research (see Appendix 1 for Technical Advisory Group members) supported the AIHW in the management of the survey.

In 2013, 23,855 people aged 12 or older provided information on their drug use patterns, attitudes and behaviours (Table 1.1). The sample was based on households, so homeless and institutionalised people were not included in the survey (consistent with the approach in previous years). Most of the analyses are based on the population aged 14 or older (unless specified), as this allows consistent comparison with earlier survey results.

See Chapter 10 'Explanatory notes' for more information on the sample, the methodology, response rate and limitations of the survey results.

**Table 1.1: National Drug Strategy Household Survey sample sizes**

Survey year	Respondents
2013	23,855
2010	26,648
2007	23,356
2004	29,445
2001	26,744
1998	10,030
1995	3,850
1993	3,500



## Report structure

This report outlines the results of the 2013 NDSHS. Some of the data presented in this report were published earlier in the year (July 2014) as part of the key findings (see <<http://www.aihw.gov.au/alcohol-and-other-drugs/ndshs>>) and these data are highlighted in the online tables.

Following this introductory chapter, an overview of the use of both licit and illicit drugs is provided (Chapter 2) which includes summary information on state and territory data and specific population groups. Chapters 3 and 4 provide information on the use of tobacco and alcohol and chapters 5 and 6 cover the use of illicit drugs and pharmaceutical misuse. Chapter 7 presents state and territory data and Chapter 8 presents data for selected population groups (for example, by remoteness area, socioeconomic status and for Indigenous people). 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.

Chapter 10 'Explanatory notes' details the survey methodology, response rates, reliability, limitations of the NDSHS and provides definitions for terminology used throughout the report. The demographic characteristics of the NDSHS sample are presented in Online tables 1.1 and 1.2 and are compared with the Australian Bureau of Statistics (ABS) 2011 Census data.

Each chapter has a set of online (excel) tables that support that chapter (see <<http://www.aihw.gov.au/publication-detail/?id=60129549469&tab=3>>). The online tables are broadly grouped into 4 categories:

- Tables that support the data shown in figures.
- Tables that are only mentioned in the text (referring to specific findings).
- Tables that are not specifically mentioned in the chapter but are similar to other tables and present additional disaggregations.
- Tables that contain age-standardised percentages (only state and territory data and most specific population groups' data).

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. All data presented in the body of the report are raw proportions and have not been age-standardised (unless indicated).

# Overview

This chapter presents a summary of alcohol, tobacco and illicit use of drugs among the Australian population. The chapter also highlights key attitudes and beliefs relating to tobacco, alcohol and other drug use.







## Use and attitudes among the general population

### Tobacco smoking

In 2013, the proportion of people aged 14 or older smoking daily declined from 15.1% to 12.8%, continuing a downward trend from 1991. The proportion of people reporting never smoking continued to rise from 58% in 2010 to 60% in 2013. Smokers also smoked fewer cigarettes per week in 2013 (96) compared to 2010 (111).

As smoking rates continued to decline, people were less likely to view tobacco as a drug that causes the most deaths (decreasing from 36% in 2010 to 32% in 2013) or thought that tobacco was of most concern to the general community (declining from 15.4% in 2010 to 14.5% in 2013).

The majority of those who had ever used unbranded tobacco no longer smoke it, with only 3.6% smoking unbranded loose tobacco at the time of the 2013 survey, declining from 6.1% in 2007.

Support for policies aimed at reducing the harm that tobacco causes remained high in 2013. In particular, there were rising levels of support for a rise in tax on tobacco products to pay for health education and to contribute to treatment costs. Smokers were the least likely to support policies aimed at reducing tobacco-related harm, particularly for measures related to increases in taxes on tobacco products, but, along with non-smokers, showed strong support for measures relating to minors.

### Alcohol use and risk

The proportion of the population aged 14 or older who consumed alcohol daily declined between 2010 (7.2%) and 2013 (6.5%). Also declining were the proportion of people exceeding lifetime risk guidelines (from 20% to 18.2%) and single occasion risk guidelines at least once a month (from 29% to 26%). The proportion abstaining from alcohol rose (from 19.9% to 22%) between 2010 and 2013.

Almost 5 million Australians aged 14 and over (26%) had been a victim of an alcohol-related incident in 2013. Most of these incidents involved verbal abuse (22%), and this proportion declined from 2010 (from 24% to 22%). While there was no change in the proportion of people suffering physical abuse between 2010 and 2013, the number of people who were physically abused rose from 1.5 million to 1.7 million.

The policy most supported to reduce alcohol harm was to establish more severe penalties for drink driving (85%), closely followed by a new measure added in 2013—stricter enforcement of the law prohibiting supply of alcohol to minors (84%). Abstainers and those drinking at low-risk levels were more likely than risky drinkers to support policies aimed at reducing alcohol-related harm.

The general population perceives excessive alcohol use as a problem. In 2013, alcohol was the most commonly mentioned drug that people thought caused the most deaths (34%) and excessive alcohol consumption was the drug of most serious concern to the general community (43%).



## Illicit use of drugs

There was no change in recent use of most illicit drugs in 2013, and use of any illicit drug remained stable between 2010 and 2013. However, there was a significant change for a few specific drugs. The proportion of people who had misused a pharmaceutical rose from 4.2% in 2010 to 4.7% in 2013, whereas there were falls in the use of ecstasy (from 3.0% to 2.5%), heroin (from 0.2% to 0.1%) and gamma hydroxybutyrate (GHB).

While there was no significant rise in meth/amphetamine use in 2013 (stable at around 2.1%), there was a change in the main form of the drug used. Among meth/amphetamine users, use of powder fell, from 51% to 29%, while the use of ice (or crystal methamphetamine) more than doubled, from 22% in 2010 to 50% in 2013.

Questions on the use of synthetic cannabis and other psychoactive substances were included in the NDSHS for the first time in 2013 and results showed that 1.2% of the population (or about 230,000 people) had used synthetic cannabinoids in the last 12 months, and 0.4% (or about 80,000 people) had used another psychoactive substance such as mephedrone. While people in their 20s are normally the most likely to use illicit drugs, it was young people aged 14–19 who were slightly more likely to use synthetic cannabinoids (2.7% compared with 2.5%).

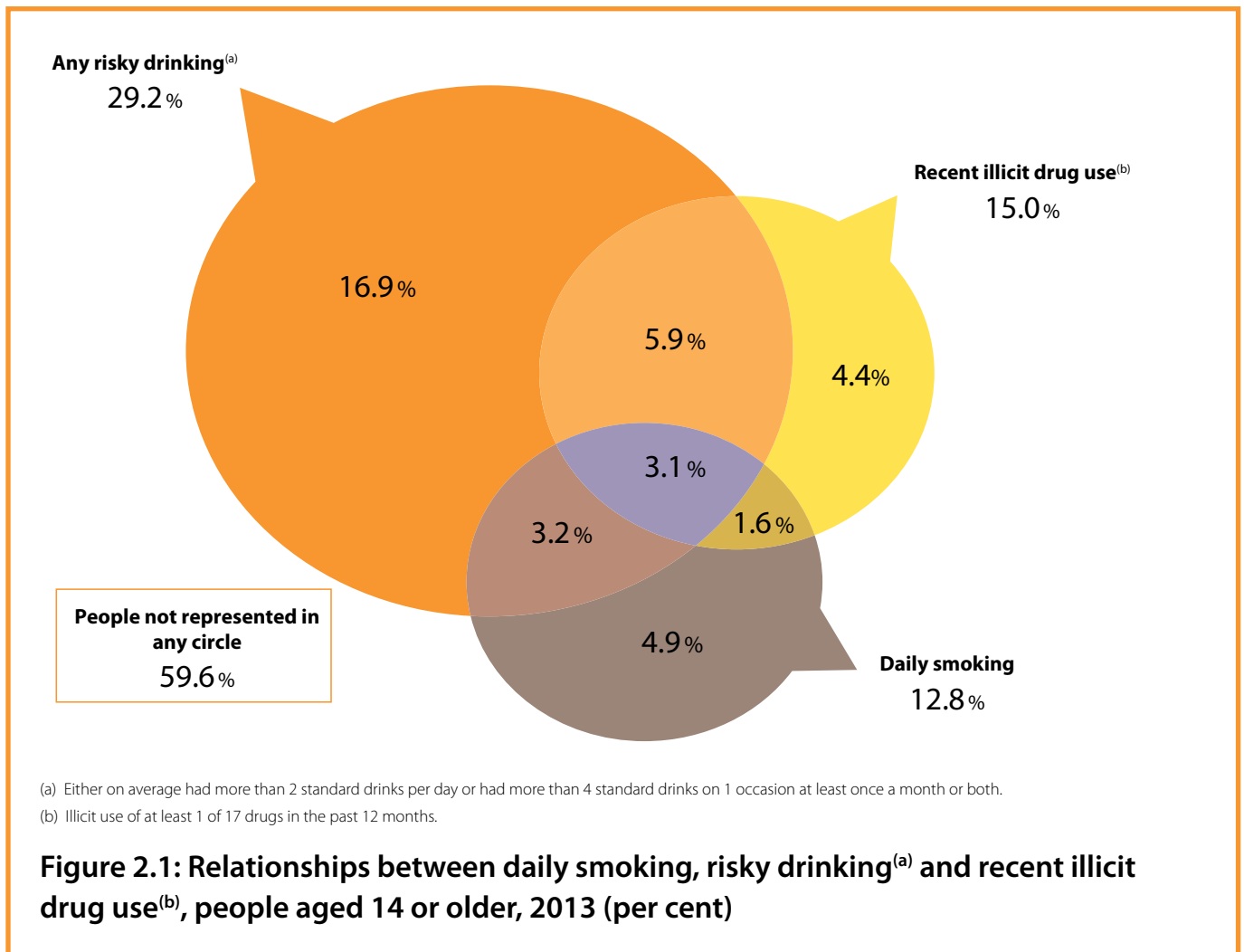
In 2013, 8.3% of the population had been a victim of an illicit drug-related incident. While this was similar to the 8.5% in 2010, the proportion experiencing physical abuse by someone under the influence of illicit drugs rose from 2.2% in 2010 to 3.1% in 2013. Verbal abuse remained the most frequently reported incident overall.

Community tolerance has increased for cannabis use, with higher proportions of people supporting legalisation and a lower proportion supporting penalties for sale and supply. People in Australia now consider meth/amphetamines to be more of a concern to the general community than any other illicit drug and the proportion who nominated it as a drug problem or as a drug that caused the most deaths also increased in 2013.



## Polydrug use

In this report polydrug use is defined as the use of more than one illicit or licit drug in the previous 12-month period. Online Table 2.2 shows the proportion of users for each type of drug who also used 1 or more additional illicit drugs in the 12 months prior to the survey (but not necessarily at the same time). In 2013, just over 40% of Australians either smoked daily, drank alcohol in ways that put them at risk of harm or used an illicit drug in the previous 12 months; 3.1% engaged in all 3 of these behaviours (Figure 2.1).



Furthermore:

- almost half (49%) of daily smokers had consumed alcohol at risky quantities, either more than 2 standard drinks a day on average or more than 4 on a single occasion at least once a month
- over one-third (37%) of daily smokers had used an illicit drug in the previous 12 months
- 60% of recent illicit drug users also drank alcohol in risky quantities and 31% smoked daily.



More specifically, among recent illicit drug users:

- cannabis was the drug most often used in addition to other illicit drugs in the previous 12 months, with proportions ranging from 30% of pharmaceuticals users to 91% of synthetic cannabinoid users
- people who misused pharmaceuticals and cannabis users were most likely to only use those substances respectively in the same 12-month period, while users of other psychoactive substances had used at least 1 other illicit drug, with quite high usage among this group—over half had used cannabis, ecstasy and meth/amphetamines.
- most synthetic cannabis users also used cannabis (91%) but a small proportion had only used synthetic cannabis and did not use any other traditional illicit drug in the previous 12 months (4.5%)
- daily smoking was more common among users of meth/amphetamines (51%) and synthetic cannabis (53%)
- among the drugs specified in Online Table 2.2, inhalants and other psychoactive substances were the drugs least likely to be used with other drugs.

## Population groups and trends

### Age and sex

Fewer young people are taking up smoking. The proportion of people aged 12–17 who have never smoked remained high at 95% in 2013, and between 2001 and 2013, the proportion of those aged 18–24 never smoking rose from 58% to 77%. People aged 18–49 were far less likely to smoke daily than they were 12 years ago, however the decline is less pronounced for older people with little change in daily smoking seen among people aged 60 or older.

Younger people are also choosing to abstain from alcohol as the proportion of those aged 12–17 abstaining increased between 2010 and 2013 (from 64% to 72%). In 2013, there were declines in the proportion of people aged under 40 drinking at risky levels between 2010 and 2013. There were no significant differences in the proportion of people aged 40 or older drinking alcohol at risky levels in 2013, and over the period from 2001, there has been little change in risky alcohol use among this group.

People aged 20–29 were more likely to have used illicit drugs, with more than a quarter (27%) reporting illicit use of drugs in the previous 12 months. People in their 50s generally have the lowest rates of illicit drug use; however, in recent years this age group has shown the largest rise in illicit use of drugs and was the only age group to show a statistically significant increase in use. For example, recent cannabis use increased significantly from 8.8% to 11.1% among people aged 50–59.

Males were far more likely than females to use all drugs (both illicit and licit), except for pain-killers/analgesics which were used by a similar proportion of males (3.3%) and females (3.2%). Females were considerably less likely than males to drink alcohol daily and in quantities that placed them at risk of harm. Females were also more likely than males to support measures aimed at reducing problems associated with drug use, and to support penalties for the sale and supply of illicit drugs.



## Social determinants and at-risk populations

Patterns of drug use differ by population characteristics depending on the drug type of interest. In general, high proportions of Aboriginal and Torres Strait Islander people smoked tobacco, drank alcohol at risky levels, used cannabis and meth/amphetamines in the last 12 months compared with non-Indigenous Australians. There were no significant changes in daily smoking or illicit use of drugs among Indigenous Australians between 2010 and 2013 but there was a decline in the proportion exceeding the lifetime risk guidelines for alcohol.

People living in *Remote* and *Very remote* areas were more likely to smoke, drink at risky levels, use cannabis and meth/amphetamines, but less likely to use illicit drugs such as cocaine and ecstasy compared with those in *Major cities*. There were no significant changes in drug use among people living in *Remote* and *Very remote* areas but, similar to the national trend, daily smoking and risky alcohol consumption declined and misuse of pharmaceuticals rose among people in *Major cities*.

Other differences in daily smoking, risky alcohol intake and use of illicit drugs were apparent for people who were unemployed, identified as homosexual/bisexual, and had high levels of psychological distress. Since 2007, the proportion of women consuming alcohol during pregnancy has declined and the proportion abstaining has increased and most pregnant women tend to change their drinking behaviour once they find out they are pregnant.

### More pregnant women abstaining from alcohol





## State and territory comparisons

The drug use patterns in states and territories generally reflect national trends. Between 2010 and 2013, daily smoking and risky alcohol consumption mostly declined, but these declines were statistically significant in only 3–4 jurisdictions. Similar to the national trend, there were no significant changes in illicit drug use for any jurisdiction.

A range of factors influence drug use prevalence including population demographics, jurisdictional legislation and policies, policing and local drug markets.

Similar to the national trend, the proportion of people in New South Wales smoking daily declined (from 15.0% to 12.2%) as did the proportion exceeding the lifetime risk and single occasion risk guidelines for alcohol consumption. There was a slight rise in the recent illicit drug use but this increase was not significant (from 13.8% to 14.2%). People in New South Wales were generally more likely to use cocaine (2.7%) and less likely to use meth/amphetamines (1.4%) than other jurisdictions.

In Victoria, the proportion smoking daily declined between 2010 and 2013 (from 15.5% to 12.2%). The proportion exceeding the lifetime risk guidelines for alcohol declined in 2013 (from 18.8% to 16.1%) and was the lowest proportion reported across all jurisdictions. Use of any illicit drug in previous 12 months remained relatively stable at about 1 in 7. Cannabis use (9.1%) was lower in Victoria than other states and territories.

Queenslanders also reduced their alcohol intake, with the proportion exceeding the lifetime risk guidelines decreasing from 24% to 20%, and the proportion exceeding the single occasion risk guidelines at least monthly decreasing from 34% to 28%. There was a slight decline in the proportion smoking daily, from 17.7% to 15.7%, which was not significant, and the proportion using illicit drugs slightly increased from 15.1% to 15.5% but again this was not significant.

The proportion consuming alcohol at risky levels remained relatively stable in Western Australia while the proportion smoking daily dropped from 16.5% to 12.5%. Illicit drug use declined from 18.6% to 17.0% but was not significant. Meth/amphetamine use was higher in Western Australia (3.8%) than any other jurisdiction.

Across the remaining jurisdictions—South Australia, Tasmania, the Australian Capital Territory and the Northern Territory—there were no significant changes in licit or illicit drug use in 2013. In South Australia, 13.6% smoked daily, 18.5% exceeded the lifetime risk guidelines for alcohol use and 15.7% used illicit drugs. In Tasmania, 16.7% smoked daily, 30% exceeded the single occasion risk guidelines for alcohol consumption and 15.1% used illicit drugs. People in the Australian Capital Territory were the least likely to smoke daily (only 9.9%), but compared to the national average, they were more likely to drink alcohol in risky quantities and exceed the lifetime risk and single occasion risk guidelines. People in the Northern Territory recorded the highest proportion smoking daily (22%), drinking alcohol in risky quantities (30% exceeded lifetime risk guidelines; and 40% exceeded single occasion risk guidelines at least monthly), and using an illicit drug in the previous 12 months (22%); this was even after adjusting for differences in the age profile.

**Table 2.1: Recent drug use, people aged 14 or older, 1993–2013 (per cent)**

Drug/Behaviour	1993	1995	1998	2001	2004	2007	2010	2013
<b>Tobacco</b>								
Current smoker <sup>(a)</sup>	29.1	27.2	24.9	23.2	20.7	19.4	18.1	15.8#
Daily smokers	25.0	23.8	21.8	19.4	17.5	16.6	15.1	12.8#
<b>Alcohol</b>								
Recent use	77.9	78.3	80.7	82.4	83.6	82.9	80.5	78.2#
Risk of lifetime harm <sup>(b)</sup>	n.a.	n.a.	n.a.	20.5	20.8	20.7	20.5	18.2#
Monthly risk of single occasion harm <sup>(c)</sup>	n.a.	n.a.	n.a.	29.2	29.5	29.2	29.0	26.4#
Monthly risk of single occasion harm and risk of lifetime harm <sup>(b)(c)</sup>	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	17.7	15.6#
<b>Illicit drugs (excluding pharmaceuticals)</b>								
Marijuana/cannabis	12.7	13.1	17.9	12.9	11.3	9.1	10.3	10.2
Ecstasy <sup>(d)</sup>	1.2	0.9	2.4	2.9	3.4	3.5	3.0	2.5#
Meth/amphetamine (speed) <sup>(e)</sup>	2.0	2.1	3.7	3.4	3.2	2.3	2.1	2.1
Cocaine	0.5	1.0	1.4	1.3	1.0	1.6	2.1	2.1
Hallucinogens	1.3	1.9	3.0	1.1	0.7	0.6	1.4	1.3
Inhalants	0.6	0.4	0.9	0.4	0.4	0.4	0.6	0.8
Heroin	0.2	0.4	0.8	0.2	0.2	0.2	0.2	0.1#
Ketamine	n.a.	n.a.	n.a.	n.a.	0.3	0.2	0.2	0.3
GHB	n.a.	n.a.	n.a.	n.a.	0.1	0.1	0.1	*<0.1
Synthetic cannabinoids	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	1.2
New and emerging psychoactive substances	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	0.4
Injected drugs	0.5	0.5	0.8	0.6	0.4	0.5	0.4	0.3#
Any illicit <sup>(f)</sup> excluding pharmaceuticals	13.7	14.2	19.0	14.2	12.6	10.9	12.0	12.0
<b>Pharmaceuticals</b>								
Pain-killers/analgesics <sup>(e)</sup>	1.7	3.4	5.2	3.1	3.1	2.5	3.0	3.3
Tranquillisers/sleeping pills <sup>(e)</sup>	0.9	0.7	3.0	1.1	1.0	1.4	1.5	1.6
Steroids <sup>(e)</sup>	0.3	0.2	0.2	0.2	—	—	0.1	*0.1
Methadone <sup>(g)</sup> or buprenorphine <sup>(h)</sup>	n.a.	n.a.	0.2	0.1	0.1	0.1	0.2	0.2
Other opiates/opioids <sup>(e)</sup>	n.a.	n.a.	n.a.	0.3	0.2	0.2	0.4	0.4
Any pharmaceutical <sup>(i)</sup>	n.a.	4.1	6.3	3.9	3.8	3.7	4.2	4.7#
<b>Any illicit<sup>(f)</sup></b>	<b>14.0</b>	<b>16.7</b>	<b>22.0</b>	<b>16.7</b>	<b>15.3</b>	<b>13.4</b>	<b>14.7</b>	<b>15.0</b>

# Statistically significant change between 2010 and 2013.

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

(a) Used in the previous 12 months. For tobacco and alcohol, recent/current use means daily, weekly and less than weekly smokers and drinkers.

(b) On average, had more than 2 standard drinks per day.

(c) Had more than 4 standard drinks on 1 occasion at least once a month.

(d) Included 'designer drugs' before 2004.

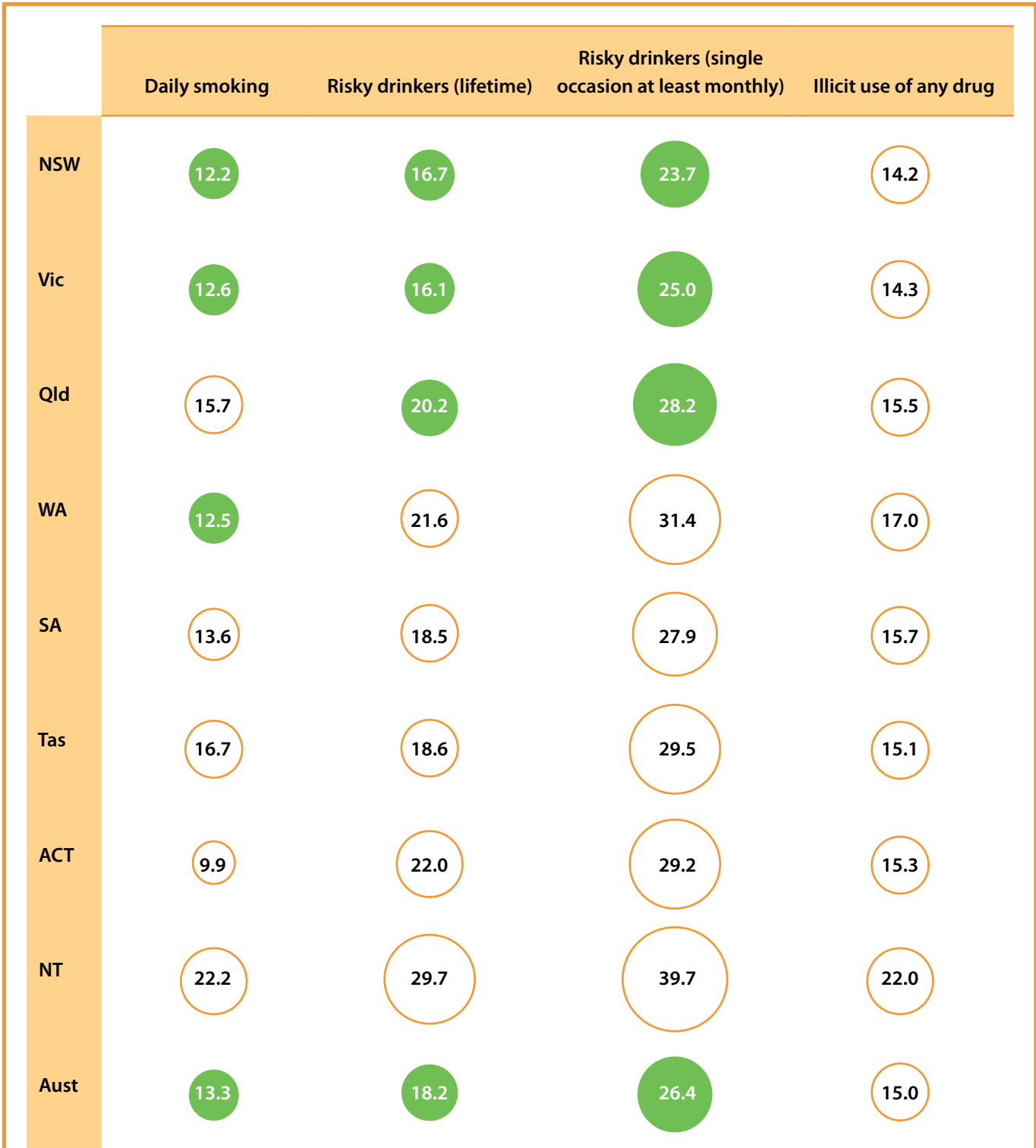
(e) For non-medical purposes.

(f) Illicit use of at least 1 of 17 illicit drugs in 2013; the number and type of drug used varied between 1995 and 2013.

(g) Non-maintenance.

(h) Did not include buprenorphine before 2007.

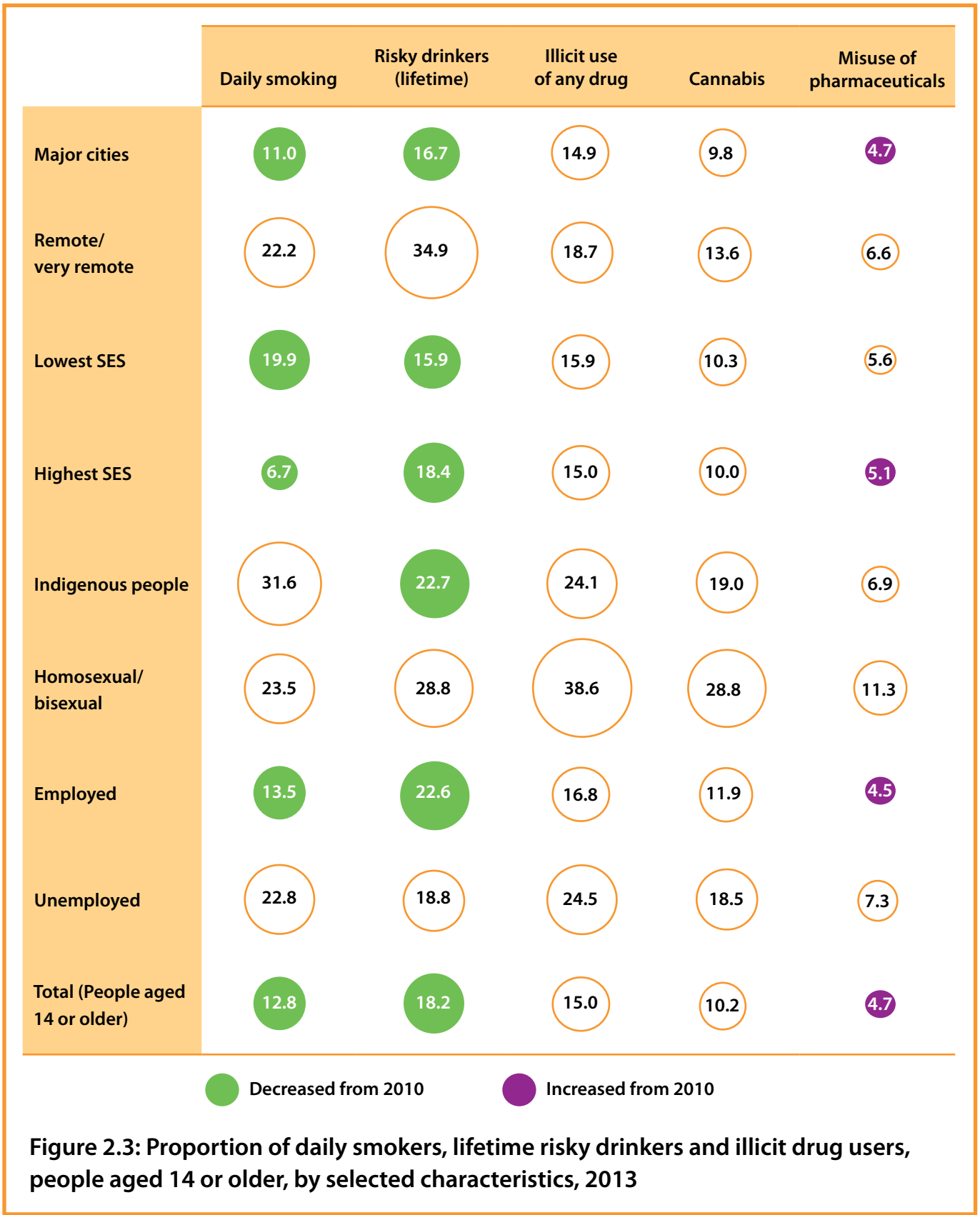
(i) Included barbiturates up until 2007; did not include methadone in 1993 and 1995; did not include other opiates from 1993 to 1998.



● Decreased from 2010      ● Increased from 2010

**Figure 2.2: Proportion of daily smokers, risky drinkers and illicit drug users, people aged 14 or older, by state and territory, 2013**





**Table 2.2: Summary of drug use patterns in Australia, persons aged 14 or older, 2013 (per cent)**

Drug	Drug of most serious concern <sup>(b)</sup>	Drug thought to cause most deaths	Ever used	Age of initiation <sup>(c)</sup>			Recent use <sup>(d)</sup>				Median age of users	Monthly or more <sup>(e)</sup>	Used with alcohol <sup>(f)</sup>
				%	%	Years	Males	Females	Persons	Trend <sup>(d)</sup>			
Tobacco	14.5	32.0	39.8	16.2	13.4	15.8	18.3	20.7	18.3	45	12.8	n.a.	
Alcohol	42.5	33.6	86.3	17.2	81.1	75.5	83.3	82.1	82.1	48	6.5	n.a.	
Marijuana/cannabis	3.8	1.0	34.8	18.5	7.6	10.2	20.8	12.3	12.3	35	45.4	81.9	
Ecstasy <sup>(g)</sup>	5.2	4.6	10.9	21.7#	3.2	1.8#	8.6	2.6#	2.6#	27	13.8	66.6	
Meth/amphetamine <sup>(g)</sup>	16.1	8.7	7.0	21.5#	2.7	1.5	5.7	3.1	3.1	31	32.1	66.5	
Cocaine	3.6	3.7	8.1	23.5	2.9	2.1	5.9	3.5	3.5	32	10.8	80.9	
Hallucinogens	n.a.	n.a.	9.4	20.0	1.9	1.3	4.4	1.1	1.1	25	8.4	n.a.	
Inhalants	n.a.	n.a.	3.8	20.3	1.1	0.8	1.9	0.7	0.7	36	29.5	n.a.	
Heroin	10.7	14.1	1.2	21.6	*0.2	0.1	n.p.	n.p.	n.p.	37	n.p.	n.a.	
Pharmaceuticals <sup>(g)</sup>	2.2 <sup>(h)</sup>	1.4 <sup>(h)</sup>	11.4#	23.9	5.1	4.4	5.8	5.3	5.3	46	32.3	32.3 <sup>(h)</sup>	

(a) Use at least once in the previous 12 months.

(b) For alcohol, respondents were asked about 'Excessive drinking of alcohol'. For inhalants, respondents were asked about 'Sniffing glue, Petrol, Solvents, Rush'.

(c) Age at which the person first used the drug.

(d) Significant difference between 2007 and 2010.

(e) Base equals recent users, percentage who used at least once a month, except for tobacco where 'at least daily' use is presented.

(f) Use at the same time on at least 1 occasion.

(g) For non-medical purposes.

(h) Only included pain-killers.





Tobacco smoking is a leading risk factor for chronic disease and death, including many types of cancer, respiratory disease and heart disease and is the major cause of cancer, accounting for about 20–30% of cancer cases (AIHW & AACR 2012). In Australia in 2004–05, about 15,000 deaths per year were attributable to smoking (Collins & Lapsley 2008).

Strategies to minimise the harm that tobacco smoking causes have been in place for a number of decades. The National Tobacco Strategy (NTS) 2012–2018 sets out a national framework to reduce tobacco-related harm in Australia, with the goal ‘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.’ (IGCD 2013). It is a policy framework for the Australian Government and state and territory governments to work together and in collaboration with non-government agencies to improve health and reduce the social and economic costs that tobacco use causes.

All data presented in this chapter is available through the online tobacco tables <<http://www.aihw.gov.au/publication-detail/?id=60129549469&tab=3>>.

Please refer to Chapter 8 ‘Specific population groups’ for information on tobacco use among: Indigenous people; pregnant women; people who identified as being homosexual/bisexual; people with mental health conditions; and state and territory results and other geographical breakdowns.

## Key findings

- Daily smoking among the general population declined between 2010 and 2013 and has almost halved since 1991 (from 24.3% in 1991 down to 12.8% in 2013).
- People in their late-20s or in their 40s were most likely to smoke daily.
- People under 50 were far less likely to smoke daily than they were 12 years ago; however, over the same period, there has been little change in the daily smoking rate among people aged 50 or older.
- The average age at which young people aged 14–24 smoked their first cigarette has steadily risen since 2001, indicating a delay in uptake of smoking.
- Smokers smoked fewer cigarettes per week in 2013 (96) compared to 2010 (111).
- Dependent children were far less likely to be exposed to tobacco smoke inside the home in 2013 (3.7%) compared to 1995 (31%).
- Only a minority of smokers currently smoke unbranded tobacco and the proportion has decreased since 2007 (from 6.1% to 3.6% in 2013).
- The majority of smokers attempted to make a change to their smoking behaviour in the last year.
- Smokers trying to quit or change their smoking behaviour tried mainly due to costs and concern for their health.
- Across all adult age groups, about 1 in 2 smokers purchased their products from supermarkets. Older people were more likely to purchase their tobacco products from a tobacconist and younger adults were more likely to purchase from a petrol station.



## Tobacco control

National, state, territory and local governments, together with national and international tobacco control organisations, are continually working on new ways to reduce the harms associated with smoking.

Australia has some of the strongest and most innovative legislation and tobacco control measures in the world. See Box 3.1 for measures at the national level and Box 3.2 for measures at the state and territory level.

### Box 3.1: National tobacco control measures

At the national level, the comprehensive set of national tobacco control measures includes:

- excise increases on tobacco
- education programs and national campaigns
- plain packaging of tobacco products
- labelling tobacco product packaging with updated and larger graphic health warnings
- prohibiting tobacco advertising, promotion and sponsorship
- providing support for smokers to quit including through subsidies for smoking cessation supports on the Pharmaceutical Benefits Scheme.

### Box 3.2: State and territory tobacco control measures

At the state and territory level, measures include:

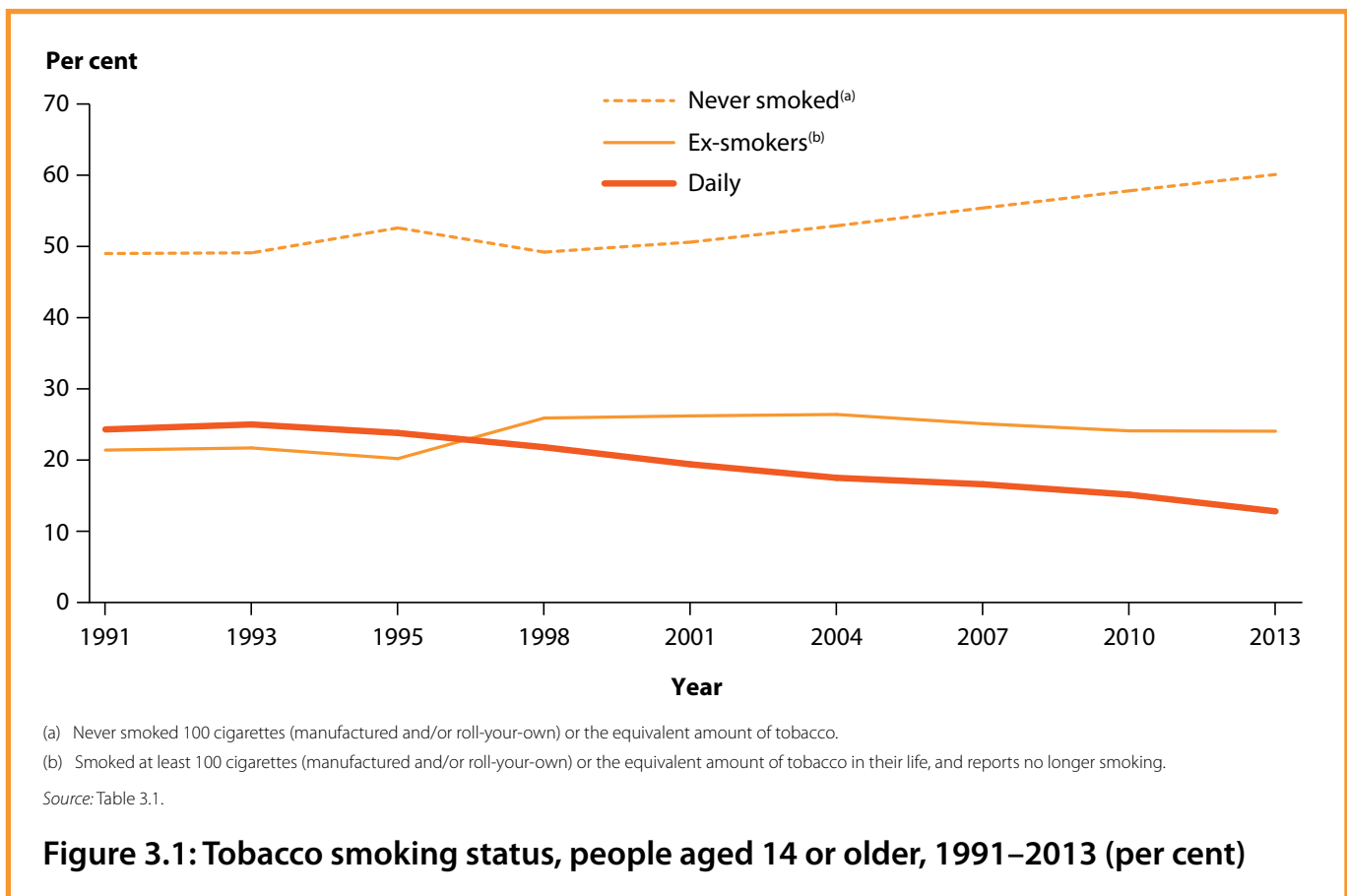
- minimum age restrictions on purchase of tobacco products
- retail display bans
- bans on smoking in offices, bars, restaurants and other indoor public spaces, and increasingly in outdoor places, particularly where children may be exposed to tobacco smoke
- the banning of smoking in a car carrying children
- extensive and continuing public education campaigns on the dangers of smoking
- support for 'Quitlines' and other smoking cessation support services to help people quit.

Further information on tobacco control and national anti-smoking campaigns is available at [www.health.gov.au/internet/main/publishing.nsf/Content/tobacco](http://www.health.gov.au/internet/main/publishing.nsf/Content/tobacco) and [www.quitnow.gov.au](http://www.quitnow.gov.au).

## Current tobacco use and trends

Tobacco smoking in Australia continues to decline. More specifically:

- in 2013, 12.8% of people in Australia aged 14 or older were daily smokers, declining from 15.1% in 2010 (Figure 3.1)
- one-quarter (24%) of the population were ex-smokers and this has remained fairly stable since 1998 when the proportion of ex-smokers first exceeded the proportion smoking daily
- since 1991, the proportion of daily smokers has almost halved, and has declined to the lowest levels seen over the 22-year period. There has also been a corresponding rise in the proportion who have never smoked from 49% in 1991 to 60% in 2013
- the number of people smoking daily in 2013 fell by approximately 200,000 people (2.7 million in 2010 down to 2.5 million in 2013).



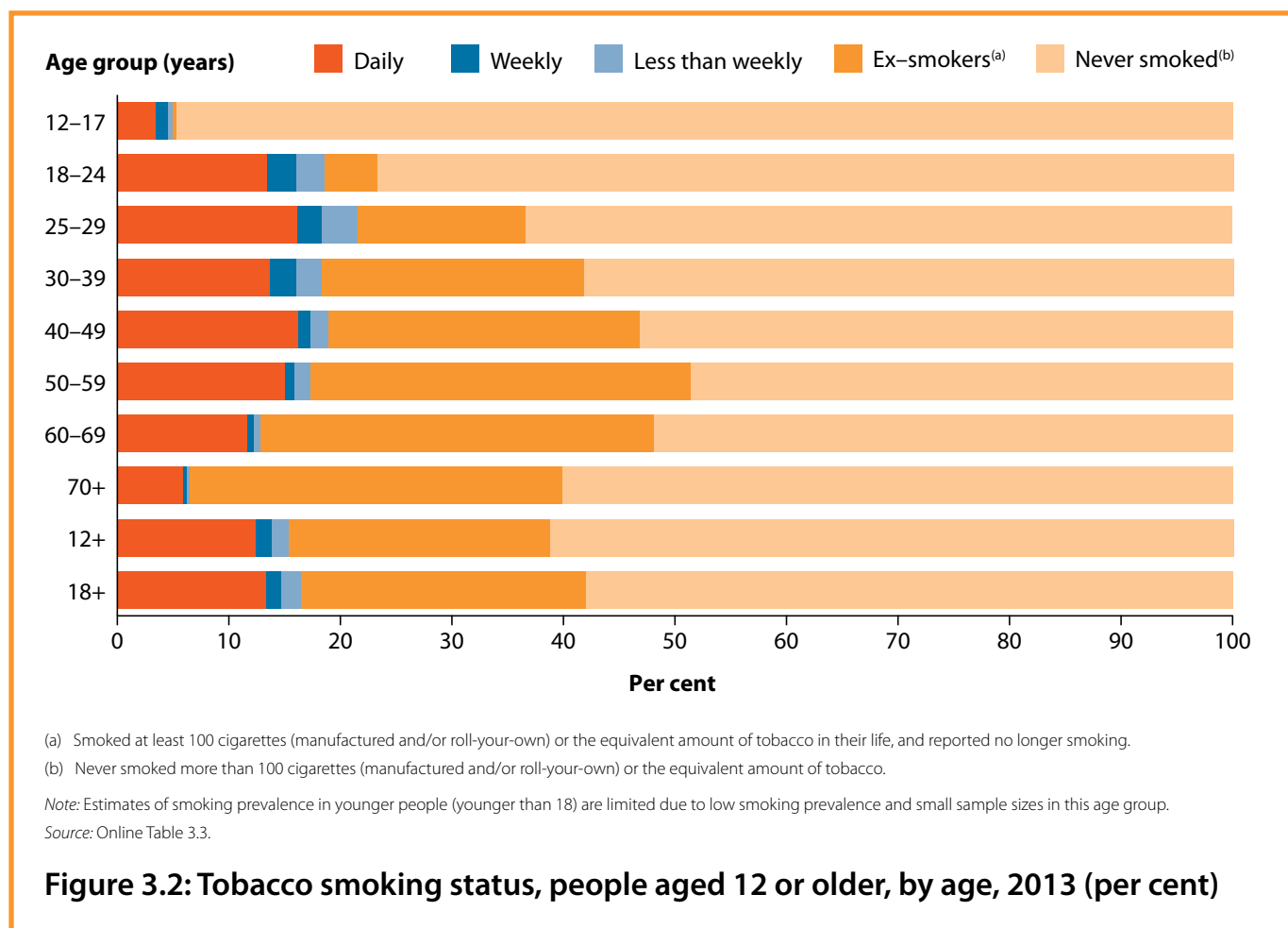


## Tobacco smoking by age and sex

The proportion of both males and females aged 14 or older who smoked daily declined between 2010 and 2013 (Online Table 3.2). As in previous years, females were less likely than males to have smoked, at any frequency, and were more likely to have never taken up smoking.

Figure 3.2 shows that in 2013:

- far fewer young people were smokers compared with older age groups
- only 3.4% of teenagers (aged 12–17) smoked tobacco daily; 95% had never smoked more than 100 cigarettes
- the proportion smoking daily was highest among people aged 25–29 and 40–49 at 16.1% and 16.2% respectively
- among males, those aged 40–49 were the most likely to smoke daily (17.9%); for females, those aged 25–29 were the most likely to smoke daily (15.0%; see Online Table 3.3)
- the proportion of ex-smokers was highest among males aged 70 or older (47%)
- females were more likely than males to have never taken up smoking, although the proportion of females aged 40–49 who had never smoked was similar to the proportion of males (54% and 53% respectively).

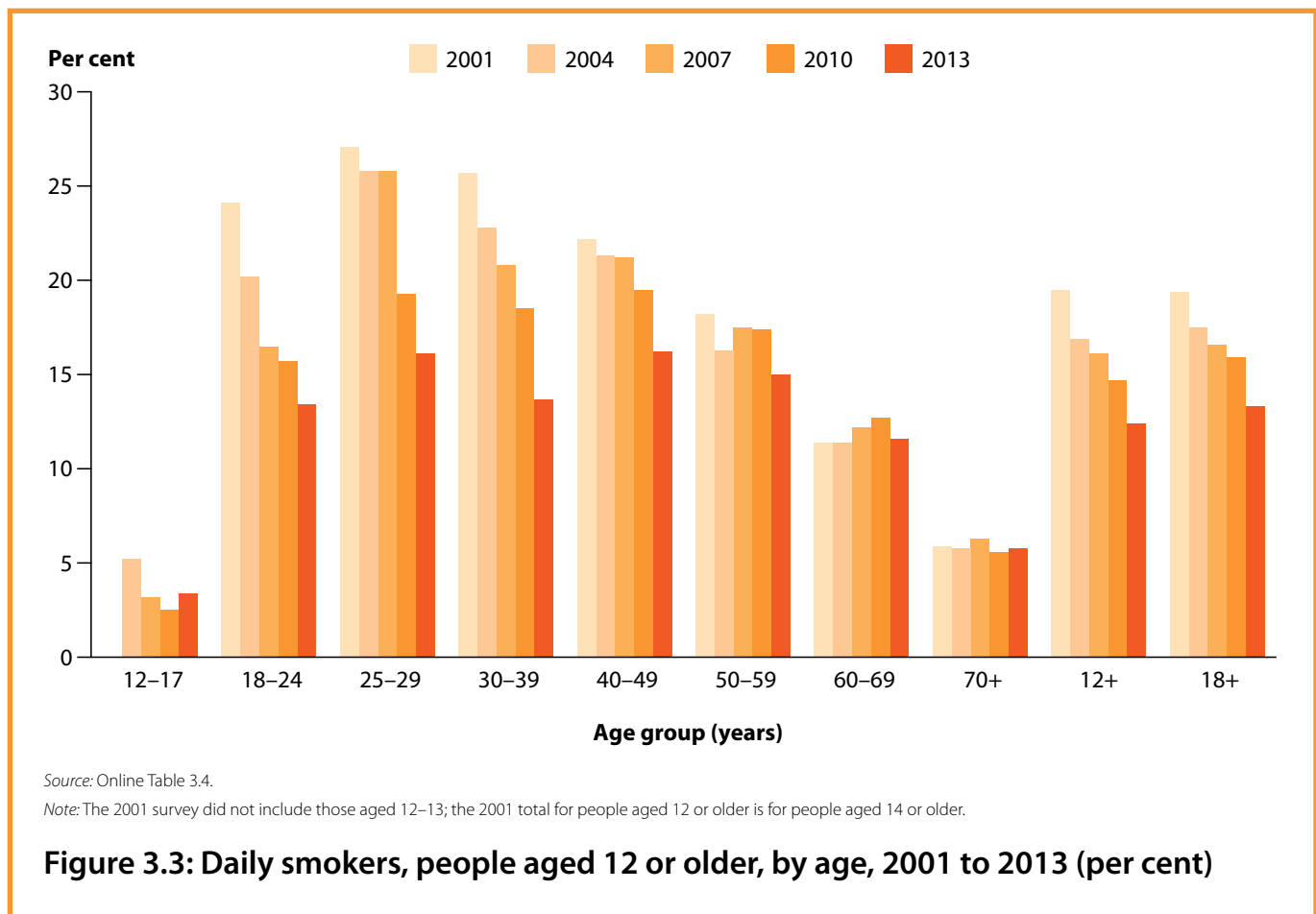


## Age comparisons over time

While there has been a steady decline in daily smoking over the past 12 years, there is a large variation in the decline by age. People aged 18–49 were far less likely to smoke daily than they were 12 years ago; however, the decline is less pronounced for older people with little change in daily smoking seen among people aged 60 or older. Figure 3.3 shows that:

- the proportion of daily smokers aged 25–59 declined between 2010 and 2013
- between 2010 and 2013, there appeared to be a slight rise in the proportion of people aged 12–17 and people aged 70 or older smoking daily, however this increase in daily smoking was not statistically significant and the trend for those aged 12–17 should be interpreted with caution
- across all age groups, the proportion of ex-smokers remained stable, except for people aged 50–59 among whom there was a significant increase between 2010 and 2013 (from 31% to 34%; see Online Table 3.4). This increase corresponds with the fall in daily smokers for this age group.

