2022

CAMH Monitor *e*Report 2022:
Substance Use, Mental Health and Well-Being Among Ontario Adults

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The 2022 CAMH MONITOR *e*REPORT
Executive Summary

The Centre for Addiction and Mental Health's *CAMH Monitor* is the longest ongoing population survey of adult substance use in Canada. The study, which spans **46** years, is based on 34 cross-sectional probability surveys, conducted between 1977 and 2019. Due to COVID-19, the 2020 and 2022 cycles of the *CAMH Monitor* are based on quota sampling and a web panel survey among adults aged 18 and older across Ontario.

This summary presents the estimates of substance use and related harms, as well as mental health and well-being indicators among Ontario adults in the 2020 and 2022 surveys.

Substance Use, Mental Health & Well-Being Indicators, 2020/2022 CAMH Monitor

Indicator	2020 (n=3,033)				2022 (n=2,650)			
	T %	M %	W %		T %	M %	W %	
Alcohol								
Percentage drinking alcohol - past 12 months	**80.4**	80.8	80.0		**80.4**	82.1	78.8	
Percentage drinking daily - total sample	**9.7**	12.0	7.6	*	**9.2**	11.3	7.3	*
- among drinkers	**12.1**	14.9	9.5	*	**11.4**	13.8	9.2	
Average number of drinks consumed weekly - among drinkers *(mean)*	**6.7**	8.7	4.8	*	**6.3**	8.0	4.7	*
Percentage consuming 5 or more drinks on a single occasion weekly (weekly binge drinking)								
- total sample	**11.3**	15.9	7.1	*	**10.7**	15.1	6.8	*
- among drinkers	**14.1**	19.6	8.9	*	**13.3**	18.4	8.6	*
Percentage reporting hazardous or harmful drinking (AUDIT 8+) - total sample	**21.2**	26.9	16.0	*	**20.1**	25.7	15.0	*
- among drinkers	**26.8**	33.8	20.3	*	**25.3**	31.6	19.3	*
Percentage reporting symptoms of alcohol dependence (based on the AUDIT) - total sample	**13.9**	17.1	11.0	*	**14.1**	18.0	10.7	*
Tobacco								
Percentage currently smoking cigarettes	**17.2**	19.3	15.3		**17.7**	19.9	15.7	*
Daily smoking	**12.4**	13.1	11.7		**12.3**	12.9	11.8	
Average number of cigarettes smoked daily- among smokers (mean)	**9.0**	8.1	10.1		**8.9**	8.2	9.8	
Percentage of daily smokers reporting high nicotine dependence - among daily smokers	**7.8**	6.2	9.4		**9.4**	8.7	10.1	
Percentage reporting electronic cigarette use - past 12 months	**15.2**	17.4	13.0		**13.7**	17.0	10.7	*
Cannabis								
Percentage using cannabis in lifetime	**53.0**	53.4	52.6		**54.1**	56.9	51.7	*
Percentage using cannabis - past 12 months	**31.7**	33.9	29.7	*	**32.9**	35.7	30.3	*
Percentage reporting moderate to high risk of cannabis use problems (ASSIST-CIS 4+)								
- total sample	**16.4**	18.9	14.0	*	**19.4¶**	23.3	16.2	*
- among users	**55.5**	62.0	48.9	*	**64.4¶**	73.0¶	56.5	*
Percentage using cannabis for medical purposes - past 12 months -total sample	**13.1**	12.6	13.5		**14.2**	13.7	14.7	
-among users	**41.5**	37.3	46.0	*	**43.7**	38.6	49.0	*

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Indicator	2020 (n=3,033)				2022 (n=2,650)			
	T %	M %	W %		T %	M %	W %	
Cocaine								
Percentage using cocaine in lifetime	**14.7**	17.0	12.6		**15.1**	17.2	13.1	*
Percentage using cocaine - past 12 months	**3.7**	4.5	3.0		**3.0**	4.0	2.1	*
Prescription Opioid Pain Relievers								
Percentage reporting any use (medical or nonmedical) of prescription opioid pain relievers - past 12 months	**32.7**	31.1	34.2		**31.3**	31.8	30.9	
Percentage using prescription opioid pain relievers for nonmedical purposes - past 12 months	**17.8**	19.1	16.6		**18.0**	20.1	16.2	
Driving[2]								
Percentage of drivers who drove after drinking two or more drinks in the previous hour - past 12 months	**4.4**	7.0	2.0		**3.9**	6.0	2.0	*
Percentage of drivers who drove after using cannabis in the previous hour - past 12 months	**2.4**	2.9	2.0		**2.5**	2.9	2.1	
Percentage of drivers who reported texting while driving - past 12 months	**26.5**	28.8	24.3		**23.5**	21.3[¶]	25.3	
Mental Health								
Percentage reporting moderate to serious psychological distress during the past 30 days (K6/8+)	**33.8**	30.0	37.5	*	**34.7**	29.9	38.6	*
Percentage reporting serious psychological distress during the past 30 days (K6/13+)	**13.5**	11.4	15.6		**14.9**	12.4	16.9	*
Percentage using prescribed antianxiety medication - past 12 months	**19.4**	16.4	22.3		**20.4**	16.5	23.5	*
Percentage using prescribed antidepressant medication - past 12 months	**16.1**	12.2	19.9	*	**17.3**	13.1	20.8	*
Percentage reporting fair or poor mental health in general	**26.2**	20.8	31.2	*	**31.8[¶]**	29.4[¶]	34.0	*
Percentage reporting frequent mental distress days (14+) during the past 30 days	**16.8**	12.3	21.1	*	**19.3**	14.9	22.9	*
Percentage reporting suicidal ideation - past 12 months	**7.7**	7.4	7.9		**7.7**	5.6	9.4	*
Physical Health								
Percentage reporting fair or poor health in general	**16.3**	16.3	16.4		**19.2[¶]**	17.9	20.3[¶]	
Percentage reporting frequent physically unhealthy days (14+) during the past 30 days	**12.4**	10.0	14.7		**14.3**	10.9	17.2	*

Notes: * Within year significant difference between men (M) and women (W) at p<0.05; [¶] Significant change between 2020 and 2022; [2] estimates are based on licensed drivers.

Key findings in 2022

- **Men** were more likely than women to report daily drinking, higher number of drinks consumed weekly, weekly binge drinking, drinking hazardously or harmfully, symptoms of alcohol dependence, current smoking, past year electronic cigarette use, lifetime and past year cannabis use, moderate to high risk cannabis use problems, lifetime and past year cocaine use, and past year driving after drinking two or more drinks in the previous hour.

- **Women** were more likely than men to report cannabis use for medical purposes among cannabis users, moderate to serious psychological distress, serious psychological distress, fair/poor self rated mental health, frequent mental distress days, use of anxiety and depression medications, suicidal ideation and frequent physically unhealthy days.

- **Adults aged 18 to 29 years old** were more likely than their older counterparts to report drinking hazardously or harmfully, symptoms of alcohol dependence, past year e-cigarette use, past year cannabis use, cannabis use problems, cannabis use for medical purposes among the total sample, texting while driving in the past year and 30 days, moderate and serious psychological distress, serious psychological distress, fair or poor mental health, frequent mental distress days, and suicidal ideation.

- **Adults aged 65 years and older** were more likely than their younger counterparts to report higher number of cigarettes smoked daily, cannabis use for medical purposes among cannabis users, fair or poor overall health and frequent physically unhealthy days in the past 30 days.

- Significant **regional** differences were observed for current smoking and average number of cigarettes smoked daily (both were highest in the **North**), past year electronic cigarette use (highest in **Toronto**), lifetime cocaine use (highest in the **North** region), past year use of antianxiety and antidepressant medications (highest in the **North**).

Overall changes between 2020 and 2022

Indicators	2020		2022
Moderate to high risk of cannabis use problems among total sample	16.4%	↑	19.4%
Moderate to high risk of cannabis use problems among cannabis users	55.5%	↑	64.4%
Fair or poor mental health	26.2%	↑	31.8%
Fair or poor general health	16.3%	↑	19.2%

Subgroup Differences between 2020 and 2022

There were some significant differences between the 2020 and 2022 surveys among men that were not evident among women, and vice versa. Specifically,

- Among **men**, there were significantly higher percentages in the 2022 survey for moderate to high cannabis use problems among past year cannabis users and for fair/poor mental health, and **lower** percentages for drivers who reported texting while driving in the past 12 months and in the past 30 days.

- Among **women**, the percentage reporting fair or poor general health was higher in the 2022 compared to the 2020 survey.