A range of factors continue to drive the decline in daily smoking including an ageing cohort of older daily smokers, a rise in younger people never taking up smoking and declines in the proportion of young people smoking daily.







## Age first smoked

Most people first try smoking tobacco during adolescence. As people who begin smoking early are more likely to continue smoking, tobacco use among young people is a key predictor of adult smoking (Tyas & Pederson 1998). One of the objectives of the *National Drug Strategy 2010–2015* is to prevent the uptake and delay the onset of drug use, including tobacco (MCDS 2011).

Results from the survey show that the average age at which young people aged 14–24 smoked their first full cigarette has steadily risen since 1995 from 14.2 to 15.9 in 2013 (Online Table 3.5), indicating a delay in uptake of smoking.

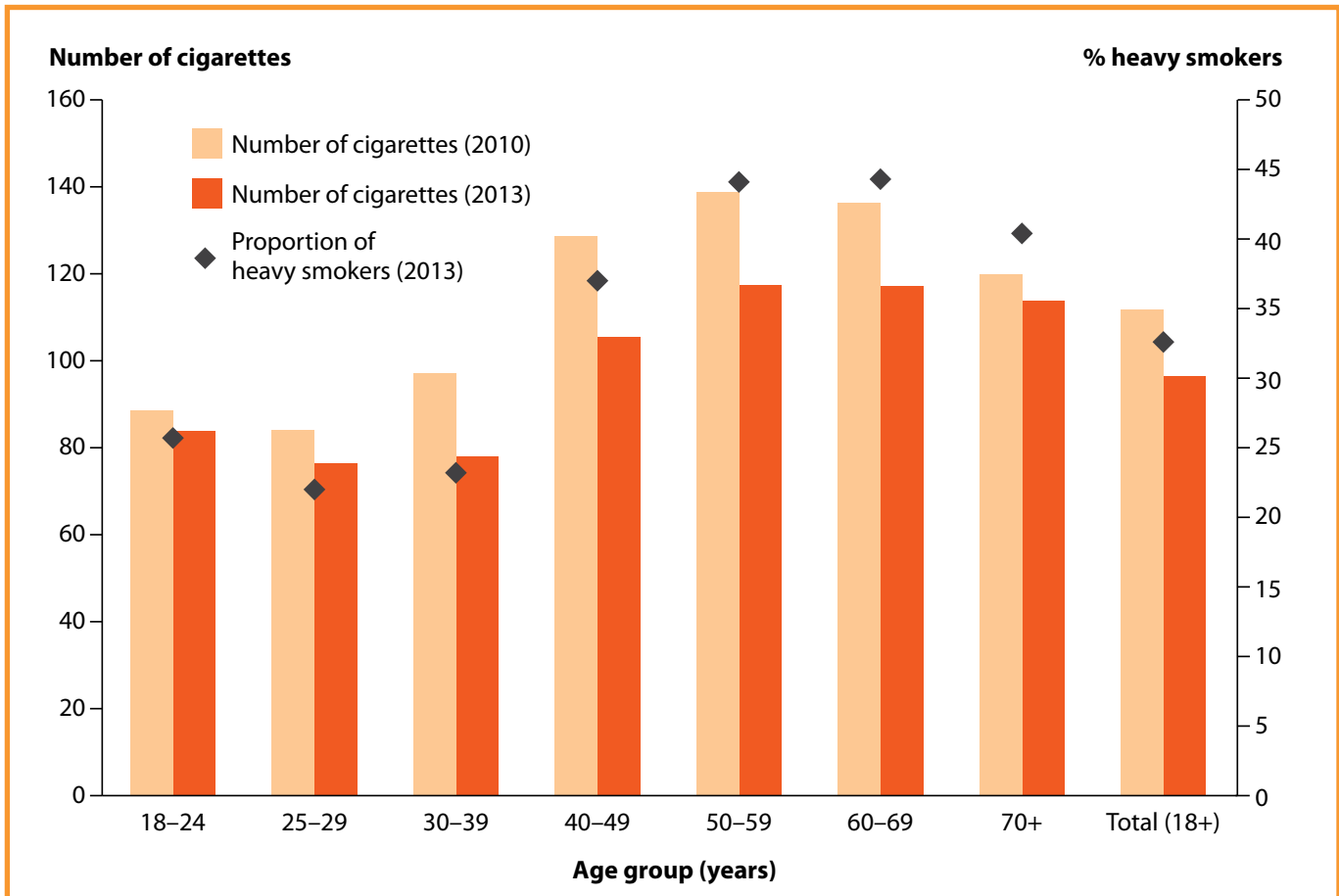
## Number of cigarettes smoked

Progress towards quitting smoking often involves reducing the number of cigarettes smoked each day. Similarly, the costs of cigarettes may also cause smokers to reduce their use. In 2013:

- the average number of cigarettes smoked per week declined from 111 in 2010 to 96 cigarettes in 2013 (Figure 3.4)
- the decrease in cigarettes smoked per week was significant for people aged 30–69
- the largest fall was seen among people aged 40–49 who, on average, smoked 23 fewer cigarettes per week.

There was variation in the number of cigarettes smoked per week between age groups. Smokers aged 50–69 remained the most likely to smoke the largest number of cigarettes per week (about 120), 60% higher than those in their 20s (about 75).

A heavy smoker is considered to be someone who smokes 20 or more cigarettes per day. In 2013, 3 in 10 (33%) smokers were considered heavy smokers and heavy smoking was highest among people aged 50–69 with more than 4 in 10 (44%) smoking 20 or more cigarettes per day (Figure 3.4).



Source: Online tables 3.7 and 3.8.

**Figure 3.4: Average number of cigarettes smoked per week, by age, 2010 and 2013**

## Product types

Tobacco smokers choose to smoke a variety of tobacco products including cigarettes, cigars and cigarillos. In 2013:

- the vast majority of smokers aged 14 or older (89%) smoked manufactured cigarettes and 1 in 3 (33%) smoked roll-your-own (Online Table 3.9)
- about 1 in 10 had smoked cigarillos (10.4%) and cigars (8.1%) (Online Table 3.9).

The 2013 survey was the first time that respondents were asked about their use of battery operated electronic cigarettes, also known as e-cigarettes, e-cigs or electronic nicotine delivery systems. Electronic cigarettes are devices for creating aerosols which contain nicotine and/or flavouring agents, the aerosol then being inhaled. The visual, physio-sensory and behavioural aspects of electronic cigarettes simulate the act of tobacco smoking.



In 2013:

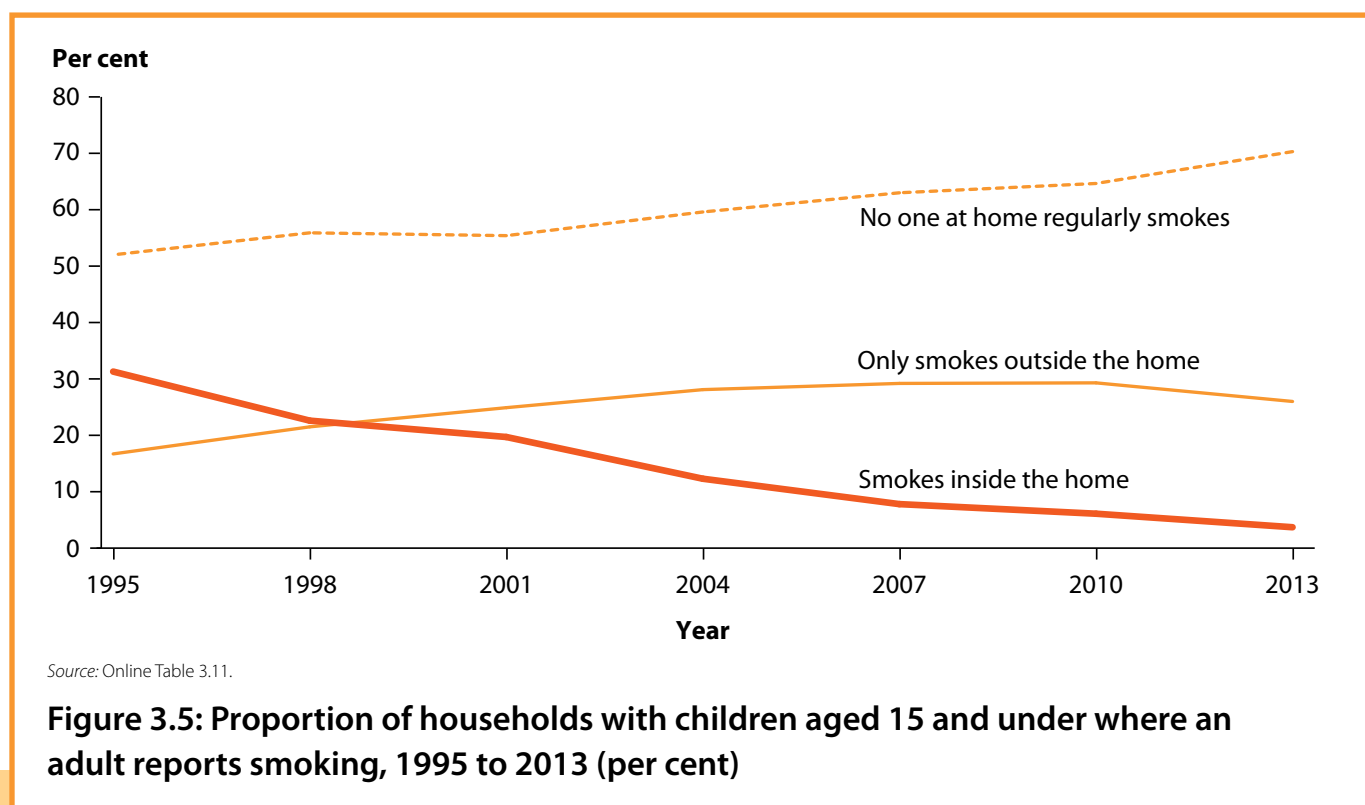
- 1 in 7 (14.8%) smokers aged 14 or older had used battery-operated electronic cigarettes in the last 12 months (Online Table 3.10)
- younger smokers were more likely to have used an e-cigarette in the last 12 months than older smokers (27% for smokers aged 18–24 compared with 7.2% for those aged 60–69)
- male smokers aged 14 or older were generally more likely than females to use e-cigarettes except among those aged 50–59 where 13.5% of female smokers had used this product compared with 6.7% of male smokers.

## Exposure to second-hand smoke

The effects of passive smoking are a focus of concern, particularly for children who may be exposed to tobacco smoke. Such exposure increases the risk of a range of health problems in children, including chest infections, ear infections, asthma and sudden infant death syndrome (Dunn et al. 2008).

Results from the survey show that parents and guardians are choosing to reduce their children’s exposure to smoke at home. More specifically:

- between 1995 and 2013, the proportion of households with dependent children where someone smoked inside the home fell from 31% to just 3.7% (Figure 3.5).
- fewer people were smoking regularly at home which reflects the continuing decline in the prevalence of smoking, and for the first time, there was also a drop in the proportion of people smoking outside the home (from 29% in 2010 to 26% in 2013).

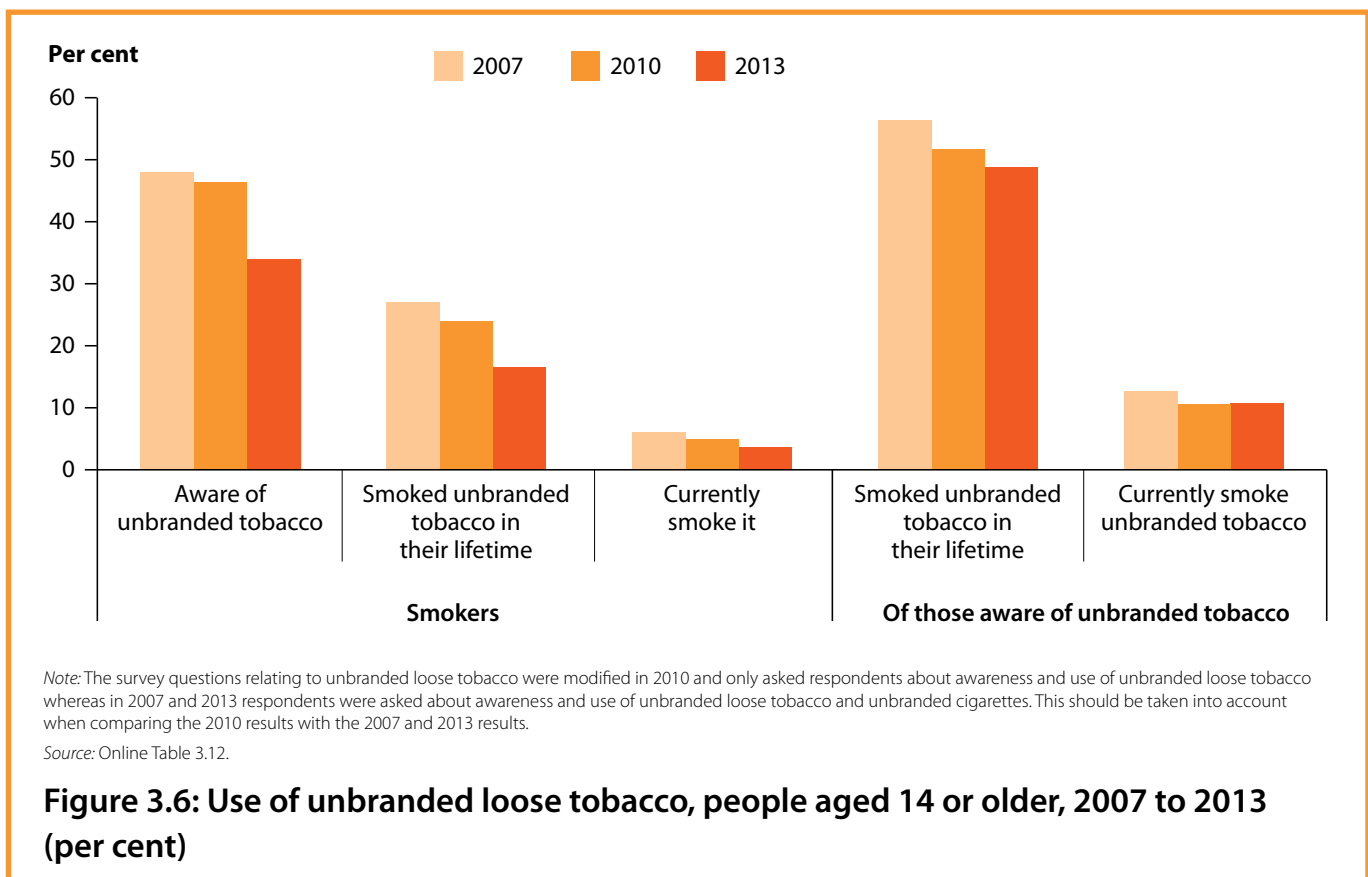


## Illicit tobacco

Illicit tobacco includes both unbranded tobacco and branded tobacco products on which no excise, customs duty or Goods and Services Tax (GST) was paid.

### Unbranded illicit tobacco

Unbranded tobacco (commonly known as chop-chop) is finely cut, unprocessed loose tobacco that has been grown, distributed and sold without government intervention or taxation (ANAO 2002). The proportion of smokers aged 14 or older who were aware of unbranded tobacco declined between 2007 and 2013, from 48% to 34%, and the proportion who have smoked unbranded tobacco in their lifetime also fell from 27% to 16.5% in 2013 (Figure 3.6). The majority of the lifetime users of unbranded tobacco no longer smoke it with only 3.6% smoking unbranded loose tobacco at the time of the 2013 survey, declining from 6.1% in 2007. As a proportion of those aware of unbranded tobacco, there was no change in current use with 10.7% currently smoking unbranded tobacco, compared with 10.6% in 2010 and 12.7% in 2007.





## Illicit branded tobacco

Illicit branded tobacco is commonly defined as tobacco products (mostly cigarettes) that are smuggled into Australia without payment of the applicable customs duty. It should be noted that it may be easier for consumers to report whether they smoke 'unbranded' tobacco (refer previous section), but they may not necessarily know whether the branded tobacco that they have seen or purchased is actually illicit (Scollo et al. 2014).

In relation to illicit branded tobacco, the 2013 survey asked whether, in the last 3 months, respondents had seen or purchased any packs of cigarettes or tobacco without plain brown packaging and graphic health warnings. While not being definitive characteristics of illicit tobacco, the absence of the required Australian health warnings on the tobacco product packaging, and packaging that does not comply with Australia's plain packaging legislation, could be an indication that the product is illicit.

Findings from 2013 showed that:

- fewer than 1 in 5 (18.5%) smokers have seen tobacco products without plain packaging in the last 3 months (Online Table 3.13)
- of those who had seen these products only half (1 in 10 overall) had purchased these products and just under half again (1 in 20 overall) bought 15 or more packets.

## Where people buy cigarettes and tobacco products

The vast majority of adult smokers (18 and over) bought cigarettes at shops/retailers (Online Table 3.18). As there are legal restrictions on the sale of tobacco products to minors, those aged 12–17 were far less likely to regularly buy cigarettes at shops, and more likely to obtain them from a friend, acquaintance or relative. The majority of adult smokers purchased their tobacco products from major supermarkets (52%), followed by other retail outlets (such as the local convenience store or petrol station) and tobacconists (21% and 18% respectively).

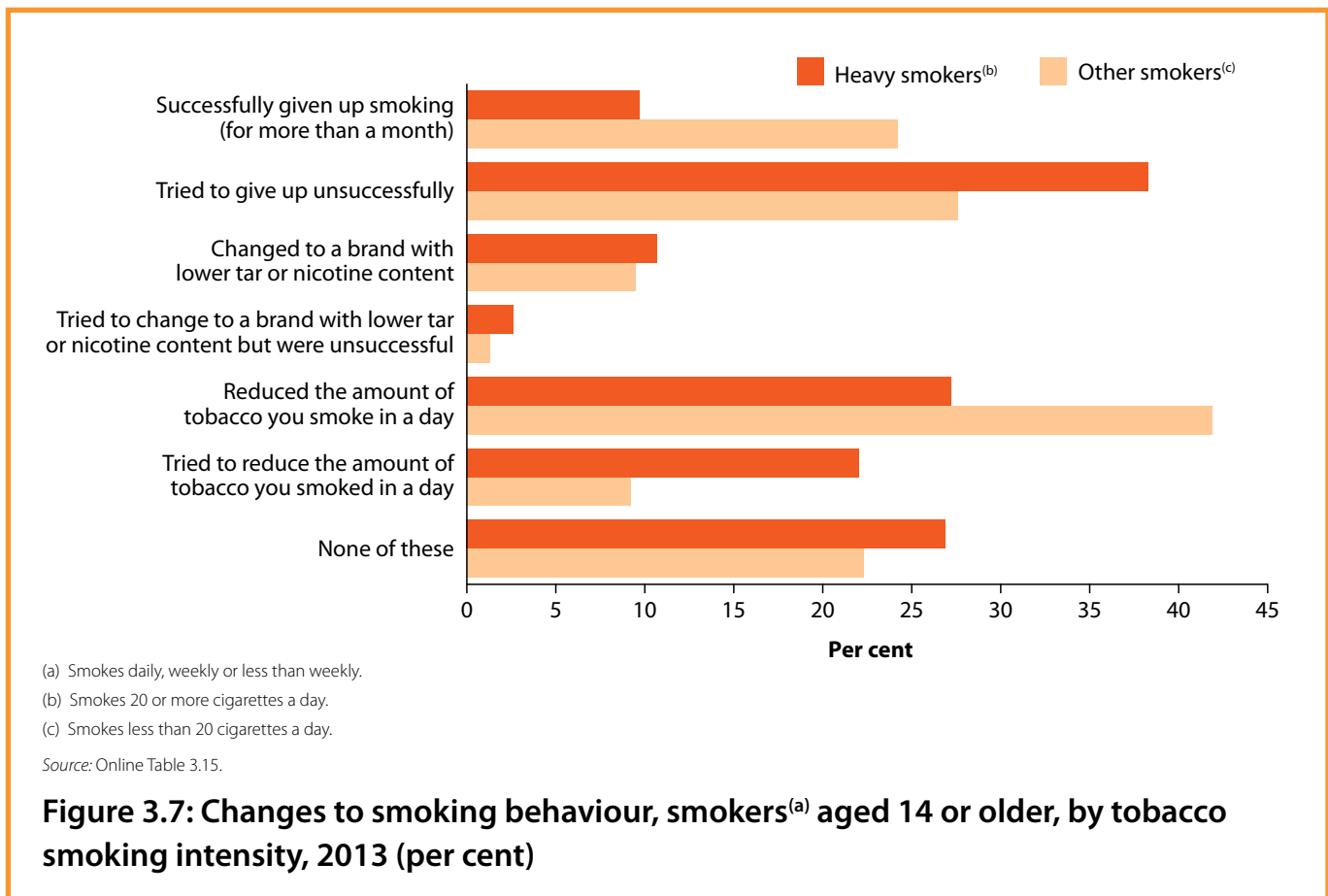
- Across all adult age groups, smokers were most likely to purchase their tobacco product from a major supermarket chain (about 1 in 2).
- Older people (aged 60 or older) were more likely to purchase tobacco from a tobacconist (than younger people), and younger adults were more likely to purchase from a petrol station.

## Changes to smoking behaviour

A wide variety of factors can influence a decision to change or reduce tobacco smoking including legislative, educational and economic factors. In 2013, more than 1 in 3 smokers reduced the amount of tobacco they smoked in a day and 1 in 5 had successfully given up for at least a month before the survey. Other 2013 findings show:

- 3 in 10 smokers tried to quit but did not succeed (Online Table 3.14)
- 1 in 4 did not attempt to make any changes to their smoking behaviour in the previous 12 months.

Smokers who smoked fewer than 20 cigarettes per day were more likely to succeed at making changes to their smoking behaviour while heavy smokers were more likely to attempt changes without success (Figure 3.7).





## Motivators for change to behaviour

When looking at broad reasons for changes to smoking behaviour, the main reasons smokers attempted to quit or change their smoking behaviour in 2013 were because smoking was costing too much money or it was affecting people's health (Online Table 3.16). More smokers nominated cost as a factor in 2013 (47% compared with 36% in 2007) and this is now the reason most frequently reported. When looking at more specific reasons, the most common motivations for trying to quit smoking in 2013 were similar to 2010, except for:

- 'wanting to get fit'—a higher proportion nominated this as a reason for changing their smoking behaviour in 2013 (from 25% in 2010 to 34% in 2013)
- 'health warnings on tobacco packets'—proportion nominating this reason declined from 15.2% in 2010 to 11.1% in 2013)
- smoking restrictions in 'public areas' and 'workplaces'—the proportion nominating these reasons fell between 2010 and 2013 (from 11.2% to 8.0% and 7.0% to 4.4% respectively)

Most smokers were motivated to change their behaviour for health reasons (Online Table 3.16); however, the type of health reason varied by age with younger people being more motivated by fitness, and older people more likely to be influenced by advice from their doctor (Online Table 3.17).

**Cost and concern for health were the main reasons smokers tried to quit or cut down**



# four

## Alcohol use in the general population

In this chapter, information is presented on: changes to alcohol use over time; age and sex comparisons; type of alcohol consumed; measures undertaken to reduce consumption; and the health and harms associated with alcohol use.







Alcohol is consumed widely in Australia. However, harmful levels of consumption are a major health issue, associated with increased risk of chronic disease, injury and premature death (AIHW 2014).

The harmful use of alcohol has both short-term and long-term health effects. In the short term, the effects are mainly related to injury of the drinker or others that the drinker's behaviour affected (Laslett, Room & Ferris 2011). With its ability to impair judgment and coordination, excessive drinking contributes to crime, violence, anti-social behaviours and accidents. Over the longer term, harmful drinking may result in alcohol dependence and other chronic conditions, such as high blood pressure, cardiovascular diseases, cirrhosis of the liver, types of dementia, mental health problems and various cancers (AIHW 2014).

In 2004–05, the cost to the Australian community of alcohol-related social problems such as crime, road accidents or lost workplace productivity, was estimated to be \$15.3 billion (Collins & Lapsley 2008). In 2010, alcohol use was estimated to be responsible for 2.7% of the total burden of disease and injury in Australasia (IHME 2014).

The Ministerial Council on Drug Strategy recommended a number of strategies to reduce alcohol harms: demand reduction strategies to prevent the uptake of excessive alcohol consumption; supply reduction strategies to control and manage the supply of alcohol; and harm reduction strategies to reduce alcohol-related harm for individuals, families and communities (MCDS 2011).

Results presented about the risks associated with alcohol intake are based on the *2009 Australian guidelines to reduce health risks from drinking alcohol* and are reported against Guideline 1 (lifetime risk) and Guideline 2 (single occasion risk). See Box 4.1 for more details.

Please refer to Chapter 8 'Specific population groups' for information on alcohol use among: Indigenous people; pregnant women; people who identified as being homosexual/bisexual; people with mental health conditions; and geographical breakdowns.

All data presented in this chapter are available through the online alcohol tables <<http://www.aihw.gov.au/publication-detail/?id=60129549469&tab=3>>.



## Key findings

### Current use and trends

- In 2013, about four-fifths of Australians aged 14 or older reported they had consumed alcohol in the past year and 6.5% drank on a daily basis.
- A lower proportion of Australians aged 14 or older consumed alcohol in risky quantities in 2013 compared to 2010— the proportion of lifetime risky drinkers and single occasion risky drinkers declined.
- Almost 1 in 5 (18.2%) people aged 14 or older consumed more than 2 standard drinks per day on average, exceeding the lifetime risk guidelines.
- More than 1 in 3 (38%) people aged 14 or older reported they had, on at least 1 occasion in the previous 12 months, consumed alcohol at a level placing them at risk of injury and 1 in 4 had done so as often as monthly (26%).
- In 2013, around 1 in 6 (15.6%) people aged 12 or older had consumed 11 or more standard drinks on a single drinking occasion in the past 12 months, a lower proportion than 2010 (16.8%).
- About half (49%) of drinkers took action to reduce their alcohol intake in 2013 and the main reason for doing this was due to concern for their health.

### Age comparisons

- The proportion of people aged 14 or older choosing to abstain from alcohol rose between 2010 and 2013 (from 19.9% to 22%) and this was influenced by an increase in young people aged 12–17 abstaining (increasing from 64% to 71%).
- Compared to 2010, adults under 40 were less likely to drink 5 or more standard drinks on a single occasion at least once a month in 2013.
- Adults aged 18–24 were more likely to drink at harmful levels on a single occasion than the rest of the adult population and males were more likely to drink at harmful levels than females.
- In contrast to single occasion risky drinking, daily drinking was higher among older Australians than younger Australians.
- Younger people are continuing to delay starting drinking with the average age among those aged 14–24 trying alcohol for the first time increasing from 14.4 in 1998 to 15.7 in 2013.

### Harms

- About 1 in 5 recent drinkers aged 14 or older put themselves or others at risk of harm while under the influence of alcohol in the previous 12 months with driving a vehicle the most common activity undertaken (12.2% of recent drinkers).
- Almost 5 million Australians aged 14 or older (26%) had been a victim of an alcohol-related incident in 2013 with most of these incidents involving verbal abuse (22%); however, this proportion declined from 2010 (from 24% to 22%). A further 8.7% involved physical abuse and this remained relatively stable between 2010 (8.1%) and 2013.



## Alcohol strategies and legislation

Australian governments use a range of measures to minimise alcohol-related harm in the community, including legislation such as placing restrictions on the times and places that alcohol can be purchased, taxation on alcoholic products, regulating promotion and advertising, providing education and information, and supporting treatment programs (ANPHA 2014).

Alcohol-related harm to people of any age remains an issue of ongoing concern for the Australian community and a challenging area for public policy response by Australian governments at all levels. Governments have adopted a number of initiatives and strategies aimed at minimising the harmful effects of alcohol use in Australian society.

In Australia, the National Health and Medical Research Council (NHMRC) produces guidelines about alcohol use. The most recent version of these guidelines, *Australian guidelines to reduce health risks from drinking alcohol*, was released in 2009. These guidelines help Australians make an informed choice in reducing their health risks arising from drinking alcohol.

Strategies to minimise alcohol-related harm have been in place for a number of decades. Strategies and activities have focused on a variety of issues including intoxication, public safety and amenity, the health impacts of drinking and the availability of alcohol.

To complement the national policy framework, all states and territories have developed strategies and plans to address alcohol issues in their own jurisdictions. Recently, some state and territory governments have introduced initiatives aimed at reducing alcohol-related harm such as lock-outs and last drink laws.

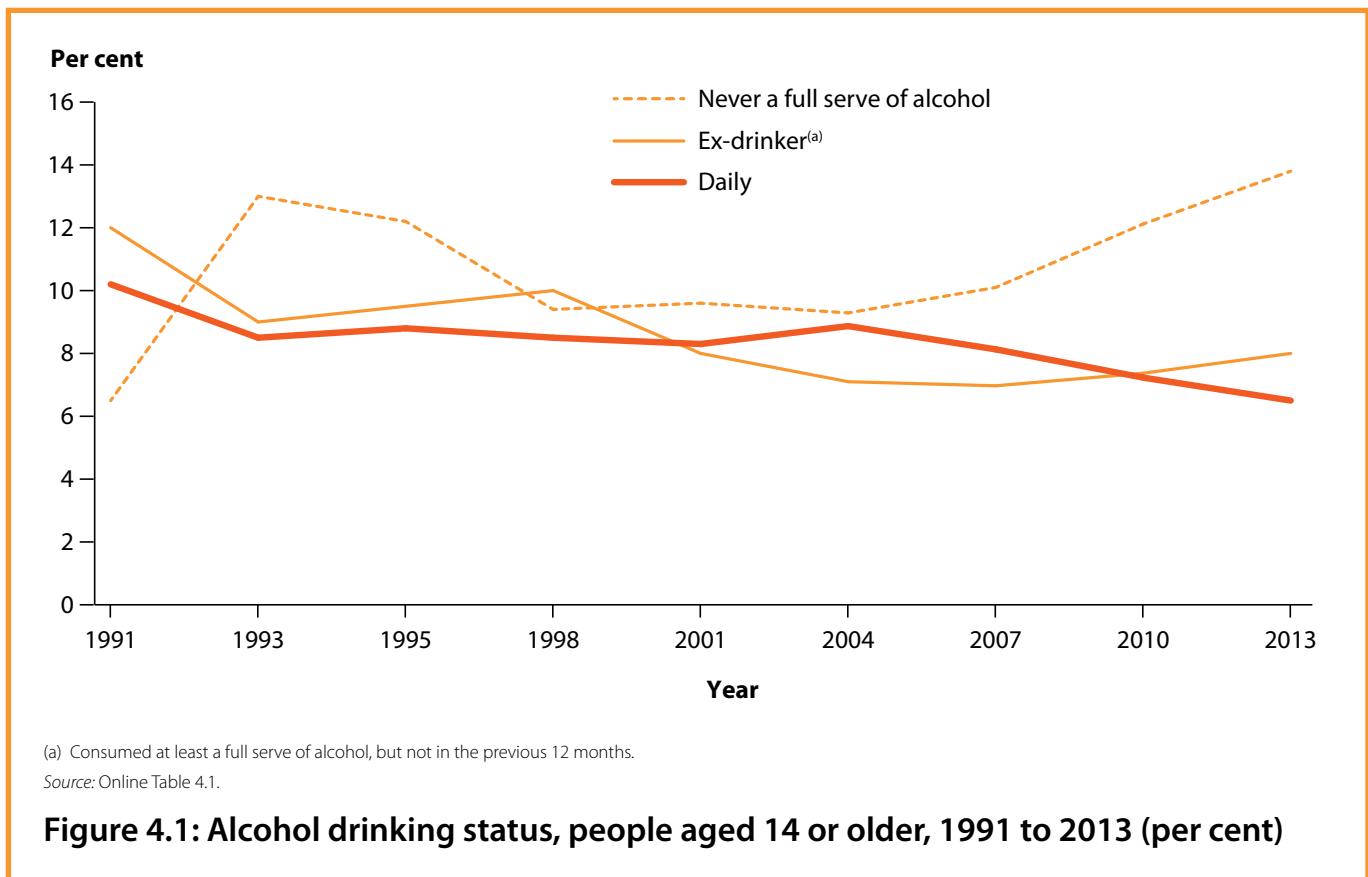
State and territory regulators have also moved to address the risks of alcohol intake for adolescents. The principal regulatory mechanism for controlling the supply of alcohol in Australia is state and territory liquor licensing legislation, which establishes a minimum legal purchasing age for alcohol and dictate where, when and how alcohol may be sold (ANPHA 2014).

## Current use and trends

Between 1993 and 2007, the daily drinking rate for people aged 14 or older remained largely unchanged, at around 8% (Figure 4.1). However, in 2010, there was a significant fall compared to 2007, and in 2013, the proportion drinking daily again declined from 7.2% to 6.5%.

In addition:

- in the previous 12 months, around three-quarters (78%) of the population aged 14 or older had consumed a full serve of alcohol, and 22% had not consumed alcohol
- the proportion of people aged 14 or older who had never had a full serve of alcohol has risen since 2004, with an increase between 2010 and 2013 (from 12.1% to 13.8%).

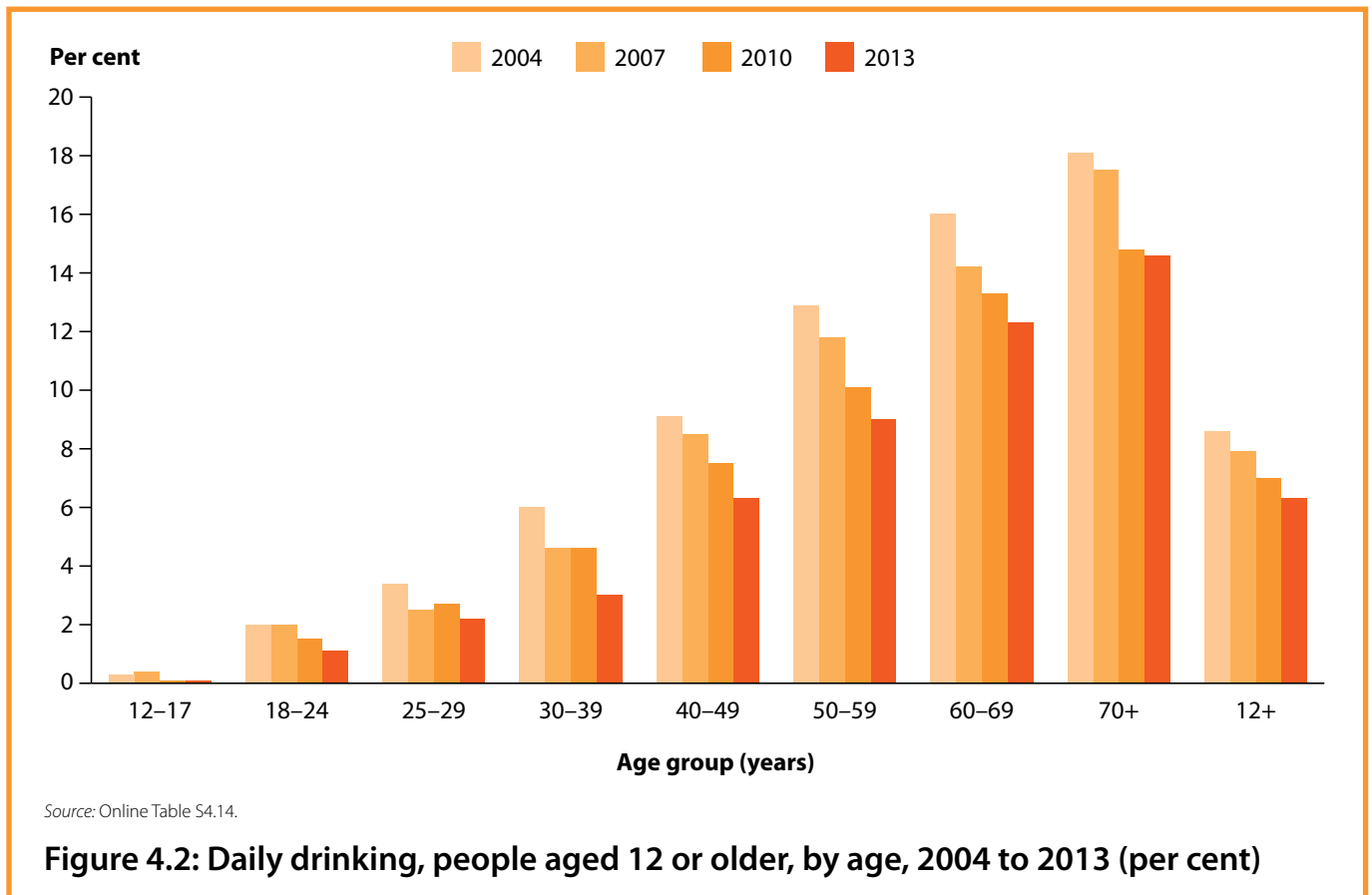




## Alcohol use by age and sex

Drinking status varied noticeably between males and females and different age groups. In particular:

- males aged 14 or older were almost twice as likely (8.5%) as females (4.6%) to drink daily in 2013 but the fall in daily drinkers described above was only significant for males (from 9.6% to 8.5%) (Online Table 4.2).
- females were more likely to have never consumed a full glass of alcohol than males but there was an increase in both sexes never having drunk alcohol in 2013 (from 14.2% to 15.8% and from 10.0% to 11.7% respectively)
- the age group most likely to drink daily continued to be those aged 70 or older, for both males (21%) and females (10.0%) (Figure 4.2; Online Table 4.3)
- overall Australia has seen a decrease in the proportion of daily drinkers, and this reduction was most noticeable among people in their late 30s to 50s.





## Alcohol risk

The *Australian guidelines to reduce health risks from drinking alcohol* aim to assist Australians with decisions about whether to drink alcohol and, if so, how much (See Box 4.1). Furthermore, under these guidelines, pregnant women and young people (aged under 18) are advised not to drink at all (NHMRC 2009).

### **Box 4.1: The Australian alcohol guidelines**

The alcohol risk data in this section is reported against Guideline 1 and Guideline 2 (see NHMRC 2009 for more details).

#### **Guideline 1: Reducing the risk of alcohol-related harm over a lifetime**

Drinking no more than 2 standard drinks on any day reduces the lifetime risk of harm from alcohol-related disease or injury.

#### **Guideline 2: Reducing the risk of injury on a single occasion of drinking**

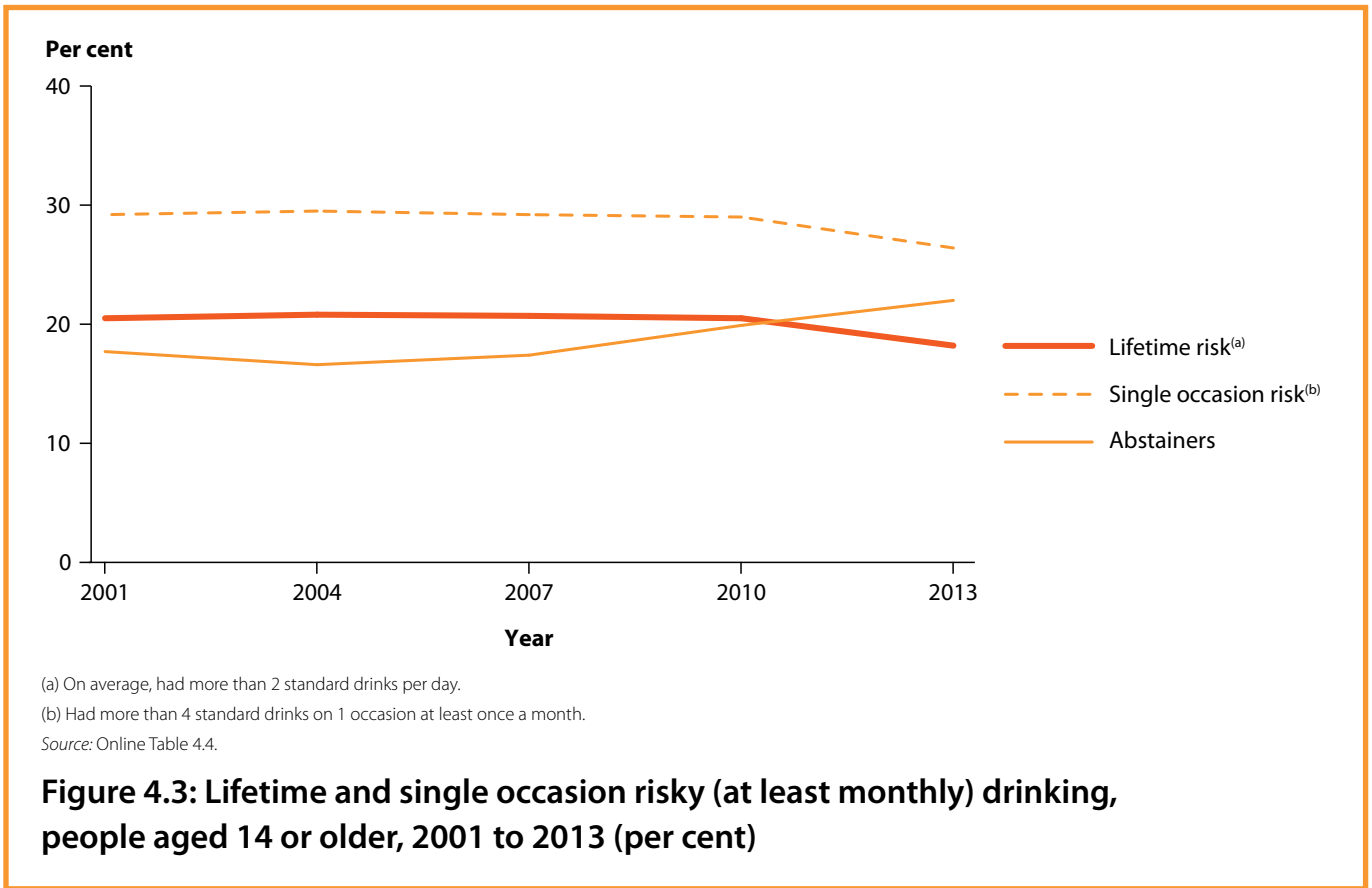
Drinking no more than 4 standard drinks on a single occasion reduces the risk of alcohol-related injury arising from that occasion.

## Current risky drinking and trends

Many drinkers consume alcohol responsibly; however, a substantial proportion of drinkers consume alcohol at a level that is considered to increase their risk of alcohol-related harm.

The consumption of alcohol in quantities that placed Australians at risk of an alcohol-related disease, illness or injury had remained fairly stable between 2001 and 2010. However, in 2013 there were some changes to peoples' drinking patterns (Figure 4.3). Between 2010 and 2013 for those aged 14 and over:

- there was a decrease in the proportion of people exceeding the NHMRC guidelines for lifetime risk by consuming more than 2 standard drinks per day on average, from 20% to 18.2%
- the number of people in Australia drinking at levels that placed them at lifetime risk of an alcohol-related disease or injury in 2013 fell by approximately 250,000 (3.7 million in 2010 down to 3.5 million in 2013)
- fewer people consumed 5 or more standard drinks on a single drinking occasion at least once a month, declining from 5.2 million in 2010 to 5.0 million in 2013. The proportion exceeding these guidelines declined from 29% in 2010 to 26% in 2013
- a higher proportion abstained from drinking alcohol and the proportion rose from 19.9% in 2010 to 22% in 2013.



## Risky consumption by age and sex

Age is an important determinant of health risks related to alcohol. Younger people experience harm from alcohol-related accident or injury disproportionately. For example, over half of all serious alcohol-related road injuries occur among those aged 15–24, while harm from alcohol-related disease is more evident among older people (NHMRC 2009).

### Lifetime risk

In 2013, most people in Australia aged 12 and older drank at levels that did not place them at risk of harm over their lifetime—they either drank at low-risk levels (58%) or abstained (24%) (Online Table 4.5). A similar proportion of adults (about 1 in 5), in all age groups, drank at levels that exceeded the lifetime risk guidelines. Some drinkers though were more likely than others to drink alcohol in a way that increased their lifetime risk of alcohol-related harm. For example:

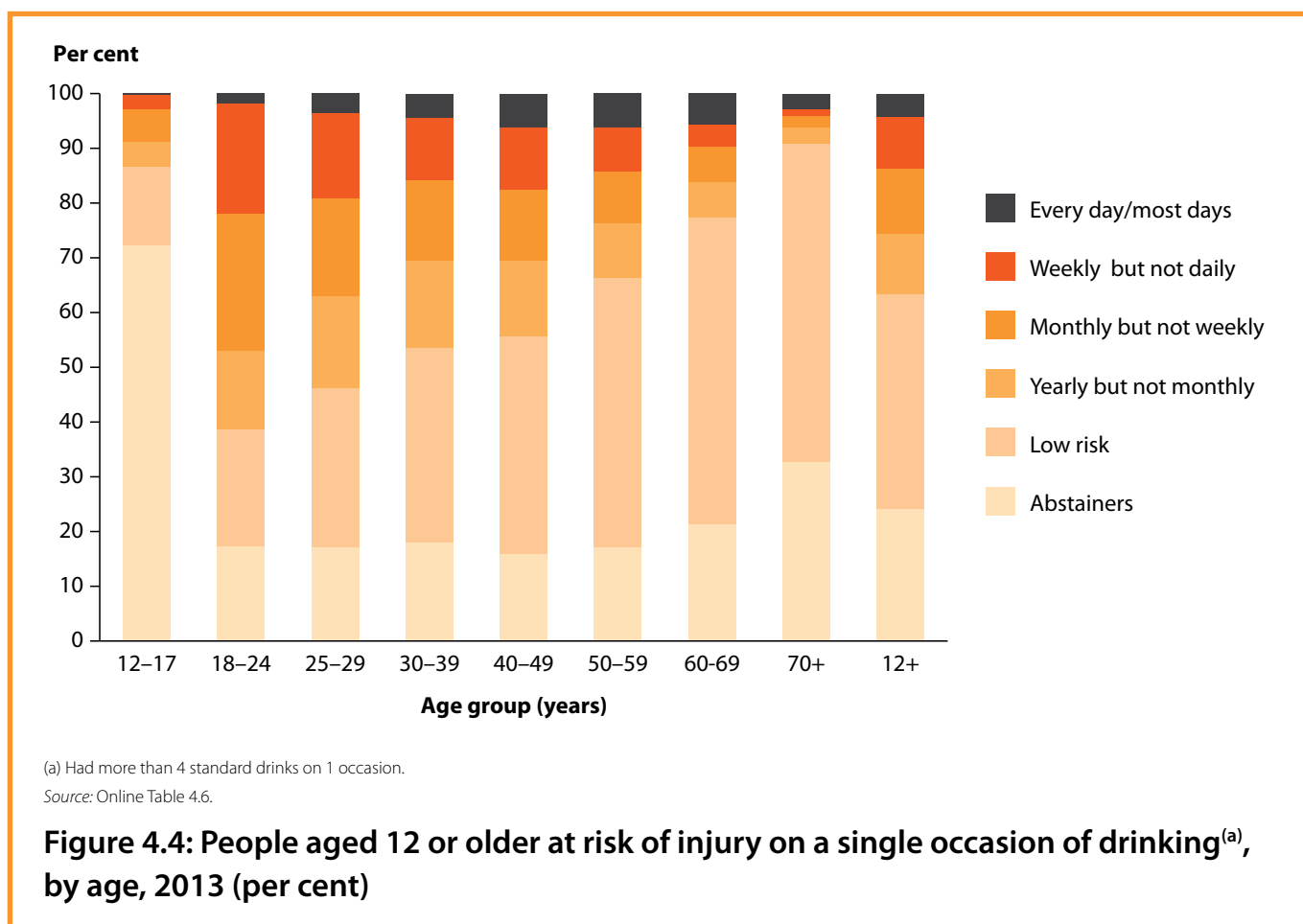
- males were twice as likely as females to drink at risky levels (26% and 9.7%, respectively)
- males in their late 20s (aged 25–29) were the most likely age group to drink at risky levels (32%).



## Single occasion risk

Among people in Australia aged 12 and older in 2013, more than 1 in 3 (37%) had consumed 5 or more standard drinks on a single occasion at least once in the past year, therefore exceeding the NHMRC single occasion risk guidelines (Figure 4.4). About 1 in 4 (26%) did so at least once a month, and 1 in 7 (13.8%) did so at least once a week. Risky alcohol intake differed by sex, for example:

- males were far more likely than females to drink alcohol in quantities that placed them at risk from a single occasion of drinking (47% compared with 27% for women) (Online Table 4.6)
- males were also more likely to consume alcohol in quantities that exceeded the guidelines more often than women, with 20% of men consuming these quantities at least weekly (compared with 7.5% of women).



The NHMRC drinking guidelines also recommend that for anyone aged under 18, not drinking alcohol is the safest option. Alcohol use among adolescents in Australia was prevalent in 2013, with 15.4% of males and 11.3% of females aged 12–17 exceeding the adult guidelines for single occasion risk. However, these proportions were lower than in 2010, when 19.9% of males and 19.7% of females aged 12–17 exceeded these guidelines.





Although people aged 70 and over were the most likely to drink daily, they were the least likely to consume alcohol in risky quantities with only 1 in 10 (9.3%) consuming 5 or more standard drinks on a single occasion in the past year. People aged 18–24 were more likely than any other age group to exceed the single occasion risk guidelines, although people in their 40s and 50s were most likely to consume 5 or more standard drinks on a single drinking occasion more regularly, with around 6% doing so on most days or every day. In comparison, people aged 18–24 were most likely to exceed single occasion risk guidelines weekly or monthly.

### **Lifetime and single occasion risk combined**

Almost 2 in 5 (38%) people in Australia drank at levels considered low risk of harm, that is from any single drinking occasion (at least once a year) and over a lifetime (Online Table 4.7). In the previous 12 months, males were far more likely than females (24% compared with 8.8%) to have shown drinking patterns that simultaneously placed them at risk of lifetime harm and single occasion harm at least once a year.

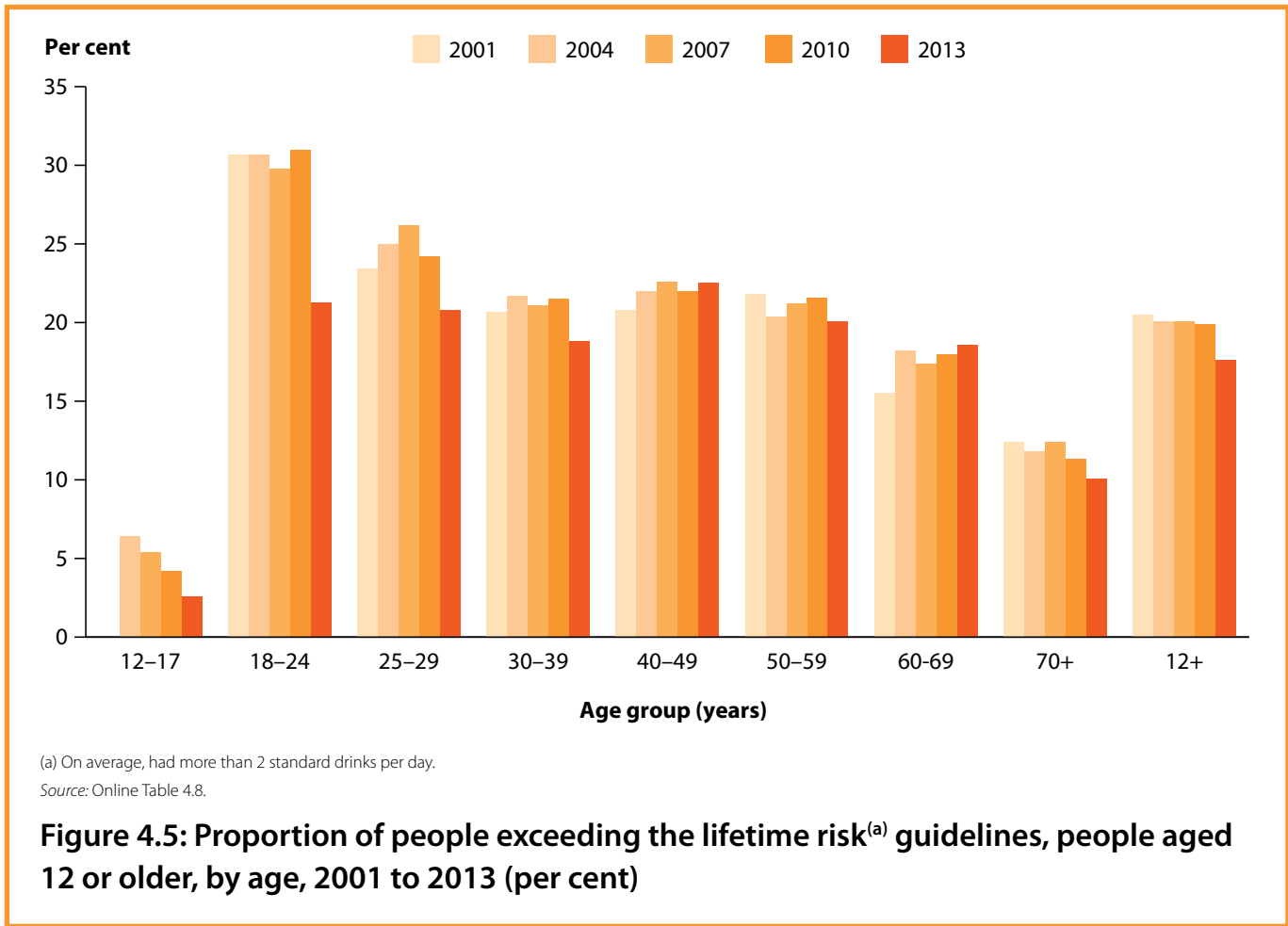
### **Age comparisons over time**

Drinking alcohol in adolescence can be harmful to young people's physical and psychosocial development. Alcohol-related damage to the brain can be responsible for memory problems, an inability to learn, problems with verbal skills, alcohol dependence and depression (MCDS 2011). There are various strategies and initiatives in place that focus on raising awareness of the short- and long-term impacts of risky drinking among young people which will, over time, contribute to the development of a more responsible drinking culture within Australian society (DoH 2013).

As discussed earlier in the chapter, the proportion of the population abstaining from alcohol rose between 2010 and 2013 with the increase in abstainers most evident among people aged 12–17 (the proportion choosing to abstain increased from 64% to 72%) (Online Table 4.8). Some age groups also reduced their intake of alcohol as the proportion drinking at risky levels between 2010 and 2013 declined, while for other age groups, particularly people aged over 40, there were no changes in the proportion exceeding the lifetime and single occasion risk guidelines.

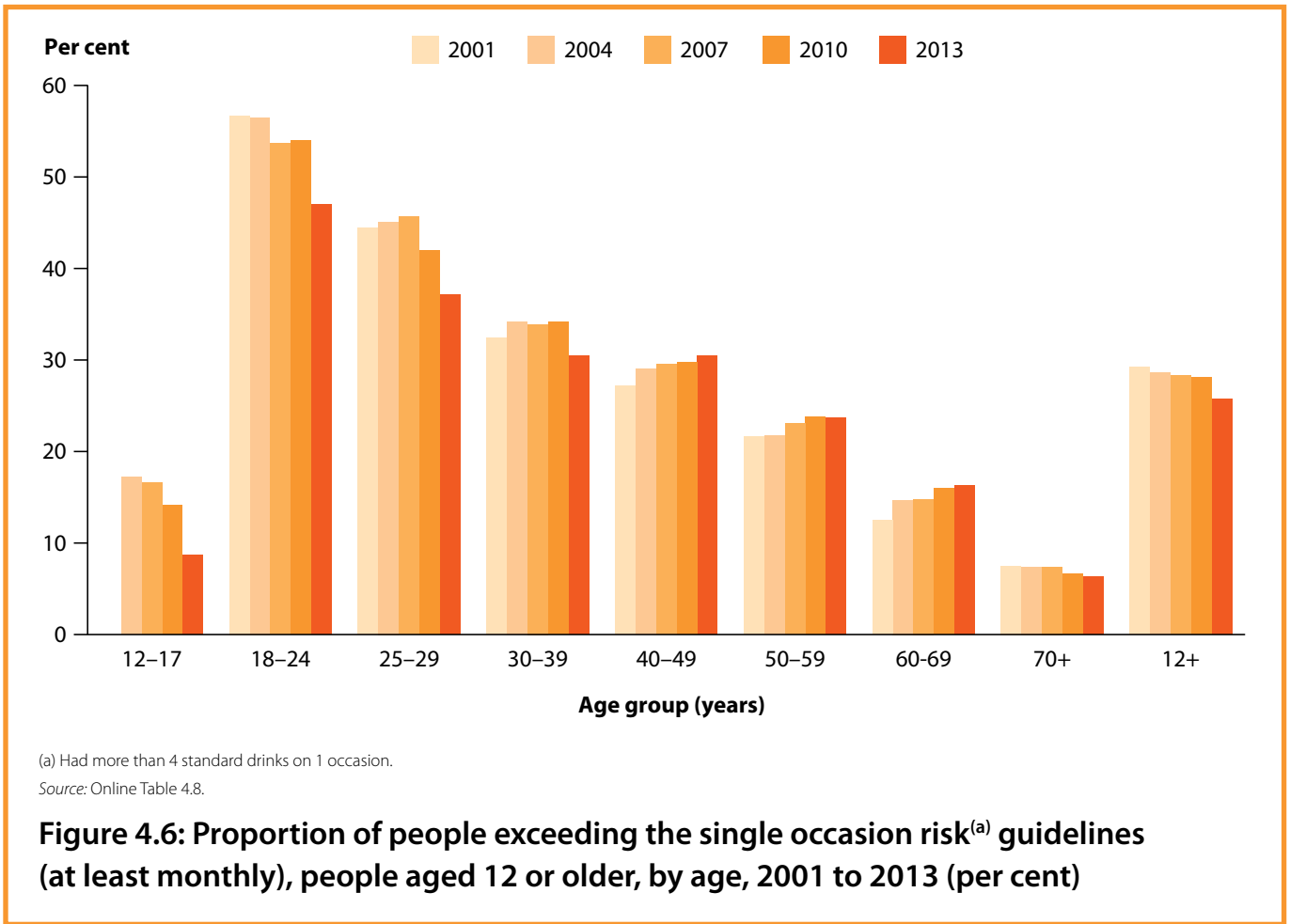
### **Lifetime risk**

Between 2001 and 2010 people in their late teens and 20s were more likely to consume more than 2 standard drinks per day on average than other age groups (Figure 4.5). Males aged 25–29 were most likely to exceed guidelines for lifetime risk (32%) (Online Table 4.5); however, as the proportion of those aged 18–29 consuming alcohol at this level declined in 2013, their level of risky drinking became more similar to that of older age groups. Considering males and females together, people in their 40s are now more likely to drink at lifetime risky levels than any other age group. There has been little change in lifetime risky drinking patterns of people aged 40–69 since 2004.



### Single occasion risk

The reduction in people exceeding the single occasion risk guideline (at least monthly) appears to be mainly due to the proportion of people under 40 reducing their alcohol use (Figure 4.6). While people aged 40 or older were generally less likely than people in younger age groups to drink alcohol in these quantities (5 or more drinks on a single occasion at least once a month), there has been little change in the drinking patterns of people in these age groups over the past decade.



## Very high risk

While it's important to understand the proportion of the population drinking at risky levels according to the NHRMC 2009 alcohol guidelines, it's also important to explore drinking patterns among these drinkers further and examine those who are drinking well in excess of the guidelines. In 2013:

- around 1 in 6 (15.6%) people aged 12 or older had consumed 11 or more standard drinks on a single drinking occasion in the past 12 months (Online Table 4.9) and 1 in 15 (7.3%) had done so in the last month (declining from 8.5% in 2010)
- people in their late teens and 20s were more likely to consume 11 or more standard drinks than people in other age groups, with about 3 in 10 reporting they had done so in the past year, but they were the only age group to significantly curb their very high risk alcohol use between 2010 and 2013 (for example, from 24% to 17.8% at least monthly and from 38% to 33% at least yearly for people aged 18–24).



## Age first tried alcohol

Guideline 3 of the NHMRC alcohol guidelines is based on an assessment of the potential harms of alcohol for young people. Epidemiological research has shown that alcohol may adversely affect brain development and lead to alcohol-related problems in later life (NHMRC 2009). Therefore the guidelines state that young people aged under 15 should not drink at all as they are at the greatest risk of harm, and that for those aged 15–17, the safest option is to delay the initiation of drinking as long as possible (NHMRC 2009). Despite these guidelines, most people try alcohol during adolescence. However, the age at which people first tried alcohol has been increasing over time. More specifically:

- the average age at which young people aged 14–24 first tried alcohol has steadily risen since 1998 from 14.4 to 15.7 in 2013 (Online Table 4.10)
- the average age of initiation was similar for males and females aged 14–24, and between 2010 and 2013, the average age increased for both sexes; from 15.2 to 15.7 for males and from 15.3 to 15.6 for females.

## What's consumed, where it's consumed and how it's sourced

Beverage preferences differ by sex and by age. Consistent with findings in 2010, male drinkers most commonly consumed regular strength beer and female drinkers mainly consumed bottled wine in 2013 (Online Table 4.11). The exceptions to these preferences were for people aged 12–17 and females aged 18–24 who preferred to consume pre-mixed spirits. There were no significant changes in drink preferences among drinkers overall between 2010 and 2013.

Underage drinkers (those aged 12–17) were more likely to consume alcohol at private parties (62%) (Online Table 4.13) and mainly sourced their alcohol from a friend (45%) (Online Table 4.12). Adults on the other hand tended to mainly drink in their own home (80%) and buy alcohol themselves (86%).

Nearly half (47%) of people (aged 12 or older) had their first glass of alcohol supplied by a friend and almost one-quarter (24%) were supplied their first glass by their parent (Online Table 4.14). Younger people were slightly more likely to say their parents supplied their first alcoholic drink while older people (aged 40 or older) were more likely to report buying their first serve themselves. This remained stable in 2013.

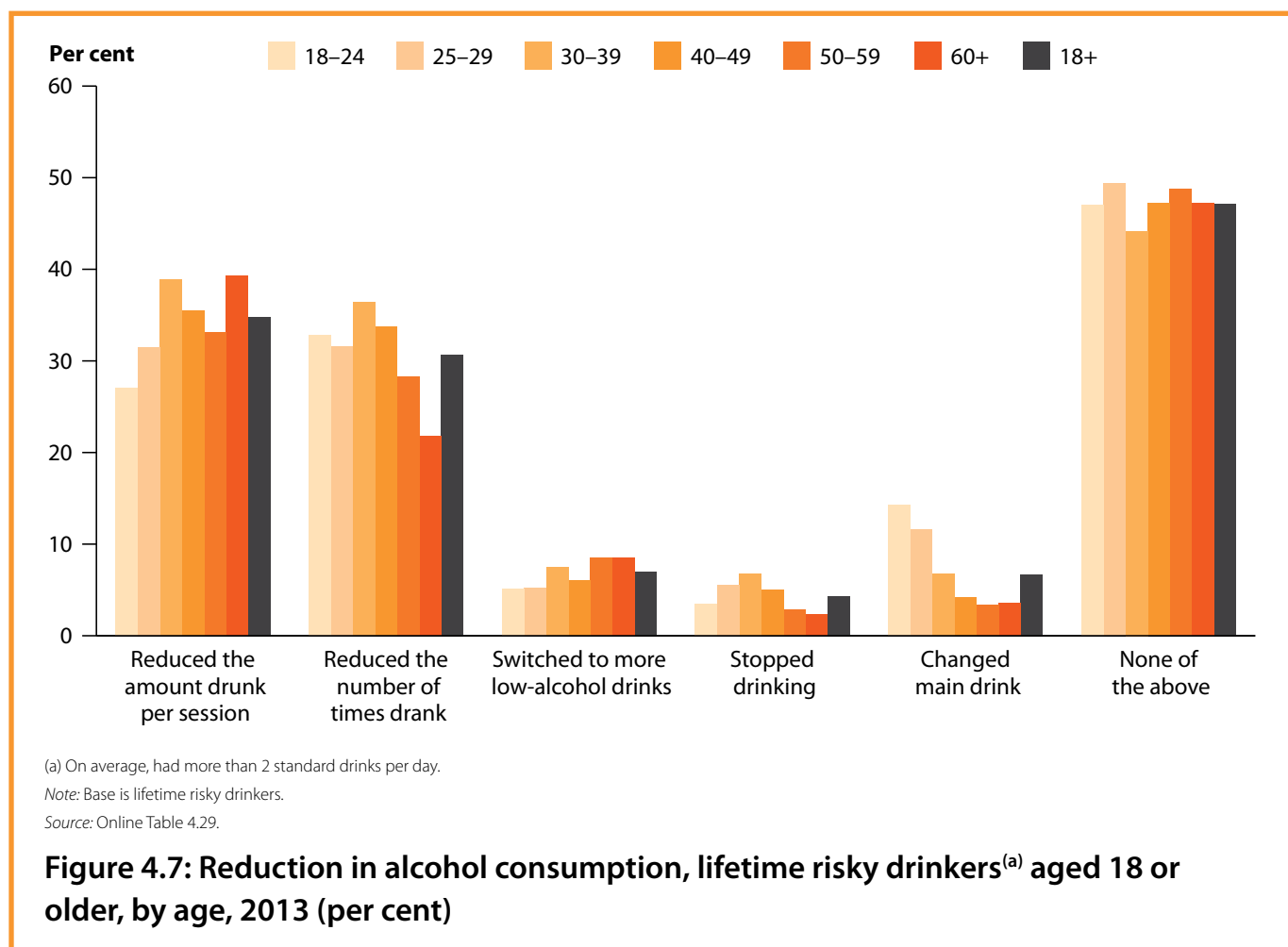
## Drinking reduction

While almost 4 in 10 (37%) people aged 14 and over drink at least once a week (Online Table 4.2), a substantial number have taken action to reduce their drinking. In 2013, 49% of recent drinkers (those who had consumed at least 1 full drink of alcohol in the last 12 months) had taken action/s to reduce their consumption (Online Table 4.15). The most common intake reduction actions were to reduce the amount of alcohol consumed at one time (30%) and/or to reduce the number of drinking occasions (29%). Lifetime risky drinkers were slightly more likely to have made changes to their drinking behaviour than low-risk drinkers.



Some age groups were more likely than others to take actions to reduce their use. Among lifetime risky drinkers:

- people aged 60 or older were more likely to reduce the amount they drank per session (39%) and less likely to reduce the number of times they drank (22%) than other age groups (Figure 4.7)
- people aged 18–24 were more likely to have changed their main drink preference in the previous 12 months (14.3% compared with 6.6% for total adult population) and the least likely to have reduced the amount consumed per session (27%)
- people in their late 20s were the least likely to have taken any actions to reduce their consumption and the proportion stating they had not undertaken any of the reduction measures specified in the survey rose from 38% to 49% between 2010 and 2013.





The main reason drinkers changed their drinking behaviour in 2013 was for health reasons (50%), followed by lifestyle reasons (37%). Lifetime risky drinkers were more likely to reduce their alcohol intake due to financial reasons than low-risk drinkers (16.4% for lifetime risky drinkers compared with 10.3% for low risk) (Online Table 4.16). Drinkers were less likely to be motivated by social reasons (decreasing from 32% in 2010 to 28% in 2013) and drink driving regulations (declined from 18.9% to 13.2%), particularly those drinkers aged 40 or older (Online Table 4.30). Drinkers aged 25–29 were considerably more likely to be motivated by financial reasons in 2013 (from 18.4% in 2010 to 31% in 2013).

## Health and harm

The excessive intake of alcohol not only affects the drinkers' health by putting them at risk of an alcohol-related disease, illness or injury, but also affects other people around them. Results from the 2013 NDSHS showed that risky drinkers were more likely to:

- lose their memory after drinking (Online Table 4.17)
- believe they can consume above the recommended guidelines without affecting or putting their health at risk (online tables 4.18–4.21)
- experience verbal or physical abuse by someone under the influence of alcohol (Online Table 4.22)
- take part in risky behaviours such as driving while under the influence (Online Table 4.23).

## Perceptions of health effects

Risky drinkers were less likely to be aware of the number of standard drinks an adult could drink before putting their health at risk—55% of male lifetime risky drinkers (Online Table 4.18) and 26% of female lifetime risky drinkers (Online Table 4.19) thought they could consume 3 or more standard drinks per day without adversely affecting their health (compared with 22% and 5.8% of low-risk drinkers). The majority of single occasion risky drinkers also thought they could consume 5 or more standard drinks in a 6-hour period before putting their health at risk (online tables 4.20 and 4.21) and male risky drinkers were more likely to believe this than female risky drinkers (79% and 53% respectively).

Compared to 2010, a higher proportion of males thought that no amount of alcohol was safe to drink without putting their health at risk over a lifetime, and a higher proportion correctly reported that 1–2 standard drinks could be consumed every day. Overall, there was little change in females' perception of the number of standard drinks they thought they could safely consume on a single occasion, but a higher proportion of female risky drinkers thought they could consume 7 or more standard drinks without putting their health at risk (from 22% to 27%).



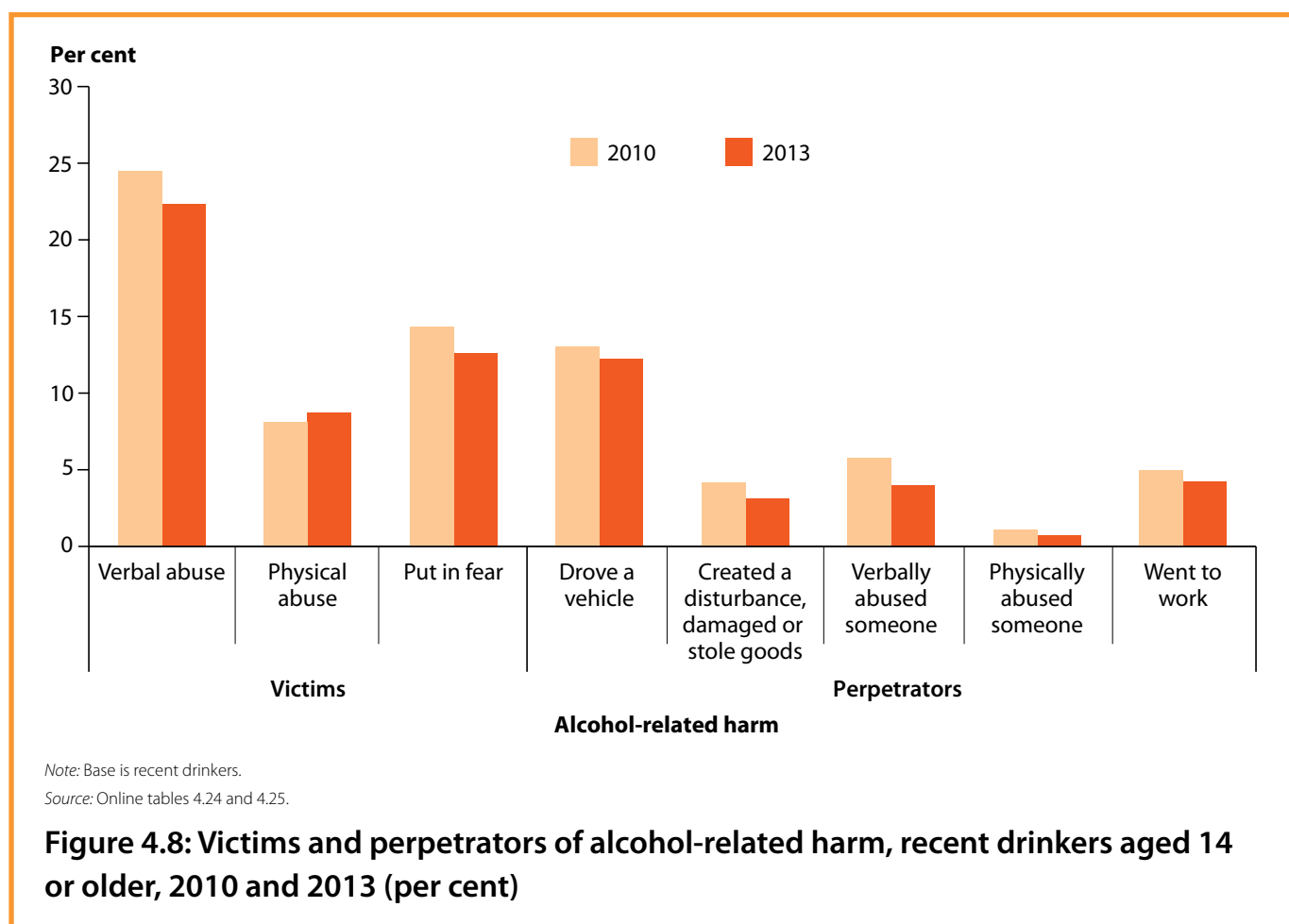
## Harms to others

Much of the alcohol-related disease burden arises from unintentional and intentional injuries, including those due to road traffic accidents, violence and suicide (WHO 2011).

An objective of the NDS is to minimise the harmful effects on the population of both licit and illicit drugs. The NDSHS contributes to this by exploring and reporting on the experiences of drug-related incidents and harm for Australians.

## Perpetrators of harm

In 2013, 1 in 5 (21%) recent drinkers aged 14 or older put themselves or others at risk of harm while under the influence of alcohol in the previous 12 months (Online Table 4.24). Driving a motor vehicle was the most likely risky activity undertaken while under the influence of alcohol (12.2% of recent drinkers). Between 2010 and 2013, there was a drop in the proportion of the population who went to work while under the influence (from 5.0% to 4.2%) and who verbally abused someone (from 5.7% to 4.0%) (Figure 4.8). Risky drinkers were also more likely to report loss of memory after drinking at least once in the last 12 months than low-risk drinkers (55% compared with 16%) (Online Table 4.17).





## Victims of harm

Respondents were asked if they had been verbally or physically abused, or put in fear, in the past 12 months, by persons affected or under the influence of alcohol. More than 1 in 4 (26%) Australians aged 14 and over (equivalent to 5 million people) had been a victim of an alcohol-related incident in 2013 (Online Table 4.25). Most of these incidents involved verbal abuse (22%), although this proportion declined from 2010 (from 24% to 22%). While there was no change in the proportion of people experiencing physical abuse between 2010 and 2013, the number of people who were physically abused rose from 1.5 million to 1.7 million.

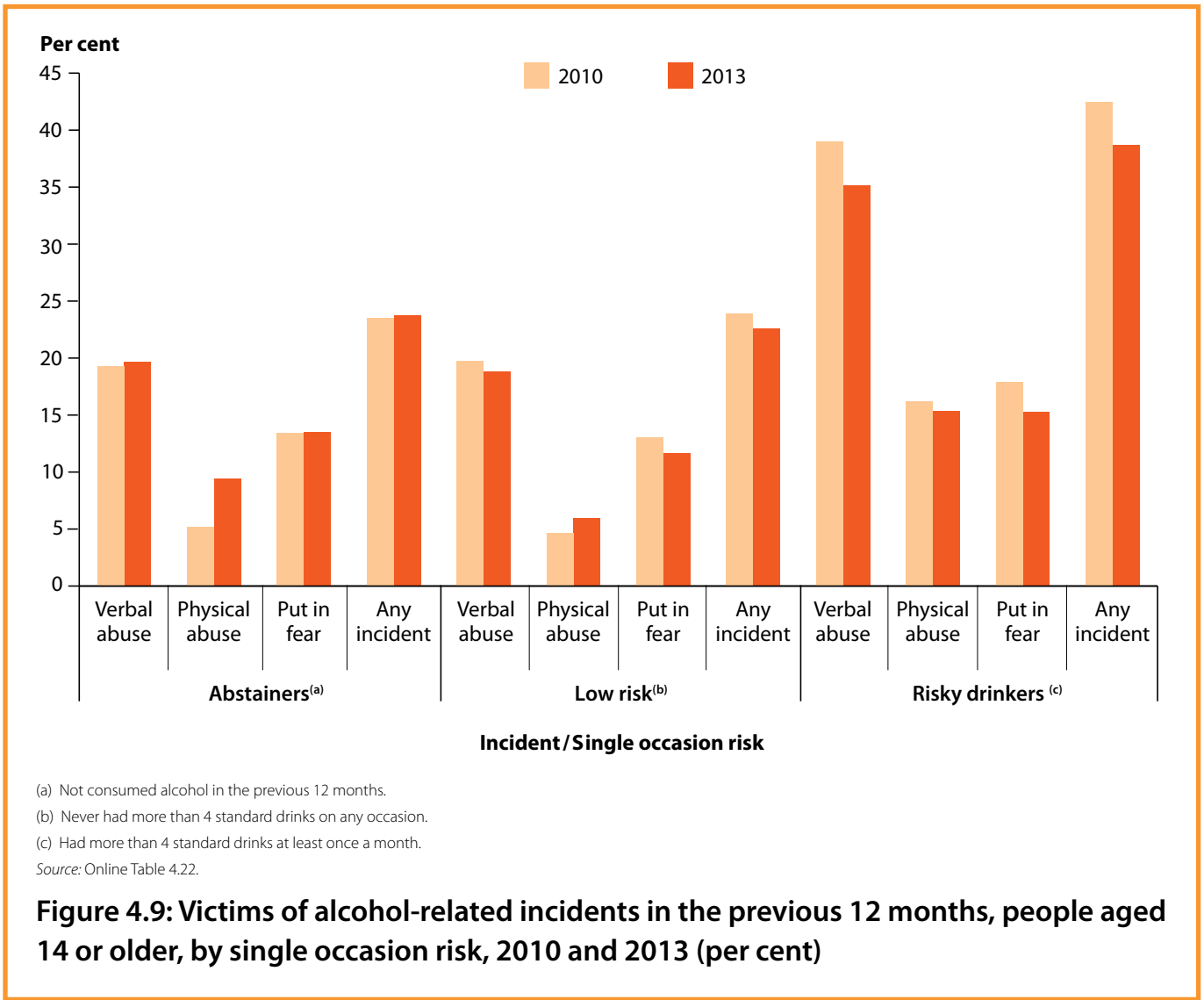
Certain groups were also more likely to have undergone alcohol-related incidents than others. For example:

- males were more likely than females to experience verbal (26% compared with 19%) or physical abuse (10.4% compared with 7.1%) in the past 12 months, but a greater proportion of females were put in fear (13.8% compared with 11.3%) (Online Table 4.25)
- people aged 18–24 were more likely than other age groups to experience verbal abuse (35%), physical abuse (15.2%) or be put in fear by someone under the influence of alcohol (18.6%) (Online Table 4.26)
- risky drinkers were more likely, compared to both low-risk drinkers and abstainers, to have suffered both verbal and physical abuse by someone affected by alcohol (Figure 4.9); but the proportion of abstainers and low-risk drinkers experiencing physical abuse increased between 2010 and 2013 (from 5.2% to 9.4% and from 4.7% to 6.0% respectively).

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 (Online Table 4.27).

Of people who had been physically abused by someone under the influence of alcohol, bruising or abrasions was the most frequent injury sustained, and 8.3% of all injuries were serious enough to require hospital admission (Online Table 4.28).





# Illicit use of drugs

This chapter presents data on illicit use of drugs not including tobacco and alcohol. When referring to illicit use of any drug this includes:

- use of illegal drugs
- misuse or use for non-medical purposes of pharmaceuticals
- inappropriate use of other substances (see Box 5.1 for more information).



The first part of the chapter focuses on combined illicit use of any drug (including pharmaceutical misuse) and the second part focuses on use of selected illegal drugs not including pharmaceuticals (see Chapter 6 for more detailed information on pharmaceutical misuse).

### **Box 5.1: Definition of illicit use of drugs**

'Illicit use of a drug' or 'illicit drug use' (used interchangeably in this report) can encompass a number of broad categories including:

- Illegal drugs—a drug that is prohibited from manufacture, sale or possession in Australia—for example cannabis, cocaine, heroin and amphetamine-type stimulants.
- Pharmaceuticals—a drug that is available from a pharmacy, over the counter or by prescription, which may be subject to misuse—for example opioid-based pain relief medications, opioid substitution therapies, benzodiazepines, over-the-counter codeine and steroids.
- Other psychoactive substances—legal or illegal, potentially used in a harmful way—for example kava, synthetic cannabis and other synthetic drugs, or inhalants such as petrol, paint or glue (MCDS 2011).

Illicit drug use has both short-term and long-term health effects, and health impacts can be severe, including poisoning, infective endocarditis (an infection that damages the heart valves), mental illness, self-harm, suicide and death. The use of inhalants may lead to brain damage, disability and death. The use of some illicit drugs by injection can also allow the transmission of bloodborne viruses, including HIV/AIDS, hepatitis C and hepatitis B. The social impacts of illicit drug use include stressed family relationships, family breakdown, domestic violence, child abuse, assaults and crime (NRHA 2012).

For Australasia, it has been estimated that 2.6% of the burden of disease and 0.5% of deaths were attributable to illicit drug use in 2010 (IHME 2014). Overall, however, illicit drug use accounts for an increasing proportion of the global burden of disease (moving from the 18th to 15th ranking risk factor between 1990 and 2010) (IHME 2014). It is estimated that illicit drug use cost the Australian economy \$8 billion annually through crime, productivity losses and health-care costs (NRHA 2012).

A limitation of the survey is that some people may not accurately or fully report information relating to illicit drug use and related behaviours, particularly where these activities may be illegal. This means that results relating to illicit drugs are likely to underestimate actual prevalence.

All data presented in this chapter are available through the online illicit use of drugs tables <<http://www.aihw.gov.au/publication-detail/?id=60129549469&tab=3>>.



## Key findings

### Overall illicit use of drugs

- The proportion of people in Australia having used any illicit drug in the last 12 months has remained relatively stable over the past decade at around 1 in 7.
- About 8 million people aged 14 and over in Australia (42%) have ever used an illicit drug, and 2.9 million (15.0%) had used an illicit drug in the 12 months before the survey, increasing from 2.7 million (14.7%) in 2010.
- There was no change in recent use of most illicit drugs in 2013, and use of any illicit drug remained stable between 2010 and 2013; however, there was a significant change for a number of specific drugs. The proportion who had misused a pharmaceutical rose from 4.2% in 2010 to 4.7% in 2013, while the use of ecstasy, GHB and heroin declined.
- Across Australia, people aged 20–29 were most likely to have used an illicit drug in the previous 12 months (27% of all people in that age group).

### Use of specific illicit drugs

- The most common drug used both recently and over the lifetime was cannabis, used by 10.2% and 35% respectively of people aged 14 and over.
- Among people aged 14–24, the age of initiation into illicit drug use rose from 16.0 in 2010 to 16.3 in 2013. More specifically, the age at which people first used cannabis and meth/amphetamines increased with both these drugs showing an older age of first use in 2013.
- People aged 50 and over generally have the lowest rates of illicit drug use; however, in recent years this age group has shown the largest rise in illicit use of drugs and were the only age groups to show a statistically significant increase in use in 2013 (from 8.8% to 11.1% for those aged 50–59 and from 5.2 to 6.4% for those aged 60 or older); this was mainly due to an increase in use of cannabis.
- In 2013, 1.2% of the population (or about 230,000 people) had used synthetic cannabinoids in the last 12 months, and 0.4% (or about 80,000 people) had used other emerging psychoactive substances such as mephedrone.
- Cannabis and meth/amphetamine users were more likely to use these drugs on a regular basis with most people using them at least every few months (64% and 52% respectively) while ecstasy and cocaine use was more likely to be infrequent, with many users only using the drug once or twice a year (54% and 71% respectively).
- While there was no rise in meth/amphetamine use in 2013, there was a change in the main form of meth/amphetamines used. Among meth/amphetamine users, use of powder fell from 51% in 2010 to 29% in 2013 while the use of ice (also known as crystal) more than doubled, from 22% to 50% over the same period. More frequent use of the drug was also reported among meth/amphetamine users in 2013 with an increase in daily or weekly use (from 9.3% to 15.5%). Among ice users there was a doubling from 12.4% to 25%.



## Motivations

- Among people who had used an illicit drug in their lifetime, most people aged 14 or older reported trying illicit drugs because they were curious to see what it was like (66%) or because they wanted to do something exciting (19.2%). Illicit drug users continued to use illicit drugs because they wanted to enhance experiences (30%) or because it was exciting (17.5%).

## Harms

- In 2013, 8.3% of the population had been a victim of an illicit drug-related incident. Verbal abuse was the most frequently reported incident overall, and the proportion experiencing physical abuse by someone under the influence of illicit drugs rose from 2.2% in 2010 to 3.1% in 2013.

## Strategies, legislation and other activities

Illicit drug policy is shared across different levels of government and also different government agencies. Strategies to address illicit drugs are the responsibility of health, law enforcement, community services, education, and employment and training agencies, and require coordinated action between the Commonwealth and the state and territory governments.


Under the National Drug Strategy 2010–2015 (and its forerunners), Australian governments, non-government organisations, researchers and community groups continue to engage in a wide variety of activities to minimise the harm associated with illicit use of drugs. These include activities such as strategies focusing on specific drugs or populations at risk, legislation, treatment service programs and law enforcement activities.

## Prevention and education

School-based and general prevention initiatives are designed to delay the first use of illicit drugs and improve awareness of risks associated with illicit drug use. These programs provide factual information about drugs and their effects through targeted education and also mass media campaigns, such as the National Drugs Campaign.

## Drug treatment services

Specialised drug treatment services for illicit drugs, like drug treatment services for other substances, are primarily provided by governments and non-government organisations with government funding. These services are complemented by private hospitals and also subsidised private services by general practitioners and allied specialists including mental health service providers.



## Legislation and law enforcement

The National Drug Strategy recognises illicit drug use as a health and social issue while acknowledging the role of law enforcement to detect and deter drug crime. Legislative and regulatory provisions relating to illicit drugs, precursor chemicals and proceeds of crime exist at the national level (for example border protection and compliance) and also within each jurisdiction.

## Illicit use of any drug

### Trends in lifetime use

In 2013 about 4 in 10 (42%) people in Australia had illicitly used a drug at some point in their lifetime (Online Table 5.1). This was a higher proportion than in 2010 (40%) but lower than the peak of 46% in 1998. Most of this rise in lifetime use was attributable to increases in the non-medical use of pharmaceuticals; lifetime illicit use of pharmaceuticals rose from 7.4% to 11.4% (Online Table 5.2). More specifically:

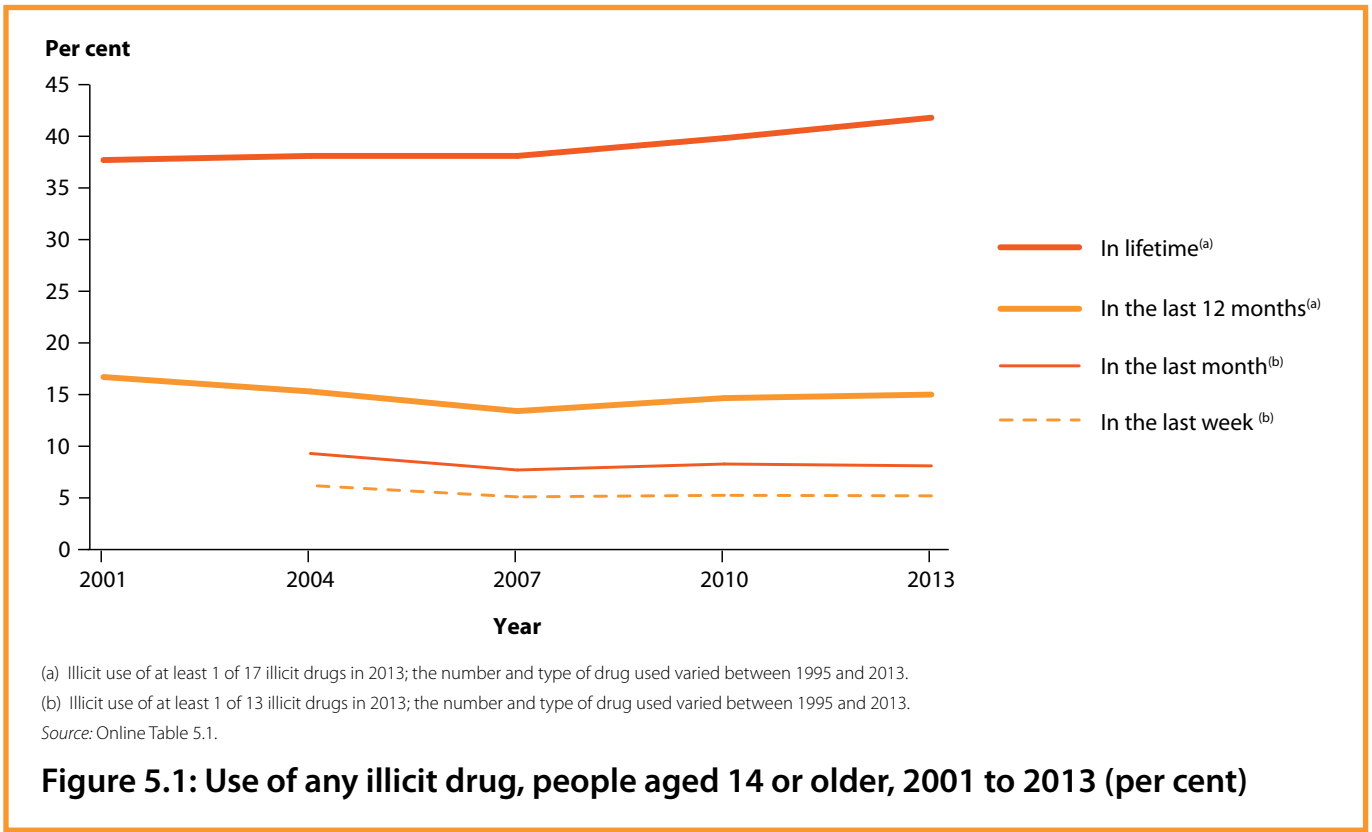
- misuse of pain-killers/analgesics showed the largest increase of all the drug types surveyed, with 7.7% of people in 2013 having ever used them for non-medical purposes compared to 4.8% in 2010
- there were small but significant rises in the proportion of people who had ever used tranquilisers/sleeping pills and other opiates/opioids (excluding heroin).

Ketamine was the only non-pharmaceutical illicit drug to show an increase in lifetime use and there was a small but significant decrease in the proportion of people having ever injected any drug.

### Trends in recent use

Around 1 in 7 (15.0%) people aged 14 or older reported having used an illicit drug in the last 12 months and this level of use remained relatively stable between 2004 and 2013. Monthly or weekly use of illicit drugs was reported by fewer than 1 in 10 people—8.1% of the population had used an illicit drug in the last month, and a further 5.2% had done so in the last week (Figure 5.1). There was no change in recent use of most illicit drugs, but there was a change for the following drugs (Online Table 5.3):

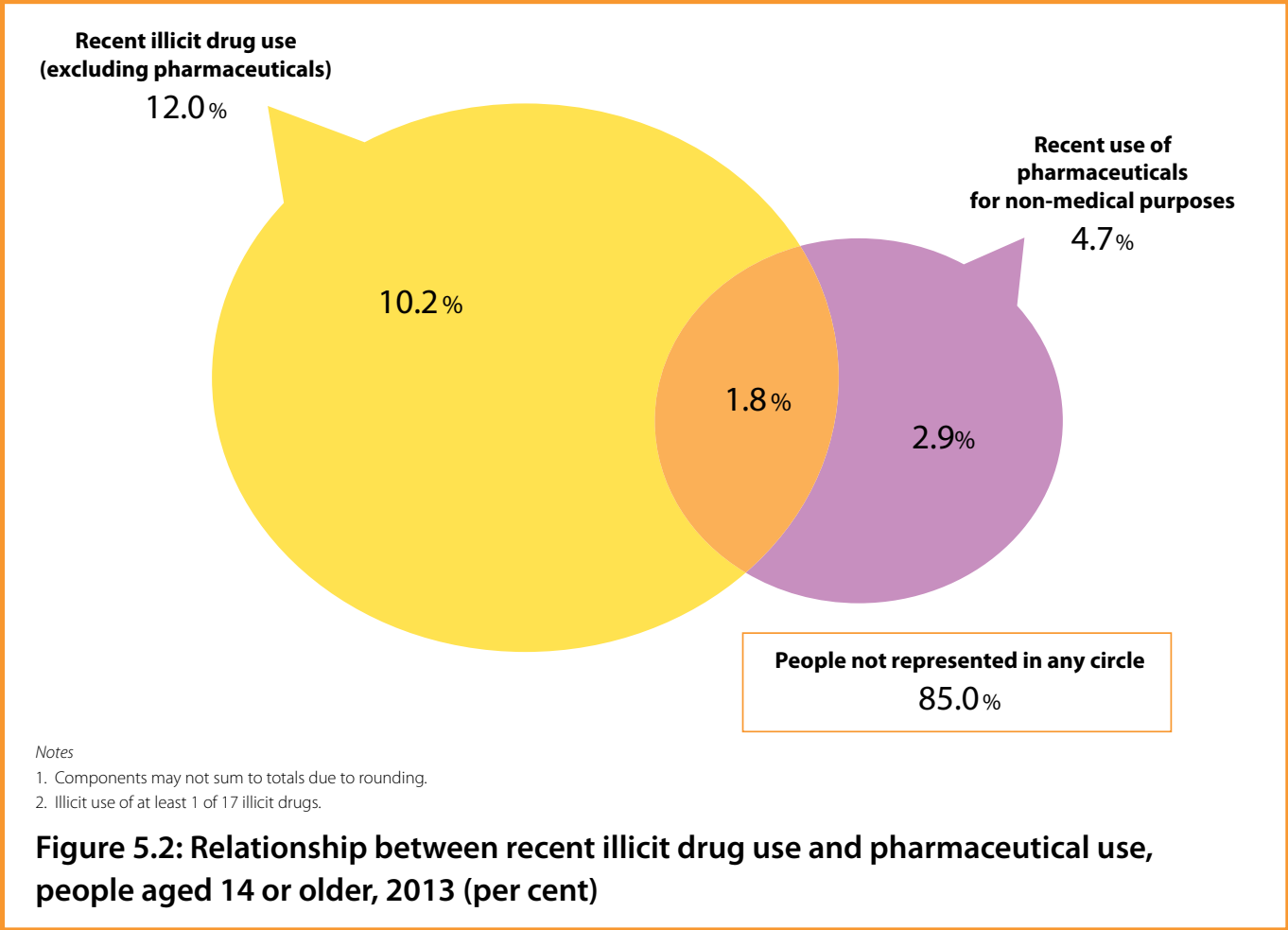
- the proportion who had misused a pharmaceutical rose from 4.2% in 2010 to 4.7% in 2013
- ecstasy use has been declining since 2007 and declined from 3.0% in 2010 to 2.5% in 2013
- there were small but significant falls in recent use of heroin and people who had injected drugs.