- **Age** group and **regional** differences (▲ increase / ▼ decrease) were also observed between 2020 and 2022 for the following substance use and mental health indicators:

  - ⇒ Past year drinking (▼ West region)

  - ⇒ Daily drinking among total and drinkers (▼ West region)

  - ⇒ Average number of drinks consumed weekly (▼ East region)

  - ⇒ Weekly binge drinking (▼ 30 to 39 years old, ▼ West region)

  - ⇒ Daily smoking (▼ 18 to 29 years old)

  - ⇒ Cannabis use in the past year (▲ 50 to 64 years old)

  - ⇒ Cannabis use problems among users (▲ 30 to 39, ▲ 50 to 64 years old, ▲ Toronto)

  - ⇒ Cannabis use for medical purposes (▲ 50 to 64 years old)

  - ⇒ Lifetime cocaine use (▲ 40 to 49 years old)

  - ⇒ Texting while driving in the past 12 months (▼ Toronto)

  - ⇒ Texting while driving in the past 30 days (▼ Toronto)

  - ⇒ Past year use of antianxiety medication use (▲ 65+ year olds, ▲ North region)

  - ⇒ Past year use of antidepressants (▲ 65+ year olds)

  - ⇒ Fair or poor mental health (▲ 18 to 29, ▲ 50 to 64 year olds, ▲ Toronto, ▲ Central East region)

  - ⇒ Frequent mental distress days (▲ 30 to 39 years old, ▲ East region)

  - ⇒ Fair or poor general health (▲ 65+ year olds, ▲ Toronto)

  - ⇒ Frequent physically unhealthy days (▲ 40 to 49 year olds, ▲ East region)

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1. INTRODUCTION

Population surveillance studies, such as the *CAMH Monitor*, describe the shifting pattern, character and social demography of substance use behaviour and mental health status in the general population. Knowledge derived from such surveys is essential to inform prevention programming, health and social planning and policy making, and any assessment of current and future treatment needs.

The ability of a given drug—be it alcohol, tobacco, medicinal or other substances—to cause harms to its users, their families, friends, and communities depends on at least three fundamental factors: (1) the **prevalence of use** in the population—what percentage use the substance; (2) its **dependence liability**—the ability of the drug to produce dependence; and (3) its **hazard liability**—the ability of the drug to produce lethal and other adverse consequences (Brands, Sproule, & Marshman, 1998). Thus, drug use prevalence in the population is only one factor in determining the harm potential of a given substance.

Similarly, population surveillance of mental health indicators is imperative for informed health planning and policy and for any informed treatment response. Screening instruments assessing compromised mental health can assist in identifying not only the prevalence of impaired mental and emotional functioning, but also the related determinants and risk factors (Tsuang & Tohen, 2002). These two domains—addiction and mental health concerns—have strong connections, and the ability to investigate their co-occurrence, risk profiles, and changes over time further their public health utility.

The *CAMH Monitor* (CM) is a substance use and mental health population survey of Ontario adults aged 18 and older. The main purpose of this report is 1) to monitor substance use —alcohol, tobacco, cannabis and other drugs and their attributable harms–, and indicators of health and mental health concerns—self-rated poor health, psychological distress, use of antianxiety and antidepressant medication and mental health-related quality of life indicators—as well as impaired and distracted driving among Ontario adults, 2) to compare substance use and mental health issues between the CM2020 and CM2022 survey estimates.

The 2020 and 2022 cycles of the *CAMH Monitor* are based on web-based quota sampling surveys of **3,033** and **3,005** adults, respectively, aged 18 and older across Ontario. In the present report, we examine changes by comparing the 2020 and 2022 estimates of substance use and related harms, as well as mental health and well-being indicators among Ontario adults.

2.   METHOD

2.1 Sampling Designs

In 2020 and 2022, the CAMH *Monitor* employed non-probability samples. Data collection without a defined sampling frame (i.e. non-probability sampling) is becoming increasingly popular as large amounts of data can be collected faster and with fewer resources relative to most probability-based designs. Online or web panels, which are made up of volunteer participants who receive compensation (in terms of redeemable points) for completing surveys, provide such non-probability samples.

In the CM2022 survey, web panel members of Leger Opinion (also referred to as "LEO") were invited to participate in the survey. Leger Opinion is the largest proprietary panel in Canada. Leger Opinion recruits panel members largely through random selection using traditional telephone and cell phone methodologies through LEO's call centre.[1]

Since Leger Opinion has information about the address of its panel members, the sample for the CM survey was selected based on forward sortation area (FSA, which is based on the first three characters of the postal code) so that respondents could be distributed as evenly as possible across the six regions of Ontario. The counties and FSAs included in each of the six regions, and the number of online surveys by questionnaire panel and region are presented in detail in the CM2022 metadata guide (Nigatu, Elton-Marshall & Hamilton, 2022). To reduce the response load or burden while maximizing questionnaire content and flexibility, the CM employed two questionnaire formats (Panel A and Panel B) whereby, within each questionnaire panel, random subsets of respondents were asked various modules of questions, while other respondents were concurrently asked modules of alternative questions. Both questionnaire panels included core items (questions asked among all respondents) and panel items (questions asked among only a single panel (or panel subsample) of respondents.

It is important to note that non-probability sampling involves recruiting participants in a non-random fashion such that there might be a potential for selection bias, limiting the generalizability of the study findings. Those who participate in the study may share attributes that may be systematically different from the attributes of those who do not participate. For example, online panel respondents tend to be somewhat more experienced and comfortable in using computer technology. As noted by Fahimi and colleagues, these differences may or may not be relevant and affect the responses to survey questions (Mansour, Frances & Randall, 2018). Pre-screened panel respondents who wish to regularly complete surveys may be more committed in providing accurate responses to survey questions which improves data quality.[2] Although selection bias cannot be completely eliminated when using non-probability sampling, it can be minimized by matching those who complete the survey to the characteristics of the population. To do this, quotas by questionnaire panel were employed so that those who completed the survey approximated the distributions shown in Table 2.1.1.

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[1] https://leger360.com/wp-content/uploads/2019/12/Panel-book-LEO-EN.pdf

[2] https://www.qualtrics.com/experience-management/research/research-panels-samples/

Once a panel member agreed to participate and entered the survey, the first questions encountered were designed as 'screening' questions related to region of residence (county), sex, age group, and level of education and foreign-born.

The responses to these questions were used to determine if that 'quota' had been filled or if more completed surveys were needed for that particular demographic. If, for example, a 20-year-old female living in Metro Toronto began the survey, but the target for that particular demographic had already been met, the respondent would receive a thank you message and they would not be able to participate further.

2.2. Data collection

Most of the questions used in the 2022 web panel survey had been used in previous versions of the CAMH Monitor. However, there were four new questions related to climate change and recreational use of cannabis. Due to the nature of online surveys, as long as the internet browser is open the time to complete the survey is indefinite. For quality assurance, respondents who took longer than 60 minutes to complete the survey were recorded as missing. Overall, the average length of the survey was 13.7 minutes (12.0 minutes for Panel A and 14.5 for Panel B).

The use of the term "response rate" in the context of a non-probability panel survey might be misleading due to unknown parameters. In non-probability surveys, the number of people who join the web panel is usually known, while the number of people who were exposed to the invitation, and the number of invitations to which they were exposed are not known so that response rate cannot be calculated. Rather, participation and completion rates can be calculated as the number of panel members invited to a particular survey and the number who respond to the invitation and complete the survey are known. Following the AAPOR Task Force (2010) recommendation, the **"participation rate,"** (defined as the number of respondents who have provided a usable response divided by the total number of initial personal

invitations requesting participation) for the CM2022 was **14%.** While **"the completion rate"** (defined as the number of respondents who completed the survey divided by the estimated number of eligible respondents)[3] was **14.8%**.

Table 2.1.1 Quotas for survey sample

Variables	Percentages*
Age	
18-29 years of age	17%
30-44 years of age	29%
45-64 years of age	35%
65+ years of age	19%
	100%
Sex	
Male	50%
Female	50%
	100%
Education	
High school or less	20%
Some post-secondary	40%
Completed diploma/degree	40%
	100%
Born in Canada	
Yes	85%
No	15%
	100%

Note: * Rounded percentages

[3] The number of eligible participants were calculated by subtracting the number of respondents screened but excluded from participation because the quota for a designated subsample had already been filled, from the number of invitations sent.

2.3. Data Weighting

For many good reasons, most notably the control of precision, most sample surveys do not select respondents at a probability matching their representation in the population. Consequently, such data require sample or case weights attached to each respondent to ensure that their share of the sample equals their share of the population. The detailed description of the weights is available in the technical documents (Nigatu, Elton-Marshall, & Hamilton, 2021; Nigatu, Elton-Marshall, & Hamilton, 2022).

As in previous cycles, the final weights are the product of the household weights, region weights, and the age/gender weights. In this manner, the final weights take account of regional population size, age and gender population compositions. However, weights did not include adjustments for household size because individuals were approached directly (considered as 1). The use of the final weights generally assist in making the results more representative of the population with respect to these demographic characteristics. The final weight *samprhhagwgtall* sums to the sample (3,005) and *poprhhagwgtall* sums to the population (10,766,695).

2.4. Sample evaluation and characteristics of the CM2022 web sample

Although the CM2022 employed a non-probability sample, which may induce selection bias, it can still be minimized by matching those who complete the survey to the characteristics of the population. Table 2.2 shows the weighted distribution (including post-stratification adjustments) of the CM2022 web sample compared to the 2016 Census. Additional demographic comparisons were available for marital status and region. There were significant differences between the 2016 Census and CM2022 figures only for marital status (data were available only for adults aged 20 and older). Compared to Ontario Census figures from 2016, the CM2022 sample overrepresented those never married and underrepresented those widowed, divorced or separated (Table 2.1.2).