## Illicit use of drugs in 2013

As discussed above, in 2013, 15.0% of Australians used an illicit drug (including use of pharmaceutical drugs for non-medical purposes) in the previous 12 months. Among illicit drug users, 4 in 5 used illegal drugs such as cannabis and cocaine, or other substances such as inhalants. In addition, 2.9% of people misused a pharmaceutical drug (and did not use any other illicit drug) in the previous 12 months. A further 1.8% of people had both misused a pharmaceutical and also used another illicit drug (Figure 5.2).

The most common illicit drug used was cannabis, with 10.2% of people aged 14 or older having used it in the previous 12 months and 35% having ever used it (Online Table 5.4). Ecstasy (10.9%) and hallucinogens (9.4%) were the second and third most common drugs for lifetime use, and pain-killers/analgesics (3.3%) and ecstasy (2.5%) were the second and third most common for recent use.



### Age and sex comparisons

The use of any illicit drug in a lifetime or in the last 12 months varied with different age groups and for males and females (online tables 5.5 and 5.7). Comparing lifetime use of illicit drugs showed that:

- males were more likely to have ever used illicit drugs than females (46% and 38% respectively)
- the age groups most likely to have ever used any illicit drug were people aged 30–39 (57%) and 40–49 (52%)
- the age group least likely to have ever used an illicit drug were those aged 60 or older (21%).

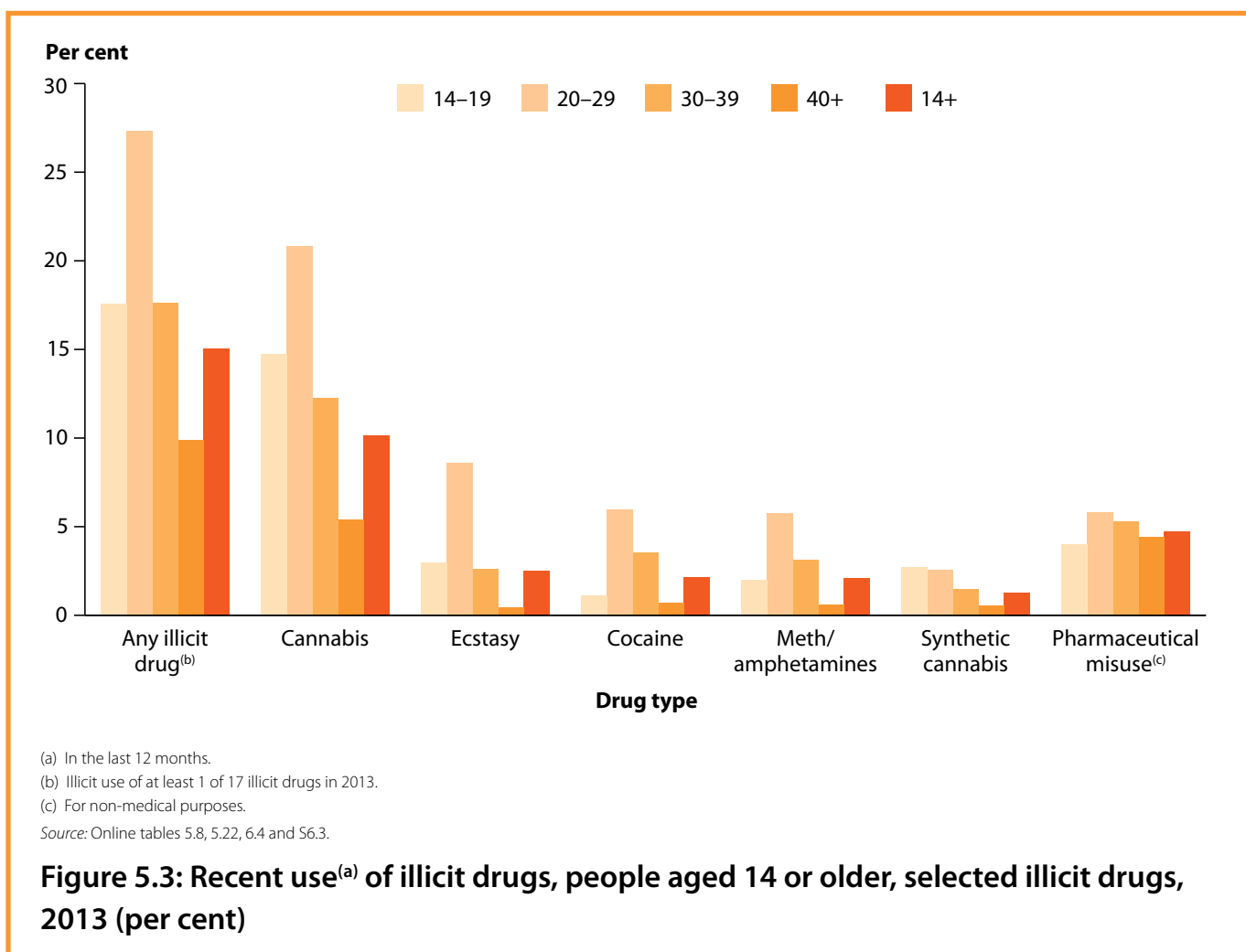




Similar to the patterns of lifetime use, the same differences in age and sex were apparent for use in the previous 12 months (Online Table 5.6).

In 2013:

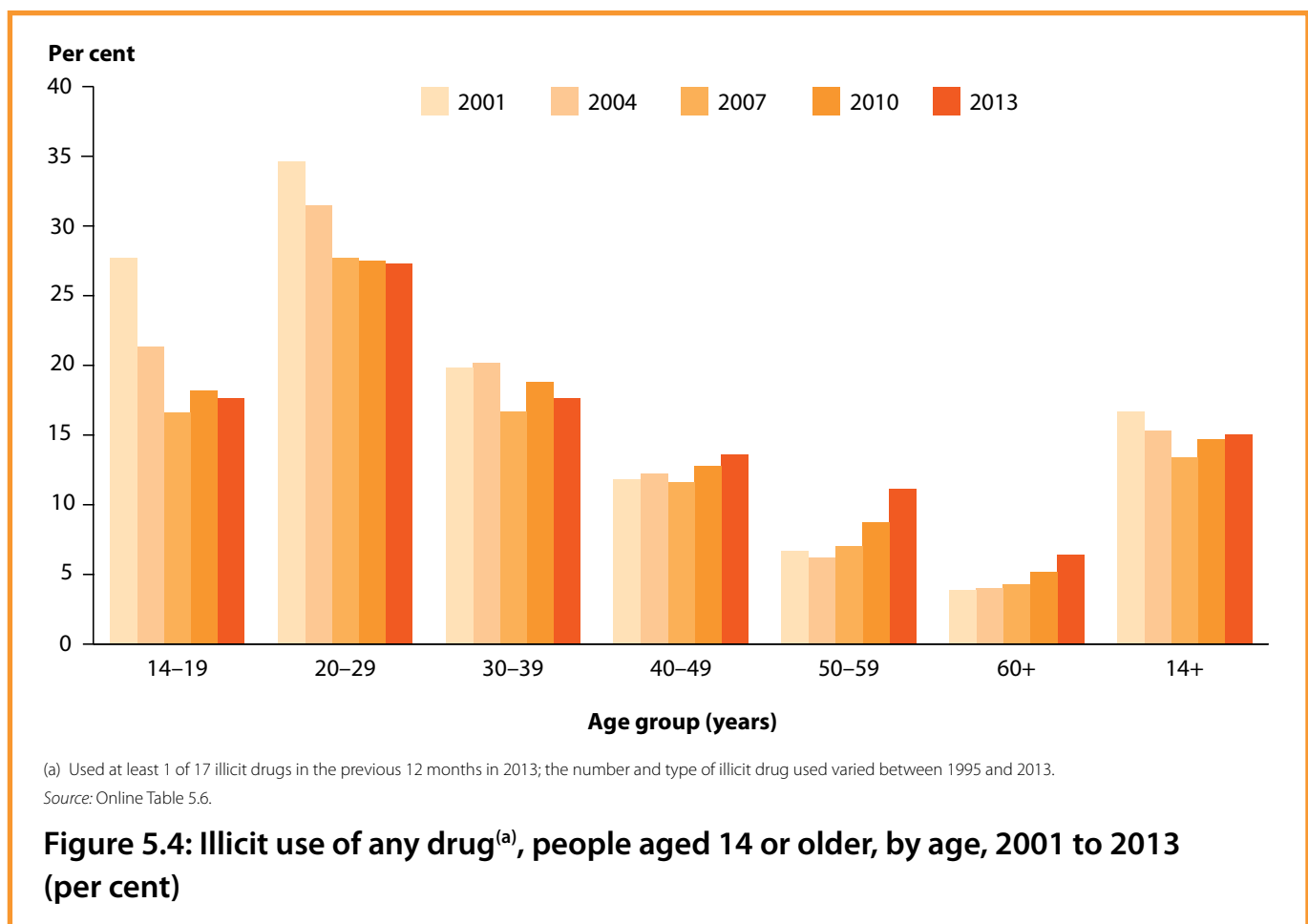
- of the 2.7 million people in Australia who had used an illicit drug in the previous 12 months, 1.5 million were male, and 1.1 million were female, with 18.1% of all males and 12.1% of all females in Australia having used an illicit drug in the previous 12 months
- people aged 20–29 were the most likely age group to have used illicit drugs, with over 1 in 4 (27%) reporting illicit use of drugs in the previous 12 months
- recent illicit drug use was also highest among those aged 20–29 for selected illicit drugs (Figure 5.3), with the exception of synthetic cannabinoids which was slightly higher among those aged 14–19.



## Age and sex comparisons over time

Overall there were no changes in illicit use of drugs (includes pharmaceutical misuse) in 2013, but there were some significant changes among different age groups. People aged 50 and over generally have the lowest rates of illicit drug use; however, in recent years this age group has shown the largest rise in illicit use of drugs and were the only age groups to show a statistically significant increase in use (Figure 5.4). More specifically, compared with 2010:

- males and females aged 50–59 were more likely to use drugs in 2013 (from 10.5% to 13.1% and from 7.1% to 9.1% respectively), and the increase in illicit drug use was also significant for males aged 60 or older (from 5.5% to 7.5%)
- females aged 40–49 were also more likely to illicitly use a drug in 2013 (from 9.0% to 11.8%) while females aged 30–39 were less likely to use (from 15.0% to 12.1%)
- drug use among younger people (aged 14–29) has remained relatively stable.



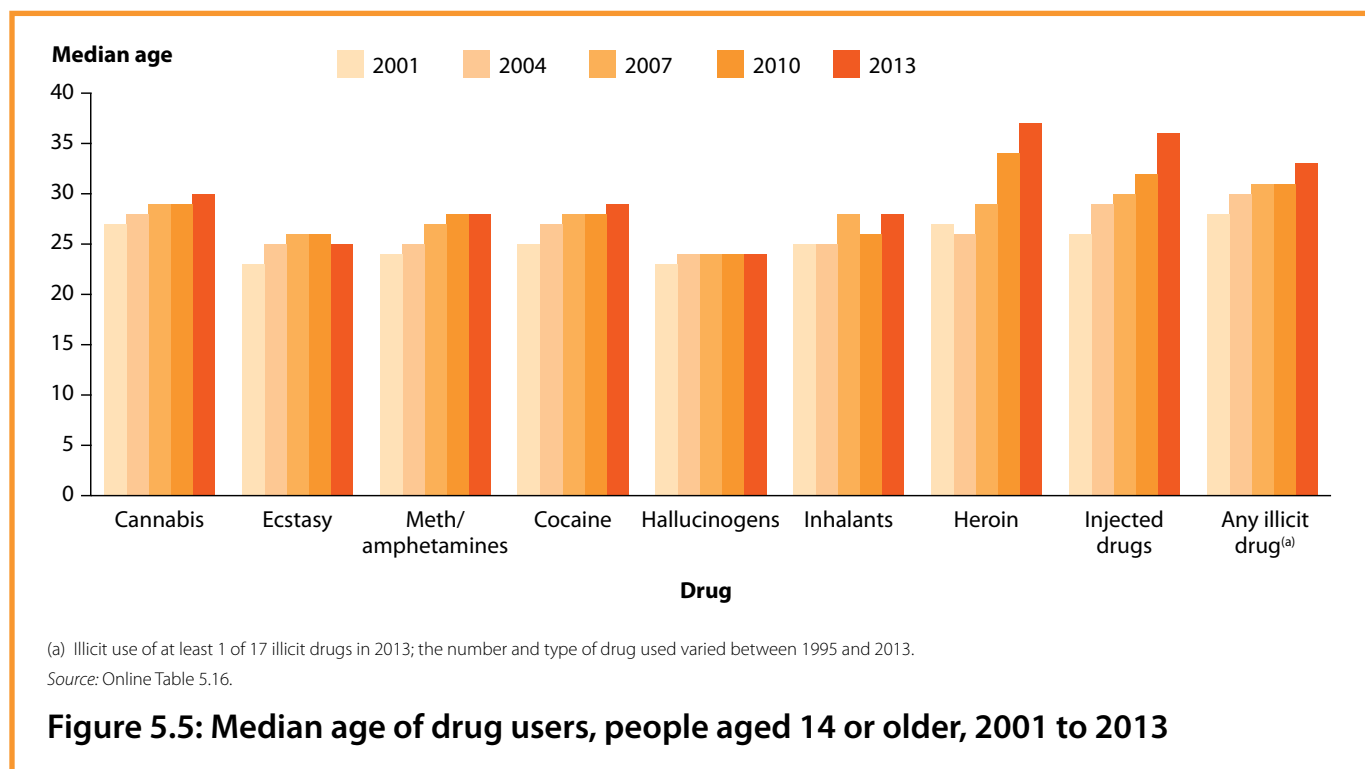


## Average age of drug users

It is often assumed that an observed increase in drug use in a particular age bracket is caused by more people in that age group taking up drug use. While this might seem an obvious interpretation of the data, 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).

There appears to be an ageing cohort of drug users in Australia. The median age of drug users has risen since 2001 for most illicit drugs (Figure 5.5). For example:

- the median age of cannabis users was 27 in 2001 and increased to 30 in 2013
- the median age of cocaine users was 25 in 2001 and rose to 29 in 2013
- there is an ageing cohort of heroin users; heroin users were 10 years older on average in 2013 than they were in 2001 (where median age increased from 27 to 37 years)
- there also appears to be an ageing cohort of injecting drug users which is strongly influenced by heroin use—people who had injected a drug in 2013 were 10 years older than they were in 2001 (their age rose from 26 to 36).





## Average age people first used drugs

Adolescence is often characterised by rapid physical and psychological transition, experimentation and risk-taking behaviour (ABS 2008). This may include illicit drug use and this behaviour can cause both short- and long-term health and other problems. Those who initiate drug use early are more likely to continue into future illicit and problematic drug use (Loxley et al. 2004).

The average age at which people aged 14 or older used their first illicit drug has fluctuated between 18.6 and 19.4 since 1995. However in 2013, the age at which people first tried an illicit drug was older, increasing (slightly but significantly) from 19.0 in 2010 to 19.4 in 2013 (Online Table 5.9). Users tended to be older when they first use pharmaceutical drugs than other illicit drugs, 24.3 for pharmaceuticals compared to 18.6 for other illicit drugs (excluding pharmaceuticals).

Among people aged 14–24, the age of initiation into illicit drug use increased from 16.0 in 2010 to 16.3 in 2013 (Online Table 5.9). More specifically, the age at which people first used cannabis and meth/amphetamines rose, with both these drugs showing an older age of first use in 2013.

## Frequency of use

The health risks of illicit drug use increase with the frequency and quantity of drugs used (Degenhardt et al. 2013). Cannabis and meth/amphetamine users were more likely to use the drug on a regular basis compared with other drugs (Online Table 5.10) with 45% and 32% (respectively) using it at least once a month while ecstasy and cocaine users were more likely to be infrequent users, only using the drug once or twice a year (54% and 71% respectively).

In 2013, there was no change in the frequency of cannabis or ecstasy use but there were some changes in use among cocaine and meth/amphetamine users. People who used cocaine also did so less often in 2013; a lower proportion used it every few months (from 26% to 18.0%) and a higher proportion only used once or twice a year (from 61% to 71%). While for meth/amphetamine users there was a rise in the proportion using it as often as daily or weekly (from 9.3% to 15.5%), particularly among ice users; one-quarter (25%) used it at least weekly (up from 12.4% in 2010) (Online Table 5.20).

## Use of selected illicit drugs

This next section of the chapter focuses on illegal drugs (such as cannabis), emerging/novel psychoactive substances (such as synthetic cannabinoids), and other substances used inappropriately (such as inhalants). Refer to Chapter 6 for more information on misuse of pharmaceuticals.



## Cannabis

There are a wide variety of strategies and services available to minimise the use and harm associated with cannabis use. In 2007, the National Cannabis Prevention and Information Centre was established to educate and train health professionals with the aim of increasing early intervention and reducing cannabis use (Hughes 2014).

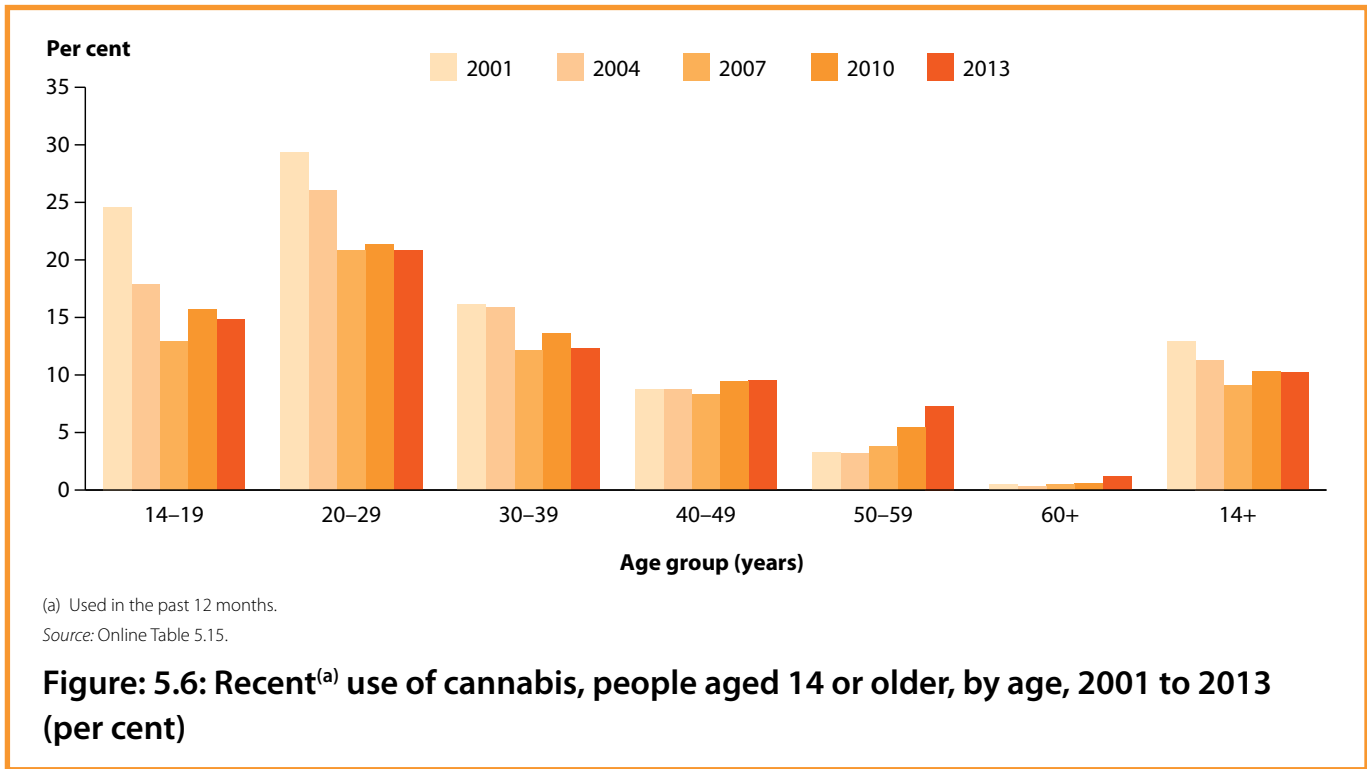
### Current use

In 2013, it was estimated that about 6.6 million (or 35%) people aged 14 or older had used cannabis in their lifetime and about 1.9 million (or 10.2%) had used cannabis in the previous 12 months (Online Table 5.4). Around 1 in 5 (21%) people aged 14 or older had been offered or had the opportunity to use cannabis in the previous 12 months (Online Table 5.12), and 1 in 10 (10.2%) reported that they did use cannabis in that time (Online Table 5.7). About 1 in 20 Australians (5.3%) had used in the month prior to the survey and 3.5% had used in the previous week. More specifically:

- males were more likely to use cannabis at any frequency, than females (Online Table 5.5)
- among people aged 14–24, the age at which they first tried cannabis increased from 16.2 to 16.7 between 2010 and 2013 (Online Table 5.10)
- cannabis users were more likely to try cannabis in their teens and age of first use was younger compared to other illicit drugs (Online Table 5.10)
- recent cannabis users (median age of 30 in 2013) were generally older than users of ecstasy (age 25), meth/amphetamines (age 28) and hallucinogens (age 24) (Online Table 5.16)
- one-third (32%) of recent cannabis users used the drug as often as weekly (Online Table 5.11) and older people (50 or older) were more likely than younger people to use cannabis regularly, with at least 4 in 10 recent users in these age groups using it as often as once a week or more (Online Table 5.13)
- one-fifth (19.8%) of recent cannabis users stated that all or most of their friends currently used cannabis, in contrast to only 0.8% of those who had never used the drug (Online Table 5.14).

### Age and sex comparisons over time

Recent use of cannabis has remained relatively stable over the past decade but there were some significant changes among different age groups (Online Table 5.15). Since 2001, recent cannabis use has generally dropped in the younger age groups (those aged 14–39), but either increased or remained stable for the older age groups (40 or older). Between 2010 and 2013, the proportion of people aged 50–59 and 60 or older using cannabis rose (from 5.5% to 7.3% and from 0.5% to 1.2% respectively) and is at the highest levels seen over the past decade among these age groups, which indicates that there appears to be an ageing cohort of cannabis users. In comparison to 2010, males aged 60 or older were twice as likely to use cannabis in 2013 (increasing from 0.8% to 1.8%) and females aged 50–59 were 1.6 times more likely to use cannabis (from 3.2% to 5.2%) but these proportions were still lower than younger age groups.



## Ecstasy

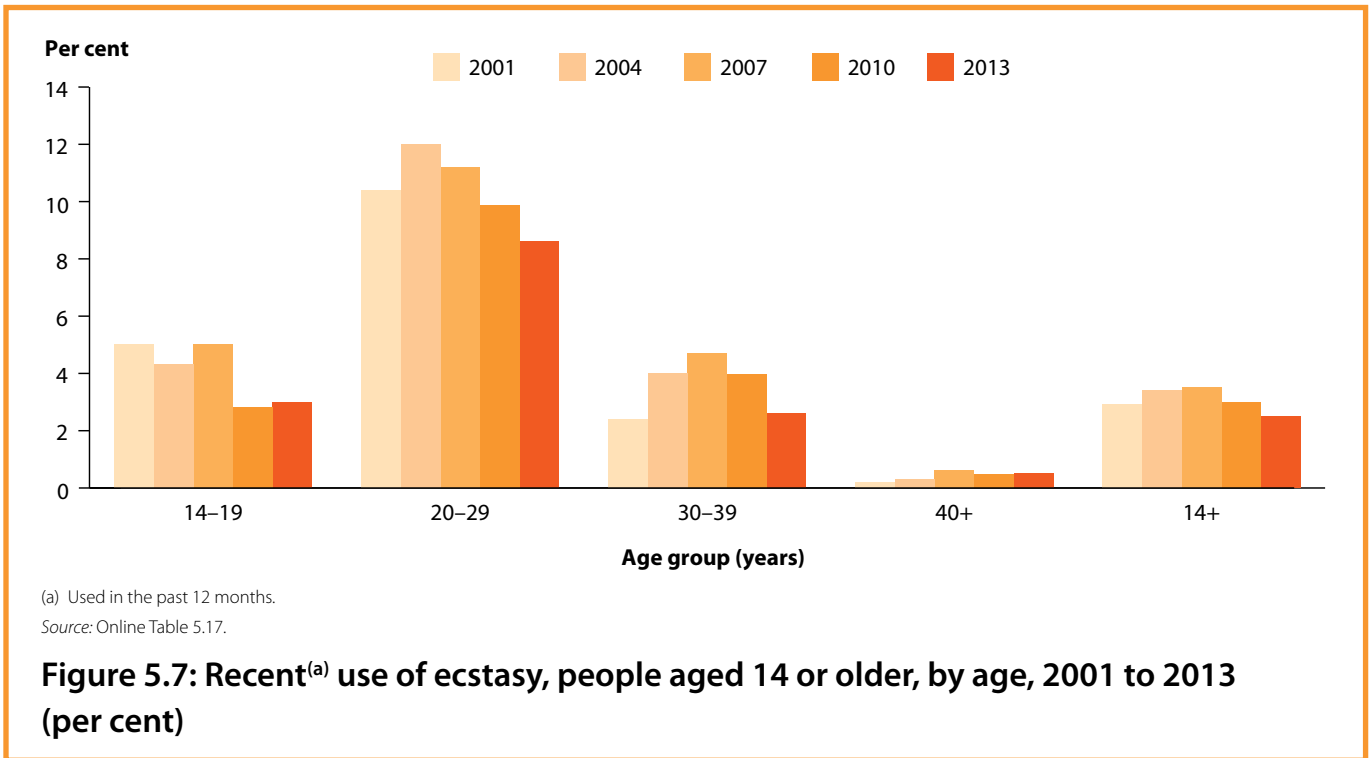
### Current use

The opportunity to use ecstasy was less common than cannabis with 7.2% of Australians stating they had been offered or had the opportunity to use the drug in the last 12 months (Online Table 5.12). Ecstasy was the second most commonly used illicit drug in a person's lifetime, with 2.1 million (10.9%) people aged 14 or older reporting having ever used the drug and 500,000 had done so in the past 12 months, representing 2.5% of the population (Online Table 5.4). In addition:

- the majority of recent ecstasy users only took ecstasy once or twice a year (54%) (Online Table 5.11)
- the median age of recent ecstasy users was 25 (Online Table 5.16) and most people tried ecstasy as adults as the average age of initiation was 18.2 among people aged 14–24 (Online Table 5.10)
- most ecstasy users claimed that at least some of their friends also used the drug; three-quarters said that about half or fewer of their friends currently used and one-quarter said all or most (Online Table 5.14).

### Age comparison over time

Ecstasy use (reported as ecstasy/designer drugs prior to 2004) had been gradually increasing since 1995, before peaking in 2007. It then declined in 2010 and again in 2013 (Online Table 5.17). Although overall there was a decrease between 2010 and 2013, the fall was only significant for females (from 2.3% to 1.8%) and for people aged 30–39 (from 3.9% to 2.6%), particularly females in this age group (from 3.0% to 1.2%). There were no significant changes in use among any other age group.



## Meth/amphetamines

Between 2004 and 2010, questions relating to meth/amphetamines use were refined to more accurately reflect substances used in Australia. More specifically in 2007 the term 'meth' was introduced and in 2010 clarification about non-medical use was added. Before 2004 the term 'meth' was not included.

### Current use

In 2013, about 1.3 million (7.0%) people had used meth/amphetamines in their lifetime and 400,000 (2.1%) had done so in the last 12 months (Online Table 5.5). Males were more likely than females to have used meth/amphetamines in their lifetime (8.6% and 5.3%, respectively) or in the last 12 months (2.7% and 1.5% respectively). In addition:

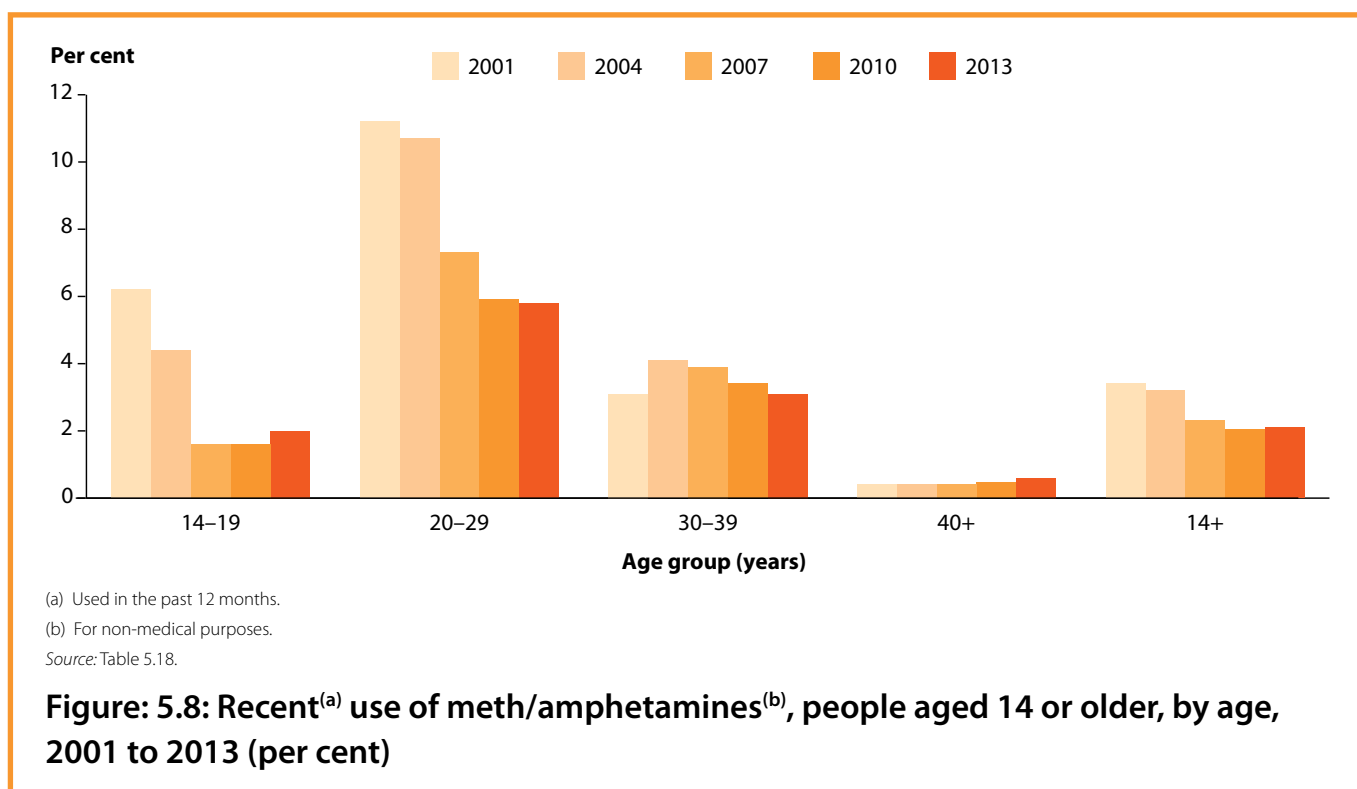
- people aged 30–39 were slightly more likely than those in other age groups to have ever used meth/amphetamines (14.7%), while people aged 20–29 were more likely to have recently used meth/amphetamines (5.8%) (Online Table 5.7)
- meth/amphetamine users are getting older; the average age of users was 24 in 2001, compared with 28 in 2013 (Online Table 5.16) and age of first use was also older, increasing from 17.9 in 2010 to 18.6 in 2013 among young people aged 14–24 (Online Table 5.10)
- most people who were offered or had the opportunity to use meth/amphetamines didn't use it—5.8% of people aged 14 or older were offered meth/amphetamines and 2.1% had used it (online tables 5.4 and 5.12)
- among people aged 20–29, 14.1% had been offered or had the opportunity to use the drug, and 5.8% had used it (online tables 5.18 and S5.28).

## Age and sex comparisons over time

Meth/amphetamine use had been declining since it peaked at 3.7% in 1998 (Online Table 5.3) but remained stable at 2.1% between 2010 and 2013. There were no significant changes in the proportion of people using meth/amphetamines in last 12 months among different age groups or sexes (Figure 5.8).

Patterns of meth/amphetamine use over time are:

- recent use among females has declined since 2001 (Online Table 5.18), but it remained relatively stable in 2013 (1.7% in 2010 compared with 1.5% in 2013)
- recent use among males has declined since 2001 but remained stable between 2010 and 2013 at around 2.5%
- there was a noticeable drop in recent use among people aged 14–19 and 20–29 between 2004 and 2007 but little change in use since 2007.



## Frequency and form of meth/amphetamines

Meth/amphetamines comes in many forms including powder/pills (speed), crystal methamphetamine (crystal meth or ice) and a sticky paste (base). 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 problems (DoHA 2013).

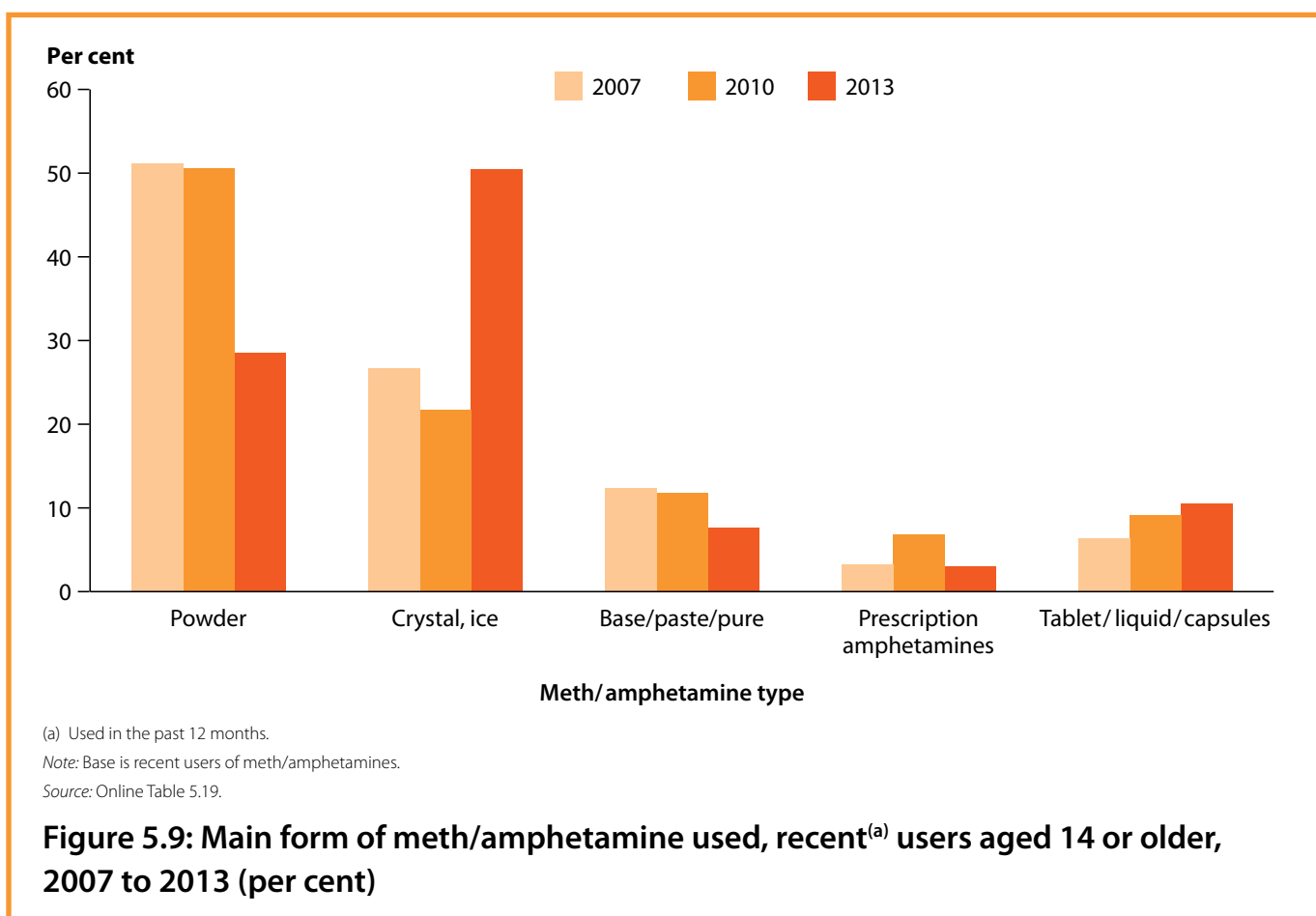




In 2013 there was a change in the main form of meth/amphetamines used with ice replacing powder as the preferred form of the drug. Among recent users, powder decreased from 51% to 29% while the use of ice more than doubled, from 22% in 2010 to 50% in 2013 (Figure 5.9).

In addition:

- recent meth/amphetamine users also used the drug more frequently in 2013 as there was a rise in the proportion of people using it daily or weekly (from 9.3% to 15.5%)
- meth/amphetamine users who mainly used ice were far more likely to use ice on a regular basis with one-quarter (25%) using it at least weekly compared with only 2.2% of those who mainly used powder (Online Table 5.20).





## Cocaine

### Current use

There was a significant increase in the proportion of people who were offered or had the opportunity to use cocaine in 2013 (from 4.4% in 2010 to 5.2%). However, there was no change in the proportion using cocaine in the previous 12 months (2.1%) (online tables 5.3 and 5.12). Recent users also used cocaine less often in 2013, with a lower proportion using it every few months (from 26% to 18.0%) and a higher proportion using it once or twice a year from 61% to 71% (Online Table 5.11).

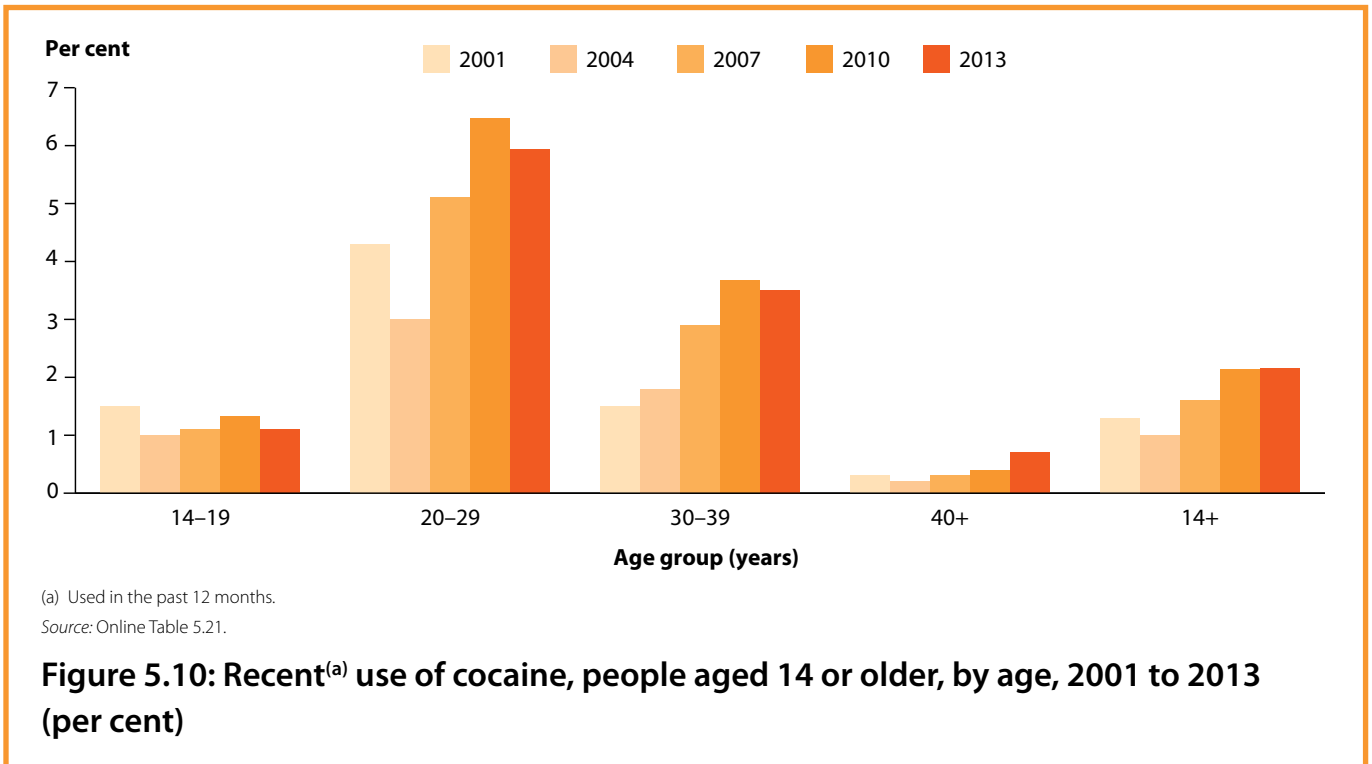
Of people aged 14 or older, 8.1% (or 1.5 million) had used cocaine in their lifetime, and 2.1% (or about 400,000 people) had used it in the previous 12 months (Online Table 5.5). Cocaine use was highest among:

- males, who were twice as likely as females to have used cocaine in the preceding 12 months (2.9% and 1.4%, respectively for those aged 14 or older)
- those aged 30–39, who were most likely to have ever used cocaine (16.2%), particularly males (19.6%) (online tables 5.7 and S5.20)
- people aged 20–29, both males (7.3%) and females (4.6%), were most likely to have used cocaine in the previous 12 months.

### Age comparisons over time

The proportion of males and females who had used cocaine in the previous 12 months has been increasing since 2004 and was highest in 2010 and 2013 (Figure 5.10). While use of drugs such as cannabis, ecstasy and meth/amphetamines has generally declined since 2004, the proportion of people using cocaine has been increasing since 2004. This is particularly so among those aged 20–29 and 30–39. Cocaine use in Australia is currently at the highest levels yet seen. More specific findings include:

- there appears to be an ageing cohort of cocaine users as the average age of use was 25 in 2001 and rose to 29 by 2013 (Online Table 5.16)
- throughout the period 2001 to 2013, males aged 20–29 have consistently been the most likely group to have used cocaine in the previous 12 months, and use increased from 5.2% to 7.3% over this period but was stable between 2010 and 2013
- there was a small but significant rise in the proportion of people aged 40 or older using cocaine between 2010 and 2013 (from 0.4% to 0.7%), but this was only significant for males (from 0.6% to 1.1%)
- after an increase in use between 2007 and 2010, the proportion of females aged 30–39 using cocaine declined in 2013 (from 2.6% to 1.6%).



## Emerging psychoactive substances

### What are they?

Novel, new or emerging psychoactive substances, or EPS, is a term used to describe drugs with mind-altering effects that are relatively new to the recreational drug market. EPS often mimic the effects of existing illicit psychoactive drugs such as cannabis, ecstasy (MDMA) and hallucinogens, or have chemical structures very similar to those substances. Other names given to this group of drugs include: research chemicals, analogues, legal highs, herbal highs, bath salts, party pills and synthetic drugs (NDARC 2013).

Psychoactive substances are emerging at an unprecedented rate as manufacturers use new chemicals to replace those that are banned (Bright 2013). By 2013, the emergence of 348 EPS had been reported to United Nations Office on Drugs and Crime (UNODC), the majority of which were identified between 2008 and 2013. However, this figure is likely to underestimate the number of these drugs, as the figure only reflects reports of official sources and does not take unofficial sources into account (UNODC 2014). There are 2 primary categories of product available in Australia: powders/pills and synthetic cannabis (Bright 2013).



## Current controls

A range of EPS with similar effects to more commonly known internationally controlled drugs such as cannabis and amphetamine-type substances (ATS) have already been identified as potential risks to public health and are controlled in Australia. Drugs in this health category have been scheduled as Prohibited Substances under the Commonwealth Poisons Standard (the Standard for the Uniform Scheduling of Medicines and Poisons or SUSMP), which is administered by the Therapeutic Goods Administration.

In 2013 there was a move towards greater alignment of Commonwealth and state and territory-level controls, and all jurisdictions have aligned their drugs and poisons legislation to cover those substances listed as prohibited under SUSMP. There is still variation in relation to approaches to enforcement.

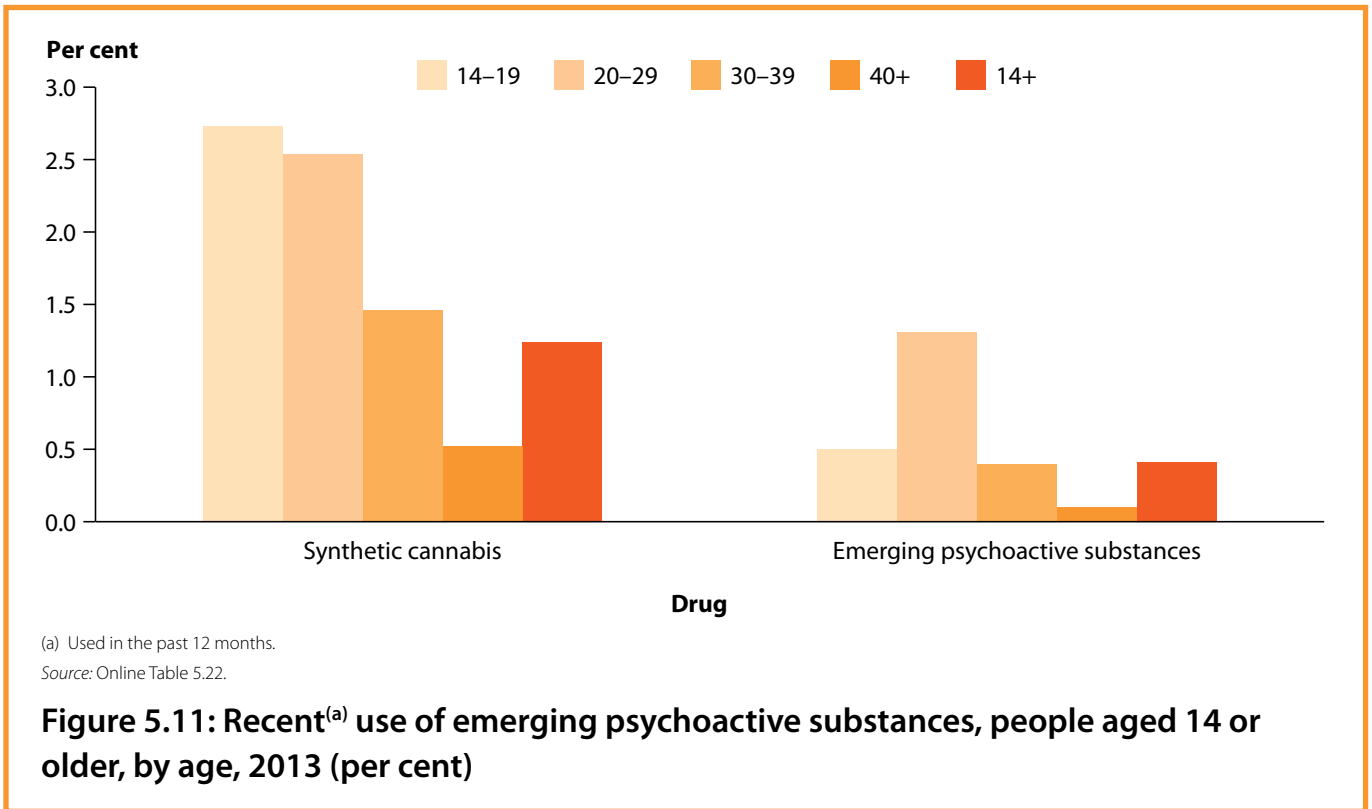
At the Commonwealth level, changes have been made to the serious drug offences framework to better meet the emerging threat of EPS. Substances may now be listed quickly and permanently in the Criminal Code Regulations 2002 (Commonwealth) once the relevant criteria, which are harm and evidence based, have been met.

Similarly, states and territories have introduced controls on many EPS. Each state and territory has its own laws that determine what substances are subject to criminal controls.

## Current use

Questions on the use of these drugs were included in the NDSHS for the first time in 2013 and results showed that 1.3% of the population (or about 230,000 people) had used synthetic cannabinoids in the last 12 months, and 0.4% (or about 80,000 people) had used another psychoactive substance such as mephedrone (Figure 5.11). More specifically:

- the most likely age groups to have used synthetic cannabis were those aged 14–19 (2.8%), closely followed by 20–29 (2.5%)
- the most likely group to have used other psychoactive substances was people aged 20–29 (1.3%); use was low among other age groups, less than 1%
- while the greater majority of synthetic cannabis users had also used a traditional illicit drug, there was a small proportion (4.5%) who had only used synthetic cannabis and did not use any other illicit drug in the previous 12 months (Online Table S2.1).



### Other illicit drugs

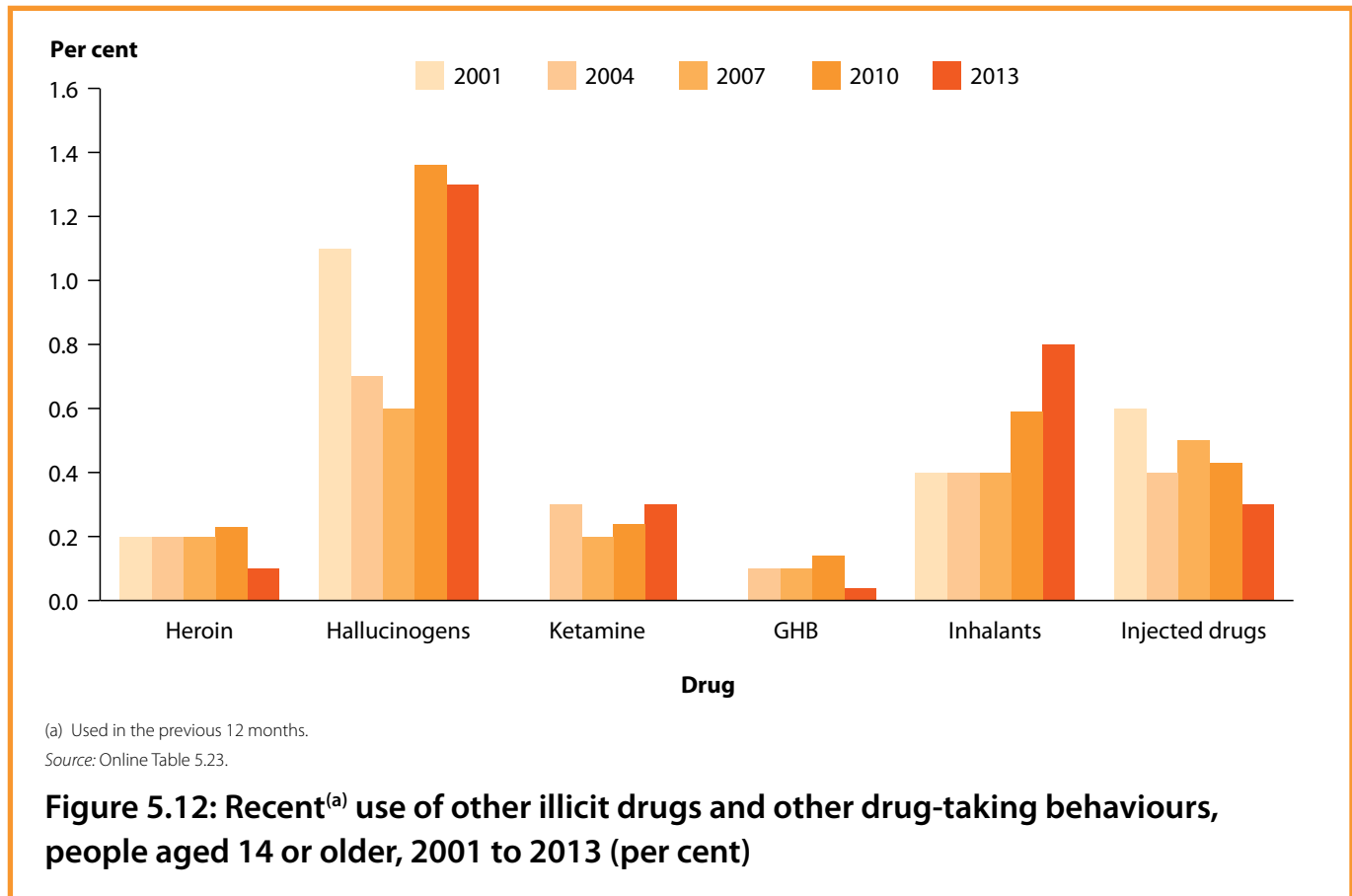
This section presents information on the use of other illicit drugs surveyed, including heroin, hallucinogens, ketamine, GHB and inhalants, as well as on drug-taking behaviour such as injecting drug use.

Injecting drug use is a major risk factor for transmitting bloodborne viruses, including HIV, hepatitis B and hepatitis C. Needle and syringe sharing among people who inject drugs is partly responsible for transmitting infection among drug users, although unsafe sexual behaviours also play a role (AIHW 2012).

Overall, the proportion of use of these drugs was small within Australia and generally stable between 2010 and 2013. In 2013:

- nearly 1 in 10 (9.4%) people aged 14 or older had used hallucinogens in their lifetime, and 1.3% in the 12 months before the survey (Figure 5.12; Online Table 5.24)
- recent use of ketamine and GHB by people aged 14 or older was very low—0.3% of people had used ketamine in the previous 12 months, and less than 0.1% had used GHB
- there were small but significant falls in recent use of heroin and people who had injected drugs (from 0.2% to 0.1% and from 0.4% to 0.3% respectively) (Online Table 5.23)
- inhalants were used recently by 0.8% of the population and of these users, 30% used once a month or more (online tables 5.24 and S5.23).

The proportion of the population aged 14 or older 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 to 2013 (less than 1% of the population; Figure 5.12). Positively in 2013, the number of people using heroin halved, from 40,000 to 20,000 (or from 0.2% to 0.1%) and the number of people who injected a drug declined from 80,000 to 60,000 (or from 0.4% to 0.3%).



## Drug sources and locations of use

Most people sourced cannabis (61%), ecstasy (63%), meth/amphetamines (57%) and cocaine (74%) from a friend (Online Table 5.25). Meth/amphetamine and ecstasy users were more likely than other drug users to source it from a dealer (31% and 30% respectively).

Ecstasy users were more likely to use the drug in a public venue (for example raves, pubs or clubs), while cannabis (87%), meth/amphetamine (76%) and cocaine (60%) users were more likely to use the drug in a private home (Online Table 5.26). Meth/amphetamine users were also less likely to use the drug in a public venue in 2013 (use at raves/dance parties and public establishments both declined significantly) which is likely to be related to the change in the main form of meth/amphetamine used.



## Motivations/factors that influence decision 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. Most people use drugs because they want to feel better or different. There are different categories of drug use including experimental use (try it once or twice out of curiosity), recreational use (for enjoyment, to enhance a mood or social occasion), situational use (cope with the demands of a situation) and dependent use (need it consistently to feel normal or avoid withdrawals) (ADF 2013). People may not be aware of the underlying reasons they take drugs or may answer in a way they deem to be more socially acceptable.

In 2013, of people aged 14 or older, the most common reason that an illicit substance was first used was curiosity (66%), followed by wanting to do something exciting (19.2%) and wanting to enhance an experience (13.3%) (Online Table 5.27). The majority of lifetime drug users said they no longer used illicit drugs (44%) or that they only tried illicit drugs once (30%) (Online Table 5.28). Among those who continued to use the drug, the most common reason for continuing drug use was because they wanted to enhance experiences (30%) or do something exciting (17.5%) (Online Table 5.29). About 1 in 10 said they were influenced by their friends or family (10.7%) or they took drugs to improve their mood or stop feeling unhappy (10.2%). Ex-users of illicit drugs were more likely to admit to being influenced by their friends and family than recent users (19.7% compared with 9.4%).

## Victims of drug-related harm

The objectives of the *National Drug Strategy 2010–2015* include reducing harm to community safety and reducing the harm to individuals from drug use (MCDS 2011). The NDSHS contributes to this by reporting on the experiences of illicit drug-related incidents and harm by people living in Australia. Online tables 5.30 and 5.31 present information about people aged 14 or older who were victims of an incident related to illicit drugs in the previous 12 months. These showed that in 2013:

- 1 in 12 people (8.3%) had been a victim of an illicit drug-related incident
- more people had been physically abused by someone under the influence of illicit drugs, increasing from 2.2% in 2010 to 3.1% in 2013; this increase was significant for both males and females
- verbal abuse was the most frequently reported incident overall (6.6%) and fewer males reported being verbally abused in 2013 (declining from 7.7% to 6.8%)
- people aged 20–29 were most likely to experience an incident caused by someone under the influence of illicit drugs, with 9.2% reporting they had been verbally abused and 4.2% physically abused.

# Misuse of pharmaceuticals

This chapter presents information on patterns of pharmaceutical misuse in Australia. All pharmaceutical use in this chapter relates to use for non-medical purposes.







A pharmaceutical is a drug that is available from a pharmacy, over the counter or by prescription, which may be subject to misuse (MCDS 2011).

In the 2013 NDSHS, pharmaceuticals reported included: pain-killers/analgesics (for example, paracetamol, over-the-counter and prescription codeine combination products), tranquillisers (for example, benzodiazepines, valium and rohypnol), steroids, methadone/buprenorphine or other opiates (not including heroin). All pharmaceutical use in this chapter relates to use for non-medical purposes which may include using medications in doses or frequencies other than those prescribed.

The pharmaceutical use questions in the survey were designed to help respondents differentiate between legitimate medical use and non-medical use. For each class of pharmaceuticals, the respondent was asked: first, if they have ever used the drugs in question and second, if they have used them for 'non-medical purposes' or when 'not supplied to you medically'. Only those who answer 'yes' to the second question are counted as using pharmaceuticals illicitly. However, the questions rely on the respondent's self-reported behaviour and the respondent understanding that they have misused pharmaceuticals.

All data presented in this chapter are available through the online misuse of pharmaceuticals tables <<http://www.aihw.gov.au/publication-detail/?id=60129549469&tab=3>>.

## Key findings

- In 2013, 4.7% of Australians aged 14 or older had misused a pharmaceutical in the previous 12 months, which was a significant rise from 4.2% in 2010. This increase was only significant for males (from 4.1% in 2010 to 5.1% in 2013 and from 4.2% to 4.4% for females).
- The rise in pharmaceutical misuse was mainly due to an increase in males in their 30s (4.5% in 2010 to 6.9% in 2013) and females in their 40s (3.1% in 2010 to 4.5% in 2013) misusing these drugs.
- People aged 20–29 (5.8%) and 30–39 (5.3%) were most likely to have misused pharmaceuticals in the previous 12 months.
- Pain-killers/analgesics (3.3%) were the most commonly misused pharmaceutical drug type and over-the-counter pain-killers (78%) were more commonly misused than prescription pain-killers (51%).
- The proportion of people who had ever misused a pharmaceutical drug rose to 11.4% in 2013, up from 7.4% in 2010, the first increase in lifetime use since 2001.



## Current pharmaceutical misuse and trends

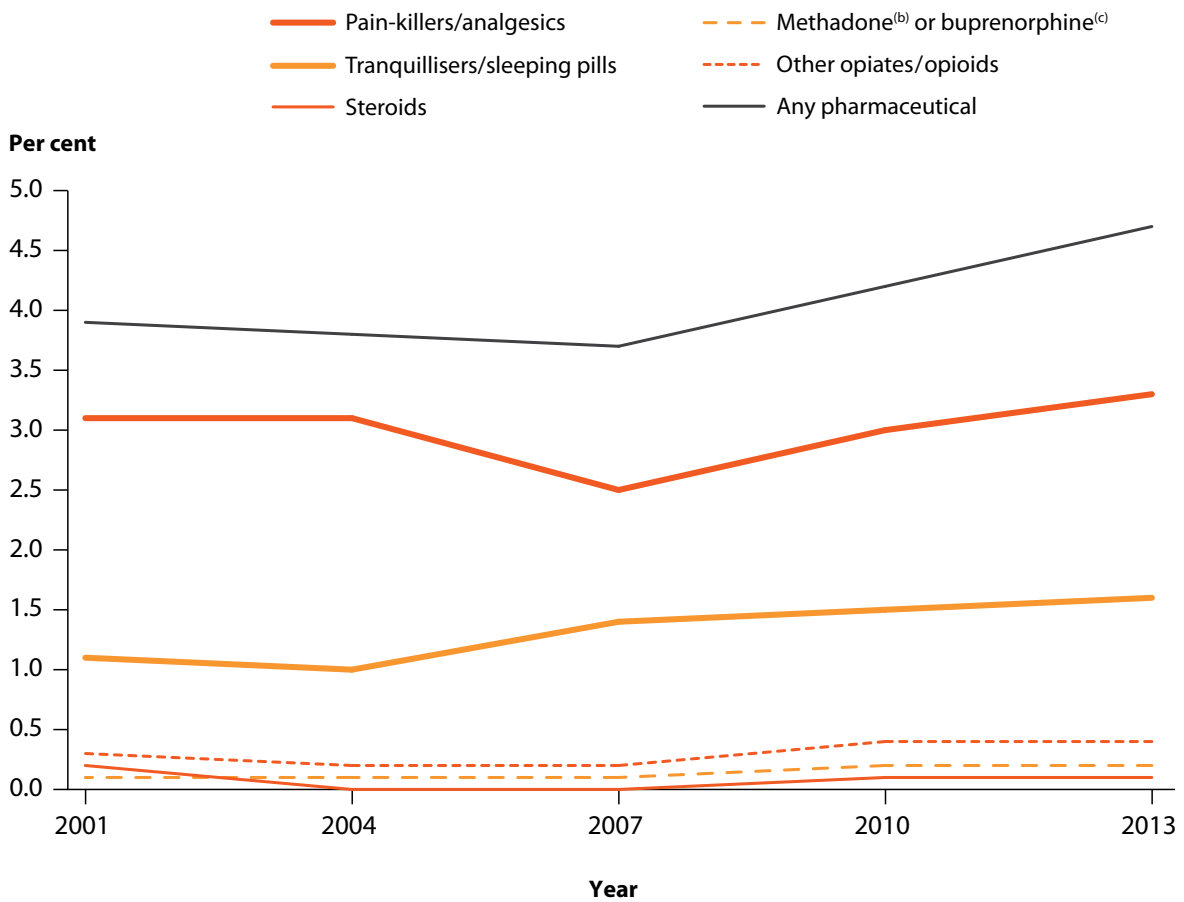
In 2013, 900,000 people (or 4.7%) aged 14 or older used a pharmaceutical drug for non-medical purposes in the previous 12 months. This represents a significant rise from 4.2% in 2010. This is the highest proportion reported since 2001 (Figure 6.1). More specifically:

- there were no significant changes in the misuse of specific types of pharmaceutical drugs but, when combined, there was an increase overall (Figure 6.1)
- misuse of pain-killers/analgesics and tranquillisers/sleeping pills increased slightly from 2001
- pain-killers/analgesics were the most commonly misused pharmaceutical drug type and around 600,000 people (or 3.3%) misused pain-killers/analgesics in the previous 12 months, increasing from 550,000 people (or 3.0%) in 2010 (online tables 6.2 and 6.3)
- tranquillisers/sleeping pills were the second most commonly misused pharmaceutical drug type and this remained stable in 2013 (1.6% of people aged 14 or older)
- less than 1% of Australians used steroids, methadone or buprenorphine or other opioids for non-medical purposes in the previous 12 months
- 1.2% of Australians reported having used pharmaceuticals for non-medical purposes in the previous week and 2.2% in the previous month (Online Table 6.4)
- the proportion of people who had ever misused a pharmaceutical drug rose to 11.4% in 2013, up from 7.4% in 2010, the first increase in lifetime use since 2001 (Online Table 5.2).

## Age and sex comparisons over time

Historically, recent pharmaceutical misuse was very similar between the sexes, with female use slightly higher than male use in most years. In 2013, males reported a higher proportion of recent use than females, and showed the largest difference in overall use between the sexes for any year since 2001 (Online Table 6.1). In addition:

- recent use of any pharmaceutical increased between 2010 and 2013 for males (4.1% in 2010 compared to 5.1% in 2013) but not for females (4.2% in 2010 to 4.4% in 2013)
- pharmaceutical misuse rose across all age groups between 2010 and 2013, but these increases were not significant
- recent pharmaceutical use increased from 2010 for males in their 30s (4.5% in 2010 to 6.9% in 2013) and females in their 40s (3.1% in 2010 to 4.5% in 2013)
- those aged 30–39 and 60 or older had the largest rises in pharmaceutical use since 2001.



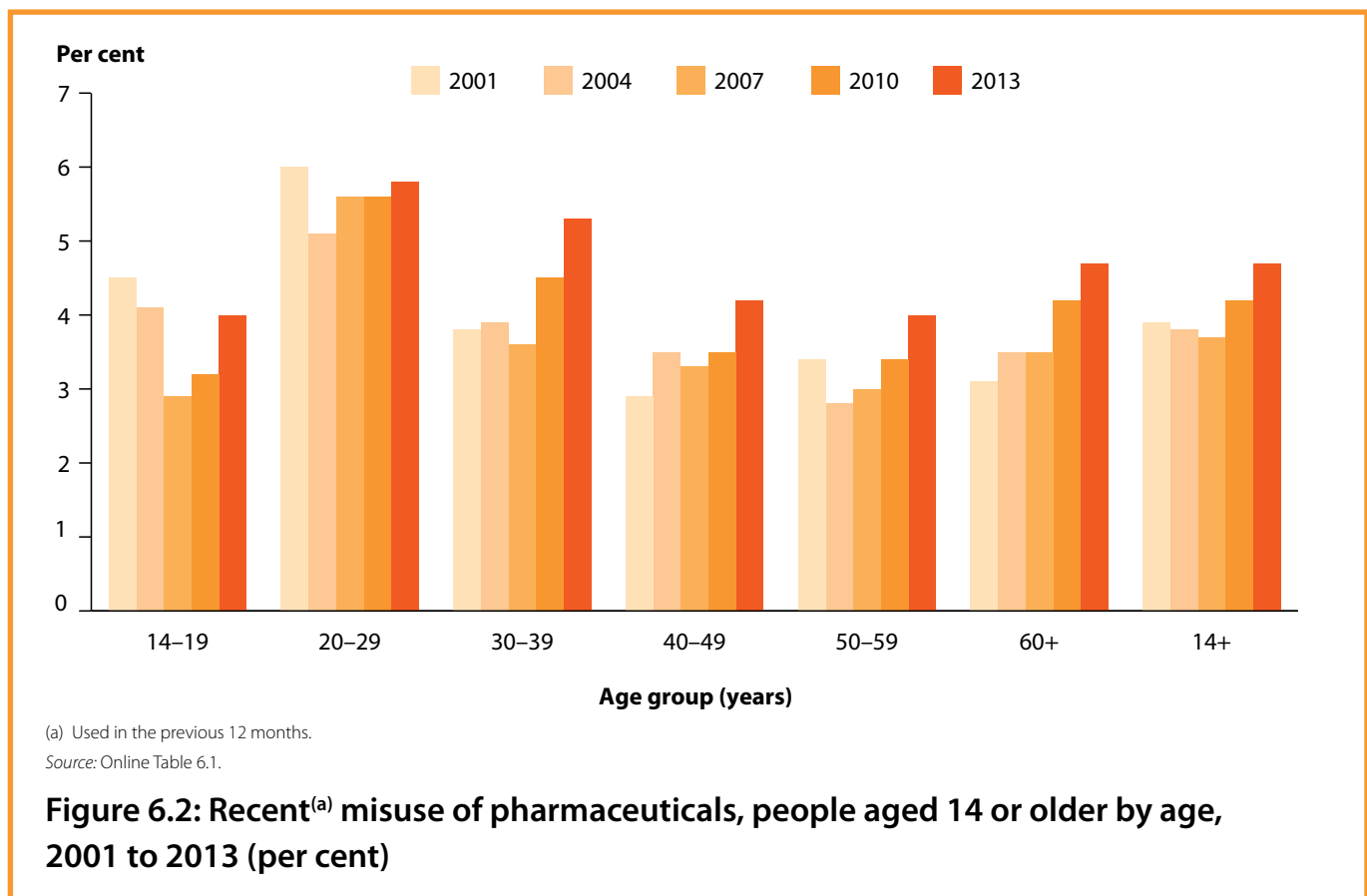
(a) Used in the previous 12 months.  
 (b) Non-maintenance.  
 (c) Did not include buprenorphine before 2007.  
 Source: Online Table 6.2.

**Figure 6.1: Recent<sup>(a)</sup> misuse of pharmaceuticals, people aged 14 or older by drug type, 2001 to 2013 (per cent)**

## Current use by age and sex

In 2013, 2.1 million people (or 11.4%) aged 14 or older had misused a pharmaceutical in their lifetime and 900,000 people (or 4.4%) had done so in the previous 12 months but usage differed by age and sex (online tables 6.3 and 6.4). For example:

- recent misuse of pharmaceuticals was highest among people in their 20s (5.8%) and 30s (5.3%) (Figure 6.2)
- older people were the third most likely to use, with 4.7% of people aged 60 or older reporting using a pharmaceutical drug for non-medical purposes in the previous 12 months
- pain-killers/analgesics and tranquillisers/sleeping pills were the most commonly misused pharmaceutical drug types across all age groups (Online Table 6.3)
- males were more likely to have used pharmaceuticals for non-medical purposes in the last 12 months than females (5.1% compared to 4.4%) and this was true across all pharmaceutical drug types in the survey (online tables 6.1 and 6.3)
- use of steroids among females was very low, less than 0.1%, compared to 0.2% for males (Online Table 6.3)
- the proportion of people who reported using pharmaceuticals in the previous week or month was generally higher in the older age groups, with 1.5% of those aged 60 or older reporting using in the past week and 2.6% using in the past month (Online Table 6.4).





## Frequency of use

Among people aged 14 or older who had misused pharmaceuticals in the previous 12 months:

- the majority used infrequently; 31% of people used once or twice a year and a further 20% of people used every few months (Online Table 6.5)
- almost 3 in 10 (29%) people used weekly or more often
- females used more frequently than males; 31% of female users used at least weekly and 22% used at least once a month, compared with 28% and 16.9%, respectively, for males (Online Table 6.6).

## Prescription vs. over-the-counter analgesics

In Australia the supply of pain-killers/analgesics is regulated according to the type and quantity of the active ingredients, recommended dosage and quantity in the package.

In this report, 'over the counter' refers to all medications that do not require a prescription. This includes medications that are available to purchase off the shelf in supermarkets and pharmacies, such as aspirin, paracetamol or ibuprofen, and medications provided under pharmacist supervision, such as ibuprofen and codeine combination product medications.

Other pain-killers/analgesics are only available by prescription; these include codeine and paracetamol combination products, fentanyl, morphine, oxycodone, and pethidine.

A person might obtain prescription pain-killers/analgesics for non-medical use by 'doctor shopping' and obtaining prescriptions from multiple prescribers, using medications prescribed to another, or obtaining medication with a forged script or on the black market.

## Types of pain-killers/analgesics used

Among people who reported misuse of any kind of pain-killer/analgesic, over-the-counter pain-killers were more commonly used than prescription pain-killers (78% and 51% respectively) (Online Table 6.7).

Of people who had used any type of pain-killer for non-medical purposes in the previous 12 months:

- paracetamol (51%) was the most common type of over-the-counter pain-killer used, followed by ibuprofen and codeine combination product medications (33%)
- the most commonly used prescription pain-killer was a codeine and paracetamol combination product (29%) which contains a higher dose of codeine than over-the-counter products
- both males and females were more likely to have used over-the-counter pain-killers than prescription pain-killers.

# seven

## State and territory comparisons

This chapter presents a summary of alcohol, tobacco and illicit drug use among states and territories.





Some of the results have a relative standard error (RSE) of 50% or greater and have been flagged with a double asterisk (see online tables at <http://www.aihw.gov.au/publication-detail/?id=60129549469&tab=3>). High RSEs most often arise where there is low prevalence or a small respondent population. Readers should exercise caution when interpreting such results, especially when making statistical comparisons or examining trends.

Further, tests of the significance of differences between jurisdictions have not been performed. Readers should use caution in concluding significant differences, even in cases where there are apparently large substantive differences.

Due to different age structures in states and territories, state and territory prevalence comparisons should be considered with age-standardised percentages. State and territory age-standardised percentages are available through the online tables.

All data presented in this chapter are available through the online state and territory tables <http://www.aihw.gov.au/publication-detail/?id=60129549469&tab=3>.

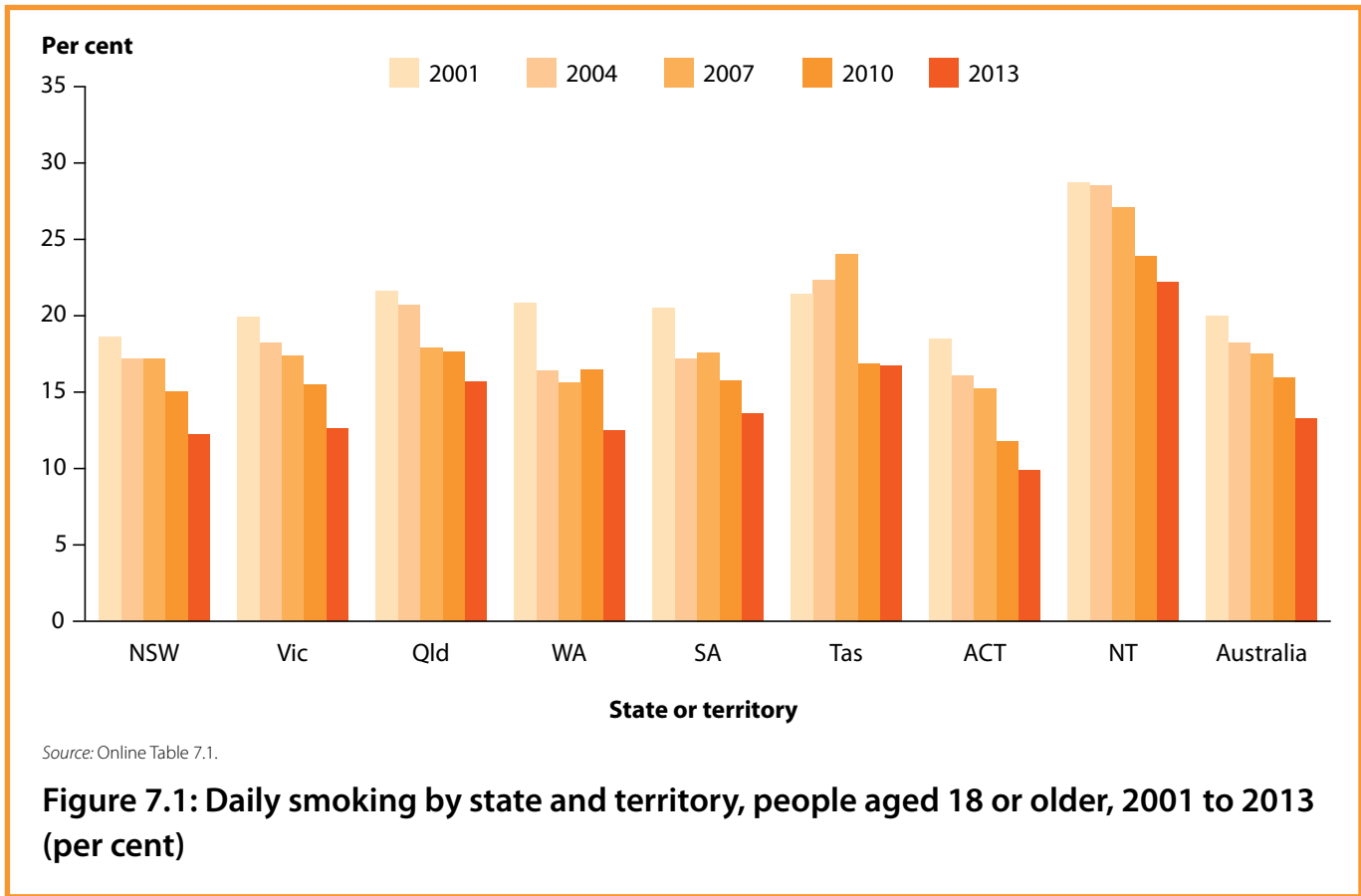
## Key findings

- Declines in daily tobacco smoking were statistically significant in New South Wales, Victoria and Western Australia.
- The proportion of daily smokers in the Northern Territory (22%) was more than double the proportion in the Australian Capital Territory (9.9%).
- Patterns of risky drinking varied across jurisdictions; for example, people in the Northern Territory and Western Australia were more likely to consume alcohol in quantities that placed them at risk of an alcohol-related disease, illness or injury.
- The proportion of abstainers in New South Wales (24%) and Victoria (24%) was slightly higher than the national average (22%).
- There were no significant changes in illicit use of drugs across any jurisdiction between 2010 and 2013.
- Illicit use of any drug was lowest in New South Wales and Victoria (14.2% and 14.3% respectively) and highest in the Northern Territory (22%).

## Smoking

All jurisdictions reported a drop in the proportion of daily smokers aged 18 or older from 2010 to 2013, but this was only statistically significant in New South Wales (from 15.0% to 12.2%), Victoria (from 15.5% to 12.6%) and Western Australia (from 16.5% to 12.5%) (Figure 7.1). Findings also showed that:

- since 2001, the Northern Territory has consistently had the highest proportion of daily smokers, and this pattern continued in 2013 although the rate has declined over the decade (Figure 7.1)
- daily smokers rose in Tasmania between 2001 and 2007 (from 21% to 24%) and then substantially declined in 2010 (by 7 percentage points), then remained fairly stable in 2013 at 16.7%, the second-highest recorded smoking rate after the Northern Territory
- after adjusting for differences in age structure, daily smoking continued to be highest in the Northern Territory and lowest in the Australian Capital Territory (see Online Table A7.1 for age-standardised percentages).



### Tobacco smoking by age and sex

Males were more likely to smoke daily than females across all jurisdictions except in South Australia (12.5% compared with 13.1% for females) and the rates were similar for the Australian Capital Territory (9.7% compared with 9.6%) (Online Table 7.2). Some age groups were more likely to smoke than others and this varied across jurisdictions (Online Table 7.3). For example:

- smoking was highest among Tasmanians aged 18–24 at 31.6%, more than double the rate of people aged 18–24 in New South Wales, Victoria, Western Australia, South Australia and Australian Capital Territory
- in New South Wales and Victoria, the proportion smoking daily was highest among people aged 25–29 (15.7% and 16.7%); while in the Northern Territory the proportion was highest among those aged 30–39 (28%). For the remaining jurisdictions, people in their 40s were more likely to smoke daily than any other age group.





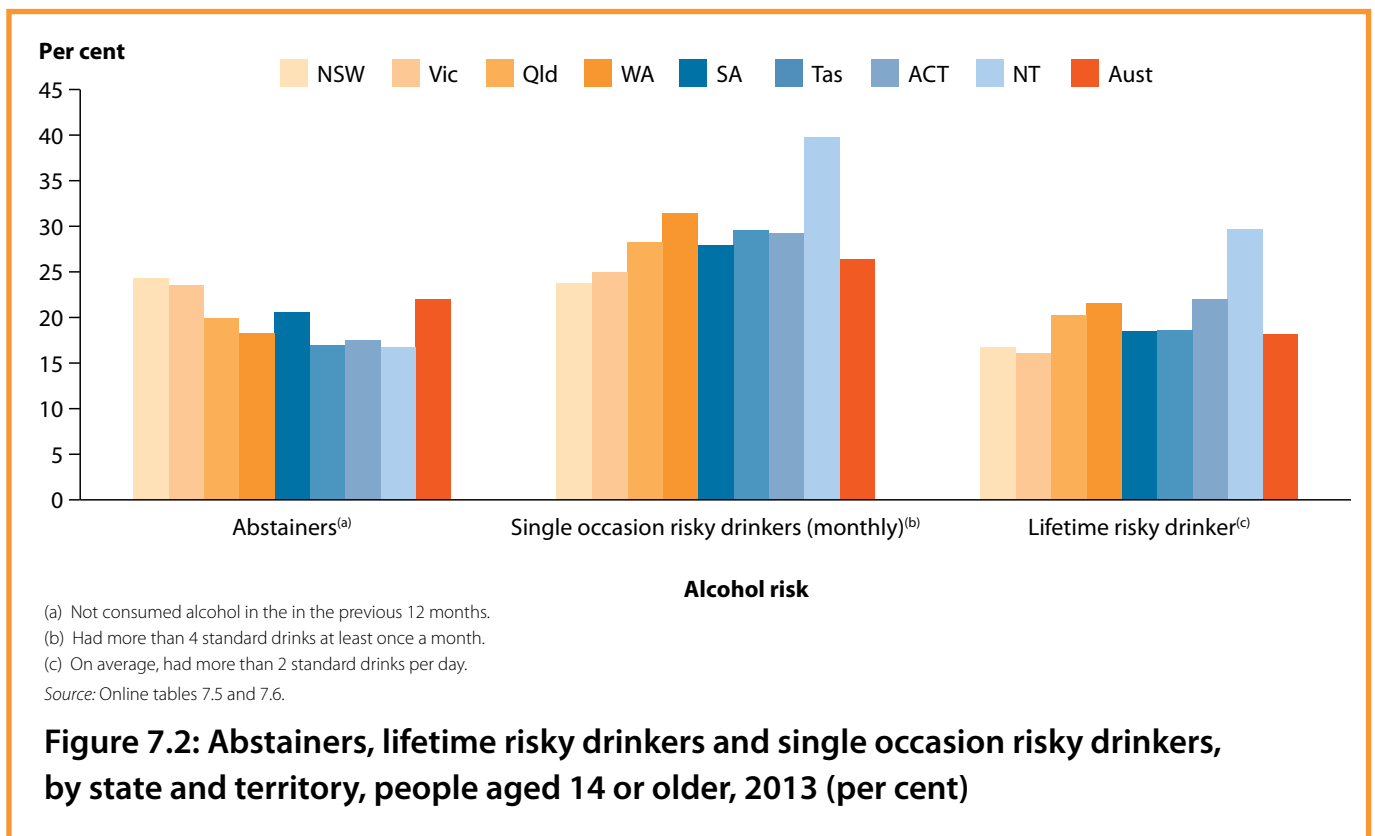
## Alcohol

There was variation in daily drinkers by states and territories. While overall there was a decrease in daily drinking between 2010 and 2013 (from 7.2% to 6.5%), the fall was only significant in Victoria (from 6.6% to 5.5%) and some jurisdictions (South Australia, the Australian Capital Territory and the Northern Territory) reported a slight rise (see Online Table S7.3).

Consumption of alcohol also differed by state and territory and some jurisdictions were more likely to consume alcohol at risky levels than others (Figure 7.2). In 2013:

- the proportion of abstainers in New South Wales (24%) and Victoria (24%) was higher than the national average (22%)
- people in the Northern Territory were far more likely to consume alcohol in quantities that placed them at risk of harm on a single occasion (at least monthly) than any other jurisdiction (40% compared with 26% for the nation)
- the pattern of lifetime risky drinkers varied across jurisdictions, ranging from a low of 16.1% in Victoria to a high of 30% in the Northern Territory
- people in the Northern Territory (40%) recorded the highest proportion of people consuming 5 or more standard drinks at least once a month (single occasion risk), while people in New South Wales were the least likely to consume alcohol in these quantities (24%).

These differences were apparent after adjusting for differences in age structure (see Online Table A7.2).





## Risky alcohol consumption by age and sex

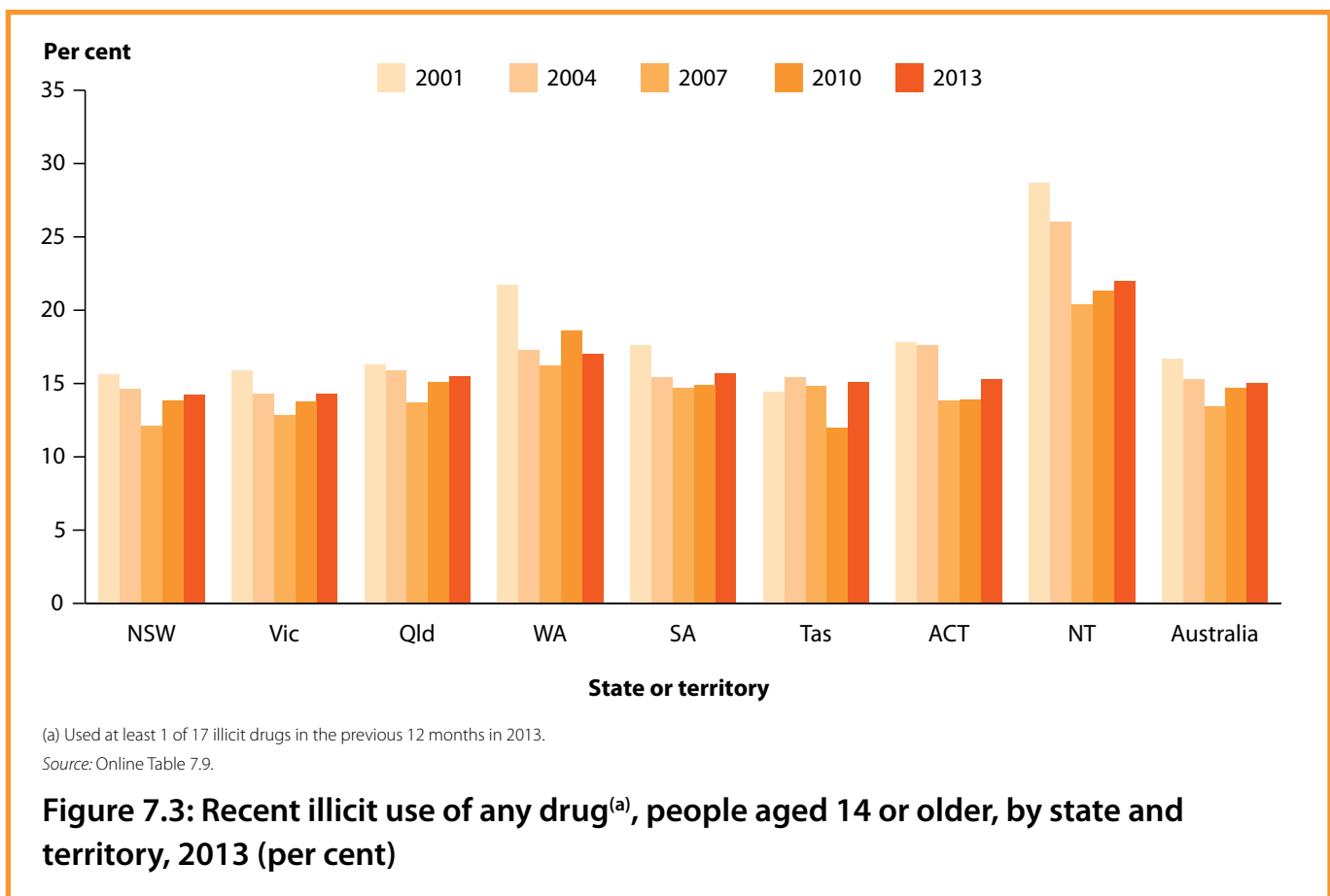
Certain age groups were more likely to drink at risky levels and this varied by jurisdiction. In New South Wales, Queensland and South Australia, people aged 40–49 were the most likely age group to be lifetime risky drinkers, while Victoria, Tasmania and the Australian Capital Territory had a higher proportion of those aged 20–29 who were lifetime risky drinkers (Online Table 7.7). People aged 50–59 living in the Northern Territory were more likely than any other age group to drink at levels that placed them at risk of lifetime harm (35% compared with a national average of 20%).

Across all jurisdictions, people in their 20s were more likely to drink 5 or more standard drinks at least once a month, ranging from 38% in New South Wales to 54% in Tasmania (Online Table 7.8).

## Illicit use of drugs

### Trends

Estimates of drug use by states and territories should be interpreted with caution due to the low prevalence and smaller sample sizes for some states and territories, particularly for low prevalence drugs. There were no significant changes in illicit use of drugs across any jurisdiction between 2010 and 2013, and there has been little change in recent use of illicit drugs over the past decade (see Figure 7.3).





The proportion using drugs illicitly has remained fairly stable across most states and territories with 2 exceptions. Over the period from 2001 to 2013, recent use of illicit drugs declined in both the Northern Territory and Western Australia (by almost one-quarter) but despite the decline these 2 jurisdictions continue to have higher rates of illicit drug use in the last 12 months than other jurisdictions and these differences remained after adjusting for age structure (see Online Table A7.3).

People living in the Northern Territory reported the highest drug use with more than 1 in 5 (22%) reporting they had illicitly used a drug in the last 12 months, almost 50% higher than the national average. Illicit use of any drug was lowest in New South Wales and Victoria (14.2 % and 14.3% respectively).

### Age and sex comparisons

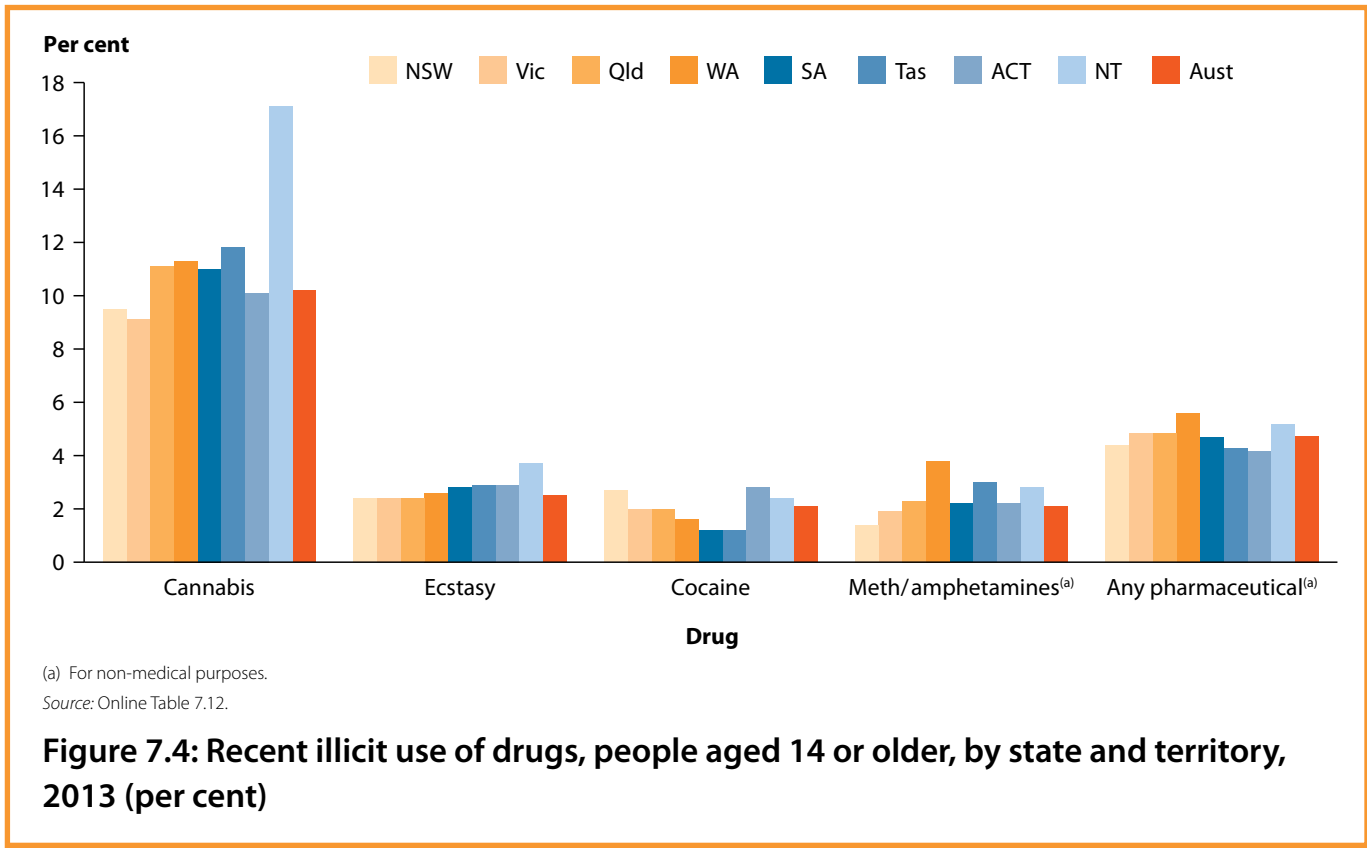
Among all the states and territories, patterns of illicit drug use differed by age and sex. Males were more likely than females to have used an illicit drug (Online Table 7.10); however, in the Northern Territory, usage by the 2 sexes was similar (23% and 21% respectively).

Across all jurisdictions, people aged 20–29 were the most likely age group to use an illicit drug in the past 12 months, ranging from 23% in the Australian Capital Territory to 33% in Tasmania (Online Table 7.11).

### Types of drugs used illicitly

The type of illicit drug used in the last 12 months varied across jurisdictions (Figure 7.4). For example:

- cannabis was most commonly used in the Northern Territory (17.1%)—almost double the usage in Victoria (9.1%)
- meth/amphetamines were used more by people in Western Australia (3.8%) than other jurisdictions
- people in New South Wales (2.7%) and the Australian Capital Territory (2.8%) were more likely to use cocaine than people in other jurisdictions
- ecstasy use in the last 12 months was most common in the Northern Territory (3.7%)
- Western Australians were more likely to misuse pharmaceuticals (5.6%) than any other state or territory.