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Table 2.1.2 Selected Demographic Characteristics: Post-adjusted Weighted CM2022 versus 2016 Census Figures, Ontario Population, Aged 18 and Older (or 20 and older)

	Unweighted (3,005)	CM2022[a] (*n*=3,005) (postadjusted)				2016 Ontario Census (N= 10,766,695)
SEX						
Men	**45.2**	(46.2	**48.2**	50.1)		48.2
Women	**54.8**	(49.9	**51.8**	53.8)		51.8
AGE						
18–24	**7.6**	(8.7	**10.0**	11.6)		11.4
25–44	**32.7**	(30.5	**32.3**	34.1)		32.1
45–64	**36.3**	(32.9	**34.7**	36.6)		35.6
65+	**23.5**	(21.4	**23.0**	24.6)		20.9
REGION						
Toronto	**17.5**	(21.4	**21.9**	22.4)		21.8
Rest of Ontario	**82.5**	(77.6	**78.1**	78.6)		78.2
MARITAL STATUS (respondents aged 20 and older)						
Never married	**25.6**	(26.7	**28.5**	30.4)	*	22.8
Married/Living as married	**60.5**	(55.4	**57.4**	59.3)	*	61.6
Widowed/Separated/ Divorced	**13.9**	(12.8	**14.1**	15.5)	*	15.6

Notes: [a] CM data refer to: lower limit of 95% confidence interval, percentage estimate, and upper limit of 95% confidence interval; * indicates census figure is outside the bounds of the CM confidence interval.
Source: Statistics Canada. [On-line]. Available: http://www12.statcan.ca/english/census/index.cfm.

Methodology

The CM2022 survey is the 26th cycle and was conducted for the second time using an online web panel. The CM2022 survey utilized a quota-sampling approach by targeting respondents with particular demographic characteristics, and use poststratification adjustments (weights) to compensate for noncoverage and nonresponse. In total, **3,005 Ontario adults** aged 18 and older completed the survey in English (Panel A=**1,002**; Panel B=**2,003**) between January 11 and February 3, 2022.

The sample data are weighted based on regional population size, and age and gender population compositions from the 2016 Census. Weights for the CM2022 survey did not include adjustments for household size because individuals were approached directly. The use of the final weights assist in making the results more representative of the population with respect to these demographic characteristics.

The CM2022 was administered by the Institute for Social Research at York University using a Leger Opinion web panel.

2.5. Analyses and reporting

Our analyses offer several features:

- The 2022 CAMH Monitor was conducted approximately 13 to 14 months after the 2020 cycle and utilized the same web panel provider. As such, there was the possibility of having some respondents complete the survey in both 2020 and 2022 especially in certain regions. Overall, 355 respondents (11.8% of the total sample) completed the survey in both 2020 and 2022. Of the 355 respondents, 55 (15%) were in questionnaire Panel A and 300 (85%) were in Panel B.

- Findings presented in this report exclude those respondents who completed the survey in both CM2020 and CM2022. During analyses, respondents who completed both surveys were excluded by using *SUBPOP* command in Stata 16 software (StataCorp, 2019). One unique feature of complex survey analysis is the **estimation among subpopulations** (e.g., drinking problems among drinkers or drinking men; distress among women; driving while intoxicated among drivers). When such analyses are implemented by simply omitting observations outside the subpopulation (as is done with the use of conditional selection methods (e.g., *select if drinker*)) the software does not retain access to the full sampling error codes needed to properly compute degrees of freedom and variances, thereby resulting in understated variances and overstated inferences.[4] In this report, all subgroup analyses employ **unconditional subclass analysis** by specifying a *SUBPOP* option in Stata 16 ensuring the correct identification of design codes of the

sampling structure.[5] All analyses are based on sample members who provided responses to *all* analysis variables (i.e., listwise deletion).

- In reporting the CM2022/2020 findings, we evaluated cross-time **change in the target population** by contrasting the estimates[6] of 2022 to the previous survey cycle in 2020.

- To examine substance use and mental health concerns during the COVID-19 pandemic, we combined the 2020 and 2022 surveys, culminating in a data set with **6,038** respondents dispersed among 12 strata (6 regions × 2 survey years).[7]

- Comparisons to pre-pandemic estimates from the 2019 survey are provided in the appendix (Table 11-A1). For purposes of assessing changes between 2020/2022 estimates and those from 2019, the three surveys were combined and estimates were adjusted for age, sex, education, region, immigration status and survey year using regression modeling. Marginal probabilities obtained from logit models reflect a weighted average over the distribution of the factors and are equivalent to estimates obtained by standardizing to the total population (Muller & MacLehose, 2014).

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[4] This underestimation occurs because a conditional IF restriction removes all cases not satisfying the logical statement, *including their PSU and stratum codes*. Consequently, the correct denominator for the number of PSUs and strata for the full design, which are components of the calculation of the degrees of freedom and variances, are understated. The SUBPOP () option is especially critical for thinly sampled subpopulations.

[5] Such a procedure rather than removing respondents, assigns a weight of zero to all cases outside the subclass and retains the original weight for subclass cases thereby retaining the relevant design codes necessary for estimation (Heeringa et al., 2010; Korn & Graubard, 1999).

[6] We apply a logit transformation meaning that as percentage estimates near 0 or 100, CIs will not subceed 0 nor exceed 100.

[7] For trend analyses, we treat each survey as a stratum representing a distinct population. This allows us to assess changes in the population at different times (Korn & Graubard, 1999:287). Because we employed sample-scaled weights (rather than expansion population weights) there is no need to rescale these weights in the cumulated data file. Moreover, when one is estimating time differences using cross-sectional surveys administered on different occasions, the original sample-scaled weights are appropriate to use (Korn & Graubard, 1999: 278–79; 284).

3. Alcohol

3.1. Alcohol Use

The past year drinking refers to the percentage consuming alcohol at least once during the 12 months prior the survey.

- The estimated percentage of adults who have used alcohol in the 12 months before the survey is **80.4%** (95% CI: 78.6% to 82.0%).

- About 13% did not drink alcohol during the past 12 months (i.e. former drinkers) and 6.6% had never consumed alcohol in their lifetime (i.e., lifetime abstainers) (Figure 3.1.1).

- There were no statistically significant difference in percentages reporting past year alcohol use by sex, age group or region (Figure 3.1.3).

Frequency of Drinking

- Among past year drinkers, about 21% reported drinking less than once a month (21%).

- One-in-five drinkers drank two to three times a week (20%).

- One-in-six drinkers (16%) drank two to three times a month and about one in 10 (11%) drank on a daily basis (Figure 3.1.2).

Figure 3.1.1 Drinking Status, adults
Aged 18+, 2022 (N=2650)
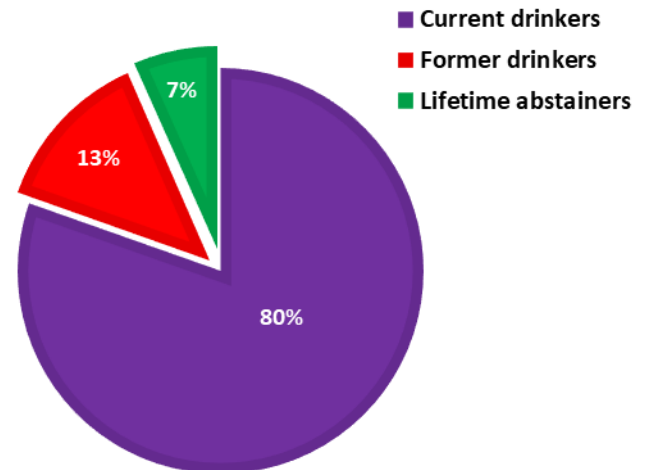
Change between 2020 and 2022

- The percentage reporting past year drinking did not change between 2020 and 2022 (80.4% vs 80.4%). Similarly, the percentages remained stable among men and women, and among age subgroups. Regional changes were observed only in the West where the percentage reporting past-year alcohol use decreased significantly from 83.8% in 2020 to 77.9% in 2022.