# eight

## Specific population groups

This chapter presents information on tobacco, alcohol and illicit drug use among specific population groups including: Indigenous people, remoteness area, socioeconomic status, employment status, sexual orientation, people with mental health issues and pregnant women.





Good health is not shared equally among people in Australia. There are substantial differences in the health of different groups, including differences in rates of death and disease, life expectancy, self-perceived health, health behaviours, health risk factors and health service utilisation. These 'health inequities' are associated with a range of factors including differences in education, occupation, income, employment status, rural location, ethnicity, Aboriginality and gender (Draper et al. 2004).

Certain groups within the population are at greater risk of developing harmful drug use behaviours or undergoing drug-related harm. These groups may require particular targeting in terms of education, treatment and prevention programs (AIHW 2007).

Social and economic factors shape risk behaviour and the health of drug users. 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. Minority groups experience a disproportionately high level of the social issues that adversely affect health, factors that contribute to disparities in health among drug users (Galea & Vlahov 2002).

There is a complex relationship between these broad social determinants and individual risk and protective factors, which means that some individuals do better than others on all health measures, including drug misuse, despite their material deprivation. Furthermore, these relationships are more pronounced for some drug types where they have more adverse outcomes than others (Loxley et al. 2004).

Social determinants are the 'environmental' or 'societal' factors that influence health outcomes of populations. These include the economic environment, the physical environment and sociocultural environment (Spooner & Hetherington 2005).

The health of individuals and populations is largely determined by social and economic factors, which can both protect against or increase the risk of ill health or harmful alcohol and other use. A review of the evidence, conducted for the World Health Organization, found a clear link between socioeconomic deprivation and risk of dependence on alcohol, nicotine and other drugs (Wilkinson & Marmot 2003).

There is scope to highlight many population groups in Australia but this chapter focuses on 6 groups—socioeconomically disadvantaged people, those living in rural and remote areas, Indigenous Australians, pregnant women, the unemployed, people who identify as being homosexual or bisexual and people with mental illnesses and high levels of psychological distress as for these groups we observe some of the largest disparities in tobacco, alcohol and other drug use.

All data presented in this chapter are available through the online specific population group tables <<http://www.aihw.gov.au/publication-detail/?id=60129549469&tab=3>>.



## Key findings

### Remoteness area

- People living in *Remote and very remote* areas were 2 times more likely to smoke daily, drink alcohol in risky quantities and use meth/amphetamines in the previous 12 months than those in *Major cities*.
- Daily smoking and risky drinking rose with increasing remoteness.
- The decline in daily smoking rates between 2010 and 2013 was only significant for people living in *Major cities*.

### Socioeconomic status

- People living in areas with the lowest socioeconomic status (SES) were 3 times more likely to smoke than people with the highest SES. People with the highest SES were more likely to consume alcohol in risky quantities and to have used ecstasy and cocaine in the previous 12 months than people with the lowest SES.
- Although smoking rates were high among people with the lowest SES, the proportion smoking daily declined (from 22% in 2010 to 19.9% in 2013) as did the proportion exceeding the lifetime risk and single occasion risk guidelines for alcohol use.

### Employment status

- Use of illicit drugs in the past 12 months was more prevalent among the unemployed, with people who were unemployed being 1.6 times more likely to use cannabis, 2.4 times more likely to use meth/amphetamines and 1.8 times more likely to use ecstasy than employed people.
- The declines (daily smoking, risky drinking, recent ecstasy use) and rises (pharmaceutical misuse) that were seen nationally were also seen among employed people but there were no significant changes in the drug-taking behaviours of unemployed people and people who were unable to work between 2010 and 2013.

### Indigenous people

- Indigenous Australians were 2.5 times as likely as non-Indigenous Australians to smoke tobacco daily (32% compared to 12.4% for non-Indigenous Australians). The proportion of Indigenous Australians smoking daily did not decline significantly, but there was a substantial fall in the number of cigarettes smoked, declining significantly from 154 in 2010 to 115 in 2013.
- Rates of cannabis use among Indigenous Australians remained relatively stable in 2013 and they were generally twice those in the non-Indigenous population (19.0% compared to 10.0% for non-Indigenous Australians).



## Pregnant women

- The proportion of pregnant women abstaining from alcohol rose slightly between 2010 and 2013 (from 49% to 53%) but this increase was not statistically significant.
- Over 50% of pregnant women consumed alcohol before they knew they were pregnant and 1 in 4 continued to drink, even once they knew they were pregnant. Of those who did consume alcohol, most (96%) usually consumed 1–2 standard drinks.

## Sexual orientation

- Compared with heterosexual people, those who identified as being homosexual or bisexual had higher rates of illicit drug use and were more likely to smoke daily and drink alcohol in risky quantities. There were no significant changes seen among this group between 2010 and 2013.

## Mental illness

- The findings of the survey show a relationship between drug use and poor mental health.
- Almost twice as many recent illicit drug users (21%) as non-illicit drug users (12.6%) have been diagnosed with, or treated for, a mental illness. Illicit drug users were also more likely to report high or very high levels of psychological distress in the 4 weeks before the survey (17.5% compared with 8.6%), however the direction and nature of this relationship is unclear.
- People who reported smoking daily were twice as likely to have high/very high levels of psychological distress and to have been diagnosed or treated for a mental health condition as those who had never smoked.
- The association between alcohol use and high or very high psychological distress and diagnosis or treatment of a mental health condition was less marked than for illicit drug use and daily smoking. There were no significant changes in drug use among people with high levels of psychological distress or those who reported being diagnosed or treated for a mental illness between 2010 and 2013.





## Social determinants of health

This section of the report focuses on 3 key social determinants of health—remoteness, SES and employment. Refer to online tables for results by marital status, household composition, education, and culturally and linguistically diverse populations.

### Drug use in geographic areas

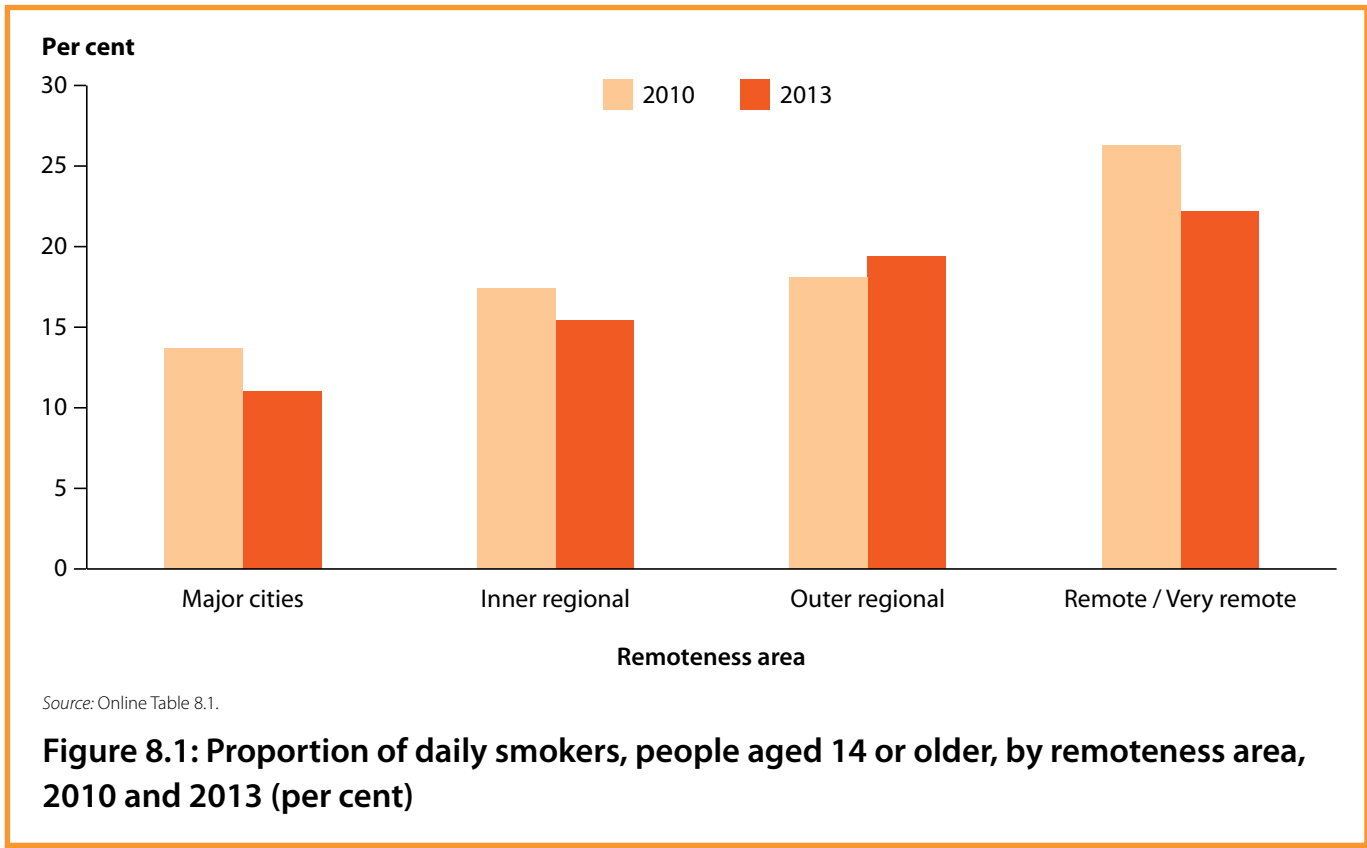
The ABS 2011 Australian Statistical Geography Standard was used to allocate remoteness categories to areas across Australia.

Overall, people living in rural and remote areas have a poorer SES than those in major cities, and they are often disadvantaged in relation to access to primary health-care services, educational and employment opportunities and income. They generally have poorer health than their major city counterparts, reflected in their higher levels of mortality, disease and health risk factors. Further, they are more likely to have higher rates of risky health behaviours, such as smoking and heavy alcohol use (AIHW 2012). Rural residents also face difficulties in accessing drug treatment services.

#### Smoking

A substantially higher proportion of people in *Remote and very remote* areas smoke tobacco daily (Figure 8.1) and they were twice as likely to smoke as those in *Major cities* (22% compared with 11.0%). Tobacco smoking is the major cause of lung cancer and people in remote areas had 1.3 times the rate of lung cancer (between 2004 and 2008) than those living in *Major cities* (AIHW & AACR 2012). As smoking remains higher in these areas, the difference in lung cancer rates between people in *Major cities* and remote areas is likely to continue.

While smoking rates in *Major cities* declined between 2010 and 2013 (from 13.7% to 11.0%), there was no significant reduction in the proportion of people who smoked daily for people in *Inner regional*, *Outer regional* and *Remote and very remote* areas. The proportion of people smoking daily rose with increasing remoteness. 2013 survey results showed 11.0%, 15.4%, 19.4% and 22% of people smoked daily in, respectively, *Major cities*, *Inner regional*, *Outer regional* and *Remote and very remote* areas. The average number of cigarettes smoked per week declined in all remoteness areas except for those living in *Remote and very remote* areas.

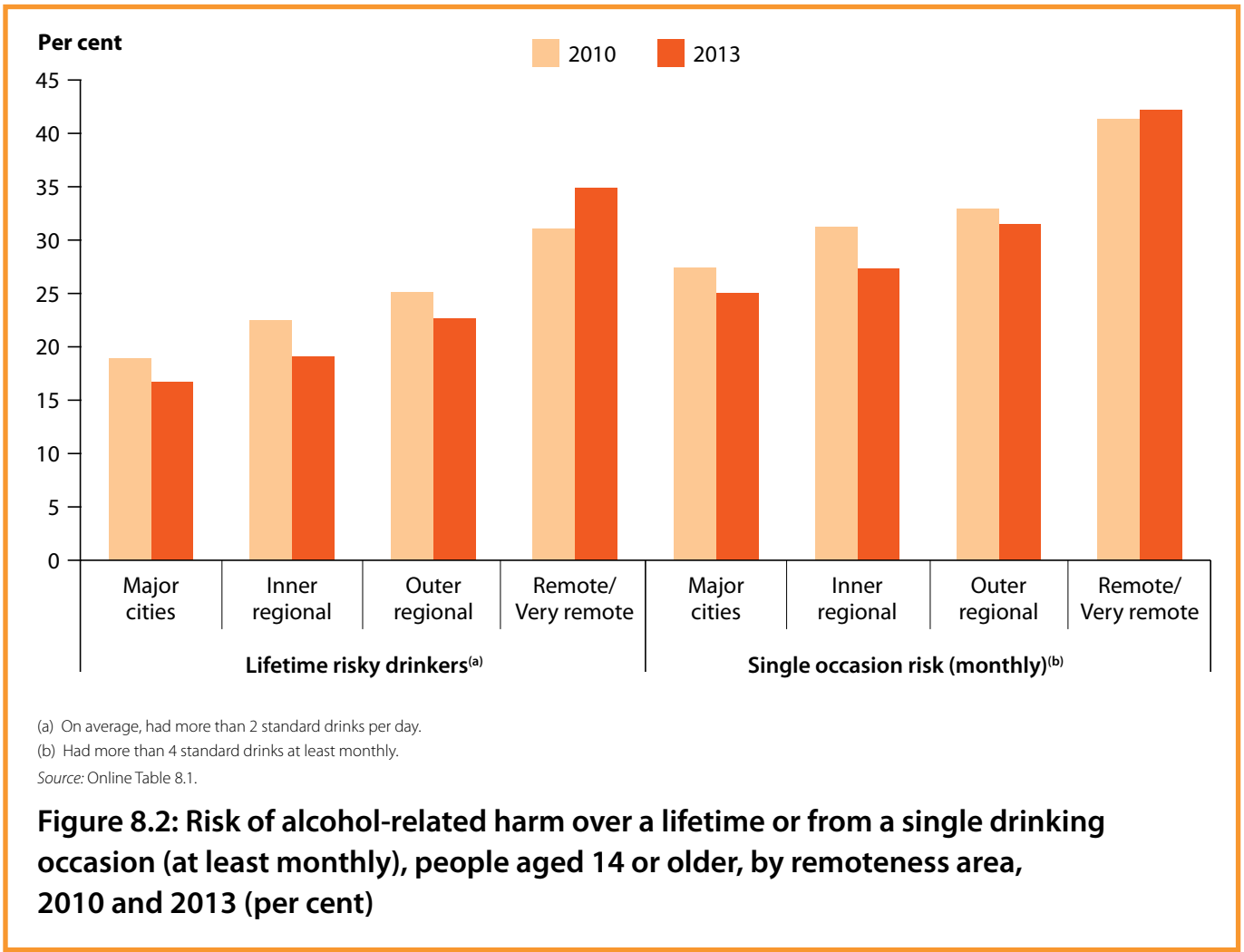


### Alcohol risk

Not only were people in *Remote and very remote* areas more likely to smoke, they were also more likely to drink alcohol in quantities that place them at risk of harm from an alcohol-related disease or injury over a lifetime or at risk of alcohol-related injury arising from a single drinking occasion (Figure 8.2).

Alcohol consumption was consistently higher in *Remote and very remote* areas and the proportion of those drinking at risky levels increased with increasing remoteness. Results showed 16.7%, 19.1%, 23% and 35% of people consumed alcohol at risky levels for lifetime risk, and 25%, 27%, 32% and 42% at risky levels for single occasion risk in, respectively, *Major cities*, *Inner regional*, *Outer regional* and *Remote and very remote* areas.

There was also no significant change in the proportion of people in *Outer regional* and *Remote and very remote* areas drinking at risky levels for both lifetime and single occasion harm, despite significant declines for people in *Major cities* and *Inner regional* areas.



### Illicit drugs

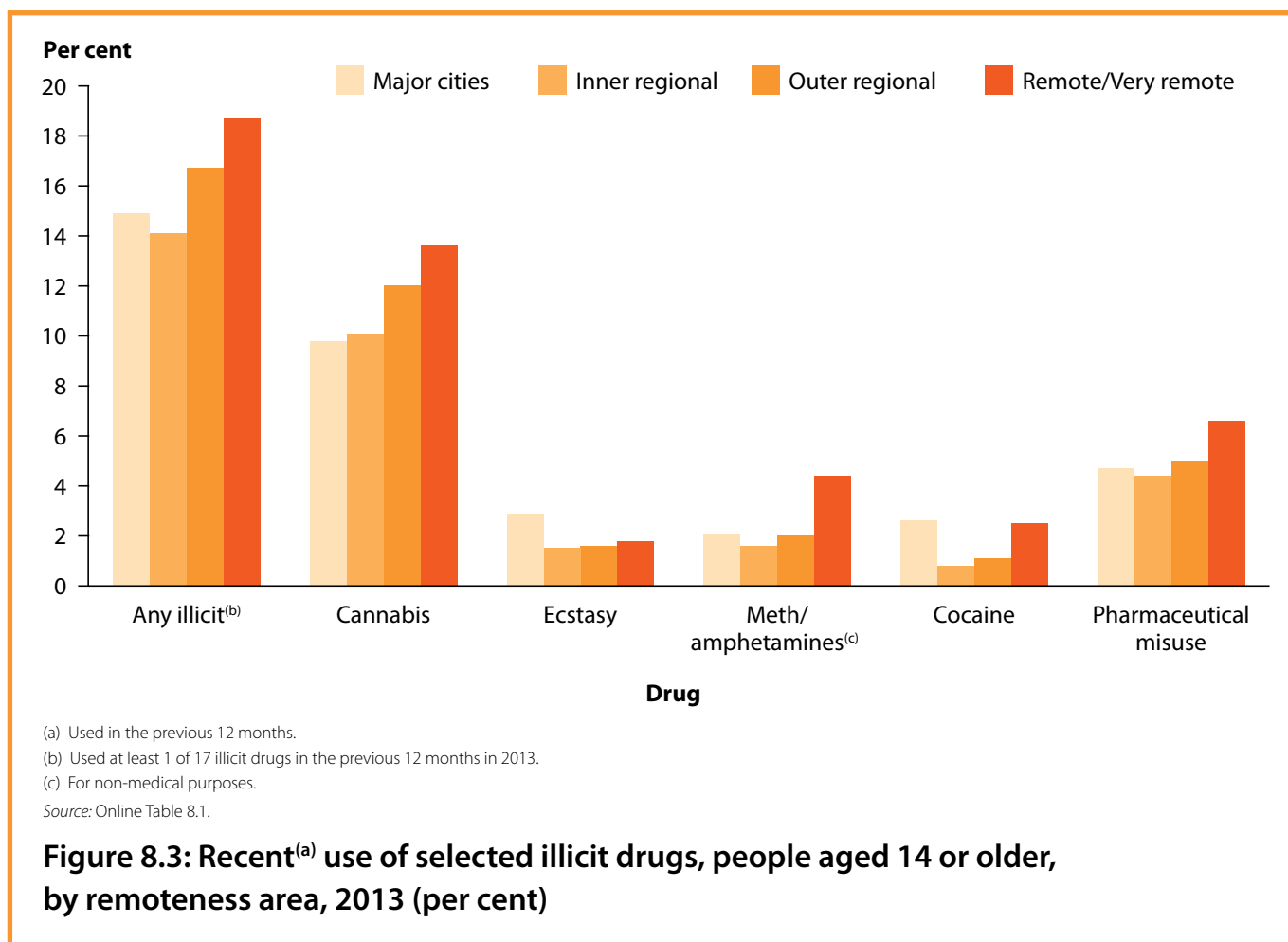
There are multiple and interrelated causes of illicit drug use in rural and regional Australia. Studies in rural Victoria and rural South Australia have identified distance and isolation, lack of public transport, lack of employment opportunities, uncertainty about the future and lack of leisure activities as contributing to illicit drug use in rural communities (NRHA 2012).



People in *Remote and very remote* areas were more likely to have used an illicit drug in the last 12 months than people in *Major cities* and *Inner regional* areas, but the type of drug used varied by remoteness area (Figure 8.3). For example:

- cannabis was more commonly used by people in *Outer regional* (12.0%) and *Remote and very remote* areas (13.6%)
- people in *Remote and very remote* areas were twice as likely to have used meth/amphetamines as people in *Major cities* (4.4% compared with 2.1%)
- ecstasy was more commonly used by people in *Major cities* (2.9%)
- cocaine was more likely to be used by people in *Major cities* (2.6%) and *Remote and very remote* areas (2.5%) when compared with people in other remoteness areas.

There were no significant changes in illicit use of drugs for *non-remote* areas, however there was a rise in the misuse of pharmaceuticals among people living in *Major cities* (from 4.1% to 4.7%) (Online Table 8.1).





## Socioeconomic status

Although the overall level of health and wellbeing of the Australian population is high when compared with the populations of many overseas countries, there are substantial differences in the health of specific groups within the population. One of the most important contributors to these differences is SES. Socioeconomic characteristics are key determinants of health and wellbeing, and contribute to differences in health or 'health inequality' across the population (AIHW 2008).

### Smoking

It is well established that people with lower incomes and/or lower levels of completed education are more likely to smoke (AIHW 2011) and these are risk factors for a number of long-term health conditions such as respiratory diseases, lung cancer and cardiovascular diseases (AIHW 2012).

Tobacco smoking is strongly associated with low SES; people with the lowest SES were almost 3 times more likely to smoke daily than people with the highest SES (19.9% compared with 6.7%) but significant declines were seen in both these groups between 2010 and 2013 (Figure 8.4).

### Alcohol risk

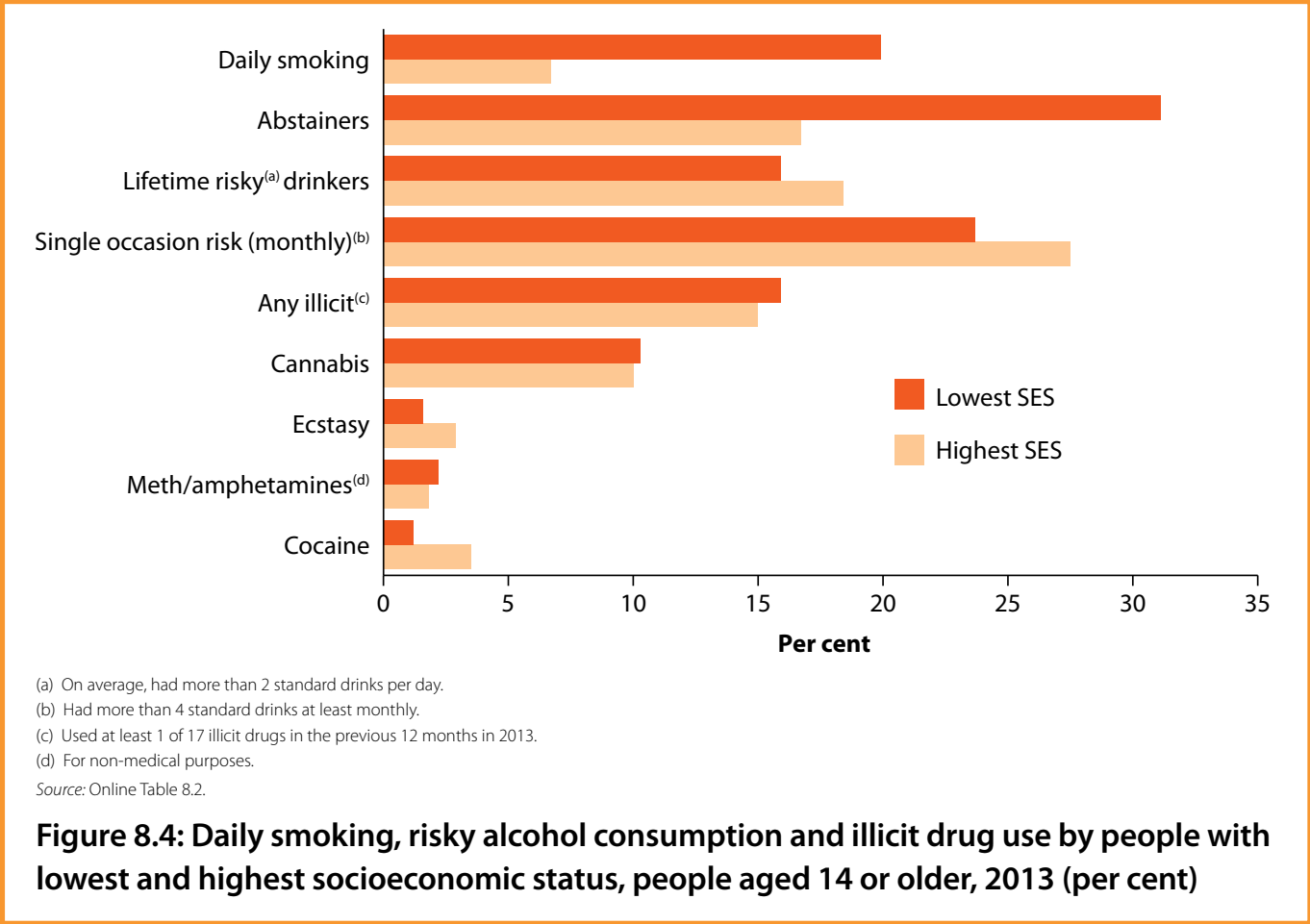
While people with the lowest SES were more likely to smoke, it was people with the highest SES who were more likely to drink at all and consume alcohol in quantities that placed them at risk of an alcohol-related disease, illness or injury. People with the lowest SES were twice as likely to abstain and a little less likely to drink alcohol in risky quantities compared with people in highest SES group (Figure 8.4).

There were fewer people in the lowest and highest socioeconomic areas drinking more than 2 standard drinks per day in 2013 (declining from 19.1% to 15.9% and from 21% to 18.4% respectively). People in the lowest SES group were also less likely to drink at risky levels at least once a month (from 27% in 2010 to 24% in 2013) but there was no change in drinking at these levels among people from the highest SES group.

### Illicit drugs

Illicit drug use patterns vary by SES depending on the drug type of interest (Figure 8.4). People with the lowest SES were slightly more likely to use meth/amphetamines (2.2% compared with 1.8%), while people with the highest SES were almost twice as likely to use ecstasy (2.9% compared with 1.6%) and 3 times more likely to use cocaine (3.5% compared with 1.2%).

There were no significant changes in illicit use of drugs for people in the lowest SES group, however there was an increase in the misuse of pharmaceuticals among people with the highest SES, from 3.8% to 5.1% (Online Table 8.2).



### Employment status

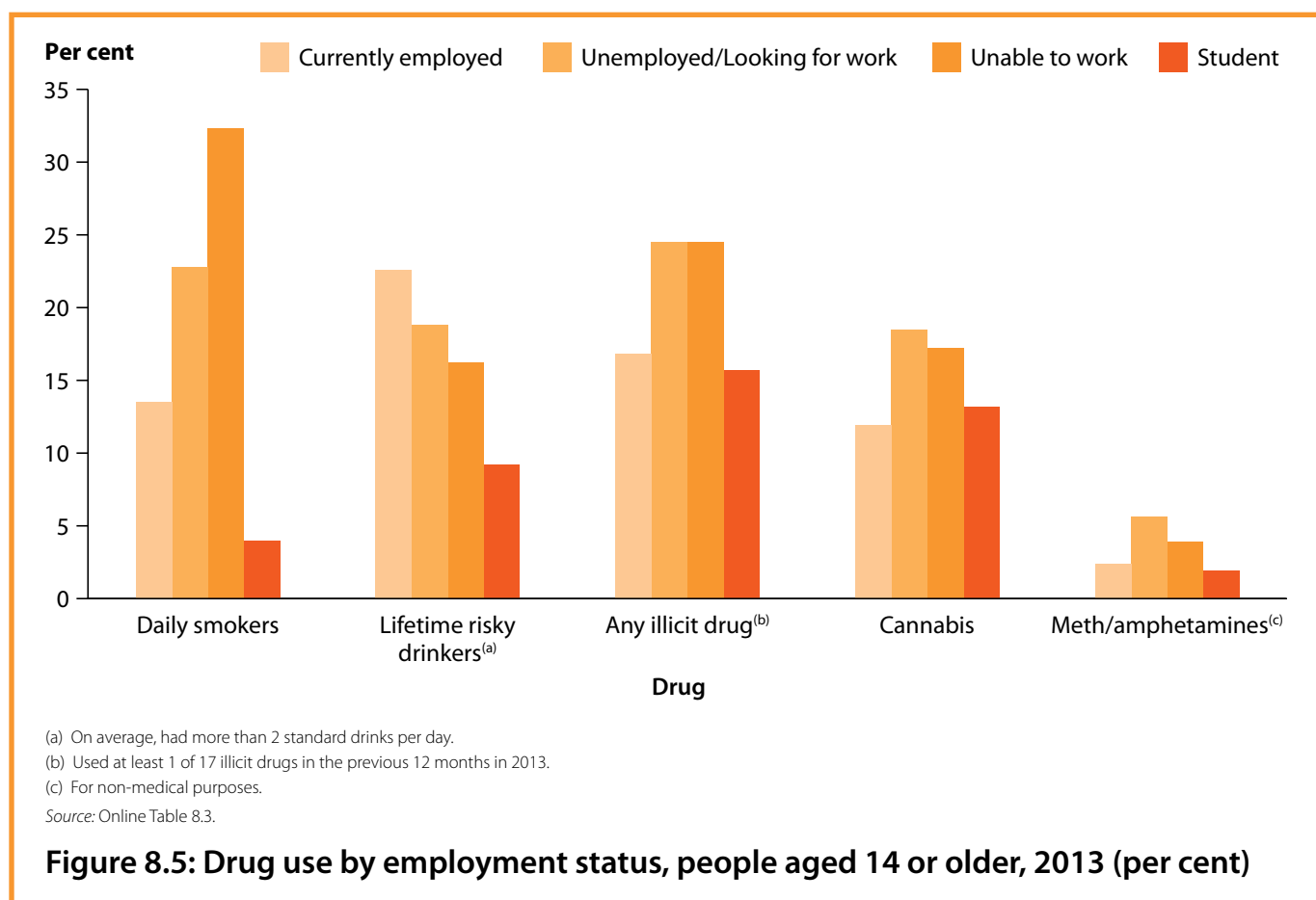
Employment status, and unemployment in particular, is strongly related to health status. Unemployed people have higher mortality and more illness and disability than those who are employed (AIHW 2008). Unemployment is a major risk factor for substance use and the subsequent development of substance-use disorders (Henkel 2011).

Drug abuse can reduce a person’s employment prospects, both by reducing productivity and by decreasing the chance of getting a job. Those who are unemployed or otherwise out of the labour force may also face financial hardship or simply have more unstructured time, either of which can result in a higher propensity to consume substances (Badel & Greaney 2013).



Figure 8.5 and Online Table 8.3 show that people who were unemployed were:

- 1.7 times more likely to have smoked daily
- 1.6 times more likely to have used cannabis
- 2.4 times more likely to have used meth/amphetamines
- 1.8 times more likely to have used ecstasy
- 1.6 times more likely to have misused pharmaceuticals
- 1.4 times more likely to have used cocaine than people who were employed.



A similar pattern was also seen among people who were unable to work. They were: 2.4 times more likely to smoke daily, 1.4 times more likely to use cannabis, 1.7 times more likely to use meth/amphetamines and 1.8 times more likely to misuse pharmaceuticals. But they were less likely to use ecstasy or cocaine than employed people (Online Table 8.3). There were also no significant changes in the drug-taking behaviours of unemployed people and people who were unable to work between 2010 and 2013.

Compared to use in 2010, employed people were less likely to:

- smoke daily (down from 16.1% to 13.5%) (Online Table 8.3)
- consume alcohol in risky quantities (from 25% to 23% for lifetime risk and from 36% to 34% for single occasion risk at least monthly)
- use ecstasy (from 3.8% to 2.9%), but they were more likely to misuse pharmaceuticals in 2013 (from 3.8% to 4.5%).



## Other at-risk groups

In addition to the factors outlined above, there are other groups within the population who are at greater risk of misusing substances or who show higher than average drug use when compared to the general population. Drug use can have a major impact on disadvantaged groups and lead to intergenerational patterns of disadvantage. Under the *National Drug Strategy 2010–2015*, socially inclusive strategies and actions are needed that recognise the particular vulnerabilities and needs of these disadvantaged groups (MCDS 2011).

This section explores drug use among: Aboriginal and Torres Strait Islander people (Indigenous Australians); people who identified as being homosexual or bisexual; pregnant women and the potential risk placed on their unborn child; and people with mental health problems and high levels of psychological distress.

### Indigenous Australians

Indigenous Australians experience significantly more ill health than other Australians. The socioeconomic disadvantage experienced by Indigenous Australians compared with other Australians places them at greater risk of exposure and vulnerability to health risk factors such as smoking and alcohol misuse.

Indigenous Australians suffer a disproportionate amount of harms from alcohol, tobacco and other drug use. Drug-related problems play a major role in disparities in health and life expectancy between Indigenous and non-Indigenous Australians (MCDS 2011).

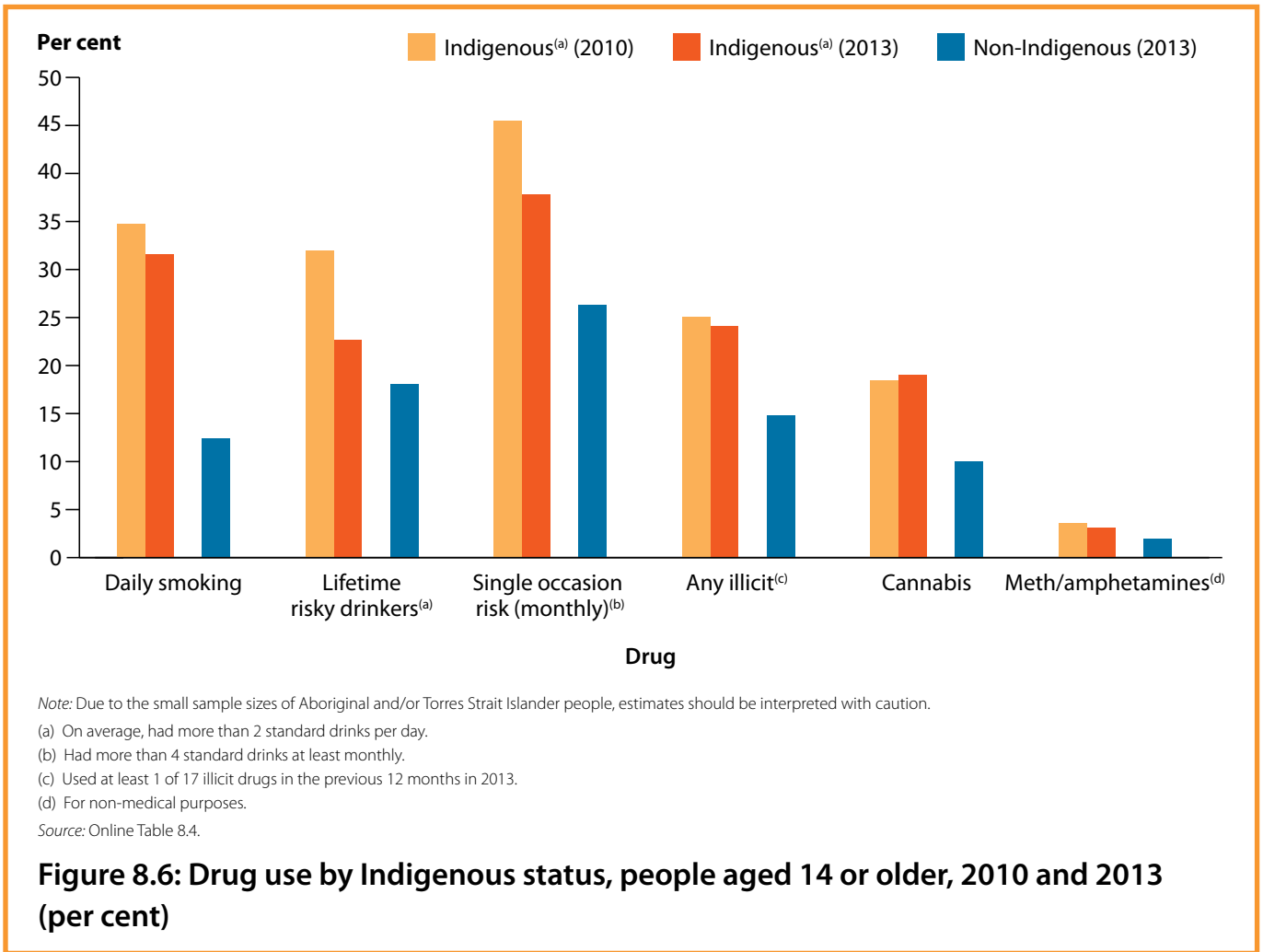
As Indigenous Australians constitute only 1.9 per cent of the sample, the results must be interpreted with caution, particularly those for illicit drug use.

### Smoking

Indigenous Australians are more likely to die of smoking-related illnesses, such as diseases of the respiratory system and cancers, than other Australians (AIHW 2008). In 2013, the smoking rate among Indigenous Australians was considerably higher than non-Indigenous people and they were 2.5 times more likely to smoke daily than non-Indigenous people (Figure 8.6). The Indigenous daily smoking rate declined from 35% in 2010 to 32% in 2013 but this was not statistically significant. The NDSHS was not designed to detect differences this small among the Indigenous population but the percentage point decline is similar to the results from the Australian Aboriginal and Torres Strait Islander Health Survey which was specifically designed to represent Indigenous Australians (see the data quality statement for further information).

There was a substantial drop in the average number of cigarettes smoked by current smokers, declining significantly from 154 in 2010 to 115 in 2013 (Online Table 8.4). After adjusting for differences in age structures, Indigenous people were 2.6 times as likely to smoke daily as non-Indigenous people (Online Table A8.4).





### Alcohol

Overall, Indigenous Australians were more likely to abstain from drinking alcohol than non-Indigenous Australians (28% compared with 22% respectively). However, among those who did drink, a higher proportion of Indigenous Australians drank at risky levels (Figure 8.6).

Positively, there was a significant decline in the proportion of Indigenous people exceeding the NHMRC guidelines for lifetime risk of alcohol-related disease by consuming, on average, more than 2 standard drinks per day. There were fewer Indigenous Australians drinking alcohol at levels that put them at risk of harm from a single drinking occasion at least once a month in 2013 (from 45% to 38%), but this decrease was not significant.



## Illicit drugs

Other than ecstasy and cocaine, Indigenous Australians use illicit drugs at a higher rate than the general population (Figure 8.6). In 2013, Indigenous Australians were: 1.6 times more likely to use any illicit drug in the last 12 months; 1.9 times more likely to use cannabis; 1.6 times more likely to use meth/amphetamines; and 1.5 times more likely to misuse pharmaceuticals than non-Indigenous people. These differences were still apparent even after adjusting for differences in age structure (Online Table A8.4). There were no significant changes in illicit use of drugs among Indigenous Australians between 2010 and 2013.

## People identifying as homosexual/bisexual

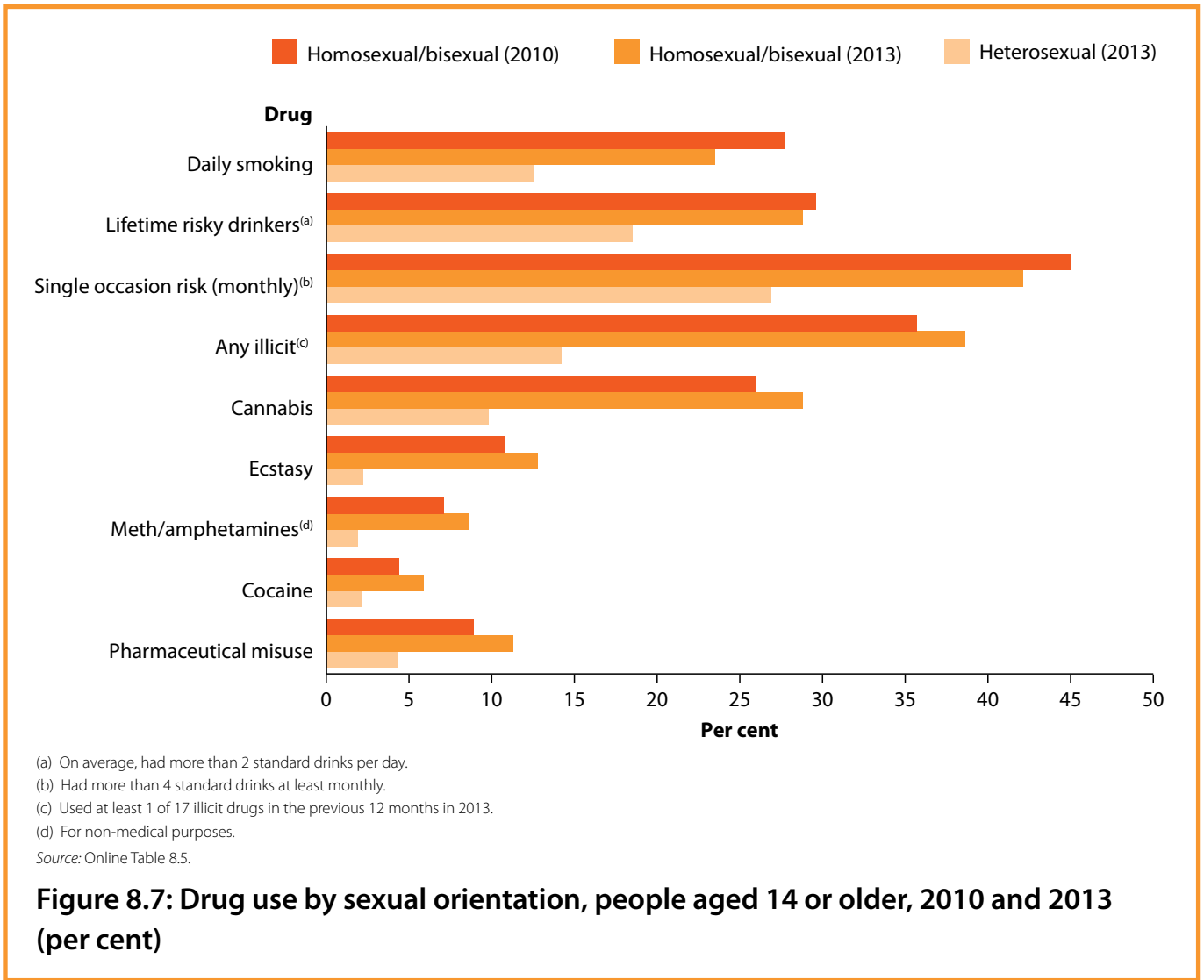
There is a growing body of evidence to suggest that people who identify as gay, lesbian, bisexual, transgender and intersex (GLBTI) may be at a higher risk of developing mental health and substance use problems. Overall, there is a range of risk and protective factors related to drug use and mental health. Some of these factors are relevant for both GLBTI and non-GLBTI populations. However, many of these risk factors are experienced to a greater extent by GLBTI populations than other populations (Ritter et al. 2012). This section only presents findings on people who identified as gay, lesbian or bisexual as the survey does not capture information on people who were transgender or intersex.

Findings for people who identify as homosexual and bisexual were grouped together for data quality purposes but it's important to note that there are differences in substance use among these 2 groups, for example, 35% of bisexual people had used cannabis in the previous 12 months compared with 23% of homosexual people. Figure 8.7 shows that:

- Use of illicit drugs in the last 12 months was far more common among people who identified as being homosexual or bisexual than people who were heterosexual and illicit drug use was more common than smoking and drinking alcohol among this population group.
- The largest differences in use among homosexual/bisexual people were in the use of ecstasy and meth/amphetamines; this was 5.8 times and 4.5 times more likely than heterosexual people.
- Homosexual/bisexual people were also 2.9 times more likely to use cannabis and 2.8 times more likely to use cocaine in the previous 12 months.
- Intake of alcohol in risky quantities and smoking tobacco daily were also more common but there was less of disparity in the use of licit drugs between homosexual/bisexual people and heterosexual people.

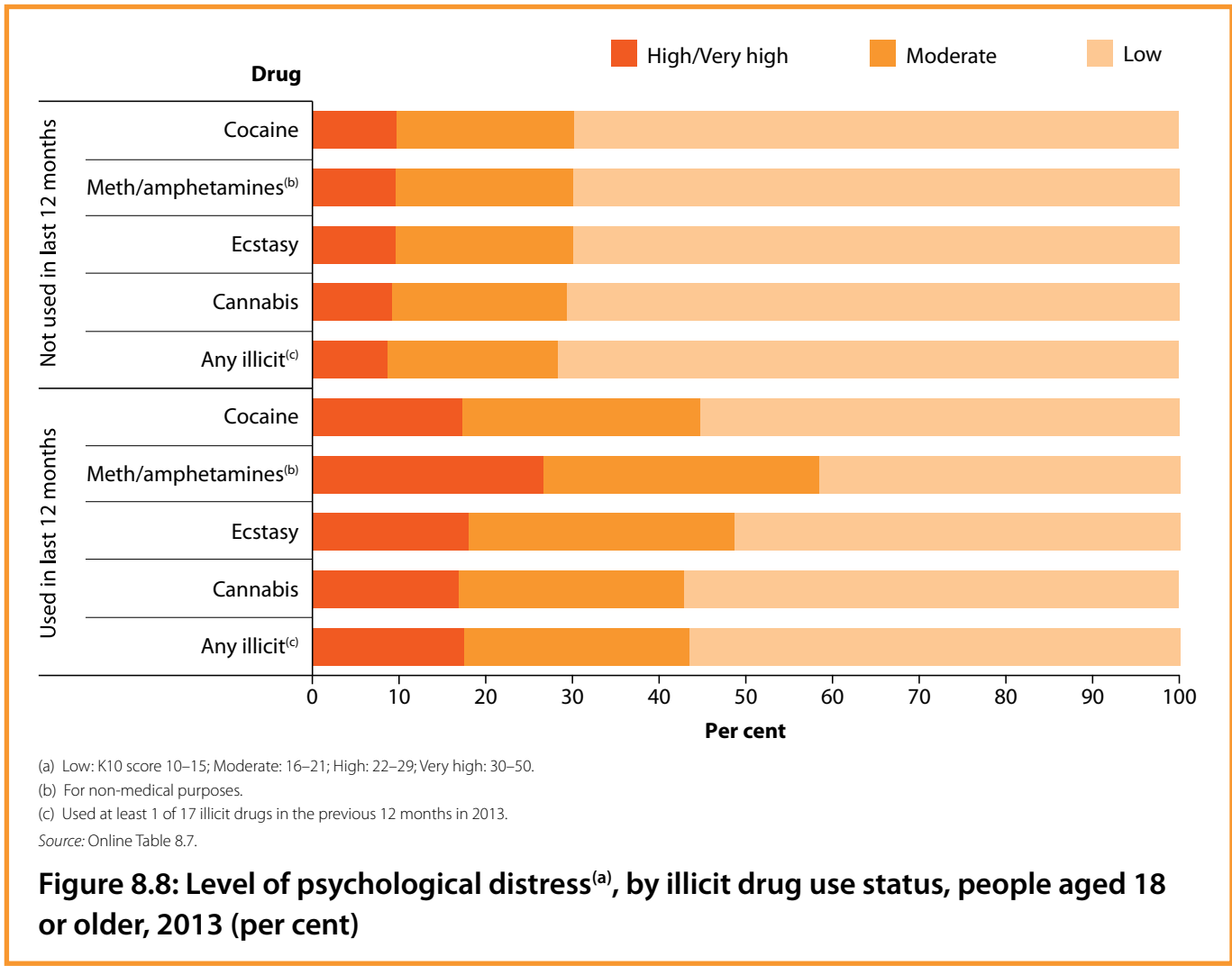
After adjusting for differences in age, people who were homosexual or bisexual were still far more likely than others to smoke daily, consume alcohol in risky quantities, use illicit drugs and misuse pharmaceuticals (Online Table A8.5).