Figure 3.1.2 Frequency of drinking among past year drinkers, Aged 18+, 2022
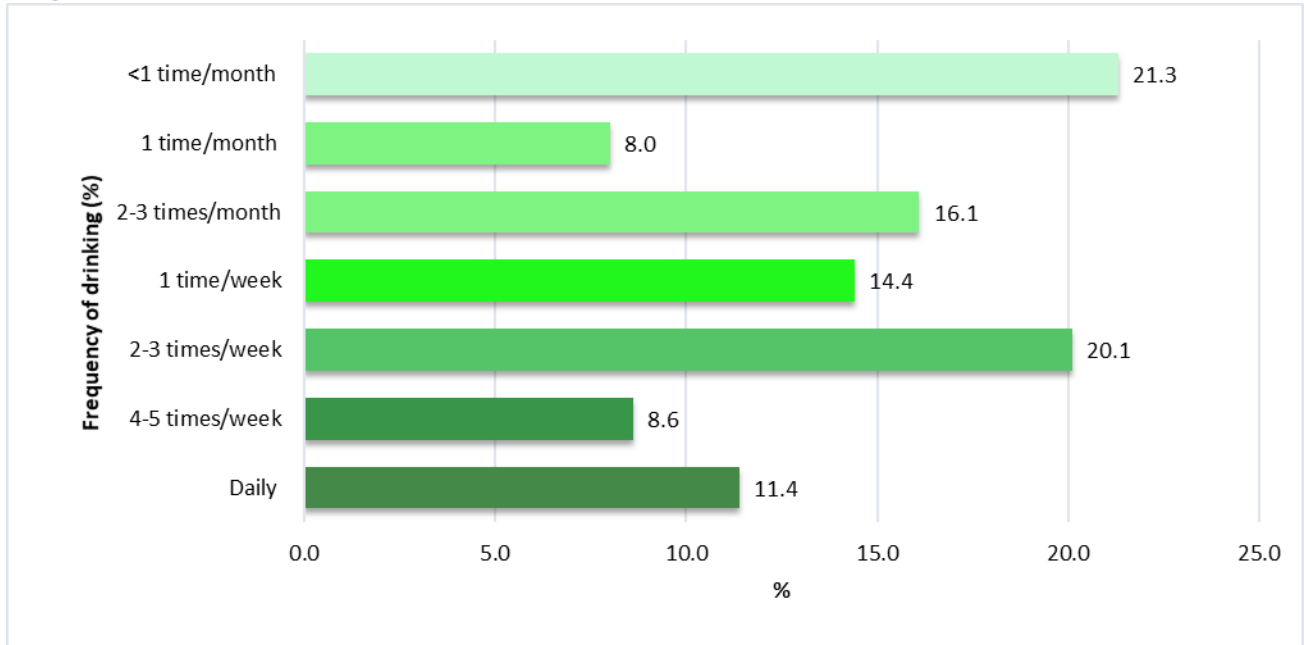
Figure 3.1.3 Past Year Alcohol Use by Sex, Age and Region, Aged 18+, 2022 (N=2650)
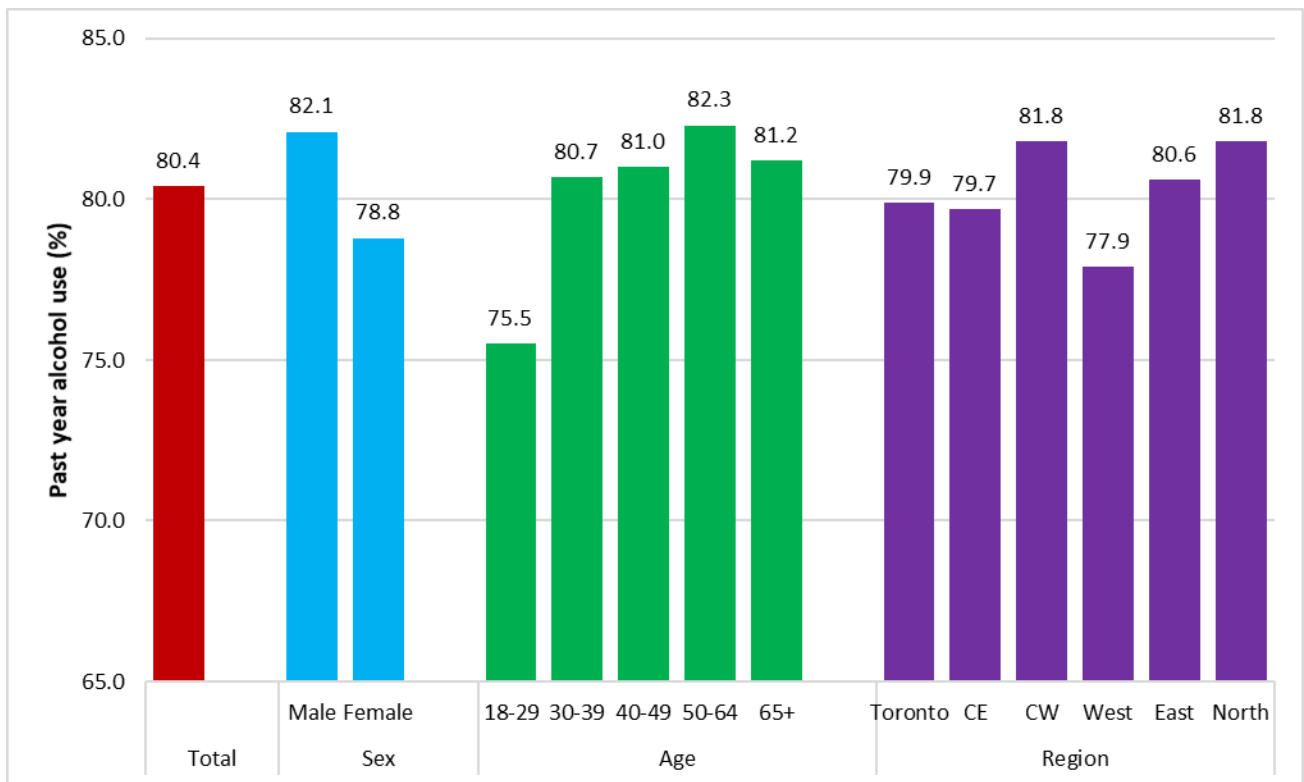
Note: Note: CE: Central East; CW: Central West.

3.2. Daily Drinking

The percentage drinking alcohol on a daily basis is an indicator of a regular pattern of drinking.

- The estimated percentage reporting daily drinking was 9.2% (95% CI: 8.1% to 10.4%).

- Men were more likely to drink daily than women (11.3% vs 7.3%). Among past year drinkers, there was no significant difference in daily drinking between men and women (13.8% vs 9.2%).

Change between 2020 and 2022

- The estimated percentage reporting daily drinking in 2022 (9.2%) was not significantly different from the 2020 estimate (9.7%).

- There were also no changes among men and women, and among age subgroups. Regional change was evident only in the West, with declines in daily drinking from 12.0% in 2020 to 7.1% in 2022) (Figure 3.2.1).

- Among drinkers, daily drinking was not significantly changed between 2020 and 2022 (12.1% vs 11.4%, respectively). There were also no changes in daily drinking among men and women, and age subgroups. Regional change was evident only in the West, with declines in daily drinking from 14.3% in 2020 to 9.2% in 2022).

Figure 3.2.1 Daily Drinking by Sex, Age and Region, Aged 18+, 2022 (N=2650)
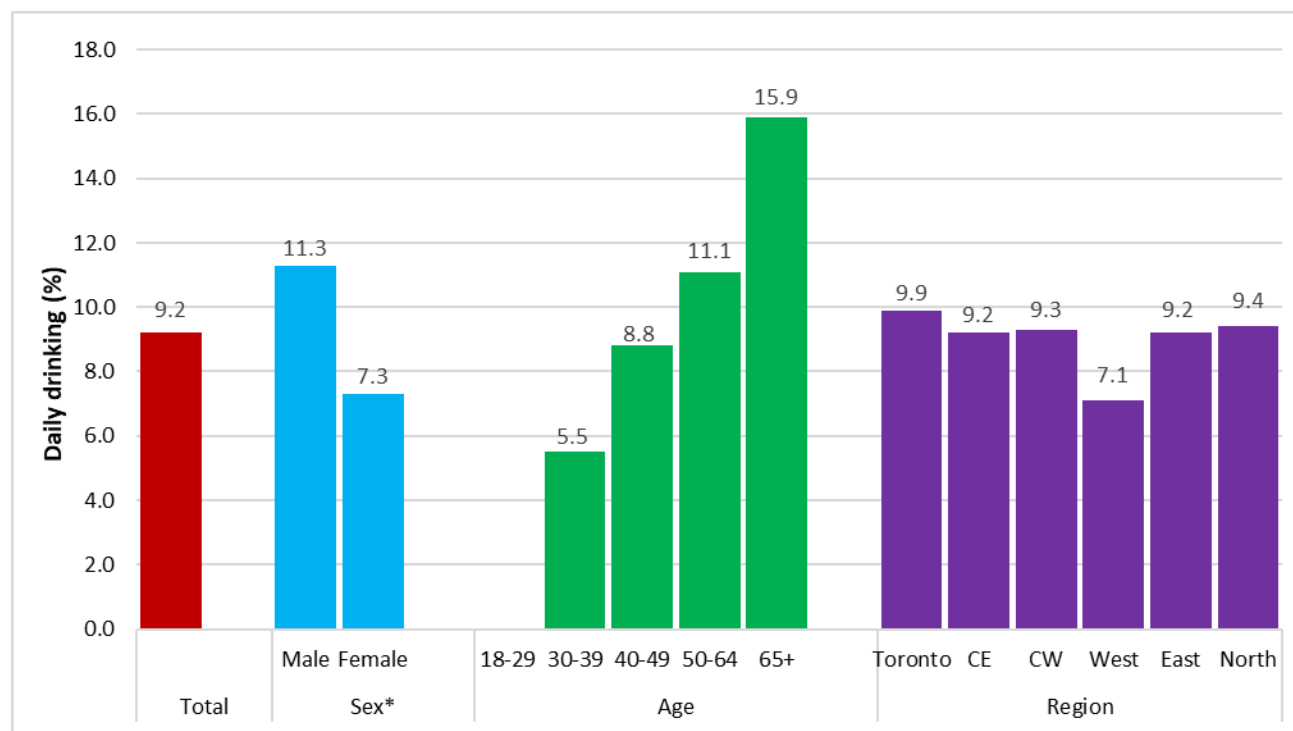
Note: CE: Central East; CW: Central West; *: Statistically significant differences between estimates, (p<0.05); Estimates for 18 to 29 were suppressed due to unreliability.

3.3. Number of Drinks Consumed Weekly

The estimated number of drinks consumed reflects respondent's recall of both the frequency of drinking and the amount consumed on a typical drinking occasion. In contrast to past year drinking, which indicates the percentage who are current drinkers, and daily drinking, which describes the percentage drinking regularly, the estimated number of drinks consumed is an indicator of the quantity of alcohol typically consumed.

▪ Among past year drinkers, the average number of drinks consumed weekly was 6.3 drinks. There was a significant difference in the number of drinks consumed per week between men (8.0 drinks) and women (4.7 drinks). For every unit increase in number of drinks, men consumed 3.3 more drinks than women (Figure 3.3.1).

Change between 2020 and 2022

▪ Among past year drinkers, there was no change in number of drinks consumed per week between 2020 and 2022.

▪ There were also no changes among men and women, and among age subgroups. Regional change was evident only in the East, with declines in average number of drinks consumed per week from 7.4 drinks in 2020 to 5.7 drinks in 2022).

Figure 3.3.1 **Estimated Number of Drinks Consumed Weekly among Past Year Drinkers by Sex, Age and Region, Aged 18+, 2022 (N=2650)**
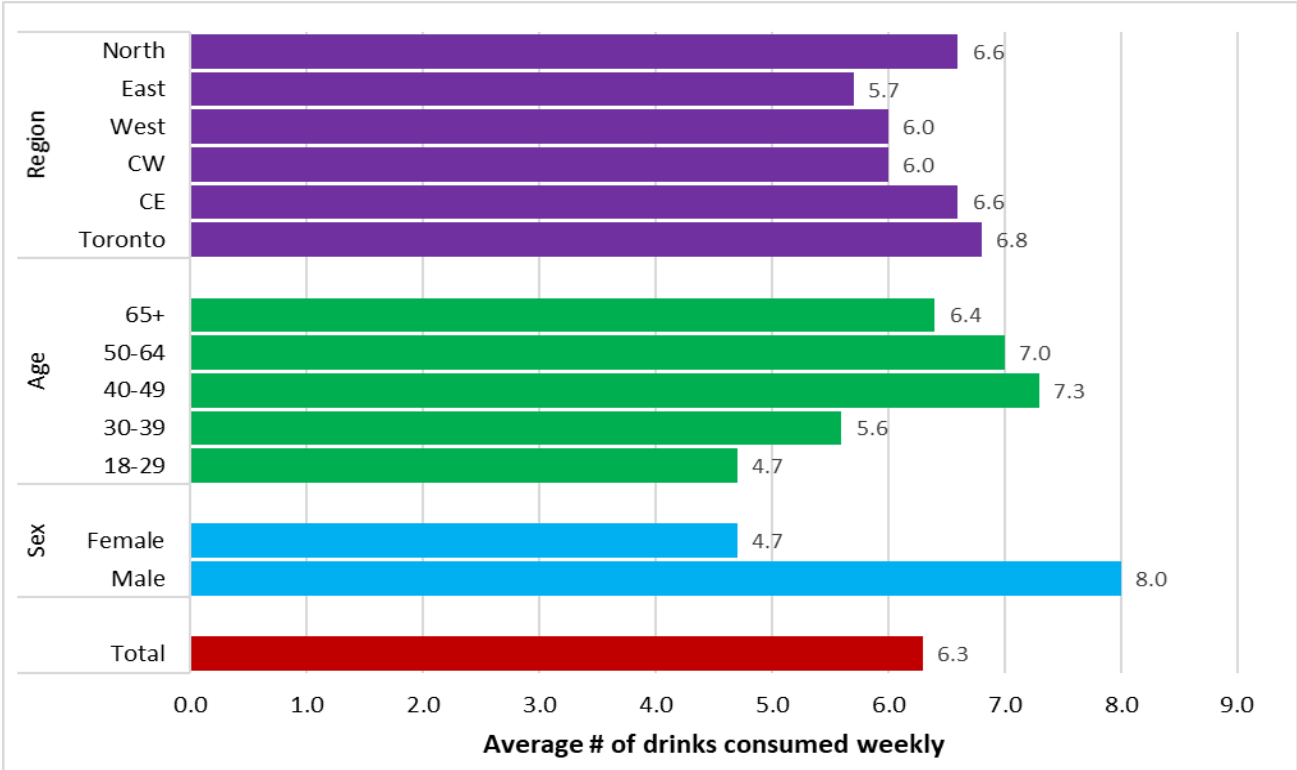
Note: CE: Central East; CW: Central West.

3.4. Weekly Binge Drinking: Five or More Drinks on a Single Occasion Weekly

The consumption of five or more drinks on a single occasion on a weekly basis ("binge drinking") during the 12 months before the survey is an indicator of regular heavy intake of alcohol. Binge drinking is also referred to as "heavy episodic drinking," and "risky single occasion drinking".

The estimated percentage reporting binge drinking was 10.7% (9.5% to 12.1%). Men were more likely to report weekly binge drinking than women (15.1% vs. 6.8%), respectively. Similar differences were also evident among age groups (Figure 3.4.1).

Change between 2020 and 2022

- Compared to 2020 estimate (11.3%), there was no significant change in weekly binge drinking in 2022 (10.7%).

- There were also no changes in weekly binge drinking among men (15.9% vs. 15.1%) and women (7.1% vs. 6.8%). However, significant changes were evident among 30 to 39 year olds (decreased from 14.7% in 2020 to 10.0% in 2022), and for the West region (decreased from 11.7% in 2020 to 7.6% in 2022).

Figure 3.4.1 Percentage Drinking Five or More Drinks on a Single Occasion Weekly in the Past Year by Sex, Age and Region, adults Aged 18+, 2022 (N=2650)
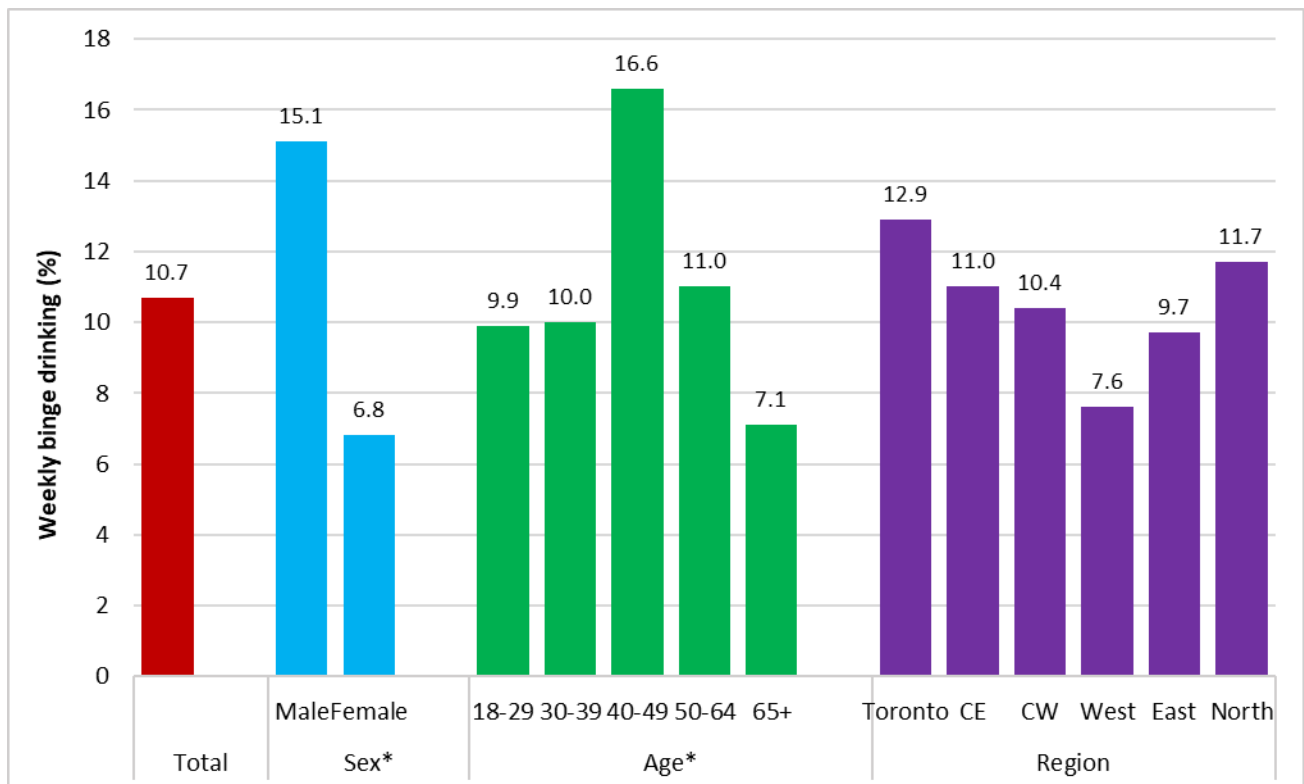
Note: CE: Central East; CW: Central West; *: Statistically significant differences between estimates, ($p<0.05$).