The trends in drug use that were seen nationally were not seen among this group—there were no significant declines in daily smoking, risky alcohol consumption or ecstasy use, and no significant rise in the misuse of pharmaceuticals.



## People with mental health conditions

There is a strong association between illicit drug use and mental health issues (Figure 8.8). However, it can be difficult to isolate to what degree drug use causes mental health problems, and to what degree mental health problems give rise to drug use, often in the context of self-medication (Loxley et al. 2004). It is therefore 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. 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 experienced in the preceding 4-week period. The psychological distress may have preceded the drug use for some and, for others, drug use may have preceded the psychological distress.

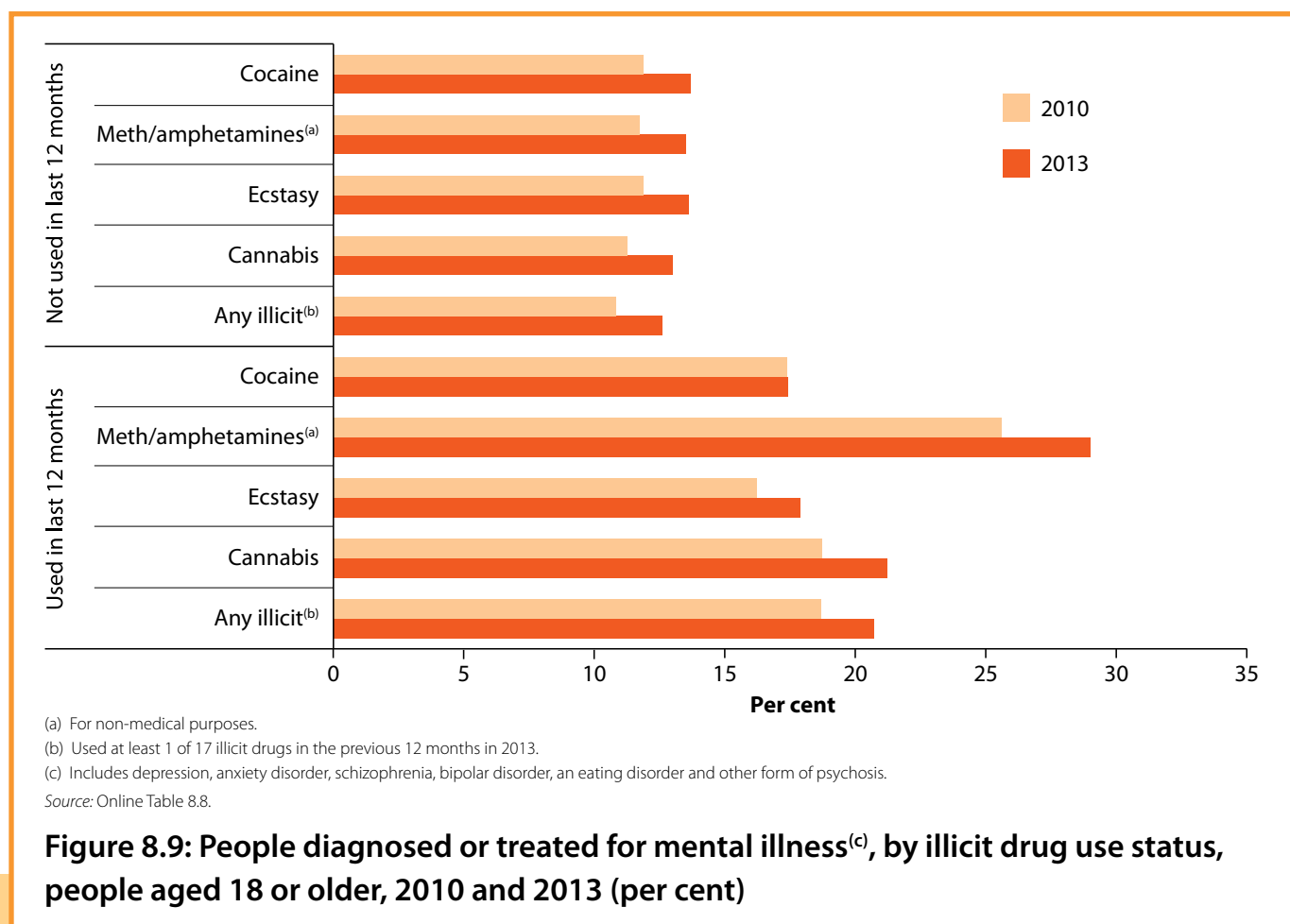


## Illicit drug use

According to the 2013 NDSHS, 1 in 10 (10.1%) people aged 18 or older experienced high or very high levels of distress. A further 13.9% had been diagnosed or treated for a mental illness in the previous 12 months, increasing from 12.0% in 2010 (Online Table 8.6). However, when this group is split into those who had used and those who had not used selected drugs in the last month, there was about a twofold difference in that experience:

- The diagnosis or treatment of a mental illness was much more common in those who had used an illicit drug in the past 12 months (21%) or in the past month (24%) than the non-using adult population (12.6%) (Figure 8.9).
- Recent illicit drug users also had higher levels of psychological distress than the adult population, with higher proportions reporting very high or high distress levels (17.5% compared with 8.6% of those who had not used an illicit drug in the last 12 months) (Figure 8.8).
- People using meth/amphetamines in the past 12 months were more likely than any other drug users to report being diagnosed or treated for a mental illness (29% compared with 13.5% of non-users) and have greater levels of high or very high psychological distress (27% compared with 9.6%).

Again it is important to note that, by themselves, these findings do not establish a causal link between psychological distress and drug use—the drug use may have preceded the psychological distress, or vice versa.





## Tobacco and alcohol use

A similar pattern to illicit drug users also emerged for daily smokers:

- People who reported smoking daily were twice as likely to have high/very high levels of psychological distress compared with people who had never smoked (18.2% compared with 9.0%, respectively) and were twice as likely to have been diagnosed or treated for a mental health condition than those who had never smoked (22% compared with 11.1%) (Online Table 8.9).

The association between alcohol use and high or very high psychological distress and diagnosis or treatment of a mental health condition was less marked. The 2013 findings showed that:

- people who exceeded the single occasion risk guidelines at least weekly were more likely to have high or very high levels of psychological distress (13.1%) than people drinking at low-risk levels for a single occasion (8.0%) (Online Table 8.9)
- the diagnosis or treatment for a mental health condition did not differ greatly by alcohol use—people drinking at risky levels (for both lifetime and single occasion risk) were only slightly more likely to be diagnosed or treated for a mental health condition than those drinking at low-risk levels or abstaining from alcohol.

## Pregnant women

Substance use among pregnant women is a particular concern as drugs can cross into the placenta and therefore leads to a range of health problems, including abnormal fetal growth and development (ACMD 2006).

Women who smoke while pregnant are at increased risk of a wide range of problems including ectopic pregnancy, miscarriage and premature labour (SGV 2014) and are twice as likely to give birth to a low birthweight baby compared to non-smokers (AIHW 2012).

Alcohol use during pregnancy can disturb the development of the fetus and lead to problems later in life. Fetal Alcohol Spectrum Disorder is a general term which describes the range of effects that can occur in a baby who has been exposed to alcohol in their mother's womb (NHMRC 2009). It is not yet known how much alcohol is safe to drink during pregnancy. However, it is known that the risk of damage to the baby increases the more women drink and that binge drinking is especially harmful. Therefore the NHMRC advises that the safest option for pregnant women is to abstain from drinking if they are pregnant, planning a pregnancy or breastfeeding.



## Questionnaire changes

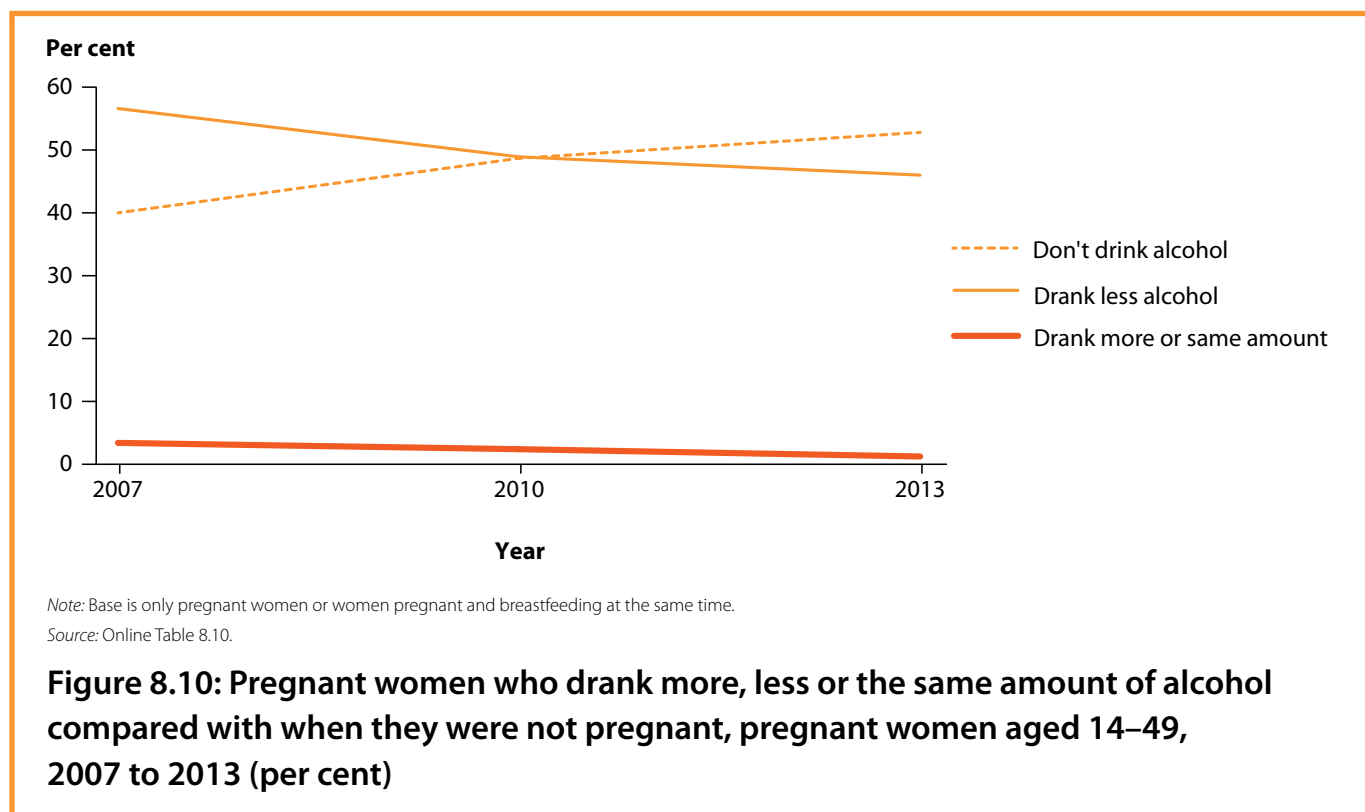
The questions on drug use during pregnancy were updated in 2013 to provide a more accurate snapshot of drinking during pregnancy. Each question collects information about slightly different concepts which should be taken into consideration when interpreting these results.

More specifically, the 2013 survey asked women about their drinking before and after knowledge of pregnancy, as well as about whether they drank more, less or the same amount compared to when they were not pregnant. The way in which pregnant women answered these 2 questions is somewhat problematic as the proportions reporting that they did use alcohol during pregnancy were different (see Chapter 10 'Explanatory notes' for further information).

As women are more likely to answer a question honestly about what they did before knowledge of their pregnancy, Online Table 8.11 provides the most accurate estimate on the amount of alcohol consumed during pregnancy. However, Figure 8.10 is useful for monitoring trends over time as this question has remained consistent since 2004.

## Trends in alcohol use

Since 2007, the proportion of women consuming alcohol during pregnancy has declined and the proportion abstaining has risen (Figure 8.10). Between 2010 and 2013 the proportion of pregnant women abstaining from alcohol slightly increased from 49% to 53% but this rise was not statistically significant.





## Alcohol consumption

For the first time in 2013, the survey included questions specifically on the amount of alcohol consumed while pregnant. The majority of women did not drink alcohol during pregnancy, and of those who did, most drank infrequently (monthly or less) and consumed 1–2 standard drinks (Online Table 8.11). More specifically:

- about 3 in 4 (78%) pregnant women who consumed alcohol while pregnant drank monthly or less, and 17.0% drank 2–4 times a month
- most (96%) usually consumed 1–2 standard drinks
- only 1.4% had consumed 6 or more standard drinks on at least 1 occasion during their pregnancy.

## Behaviour changes

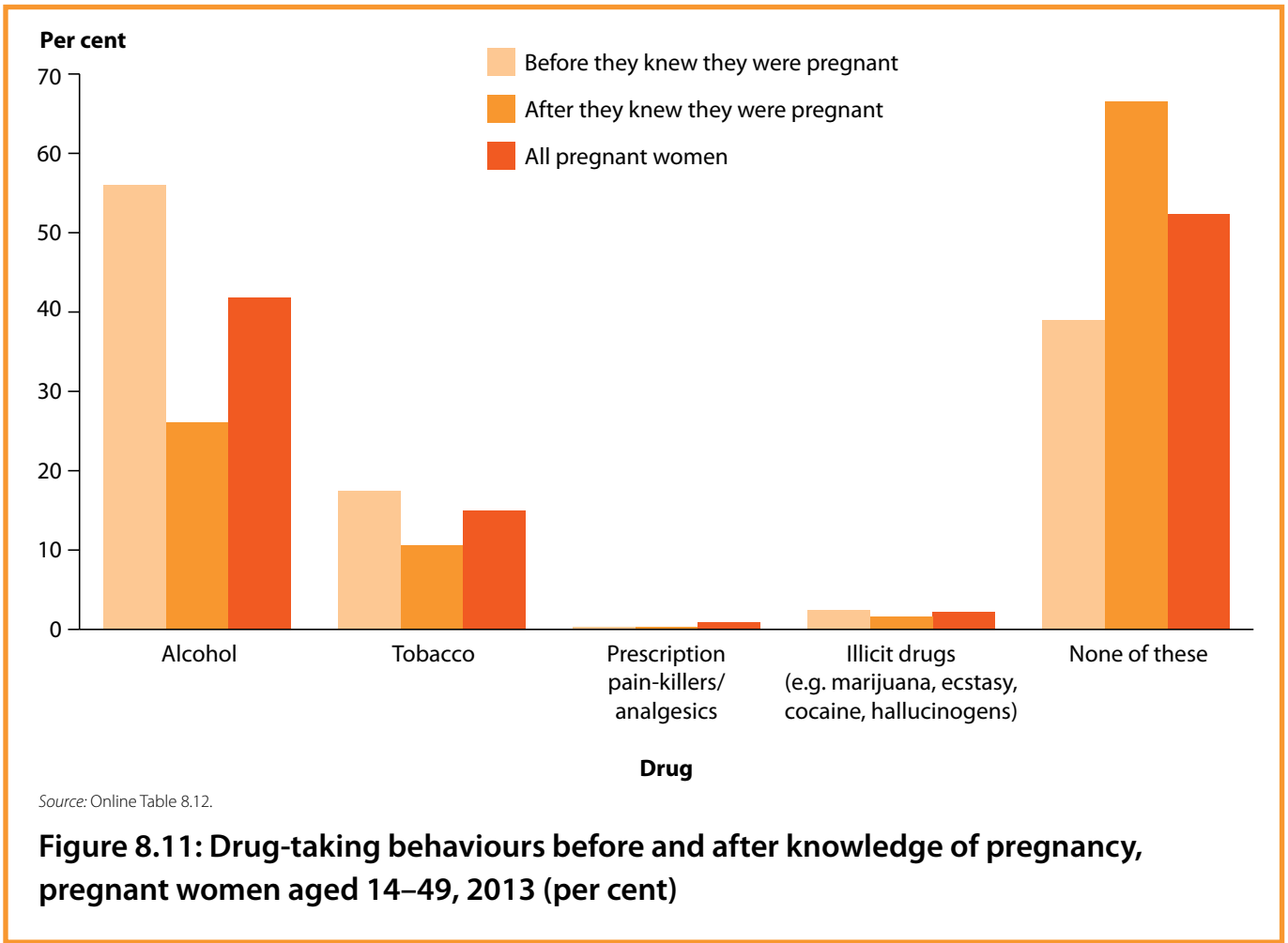
Pregnant women were asked if there was any time during their pregnancy that they were not aware they were pregnant and what their drug-taking behaviours were during this time. Of pregnant women who were unaware of their pregnancy:

- more than half (56%) had consumed alcohol during their pregnancy, and while a large proportion of these women stopped drinking alcohol once they find out that they were pregnant, one-quarter (26%) continued to drink even once they knew they were pregnant (Figure 8.11)
- about 1 in 6 (17.4%) women smoked tobacco before they knew they were pregnant, and 1 in 10 (10.6%) continued smoking after they found out they were pregnant
- a small minority had used illicit drugs; 2.4% used an illicit drug before knowledge of their pregnancy and 1.6% used illicit drugs after they knew they were pregnant.

Regardless of whether women knew they were pregnant or not, the following proportion consumed drugs during pregnancy:

- around 4 in 10 (42%) consumed alcohol during pregnancy
- 15% smoked tobacco during pregnancy
- 2.2% had used an illicit drug such as marijuana and 0.9% had misused prescription analgesics.





# Policy and attitudes

This chapter presents findings on the opinions and perceptions of people in Australia on various drug-related issues, and information on public support for different measures that aim to reduce drug use or drug-related harm.





A variety of factors influence public perceptions of tobacco, alcohol and other drug use and the harms they cause including personal experience, culture and family attitudes, peer relationships, media, advertising and public health and safety campaigns. As a result, there is sometimes a lack of alignment between public perceptions and the available evidence. For example, a very small minority (about 0.1%) of the population use heroin but a considerable proportion of the population believe that heroin causes the most deaths, is of the most serious concern to the community and nominate it as the drug they first associate with 'a drug problem'. This chapter presents findings on the opinions and perceptions of people in Australia on various drug-related issues, including personal approval of drug use, the impact of drugs on the general community and on mortality, and factors that influence the choice of whether or not to use illicit drugs. It also presents information on public support for different measures that aim to reduce drug use or drug-related harm. Specifically, differences across time, as well as sex, state and territory, and user status are examined for tobacco, alcohol, cannabis and heroin. More general support for legalisation and policy on penalties, and actions taken against people involved with specific illicit drugs is also examined. People's priorities are explored by looking at how a hypothetical \$100 should be split between education, treatment or law enforcement activity aimed at reducing the harm of from alcohol, tobacco and illicit drug use. All data presented in this chapter are available through the online policy and attitudes tables <<http://www.aihw.gov.au/publication-detail/?id=60129549469&tab=3>>.

## Key findings

### Attitudes and perceptions

- The proportion of people nominating cannabis and heroin as a 'drug problem' declined between 2010 and 2013, whereas the proportion associating meth/amphetamines and pain-killers/analgesics as a 'drug problem' rose.
- A higher proportion of people thought that alcohol caused the most drug-related deaths in 2013 (increasing from 30% to 34%) and this was the first time more people nominated alcohol than tobacco (32%). A higher proportion also thought that meth/amphetamines caused the most deaths (increasing from 4.7% to 8.7%) but this was still lower than heroin (14.1%).
- As in previous years, excessive alcohol use was mentioned more often than other drugs as being the most serious concern to the community in 2013.
- In 2013, the drug of most concern to the community, other than alcohol and tobacco, was meth/amphetamines (increasing from 9.4% to 16.1%).
- Alcohol was identified by 45% of people as the drug with most approval for regular adult use, and this proportion has remained stable since 2007. Approval of regular adult use of cannabis was higher in 2013 than in 2010 (9.8% compared with 8.1%), as was approval of non-medical use of tranquilisers/sleeping pills (8.2% compared with 6.4%).
- Perceptions and attitudes towards drugs differed by social characteristics. For example, those with the lowest SES and Indigenous Australians were more likely than their counterparts to identify cannabis as the drug most associated with a drug problem.



## Policy support

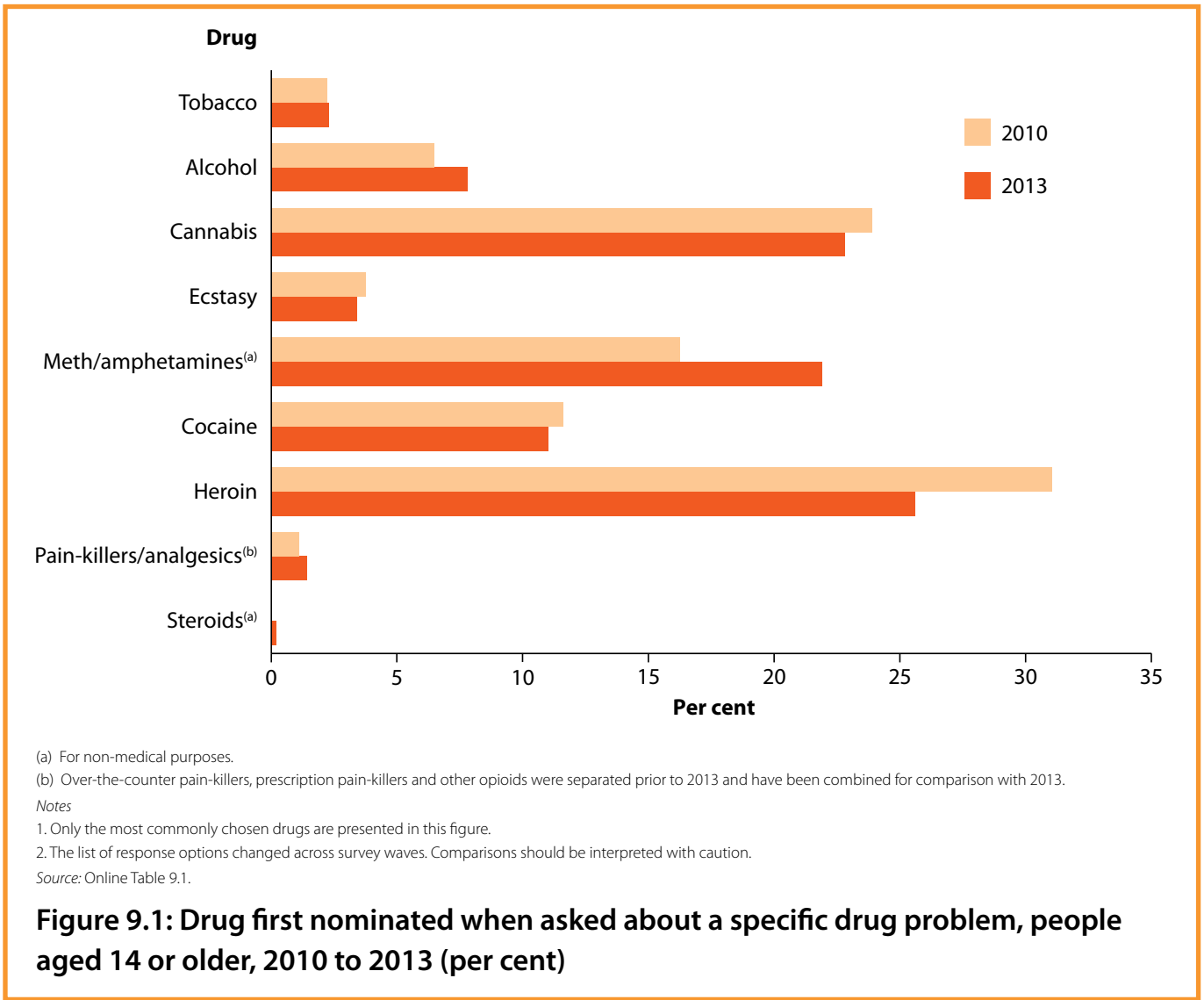
- Support for policies aimed at reducing harm that tobacco causes remained high in 2013 and stricter enforcement of the law and penalties for supplying to minors continued to receive the highest level of support with around 9 in 10 supporting these measures.
- The policy with most support to reduce alcohol harm was to establish more severe penalties for drink driving (85%), followed by stricter enforcement of the law against supplying to minors (84%).
- About two-thirds (69%) of people would support a change to the legislation permitting the use of cannabis for medicinal purposes but only one-quarter (26%) believed that the personal use of cannabis should be legal.
- People who used drugs generally had more accepting attitudes towards drugs and were less likely to support measures to reduce harm.
- When asked about appropriate action for people found in possession of small quantities of drugs, for all drugs except cannabis, most support was for referral to treatment or an education program, while for cannabis the most popular action was a caution, warning or no action and this increased in 2013 (from 38% to 42%).
- Between the sexes, higher proportions of females than males supported measures aiming to reduce problems associated with drug use and penalties for the sale and supply of illicit drugs. Conversely, males gave higher support to legalising personal use of illicit drugs.

## Perceptions and attitudes towards drug use

### Perception of drugs that cause a drug problem

In 2013, as in 2010, for those aged 14 or older heroin was nominated as the drug most likely to be associated with a 'drug problem', with one-quarter (26%) nominating heroin but this was lower (for both males and females) than in 2010 (31%) (Figure 9.1). This may be influenced by the social disruption caused by drug use such as antisocial behaviour and violence, as only a very small minority of the population in 2013 (0.1%) used heroin (Online Table 5.4). In addition between 2010 and 2013:

- similar levels of concern were expressed about cannabis and meth/amphetamine in 2013; this resulted from rising concern about meth/amphetamine (from 16.3% to 22%)
- the proportion of people nominating alcohol rose (from 6.5% to 7.8%)
- males and females had similar perceptions about drugs that are most likely to be associated with a 'drug problem' (Online Table 9.1).



### Drugs perceived to be associated with mortality

In comparison to tobacco, there were relatively fewer deaths attributable to alcohol and illicit drugs. In 2003, an estimated 15,511 deaths were attributable to tobacco; 1,705 were attributable to illicit drugs; and 3,430 were attributable to alcohol (Begg et al. 2007). Tobacco is the single most preventable cause of ill health and death in Australia, contributing to more drug-related hospitalisations and deaths than alcohol and illicit drug use combined (Begg et al. 2007).



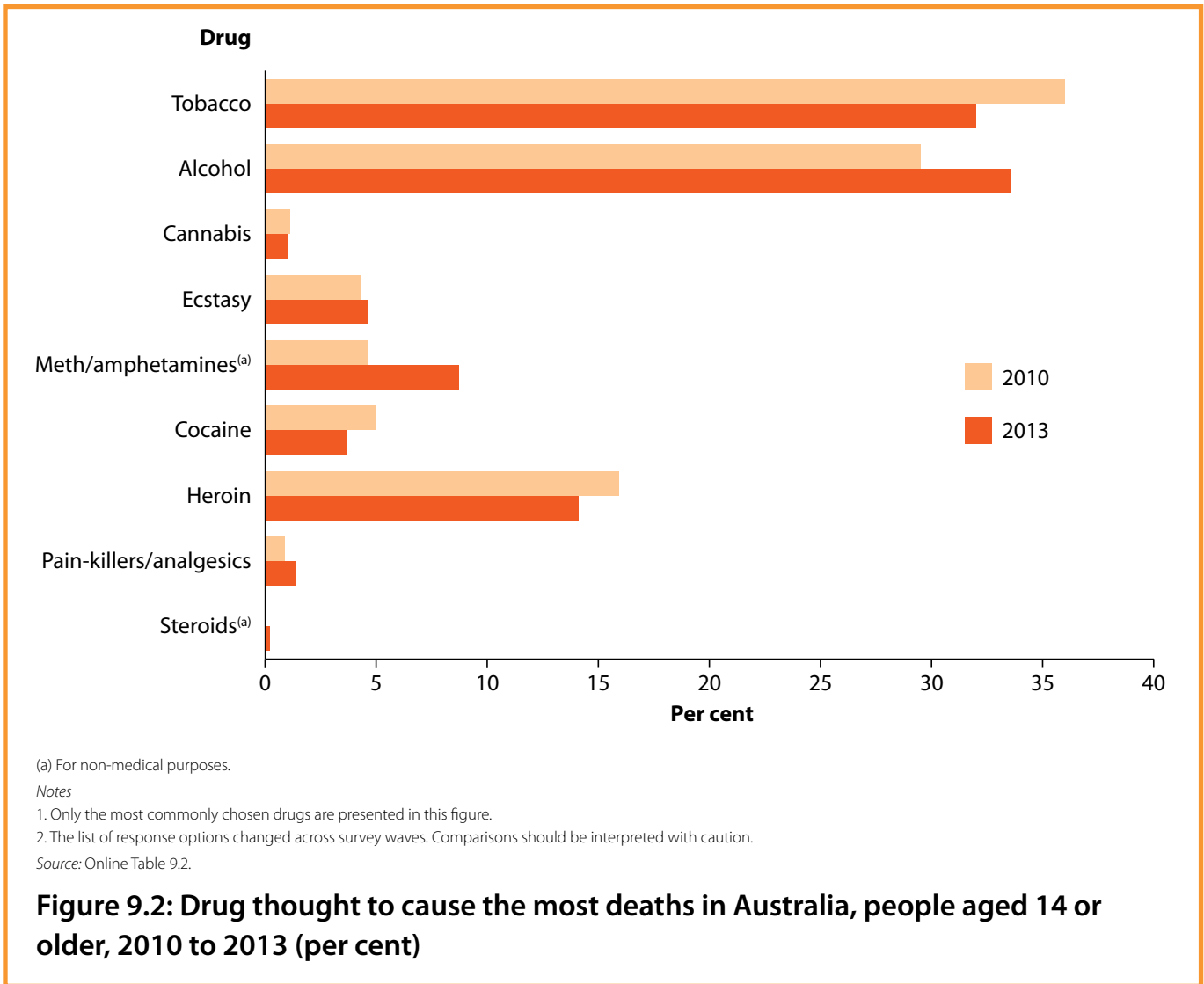
In Australia, 'drug-induced deaths' are those where drugs are determined to be the main cause of death (ABS 2002). In comparison to opioid-related deaths, meth/amphetamines and cocaine contribute to a small fraction of drug-induced deaths. In 2009 it was estimated that there was a total of 86 drug-induced deaths in which methamphetamine was mentioned (Roxburgh & Burns 2013a). This compared to 563 deaths that were due to opioids (Roxburgh & Burns 2013b).

In addition to being asked about which drugs people thought caused the most deaths, survey respondents were also asked their opinion about which drugs they thought either directly or indirectly caused the most deaths in Australia. A range of factors such as news media coverage, age and personal experience are likely to influence opinions on this issue.

Survey results showed that only one-third (32%) of the population aged 14 and over correctly nominated tobacco as the greatest cause of drug deaths in Australia. In 2013, for the first time, more people nominated alcohol (34%) than tobacco (Figure 9.2). More specifically:

- males were more likely than females to think that tobacco caused the most deaths (35% compared with 29%) (Online Table 9.8)
- heroin was the illicit drug most commonly identified as causing the most deaths, however this declined (from 15.9% in 2010 to 14.1% in 2013)
- meth/amphetamines has risen as a concern, with the proportion almost doubling since 2010 (from 4.7% to 8.7%).

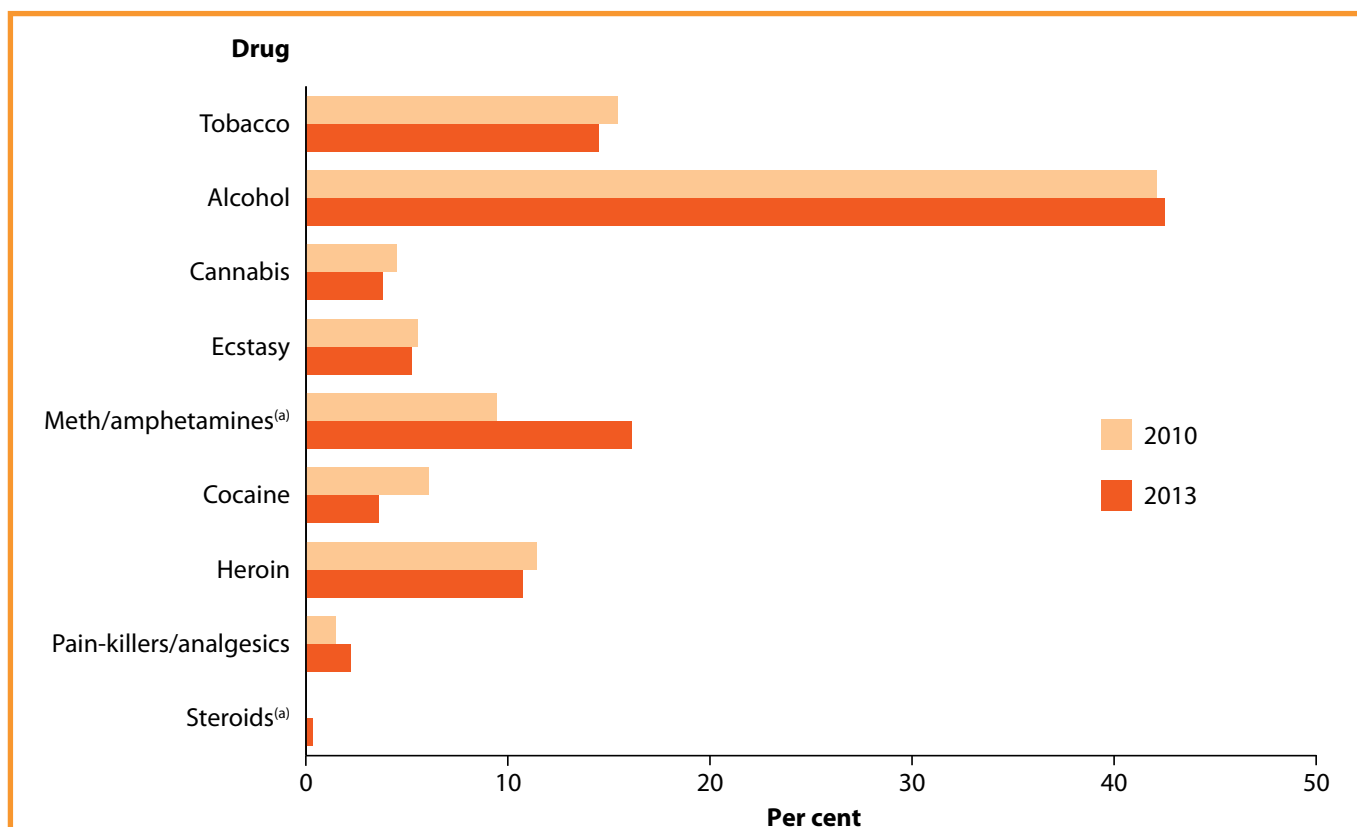
People aged 50–59 were most likely to nominate tobacco (36%), and people aged 14–19 were the least likely to nominate tobacco (24%) (Online Table 9.3). For alcohol, it was younger people (aged 14–29) who were more likely to associate this drug with mortality (37%) than older people (for example, 30% for people aged 50–59). While tobacco is responsible for the most deaths in Australia, alcohol causes more deaths among young people (Begg et al. 2007) which may be why young people were more likely to associate alcohol with mortality than tobacco.



## Drug of most concern for the general community

Survey respondents were also asked their opinion about which form of drug use they thought to be of most serious concern for the general community. Excessive use of alcohol continues to be the drug that people feel is of the most concern to the general community (43%) (Online Table 9.3). A higher proportion nominated meth/amphetamines as the drug of most concern and this drug is now the most commonly nominated illicit drug (more common than heroin). Following a large rise from 2010, it overtook tobacco as the second most nominated drug of concern. Additionally:

- males and females had similar perceptions about which drugs they thought were the most concerning for the community, although males were more concerned about smoking (16.0% compared with 13.0%), and females were more concerned about excessive alcohol use (44% compared with 41%) (Online Table 9.7)
- levels of concern varied across age groups, with older people more concerned with excessive alcohol use (45% for those aged 50 or older compared with 39% for those aged 14–29) and teenagers (aged 14–19) more concerned about tobacco smoking (17.7%), cannabis (7.0%) and ecstasy (6.9%).
- people in their 30s and 40s were more concerned about meth/amphetamines being a problem for the community than teenagers with about 1 in 5 nominating this drug compared with 1 in 10 (11.5%) teenagers.



(a) For non-medical purposes.

Source: Online Table 9.3.

**Table 9.3: Drug thought to be of most concern for the general community, people aged 14 or older, 2010 to 2013 (per cent)**





## Approval of regular adult drug use

Respondents were asked what they thought of regular adult use of various drugs. The results presented are for those respondents who said they 'strongly approve' or 'approve' the use of drugs by adults (shown together as 'approve').

Personal approval of regular adult use was higher for licit drugs than illicit drugs. Of all drugs used in Australia, alcohol (45%) has the highest level of personal approval, followed by tobacco (14.7%) and cannabis (9.8%) (Figure 9.4). More specifically:

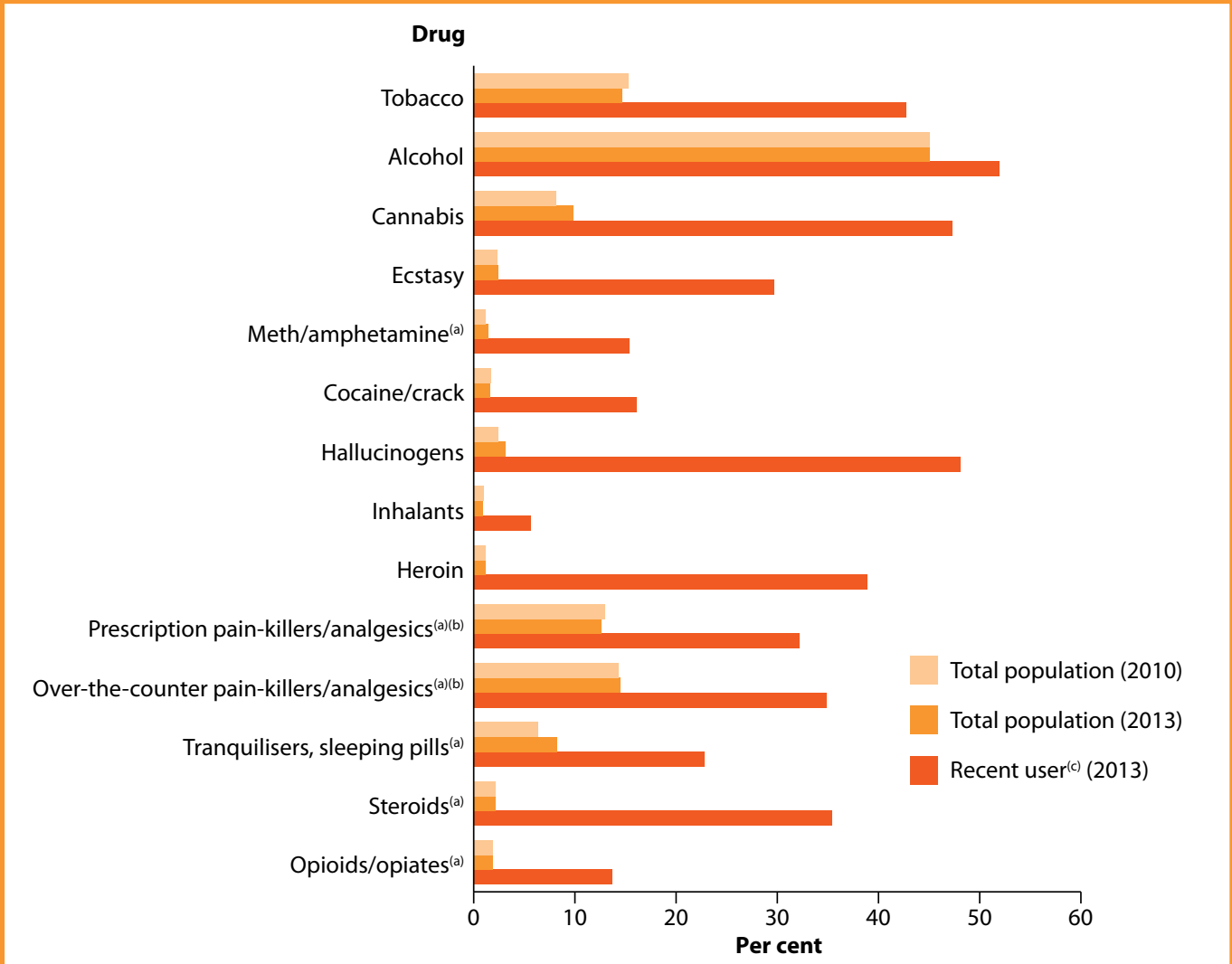
- the proportion of people approving the regular use of alcohol has remained stable since 2007 (Online Table 9.4)
- approval of regular adult use of cannabis was higher in 2013 than in 2010 (9.8% compared with 8.1%), as was the approval of tranquilisers/sleeping pills (8.2% compared with 6.4%)
- the approval of adult drug use was usually highest among those aged 20–29, and lowest for those aged 60 or older (Online Table 9.5); this was different for misuse of pain-killers and analgesics, as approval of use was highest among people aged 60 or older.

Not surprisingly, personal approval of regular drug use was consistently higher among individuals who have used that particular drug recently compared to those who have not used the drug in the preceding year. Despite this tendency, even users of inhalants, meth/amphetamines, cocaine, methadone and other opiates (Online Table 9.6) did not generally approve the regular use of these drugs (less than 20% personally approved).

## Social characteristics, perceptions and attitudes towards drugs

People's perceptions and attitudes towards drug use varied by SES, Indigenous status, remoteness area and sexual orientation (Online Table 9.27). Specifically:

- differing from the national totals, those with lowest SES, people living in *Remote and very remote* areas and Indigenous Australians were more likely than their counterparts to associate cannabis with a drug problem, and recent cannabis use was also higher among these population groups
- people with the highest SES, people living in *Major cities* and non-Indigenous Australians were more likely to associate heroin with a drug problem
- people with the lowest SES approved regular tobacco use by adults more often than those with the highest SES (19.1% compared with 11.3% respectively), but were less likely to approve of regular adult alcohol use than those with the highest SES (38% compared with 51%)
- Indigenous Australians were more likely than non-Indigenous Australians to approve the regular use of tobacco (24% compared with 14.5%) and cannabis (21% compared with 9.6%)
- those who identified as being homosexual or bisexual were more accepting of regular adult use of drugs than people who were heterosexual; for example, 24% approved the regular use of tobacco (compared with 13.9% for heterosexual people) and 24% approved the regular use of cannabis (compared with 9.1% for heterosexual people).



(a) Used for non-medical purposes.  
 (b) Use status refers to any pain-killer/analgesic.  
 (c) Used in the previous 12 months.  
 Note: Use status refers to the use of each drug specified.  
 Source: Online tables 9.4 and 9.6.

**Figure 9.4: Personal approval of the regular use by an adult of selected drugs, people aged 14 or older and recent drug users, 2010 and 2013 (per cent)**



## Support for policy

Australia has had a coordinated national policy for addressing alcohol, tobacco 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 (both numerator and denominator). Survey questions were expressed in terms of reducing problems associated with the use of alcohol, tobacco, cannabis and heroin.

### Support for measures to reduce problems associated with tobacco

In 2013, backing of policies aimed at reducing the harm that tobacco caused received the highest levels of support overall when compared with policies for alcohol, cannabis and heroin. Measures related to minors received the highest support and this was similar to the level of support given for the alcohol measure related to minors. Specifically:

- measures enforcing restriction of access to minors were highly supported (88% supported stricter enforcement of the law against supplying cigarettes to minors and 86% supported stricter penalties for the sale and supply of tobacco products to minors) (Online Table 9.9) and were highly supported across all smoking status categories
- the degree of support only changed for 1 measure between 2010 and 2013—support for introducing a licensing scheme for tobacco retailers declined from 69% to 67%
- those who had never smoked were the most likely to support all measures, while the lowest support for all measures was from current smokers (Online Table 9.10)
- smokers were the least likely to support increases in taxes on tobacco products; for example, only 26% of smokers approved of a tax increase on tobacco products to discourage smoking compared with 78% of people who had never smoked and 68% of ex-smokers.



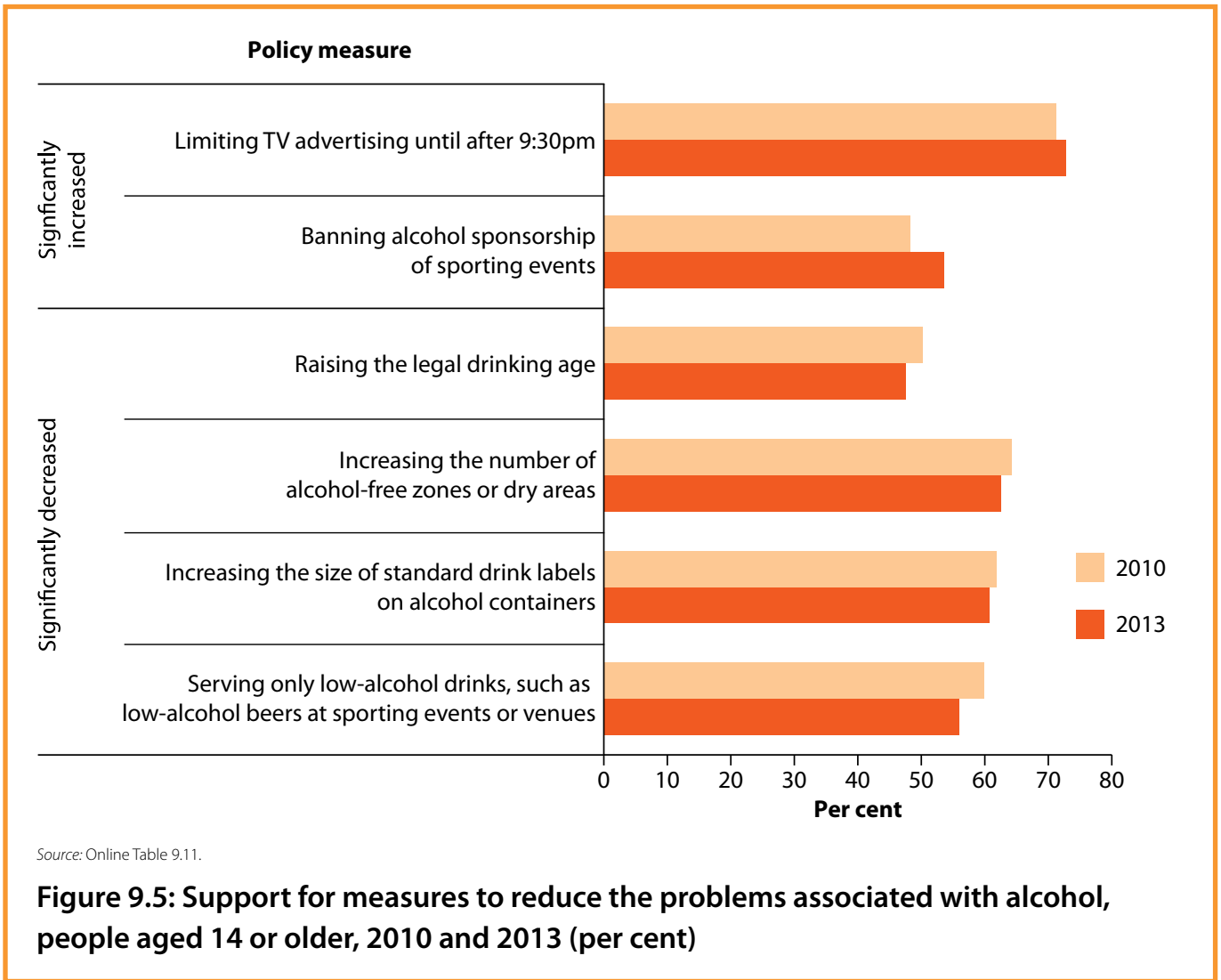
## Support for measures to reduce problems associated with alcohol

As in previous years, the support for measures aimed at reducing problems associated with alcohol use were generally lower than for measures to reduce tobacco-related harm. The policy with the most support to reduce alcohol harm was to establish more severe penalties for drink driving (85%), closely followed by a new measure added in 2013—stricter enforcement of law against supplying alcohol to minors, with 84% supporting this policy (similar to the support given for tobacco). The lowest level of support was for increasing the price of alcohol at 28%.