3.5. Hazardous or Harmful Drinking (AUDIT)

Hazardous or harmful drinking was measured by the *Alcohol Use Disorders Identification Te*st (AUDIT). The AUDIT is a 10-item screener– was constructed to detect problem drinkers at the less severe end of the spectrum of alcohol problems. The AUDIT identifies **hazardous** alcohol use, which is an established pattern of drinking that *increases the likelihood of future* physical and mental health problems (e.g., liver disease). It also identifies **harmful** consequences of that use, which reflects a pattern of drinking that is *already causing damage* to health (e.g., alcohol-related injuries, depression) and indications of dependence (Babor et al., 2001; Saunders et al., 1993). The AUDIT includes items such as drinking in the morning, lack of control over one's own drinking, feelings of guilt, injuries resulting from drinking, failure to meet expectations, black-outs, and having someone express concern about drinking).

Conventionally, a score of **8 or more** out of 40 on the AUDIT scale is used to identify drinkers that **drink at hazardous or harmful levels** or are at risk of becoming dependent. A score of 8 or more should not be viewed as "alcoholism," but as a pattern of drinking that is causing current problems or likely to cause future problems.

- About 20.1% of adults drank hazardously or harmfully during the past 12 months before the survey.

- There was a significant difference in percentage reporting hazardous or harmful drinking among men (25.7%) and women (15.0%).

- There were also significant differences in hazardous drinking between age groups where younger adults were more likely to report harmful drinking than older adults (Figure 3.5.1).

- Among past year drinkers, the estimated percentage for hazardous drinking was 25.3% (23.3% to 27.5%). A significant difference in percentage reporting harmful drinking was evident among men and women (31.6% vs. 19.3%), respectively.

Change between 2020 and 2022

- During 2020 and 2022, there was no significant change in reports of **hazardous or harmful drinking** (21.2% in 2020 and 20.1% in 2022).

- There were also no significant changes in reports of hazardous or harmful drinking among men and women, age subgroups and regions.

Figure 3.5.1 Percentage Drinking Hazardously or Harmfully (AUDIT 8+) in the Past Year by Sex, Age and Region, adults Aged 18+, 2022 (N=2650)
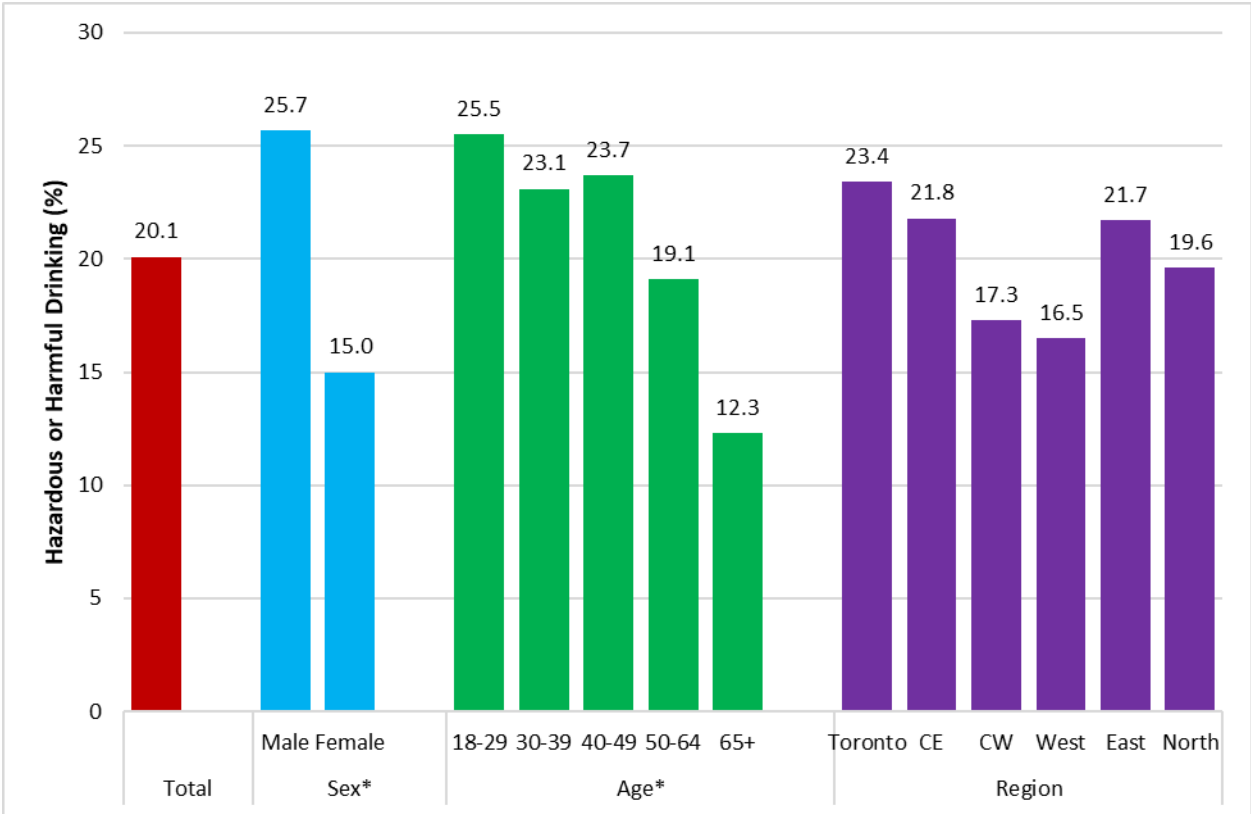
Note: CE: Central East; CW: Central West; *: Statistically significant differences between estimates, (p<0.05).

3.6. Symptoms of Alcohol Dependence (AUDIT)

As with hazardous/harmful drinking, symptoms of **alcohol dependence** experienced in the past year among adults were also assessed through the AUDIT.

Three of the 10 AUDIT items are indicators of alcohol dependence. This section outlines the estimated percentage of adults reporting **one or more of the three dependence indicators** included in the AUDIT: (1) *not able to stop drinking once you had started*; (2) *failed to do what was normally expected from you because of drinking*; or (3) *needed a first alcoholic drink in the morning to get yourself going after a heavy drinking session*.

- An estimated **14.1%** (12.7% to 15.7%) of adults experienced at least one dependence symptom during the past year.

- There was a significant difference in experiencing a dependence symptom among men (18.0%) and women (10.7%).

- There were also significant differences in experiencing a dependence symptom between age groups that young adults were more likely to experience symptoms of alcohol dependence than older adults (Figure 3.6.1).

Change between 2020 and 2022

- There was no significant change in reports of **symptoms of alcohol dependence** between the 2020 and 2022 surveys (13.9% in 2020 and 14.1% in 2022).

- There were also no significant changes in reports of symptoms of alcohol dependence among men and women, age subgroups and regions.

Figure 3.6.1 **Percentage Reporting One or More Alcohol Dependence Symptoms (based on AUDIT) in the Past Year by Sex, Age and Region, Adults Aged 18+, 2022 (N=2650)**
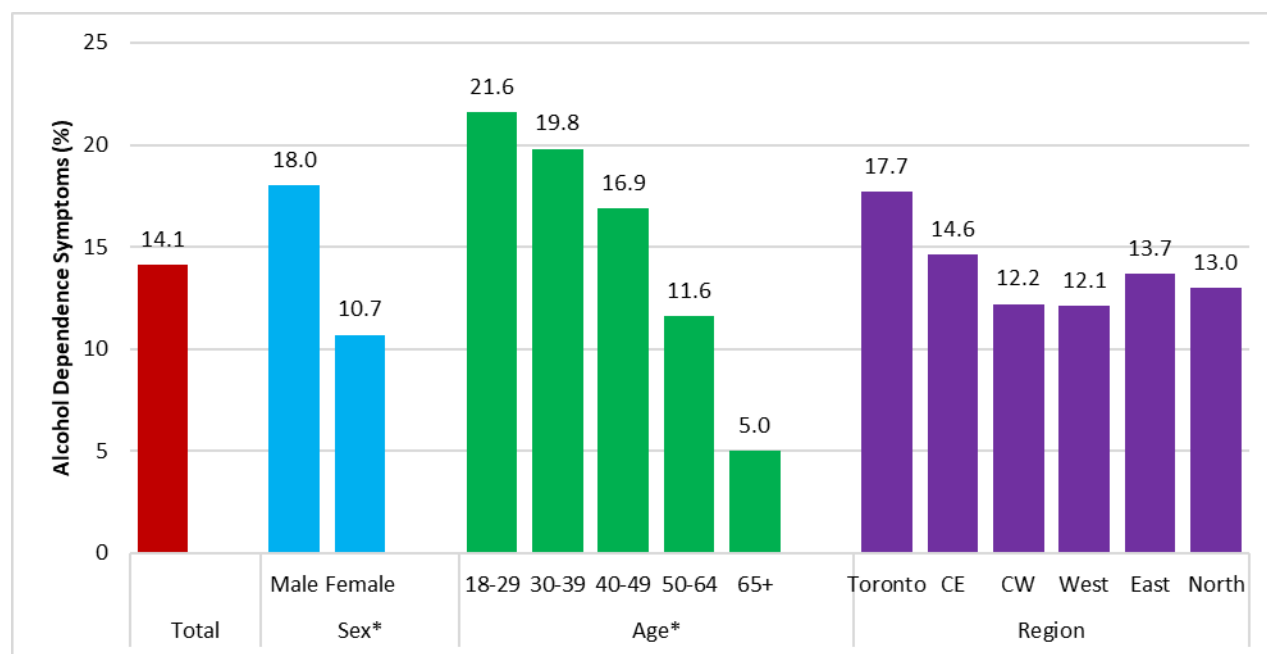
Note: CE: Central East; CW: Central West; *: Statistically significant differences between estimates, (p<0.05)

4. TOBACCO
AND ELECTRONIC CIGARETTE USE

4.1 Cigarette Smoking

Overall, the estimated percentage of *current* smokers – respondents who (1) smoked 100 or more cigarettes in their lifetime, *and* (2) smoked occasionally or daily during the past year, *and* (3) smoked during the past 30 days – was **17.7%** (95% CI: 16.2% to 19.3%).[8]

More than half (55.7%) of adults were classified as *lifetime abstainers* (never smoked more than 100 cigarettes in their lifetime). About 23.4% were classified as former smokers comprising *former daily* and *former nondaily* (3.2%) smokers. Finally, 12.3% were estimated to be *daily smokers,* while 5.4% were estimated to be *nondaily smokers* (Fig 4.1.1).

- The estimated percentage reporting current smoking was significantly different for men (19.9%) and women (15.7%).

- There were also significant differences in current smoking between age groups where adults aged 40 to 49 years (28.7%) were more likely to report current smoking than those aged 18 to 29 (9.8%) (Figure 4.1.2).

- There were also significant differences in current smoking between regions. Adults residing in the North (22.3%) were more likely to report current smoking than adults who reside in the Central West region (15.3%) (Figure 4.1.2).

Figure 4.1.1 Smoking status, adults Aged 18+, 2022 (N=2650)

■ Current daily smokers ■ Current non-daily smokers
■ Former daily smokers ■ Former non-daily smokers
■ Lifetime abstainers
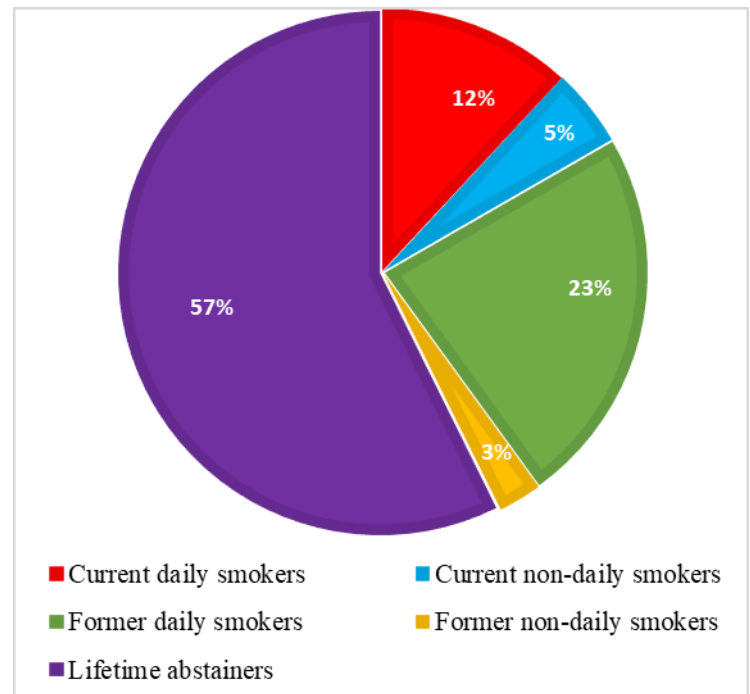
Change between 2020 and 2022

- There was no significant change in reports of **current smoking** between the 2020 and 2022 surveys (17.2% in 2020 and 17.7% in 2022).

- There were also no significant changes in reports of current smoking among men and women, age subgroups and regions.

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[8] Standard to Health Canada guidelines.

Figure 4.1.2 Current smoking by Sex, Age and Region, Aged 18+, 2022 (N=2650)
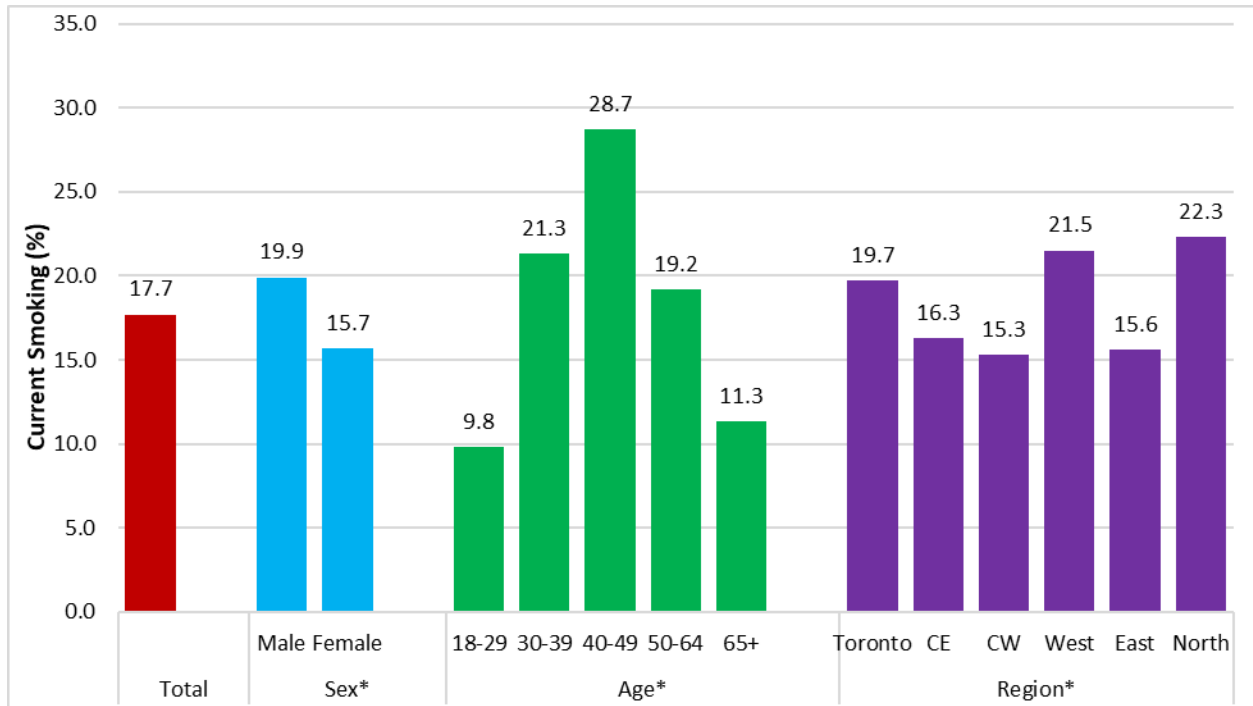
Note: CE: Central East; CW: Central West; *Statistically significant differences between estimates, (p<0.05)

Average Number of Cigarettes Smoked Daily

- On average, current smokers reported smoking 8.9 cigarettes per day.

- There was no significant difference in average number of cigarettes smoked daily between men and women (Figure 4.1.3).

- Age was significantly associated with the number of cigarettes smoked daily among smokers, with older age smoker higher number of cigarettes per day compared to 18 to 29 year olds.

- The average number of cigarettes smoked daily was highest among those aged 65+ (11.9) and lowest among those aged 18 to 29 (4.7).

- In terms of regional difference, adults reside in Toronto were less likely to smoke cigarettes daily on average compared to the provincial average number of cigarettes smoked daily (Figure 4.1.3).