Compared with 2010, in 2013:

- there was more support for alcohol measures related to advertising, including limiting TV advertisements until after 9.30 pm (from 71% to 73%) and banning alcohol sponsorship of sporting events (from 48% to 54%) (Figure 9.5)
- although it remained strong, there was less support for serving only low-alcoholic drinks at sporting events (from 60% to 56%); increasing the number of alcohol-free areas (from 64% to 63%); and raising the legal drinking age (from 50% to 48%).

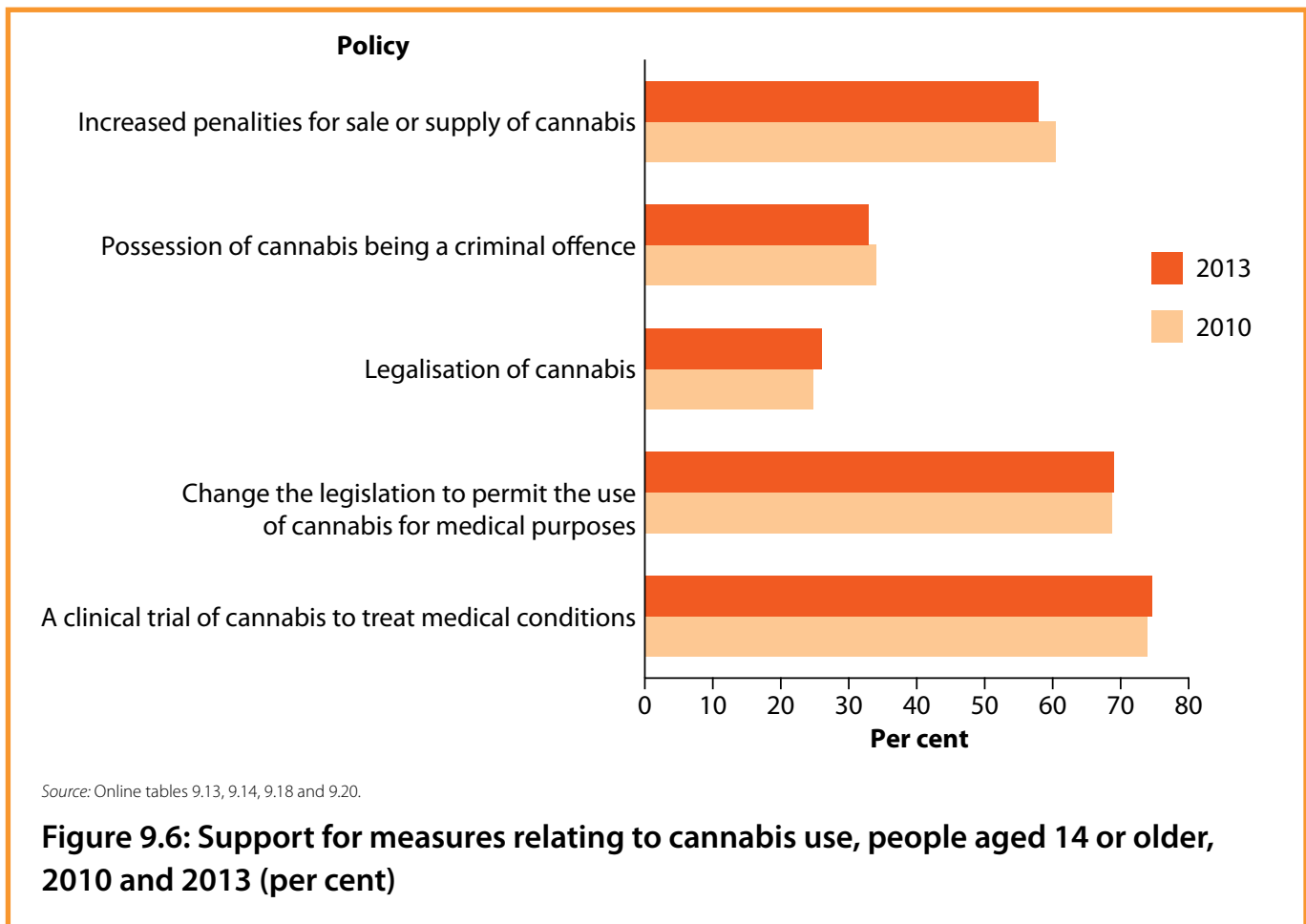
Abstainers and those drinking at low-risk levels were more likely than risky drinkers to support policies aimed at reducing alcohol-related harm (Online Table 9.12). Risky drinkers were far less likely to support increasing the price or tax on alcohol and the level of support for this measure among abstainers was at about 5 times the level of support shown by risky drinkers.



## Support for cannabis measures

In addition to policies aimed at reducing harm from tobacco and alcohol, respondents were asked about their level of support for policies on cannabis use. Respondents were asked about their support for legalisation, penalties, use of cannabis in medicinal settings and actions taken against people involved with cannabis.

Three-quarters (75%) of people aged 14 or older would support a clinical trial of cannabis to treat medical conditions (Figure 9.6). About two-thirds (69%) of people would also support a change to the legislation permitting the use of cannabis for medicinal purposes but only one-quarter (26%) believed that the personal use of cannabis should be legal. Even if cannabis were to be legalised, the great majority of the population (85%) claimed they would still not use it and 5.4% said they would try it (Online Table 9.15). While only one-third (33%) thought that possession of cannabis for personal use should be a criminal offence, 58% thought the penalties should be increased for the sale or supply of this drug.





## Support for measures to reduce problems associated with injecting

In 2013, the questions on support or opposition to measures taken to address problems associated with injecting drug use were reworded and new responses were added. Therefore comparisons to previous surveys should not be made.

In 2013, most people supported measures to reduce problems associated with injecting drugs. About two-thirds of the population aged 14 or older supported rapid detoxification therapy (69%), needle and syringe programs (67%), methadone/buprenorphine maintenance programs (67%), treatment with drugs other than methadone (66%) and the use of Naltrexone (68%), which is a medication that blocks the effect of opioids such as heroin (Online Table 9.28). In addition:

- a trial of prescribed heroin received the least support (34%)
- apart from a trial of prescribed heroin, higher proportions of females than males supported measures aimed at reducing problems associated with heroin
- support for needle and syringe programs was particularly high among heroin users at 90%
- the biggest variation between those who had used heroin and those who had not was for a trial of prescribed heroin, with 66% of those having used heroin supporting a trial compared with 34% of those who had never used.

## Support for other illicit drug measures

Support for legalisation of selected drugs remained stable in 2013, with no changes in the proportion supporting the legalisation of heroin (5.7%), meth/amphetamines (4.8%), cocaine (6.2%) and ecstasy (7.3%) (Online Table 9.18). Males and illicit drug users were far more likely than their counterparts to support legalisation (Online tables 9.18 and 9.23). In 2013, compared with people who had never used:

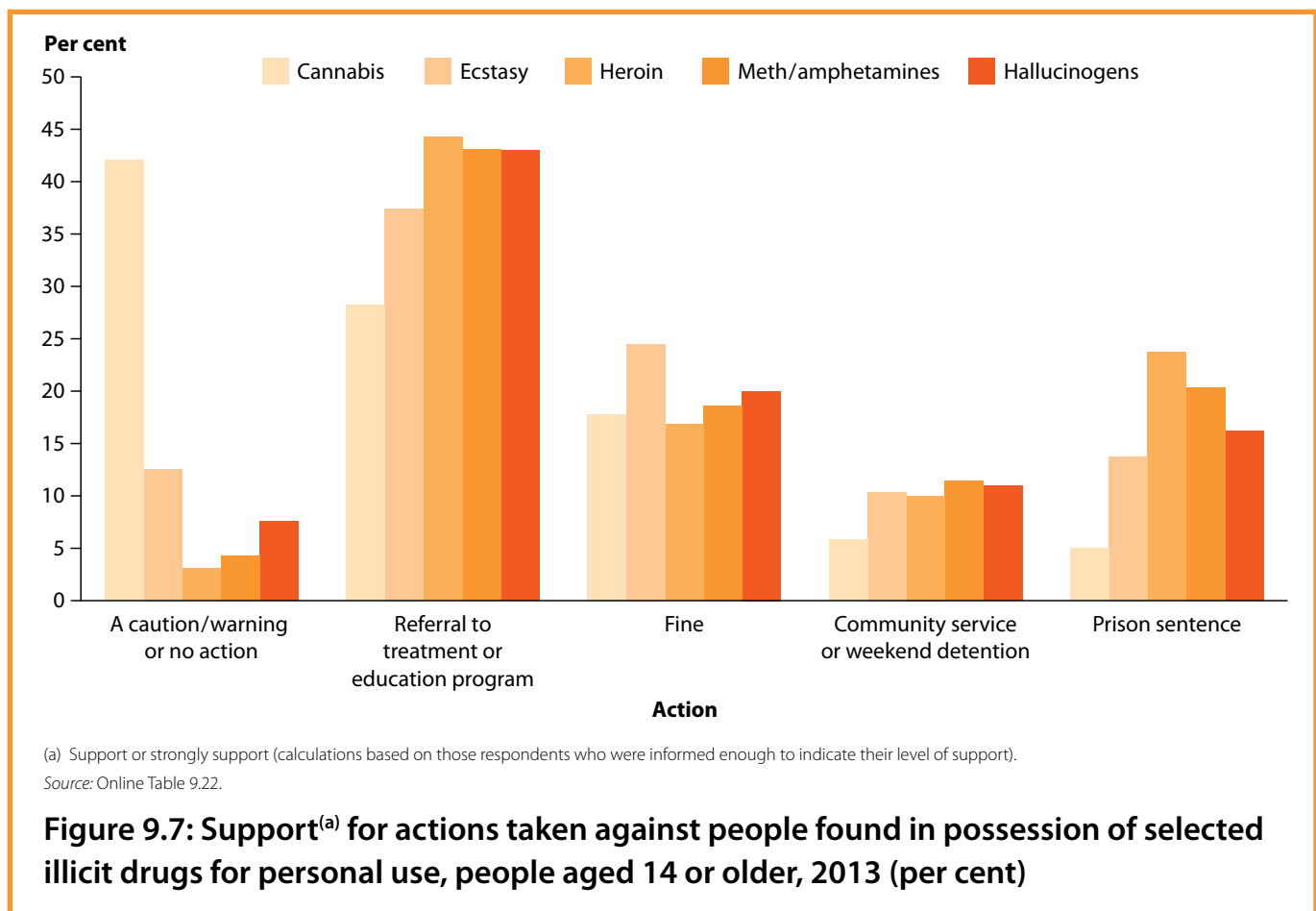
- heroin users were 9 times more likely to support legalisation of heroin
- ecstasy users were 7.6 times more likely to support legalisation of ecstasy
- cocaine users were 6.6 times more likely to support legalisation of cocaine.

People were less supportive of increasing the penalties for the sale or supply of cocaine and ecstasy in 2013 (from 83% to 81% for cocaine and from 82% to 80% for ecstasy) (Online Table 9.24). Among illicit drug users, recent cannabis users were the least supportive of increasing penalties for the supply of cannabis (13%) and meth/amphetamines users were the most supportive of this action for people supplying meth/amphetamines (42%).

## Actions taken against people found in possession of drugs

For people aged 14 or older, support for actions taken against people found in possession of illicit drugs for personal use differed according to drug type (Figure 9.7). In 2013:

- for all drugs except cannabis, most support was for referral to treatment or an education program, while for cannabis the most popular action was a caution, warning or no action and this rose in 2013 (from 38% to 42%)
- a lower proportion thought that possession of cannabis, ecstasy and heroin should result in a prison sentence
- for all drugs, teenagers (aged 14–19) were more likely to support fines than any other age group, and those aged 50 or older were more likely to support referral to treatment or an education program than other age groups (Online Table 9.22).



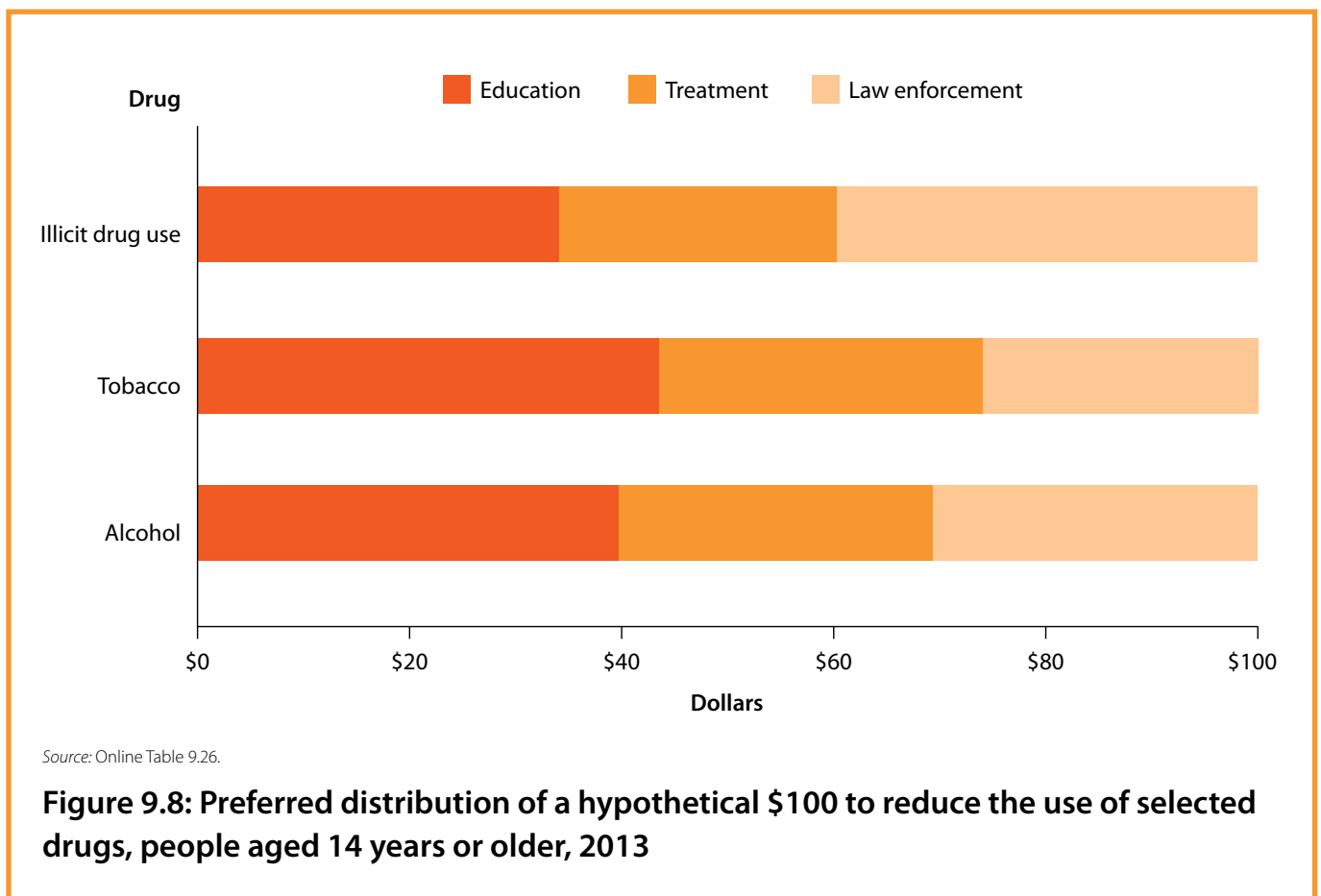
Illicit drug users had different views on the actions that should be taken for different drugs. Support for a caution or warning for those found in possession of cannabis and ecstasy was considerably higher among illicit drug users while those who had never used were more likely to support a referral to treatment or education program (Online Table 9.25). However, for possession of heroin or meth/amphetamines, illicit drug users were more likely support a referral to treatment or education program than those who had never used an illicit drug.





## Budget distribution for education, treatment and 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. As in previous years, on average in 2013, education received the greater proportion of the allotted \$100 for alcohol (\$39.70) and tobacco (\$43.50) (Online Table 9.26). For illicit drugs, the emphasis was on law enforcement, with little change over recent years (from \$40.50 to \$39.70). Across the 3 drug types, between about 60% and 75% of funds were allocated to education or treatment. These findings have remained fairly stable since 2004.



ten

# Explanatory notes





The estimates for 2013 contained in this publication are based on information obtained from people aged 12 or older or 14 or older (as specified) from all states and territories.

The scope of the survey was residential households, and excluded institutional settings, hostels, motels, and homeless people. Foreign language interviews were not conducted.

See 2013 NDSHS data quality statement for further information

<<http://www.aihw.gov.au/publication-detail/?id=60129549469&tab=3>>.

## Methodology

The 2013 survey consisted solely of a self-completion drop-and-collect method, which was consistent with the methodology employed in 2010, but different to the methodologies employed in earlier years. In 2004 and 2007, computer-assisted telephone interviews (CATI) were used in addition to the drop-and-collect survey, and prior to 2001, face-to-face interviews were also used. Table 10.1 provides a summary of the data collection methodologies and fieldwork timing between 1998 and 2013. Changes to the methodology should be taken into consideration when making comparisons over time.

Households were selected in a multistage, stratified area random sample. In distributing questionnaires, interviewers made 3 attempts to establish contact with selected households, and 3 attempts were also made to personally collect the completed questionnaire. If collection was not possible at that time, a reply-paid pre-addressed envelope was provided. As in 2010 and 2007, interviewers were able to make a reminder telephone call, before leaving a reply-paid envelope. The respondent was the household member aged 12 or older with the next birthday.

Roy Morgan Research conducted the 2013 drop-and-collect methodology from 31 July to 1 December 2013.

**Table 10.1: Data collection methodologies and fieldwork timing, 1998 to 2013**

Year	Data collection methodology	Total complete questionnaires	Fieldwork conducted
1998	Personal interviews (40%)	10,030	June–September 1998
	Drop and collect (60%)		
2001	Personal interviews (8%)	26,744	June/July–November 2001
	Drop and collect (85%)		
	CATI (8%)		
2004	Drop and collect (82%)	29,445	June/July–November 2004
	CATI (18%)		
2007	Drop and collect (85%)	23,356	June/July–November 2007
	CATI (15%)		
2010	Drop and collect (100%)	26,648	April–September 2010
2013	Drop and collect (100%)	23,855	July–December 2013



## Sample design

Consistent with previous surveys, the sample was stratified by region (15 strata in total—capital city and rest of state for each state and territory, with the exception of the Australian Capital Territory, which operated as 1 stratum). To produce reliable estimates for the smaller states and territories, sample sizes were boosted in Tasmania, the Australian Capital Territory and the Northern Territory.

For capital cities within each stratum, statistical areas level 1 (SA1s) were selected (previously census collection districts) with probability proportional to the number of private households at the 2011 Census. In non-capital city areas, statistical areas level 2 (SA2s) were selected for the first stage (previously statistical local areas), rather than SA1s. In non-capital city areas, SA2s for each stratum were selected with probability proportional to the number of households at the 2011 Census. From within each selected SA2, SA1s were selected with probability proportional to the number of private households at the 2011 Census.

A starting address within each selected SA1 was randomly selected, and interviewing started at the dwelling next door to this. Interviewers then followed a comprehensive set of procedures to select a dwelling, including skip intervals, eligible and ineligible addresses, and dealing with blocks of flats and units.

## Weighting

The sample was designed to provide a random sample of households within each geographic stratum. Respondents within each stratum were assigned weights to overcome imbalances arising in the design and execution of the sampling. The main weighting took into account geographical stratification, household size, age and sex. The population estimates used for the weighting were based on the latest available age/sex profile of each stratum using the latest published ABS estimated resident population data—June 2012.

All estimates in the report are based on the weighted sample. Table 10.2 provides a comparison of the age and sex profile of both the sample and the estimated resident population.



**Table 10.2: Comparison of the 2013 unweighted sample and estimated population distributions**

Age group	Unweighted 2013 sample			Population estimates <sup>(a)</sup> (weighted 2013 sample)		
	Males	Females	Total	Males	Females	Total
12–19	3.3%	3.4%	6.7%	6.1%	5.8%	11.9%
20–29	5.2%	6.9%	12.1%	8.7%	8.5%	17.2%
30–39	6.9%	10.1%	17.0%	8.2%	8.2%	16.3%
40–49	7.2%	9.4%	16.5%	8.2%	8.3%	16.4%
50–59	7.1%	9.1%	16.2%	7.4%	7.6%	15.0%
60–69	8.0%	9.0%	17.1%	5.8%	5.9%	11.7%
70–79	4.5%	5.1%	9.6%	3.3%	3.6%	6.9%
80+	2.4%	2.5%	4.9%	1.8%	2.7%	4.5%
<b>Total (12+)</b>	<b>44.5%</b>	<b>55.5%</b>	<b>100%</b>	<b>49.5%</b>	<b>50.5%</b>	<b>100%</b>

(a) The population estimates used for the weighting were based on a customised report of estimated resident population specially requested from the ABS to provide population data at the SA1 level. The latest reference period for which the ABS was able to provide for this level of detailed data was 30 June 2012.

## Response rates

Overall, contact was made with 48,579 in-scope households, of which 23,855 questionnaires were categorised as being complete and useable, representing a response rate for the 2013 survey of 49.1%, slightly lower than the drop-and-collect component of the 2010 survey (50.6%—Table 10.3).

There are several ways to calculate a response rate, depending on how partial interviews are considered and how cases of unknown eligibility are handled (AAPOR 2008). The response rate for the NDSHS was calculated using the total number of dwellings where contact was made as the number of eligible reporting units in the sample. If the entire eligible sample for the 2013 NDSHS is used—that is, it includes all cases of non-contact as part of the denominator (72,986 dwellings)—the response rate is reduced to 32.7%, meaning that about two-thirds of the sample did not respond or return a completed, useable questionnaire.

**Table 10.3: Sample disposition and participation rates, by sample, 2010 and 2013**

<b>Disposition</b>	<b>2010</b>	<b>2013</b>
	<b>Number</b>	
Original sample	81,708	75,992
<b>Less out-of-scope households</b>		
Not residential	1,786	1,506
Selected respondent not available	604	789
Other ineligible	175	711
<b>Total</b>	<b>2,565</b>	<b>3,006</b>
Eligible sample	79,143	72,986
Less households not contacted	-26,453	-24,407
Eligible sample contacted	52,690	48,579
Questionnaire left at household	37,566	32,972
<b>Less eligible respondents contacted but not willing or able to take part</b>		
Refusals	13,450	13,945
Foreign/no English	979	1,063
Incapacitated	370	341
Other non-response	325	258
Questionnaire not returned/unuseable	10,918	9,117
<b>Total</b>	<b>26,042</b>	<b>24,724</b>
<b>Completed</b>	<b>26,648</b>	<b>23,855</b>
	<b>Per cent</b>	
<b>Participation rate</b>	<b>50.6</b>	<b>49.1</b>



## Non-response bias and non-sampling error

Non-response bias can potentially occur when selected respondents cannot or will not participate in the survey, or cannot be contacted during the fieldwork period. The magnitude of any non-response bias depends on the level of non-response and the extent of the difference between the characteristics of those people who responded to the survey and those who did not, as well as the extent to which non-response adjustments can be made during estimation (ABS 2007).

### Non-sampling error

In addition to sampling errors, survey estimates are also subject to non-sampling errors. These can arise from errors in reporting of responses (for example, failure of respondents' memories, incorrect completion of the survey form), the unwillingness of respondents to reveal their true responses and the higher levels of non-response from certain subgroups of the population.

The level of non-sampling error cannot be quantified. However, careful survey design including layout of the questionnaire form and instructions to respondents, as well as management of the collection and processing steps, aim to minimise non-sampling error to the point where it is considered negligible.

A limitation of the survey is that people may not accurately report information relating to illicit drug use and related behaviours because these activities may be illegal. This means that results relating to illicit drugs are likely to underestimate actual prevalence. The reported findings are based on self-reported data and not empirically verified by blood tests or other screening measures.

## Sample representativeness

No sample will ever be fully representative of the population, but if carefully designed and implemented samples will be highly representative for drawing conclusions about characteristics of the population. To assist in understanding the level of representativeness, known population benchmarks for selected demographic characteristics may be used to assess the representativeness of the sample. Online tables 10.1 and 10.2 show the weighted and unweighted estimates obtained from the survey and compare these with the 2011 Census. A comparison between the 2011 Census and the NDSHS sample indicates that:

- a lower proportion of employed people and a higher proportion of unemployed people were captured in the sample
- completion of Year 12 and post-graduate qualifications were over-represented
- couple families were over-represented, while single person households were under represented
- people who did not speak English as their main language at home were under represented
- very low socioeconomic decile were slightly under-represented, and very high socioeconomic deciles were slightly over-represented.

The representativeness of the 2013 sample of the Australian population aged 12 or older in scope of the collection continues to improve.



## New strategies employed in 2013

For the 2013 survey, interviewers made 3 attempts to personally pick up the questionnaire in an effort to improve responses, whereas in 2010 pick-ups were limited to 2 attempts. The third pick-up call resulted in more questionnaires being returned to the interviewer, and more useable questionnaires being processed. However, questionnaire acceptance rates within eligible households declined, as has been the trend over time, primarily as a result of the increasing refusal rate. As a consequence, the increase in returned and useable questionnaires resulted in response rates remaining at a similar level to those attained in 2010.

Several other strategies were also used in 2013 to minimise cases of non-contact and non-response by the originally selected respondent, including:

- fieldworkers called back at different times on different days
- strict protocols were applied to ensure that selected dwellings were fully attempted
- respondents were given a letter of introduction and support from the Director of the Australian Institute of Health and Welfare
- the colour brochure, which outlines information about the survey and frequently asked questions, was redesigned
- interviewers made at least 3 attempts to personally pick up the completed questionnaire, whereas in 2010 pick-ups were limited to 2 attempts
- calling cards were left where appropriate
- 2 '1800' numbers were set up to answer queries, one to AIHW for questions about the confidentiality of the survey, and one to Roy Morgan Research for operational queries
- a letter of introduction and frequently asked questions were translated into 5 languages (Italian, Greek, traditional Chinese, Vietnamese and Arabic).





## Questionnaire

The 2013 questionnaire was modelled on the 2010 version, to maintain maximum comparability. However, some refinements were made to ensure the questions remained relevant and useful. The major additions to the questionnaire included:

- more detailed information about the type of tobacco products used
- awareness and use of unbranded and illicit tobacco
- amount of alcohol consumed during pregnancy
- factors that influence the decision to use illicit drugs
- use of emerging synthetic/psychoactive substances
- types of prescription and over-the-counter analgesics used.

In addition, the following changes were also made to the questionnaire:

- some demographic questions were moved from Section ZZ to the front of the questionnaire (sex, age, marital status, Indigenous status, household composition, number of people aged 12 and over in household, and questions on dependent children in the household)
- the lists of drugs were reduced for questions A1, A2, and A3
- questions on unbranded loose tobacco and cigarettes were modified to align with the 2007 versions of these questions
- 2 statements were added to policy support questions on alcohol (YY1)
- 2 statements were added to policy support questions on tobacco (YY2)

The 2013 NDSHS technical report contains a complete list of questionnaire changes. A copy of the technical report is available on request.

Not all respondents were asked all questions; the questionnaire <<http://www.aihw.gov.au/publication-detail/?id=60129549469&tab=3>> provides a full description. People aged 12–15 completed the survey with the consent of the adult responsible for them at the time of the survey. A separate, shorter questionnaire was administered to teenagers aged 12–13 to minimise respondent burden. Those questions that were not asked of respondents aged 12–13 are indicated by the following image:

**NOT ASKED  
12–13**



## Terminology

### Unbranded and illicit branded tobacco

Illicit tobacco includes both unbranded tobacco and branded tobacco products on which no excise, customs duty or GST was paid. Unbranded tobacco (commonly known as chop-chop) is finely cut, unprocessed loose tobacco that has been grown, distributed and sold without government intervention or taxation (ANAO 2002).

Illicit branded tobacco products include overseas-produced cigarettes (or packets of smoking tobacco) designed to comply with packaging laws in countries other than Australia but which make their way into Australia, without payment of customs duty, for sale to consumers in Australia.

### Alcohol risk

The alcohol risk data presented in the snapshots are reported against guidelines 1 and 2 of *The Australian guidelines to reduce health risks from drinking alcohol* released in March 2009 by National Health and Medical Research Council (NHMRC) (see Box 10.1 for further details).

#### **Box 10.1: The Australian guidelines to reduce health risks from drinking alcohol**

In summary, there are 4 guidelines:

- Guideline 1—reducing the risk of alcohol-related harm over a lifetime. 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—reducing the risk of injury on a single occasion of drinking. 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 aged under 18 years. For children and young people aged under 18 years, not drinking alcohol is the safest option, with those under 15 years of age at greatest risk of harm.
- Guideline 4—pregnancy and breastfeeding. For women who are pregnant, planning a pregnancy or breastfeeding, not drinking is the safest option.



## Licit drugs—illicit use

In the 2013 survey, as in the past, respondents were asked about their use of certain drugs that have legitimate medical uses—pain-killers/analgesics, tranquillisers/sleeping pills, steroids, methadone/buprenorphine, other opioids such as morphine (termed ‘pharmaceuticals’) and meth/amphetamines. The focus of the survey and corresponding data are on the use of these drugs for non-medical purposes. The term ‘illicit drugs’ in this report includes the following: illegal drugs (such as cannabis), pharmaceutical drugs (such as pain-killers, tranquillisers) when used for non-medical purposes (strictly an illicit behaviour), and other substances used inappropriately such as inhalants (see Box 10.2 for further details). Note that where each of these licit/illicit drugs is central to the analysis, it is their illicit use that is analysed.

### Box 10.2: Definition of illicit use of drugs

‘Illicit use of a drug’ can encompass a number of broad categories including:

- Illegal drugs—a drug that is prohibited from manufacture, sale or possession in Australia—for example, cannabis, cocaine, heroin and amphetamine type stimulants.
- Pharmaceuticals—a drug that is available from a pharmacy, over the counter or by prescription, which may be subject to misuse—for example, opioid-based pain relief medications, opioid substitution therapies, benzodiazepines, over-the-counter codeine and steroids.
- Other psychoactive substances—legal or illegal, potentially used in a harmful way—for example, kava, synthetic cannabis and other synthetic drugs, or inhalants such as petrol, paint or glue (MCDS 2011).

## Emerging psychoactive substances

Emerging psychoactive substances, or EPS, is a term used to describe drugs that are relatively new to the recreational drug market and have mind-altering effects. EPS often mimic the effects of existing illicit psychoactive drugs such as cannabis, ecstasy (MDMA) and LSD, or have a chemical structure very similar to existing illicit substances. Other names given to this group of drugs include: research chemicals, analogues, legal highs, herbal highs, bath salts, party pills and synthetic drugs (NDARC 2013).



## Presentation of estimates

Proportions are shown as percentages rounded to 1 decimal place when less 20%, and rounded to a whole number when over 20%. All data presented in the body of the report are raw proportions and have not been age-standardised (unless indicated).

## Population estimates

Population estimates are calculated by applying survey prevalence rates to the relevant population count and were based on the June 2013 ABS estimated resident population (see Online Table 10.6). Population estimates are shown to the nearest 100,000 or 10,000 in text, depending on the size of the estimate.

## Age standardisation

The age profile of Australians varies across jurisdictions, other geographic classifications, such as remoteness areas, periods of time and/or population subgroups (for example, between Indigenous and non-Indigenous populations). Age-standardisation is a process that removes differences in the age compositions of 2 or more populations, to allow comparisons between these populations independent of their age structure.

Age-standardisation is important in this publication, as drug-related behaviours can be age related. Age-standardisation accounts for this by allowing comparisons between groups independent of their differing age profiles. A standard age composition is used against which subpopulations are standardised, in this case the age composition of the 30 June 2001 Australian estimated resident population.

All state and territory data and some social characteristics data have been age-standardised, and are presented as age-standardised percentages in Chapter 7 'State and territory comparisons' and Chapter 8 'Specific population groups'. All data presented in the body of the report have not been age-standardised. Age-standardisation has been done using the direct method.

## Reliability of estimates

A measure of the sampling error for a given estimate is provided by the standard error (SE), which is the extent to which an estimate might have varied by chance because only a sample of persons was obtained. The relative standard error (RSE) is the SE expressed as a percentage of the estimate, and provides an immediate indication of the percentage of errors likely to have occurred due to sampling. The smaller the estimate, the higher the RSE. Only estimates with RSEs of less than 25% are considered sufficiently reliable for most purposes.

Results subject to RSEs of between 25% and 50% should be considered with caution and those with RSEs greater than 50% should be considered as unreliable for most practical purposes. Estimates that have RSEs greater than 50% are marked in the report with \*\* and those with RSEs of between 25% and 50% are marked with \*.



## Statistical significance

For comparing estimates between surveys, it is necessary to determine whether differences are 'real' differences between the corresponding population characteristics or simply the result of sampling variability between the survey samples. One way to examine this is to determine whether the difference between the estimates is statistically significant (ABS 2010).

All time series tables have been tested for statistically significant changes between 2010 and 2013 and are indicated with a # for significant decrease or increase. The difference is statistically significant if the z-statistic of the pooled estimate of the 2 rates being compared is more than 1.96 or less than -1.96 (a 5% 2-tailed test).

Throughout the report, any time series increase or decrease mention is statistically significant unless specified otherwise.

## Pregnancy questions

The questions on drug use during pregnancy were updated in 2013 to provide a more accurate picture of drinking during pregnancy. However, these extra questions raised issues in the way pregnant woman responded in the survey.

The 2013 survey asked women about their drinking before and after knowledge of pregnancy, as well as about whether they drank more, less or the same amount compared to when they were not pregnant. The way in which pregnant women interpreted these 2 questions differed and as such, the proportions reporting that they did use alcohol during pregnancy differed.

There are 2 plausible reasons as to why these results differ. Faced with a question about drinking 'in the last 12 months' it is not clear how a respondent who abstained for most of their pregnancy but did drink for a part of their pregnancy (before they knew they were pregnant) should respond. The pattern of responses suggests that some women answer in terms of social acceptability—it's more acceptable to acknowledge drinking before knowledge of pregnancy but they felt that this didn't 'count' as drinking during pregnancy.

This impacted how some women responded to the question that asked if they drank more, less or the same amount of alcohol. While some women who said they drank alcohol before they knew they were pregnant said that they drank less, other pregnant women answered this questions differently and said they 'don't drink alcohol'.

# Membership of the Technical Advisory Group

A





**Table A1.1: 2013 National Drug Strategy Household Survey Technical Advisory Group**

Name	Organisation
Mr Geoff Neideck (Chair)	Australian Institute of Health and Welfare (AIHW)
Professor Paul Dietze	Alcohol and Other Drug Research, Burnet Institute
Mr Matthew Montgomery	Australian Bureau of Statistics (ABS)
Ms Louise Gates	ABS
Dr Jason Payne	Australian Institute of Criminology
Dr Julia Tresidder	Australian National Preventive Health Agency
Professor Toni Makkai	The Australian National University
Professor Melanie Wakefield	Cancer Council of Victoria
Dr Victoria White	Cancer Council of Victoria
Ms Jenny Taylor	Department of Health (Research and Marketing Unit)
Professor Alison Ritter	Drug Policy Modelling Program
Dr Ken Pidd	National Centre for Education and Training on Addiction
Professor Louisa Degenhardt	National Drug and Alcohol Research Centre
Professor Tanya Chikritzhs	National Drug Research Institute
Associate Professor John Glover	Public Health Information Development Unit, University of Adelaide
Ms Helen Catchatoor	Department of Health (Tobacco Taskforce)
Mr Chris Killick-Moran	Department of Health
Mr Roland Balodis	Department of Health
Ms Amber Jefferson	AIHW
Ms Cathy Claydon	AIHW
Ms Karen Webber	AIHW



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### Online tobacco smoking tables

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## Glossary

### **Abstainer (alcohol)**

Never consumed a full serve of alcohol.

### **Australian Statistical Geographic Standard (ASGS) Remoteness Area**

The ABS Australian Statistical Geographic Standard (ASGC) Remoteness Areas classification allocates 1 of 5 remoteness categories to areas, depending on their distance from a range of 5 types of population centre. These classifications reflect the level of remoteness at the time of the 2011 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.

### **Concurrent (12-month) drug use**

Use of 2 or more substances during the past 12 months.

### **Current smoker**

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

### **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.

### **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/analgesics\*

tranquillisers/sleeping pills\*

steroids\*

meth/amphetamines\*

cannabis

heroin

Methadone or buprenorphine\*\*

other opiates (opioids)\*

cocaine



- hallucinogens
- ecstasy
- ketamine
- GHB
- synthetic cannabinoids
- other emerging psychoactive substances
- inhalants
- (any) injected drug

*Note*

\*used for non-medical purposes

\*\* non-maintenance program

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

**Injected drugs**

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

**Kessler Psychological Distress Scale (K10)**

A survey device that is used to measure 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 only used for people aged 18 or older.

**Lifetime risk (alcohol)**

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

**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-maintenance**

Use of a substance other than as part of a medically supervised maintenance program. In this report this includes methadone.

**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 and meth/amphetamines and other opioids such as morphine or pethidine.

**Non-smoker**

Never smoked or an ex-smoker.

**Recent**

In the previous 12 months.



**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 is one of four Socio-Economic Indexes for Areas (SEIFA) compiled by the Australian Bureau of Statistics after each Census of Population and Housing. The SEIFA aims to represent the socioeconomic status (SES) of Australian communities, and pinpoint areas of advantage and disadvantage. In this report, the population living in the 20% of areas with the greatest overall level of disadvantage is described as the 'lowest SES'. The 20% at the other end of the scale—the top fifth—is described as the 'highest SES'.

**Standard drink**

Containing 10 grams of alcohol (equivalent to 12.5 millilitres of alcohol). Also referred to as a full serve.



## References

- AAPOR (American Association for Public Opinion Research) 2008. Standard definitions: final dispositions of case codes and outcome rates for surveys. 7th edn. AAPOR.
- ABS (Australian Bureau of Statistics) 2002. Information paper: Drug-induced deaths—A guide to ABS causes of death data. Cat. no. 4809.0.55.001. Canberra: ABS.
- ABS 2007. National Survey of Mental Health and Wellbeing: User's guide, 2007. Cat no. 4327.0. Canberra: ABS.
- ABS 2008. Australian social trends. Cat. no. 4102.0. Canberra: ABS.
- ABS 2010. Education and work, Australia, May 2010. Cat no. 6227.0. Viewed 14 May 2014, <<http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/6227.0.55.002Main+Features10Sep+2011>>.
- ACMD (Advisory Council on the Misuse of Drugs) 2006. Pathways to problems: hazardous use of tobacco, alcohol and other drugs by young people in the UK and its implications for policy. London: ACMD 2006.
- ADF (Australian Drug Foundation) 2013. Drugs: the facts. Viewed 13 June 2014, <<http://www.druginfo.adf.org.au/drug-facts/drugs-the-facts#sthash.dtBnskPY.dpuf>>.
- AIHW (Australian Institute of Health and Welfare) 2007. Statistics on drug use in Australia 2006. Cat. no. PHE 80. Canberra: AIHW.
- AIHW 2008. Australia's health 2008. Cat. no. AUS 99. Canberra: AIHW
- AIHW 2010. Australia's health 2010. Australia's health series no. 12. Cat. no. AUS 122. Canberra: AIHW.
- AIHW 2011. 2010 National Drug Strategy Household Survey report. Drug statistics series no. 25. Cat. no. PHE 145. Canberra: AIHW.
- AIHW 2012. Australia's health 2012. Australia's health series no. 13. Cat. no. AUS 156. Canberra: AIHW.
- AIHW 2014. Australia's health 2014. Australia's health series no. 14. Cat. no. AUS 178. Canberra: AIHW.
- AIHW & AACR (Australasian Association of Cancer Registries) 2012. Cancer in Australia: an overview, 2012. Cancer series no. 74. Cat. no. CAN 70. Canberra: AIHW.
- ANAO (Australian National Audit Office) 2002. Administration of tobacco excise. Audit report No. 55, 2001–02 Performance Audit. Canberra: ANAO, Commonwealth of Australia. Viewed 2 April 2014, <[http://www.anao.gov.au/uploads/documents/2001-02\\_Audit\\_Report\\_55.pdf](http://www.anao.gov.au/uploads/documents/2001-02_Audit_Report_55.pdf)>.
- ANPHA (Australian National Preventive Health Agency) 2014. Alcohol advertising: the effectiveness of current regulatory codes in addressing community concern. ANPHA: Canberra.
- Badel A & Greaney B 2013. Exploring the link between drug use and job status in the U.S. The Regional Economist. Viewed 13 May 2014, <<https://www.stlouisfed.org/publications/re/articles/?id=2396>>.
- Begg S, Vos T, Barker B, Stevenson C, Stanley L & Lopez AD 2007. The burden of disease and injury in Australia 2003. Cat. no. PHE 82. Canberra: AIHW.
- Bright S 2013. New and emerging drugs. Prevention Research, Issue 1 April 2013. Melbourne: Australian Drug Foundation.



- Collins D & Lapsley H 2008. The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004–05. National Drug Strategy Monograph Series no. 66. Canberra: Australian Government Department of Health and Ageing.
- Degenhardt L, Whiteford HA, Ferrari AJ, Baxter AJ, Charlson FJ et al. 2013. Global burden of disease attributable to illicit drug use and dependence: findings from the Global Burden of Disease Study 2010. *The Lancet* 382(9904):1564–74.
- DoH (Department of Health) 2013. National Binge Drinking Strategy. Viewed 21 May 2014, <<http://www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/cli>>.
- DoHA (Department of Health and Ageing) 2013. National Drugs Campaign. 3 June 2014, <<http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/content/ice2>>.
- Draper G, Turrell G & Oldenburg B 2004. Health inequalities in Australia: mortality. Health Inequalities Monitoring Series No. 1 AIHW Cat. no. PHE 55. Canberra: Queensland University of Technology and the AIHW.
- Dunn J, Greenbank S, McDowell M, Mahoney C, Mazerolle P, Occhipinti S et al. 2008. Community knowledge, attitudes and behaviours about environmental tobacco smoke in homes and cars. *Health Promotion Journal of Australia* 19:113.
- Galea S & Vlahov D 2002. Social determinants and the health of drug users: socioeconomic status, homelessness, and incarceration. *Public Health Report* 117, Supplement 1:S135–45.
- Henkel D 2011. Unemployment and substance use: a review of the literature (1990–2010). *Current Drug Abuse Reviews* 4(1):4–27.
- Hughes, C 2014. The Australian (illicit) drug policy timeline: 1985–2014. Viewed 11 June 2014, <<http://www.dpmp.unsw.edu.au/resource/drug-policy-timeline>>.
- IGCD (Intergovernmental Committee on Drugs) 2013. National Tobacco Strategy 2012–2018. Canberra: Commonwealth of Australia.
- IHME (Institute for Health Metrics and Evaluation) 2014. Data visualizations. Seattle: IHME. Viewed 16 September 2014, <<http://www.healthmetricsandevaluation.org/tools/data-visualizations>>.
- Laslett AM, Room R & Ferris J 2011. Surveying the range and magnitude of alcohol's harm to others in Australia. *Addiction* 106(9):1603–1611.
- Loxley W, Toumbourou J, Stockwell TR, Haines B, Scott K, Godfrey C et al. 2004. The prevention of substance use, risk and harm in Australia: a review of the evidence. Canberra: The National Drug Research Institute and the Centre for Adolescent Health.
- MCDS (Ministerial Council on Drug Strategy) 2011. The National Drug Strategy 2010–2015. Canberra: Commonwealth of Australia.
- McKetin R, Chalmers J, Burns L, Vogl L, Grech K, Slade T et al. 2010. Research to explain and respond to the ecstasy use situation in Australia: a birth cohort analysis of national ecstasy use trends. NDARC technical report No. 313. Sydney: National Drug and Alcohol Research Centre, University of New South Wales.





NDARC (National Drug and Alcohol Research Centre) 2013. Emerging psychoactive substances. Viewed 12 June 2014, <<https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/EPS%20Fact%20Sheet.pdf>>.

NHMRC (National Health & Medical Research Council) 2009. Australian guidelines to reduce health risks from drinking alcohol. Canberra: NHMRC.

NRHA (National Rural Health Alliance) 2012. Illicit drug use in rural Australia. Fact sheet 33, June 2012. Canberra. Viewed 5 June 2014, <<http://ruralhealth.org.au/sites/default/files/publications/fact-sheet-33-illicit-drug-use-rural-australia.pdf>>.

Ritter A, Matthew-Simmons F & Carragher N 2012. Prevalence of and interventions for mental health and alcohol and other drug problems amongst the gay, lesbian, bisexual and transgender community: A review of the literature. DPMP Monograph Series No. 23. Sydney: National Drug and Alcohol Research Centre.

Roxburgh A & Burns, L (2013a). Cocaine and methamphetamine related drug-induced deaths in Australia, 2009. Sydney: National Drug and Alcohol Research Centre.

Roxburgh A & Burns, L (2013b). Accidental drug-induced deaths due to opioids in Australia, 2009. Sydney: National Drug and Alcohol Research Centre

Scollo M, Zacher M, Durkin S et al. 2014. Early evidence about the predicted unintended consequences of standardised packaging of tobacco products in Australia: a cross-sectional study of the place of purchase, regular brands and use of illicit tobacco. *British Medical Journal* September 2014; Available at: <<http://bmjopen.bmj.com/content/4/8/e005873.full.pdf+html>>.

Spooner C & Hetherington K 2005. Social determinants of drug use. Sydney: National Drug and Alcohol Research Centre.

SGV (State Government of Victoria) 2014. Pregnancy and smoking. Viewed 15 May 2014, <[http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Pregnancy\\_and\\_smoking](http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Pregnancy_and_smoking)>.

Tyas S & Pederson L 1998. Psychosocial factors related to adolescent smoking: A critical review of the literature. *Tobacco Control* 7:409–42.

UNODC (United Nations Office on Drugs and Crime) 2014. Global synthetic drugs assessment: Amphetamine-type stimulants and new psychoactive substances. Vienna: United Nations.

WHO (World Health Organization) 2011. Alcohol—fact sheet. Geneva: WHO.

Wilkinson R & Marmot M (eds) 2003. *Social determinants of health: the solid facts*. 2nd edn. Copenhagen: WHO.

This 2013 National Drug Strategy Household Survey report shows that:

- fewer Australians are smoking daily and are smoking less cigarettes
- fewer people are exceeding the lifetime risk and single occasion risk guidelines for alcohol use
- overall illicit drug use has remained stable but some drugs have declined and some have increased
- alcohol continues to be the drug of most concern to the community but an increasing number of people are concerned about meth/amphetamines.