Figure 4.1.3 Average Number of Cigarettes Smoked Daily, Current Smokers by Sex, Age and Region, Aged 18+, 2022 (N=483)
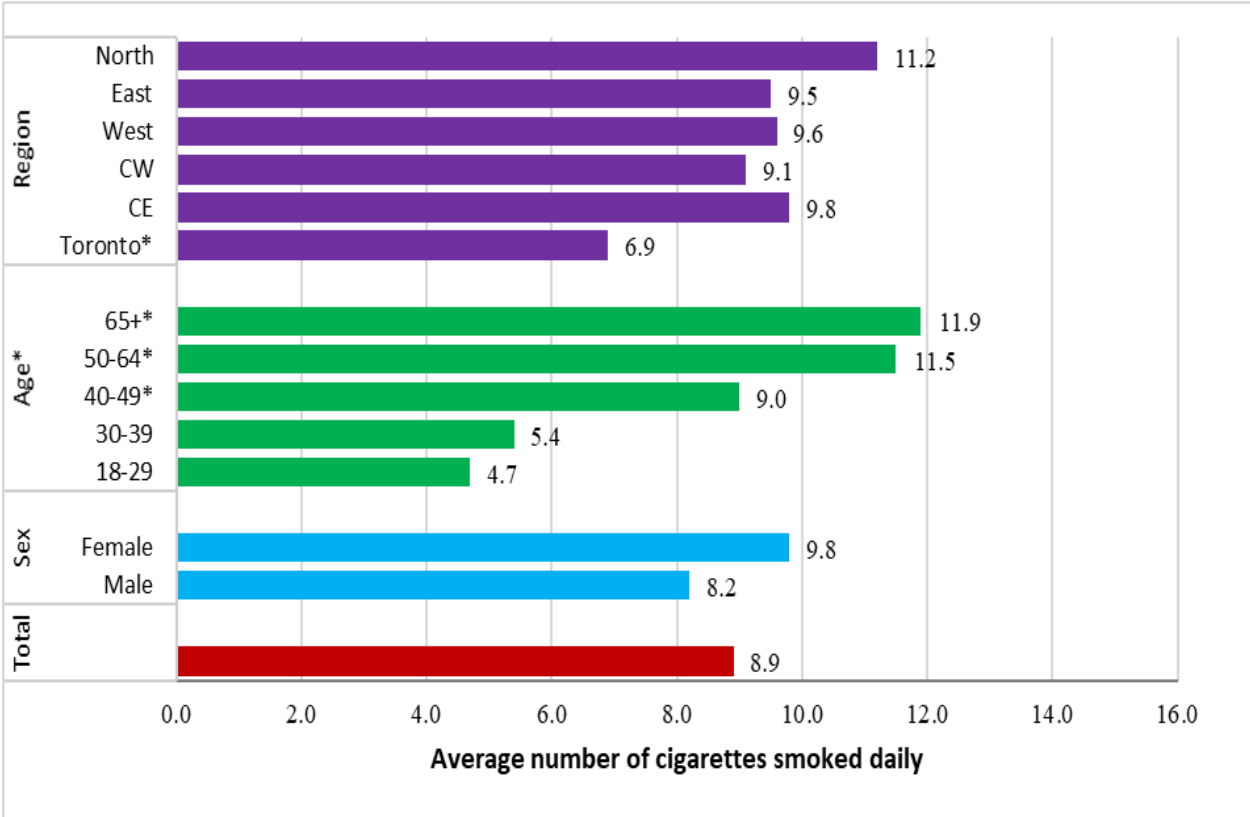
Note: CE: Central East; CW: Central West; *: Statistically significant differences between unadjusted estimates from linear regression, (p<0.05). The reference for region is the provincial average number of cigarettes smoked daily. The reference for age is 18 to 29 years old.

4.2 Daily Smoking

An estimated, **12.3%** (95% CI: 11.8% to 13.7%) of adults smoked cigarettes daily.

- There was no significant difference in daily smoking between men and women (12.9% vs. 11.8%, respectively).

- There was a significant difference in daily smoking between age groups, with adults 40 to 49 years of age (20.8%) more likely to smoke daily than those 18 to 29 years old (4.1%).

- There was no significant difference in daily smoking between regions in Ontario (Figure 4.2.1).

Change between 2020 and 2022

- The estimated percentage reporting daily smoking in 2022 (12.9%) was not significantly different from the 2020 estimate (13.1%).

- There were also no changes in estimated percentage reporting daily smoking among men and women, and among age subgroups except among adults aged 18 to 29 years (decreased from 7.6% in 2020 to 4.1% in 2022).

- No changes in daily smoking were evident among regions.

Figure 4.1.4 Daily Smoking by Sex, Age and Region, Aged 18+, 2022 (N=2650)
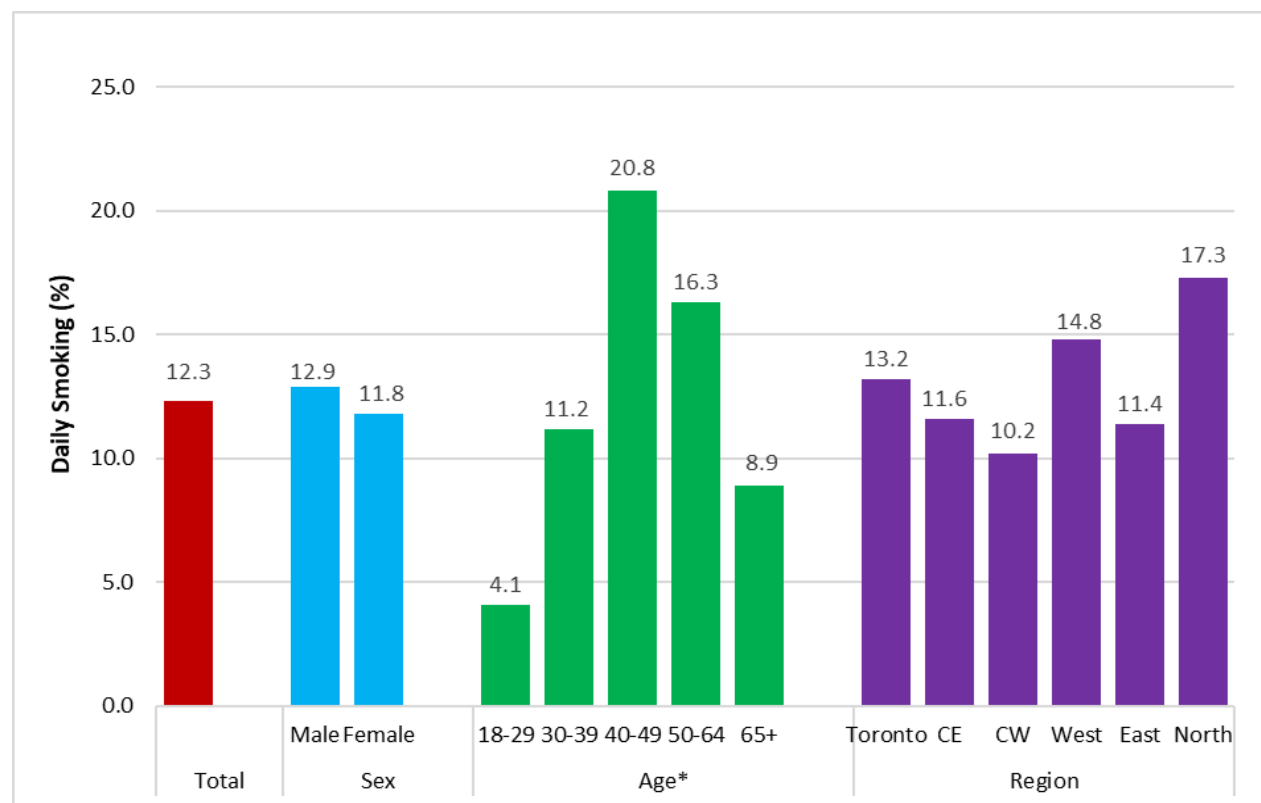
Note: CE: Central East; CW: Central West; *: Statistically significant differences between estimates, (p<0.05).

4.3 Nicotine Dependence (HSI)

Nicotine dependence was assessed using the *Heaviness of Smoking Index* (HSI) among daily smokers[9]. HSI is based on the scores assigned to the items: *time to the first cigarette each morning* and *number of cigarettes smoked per day* (Heatherton et al., 1989). The HSI sum score ranged from 0 to 6, with scores of 0-2, 3-4 and 5-6 indicating classifications of low, moderate and high dependence on nicotine, respectively.

- An estimated **9.4%** (95% CI: 6% to 12.9%) of daily smokers (*n*=342) met the HSI cut-off for **high nicotine dependence**. An additional 43.1% and 47.5% of daily smokers were classified as experiencing moderate or low nicotine dependence, respectively.

- There was no significant difference in percentages reporting high nicotine dependence between men (8.7%) and women (10.1%). Estimates for age and region groups were suppressed due to small sample size.

Change between 2020 and 2022

- The estimated percentage reporting **high nicotine dependence** in 2022 (9.4%) was not significantly different from the 2020 estimate (7.8%). There were also no changes among men and women. Due to small sample size, the estimates in high nicotine dependence between age groups and regions were suppressed.

4.4. Electronic Cigarette Use

Questions about the use of electronic cigarettes were included in the CAMH Monitor for the first time in 2013. Respondents were asked the following:

"E-cigarettes, also known as "vape pipes," "hookah pens," and "e-hookahs" are electronic devices that create an inhaled mist, simulating the act of smoking. Have you ever taken at least one puff from an e-cigarette?"

Two follow-up questions asked respondents whether they used an e-cigarette in the past year and if the e-cigarette they smoked the last time contained nicotine:

1) *"Was it in the past 12 months that you had at least one puff of an e-cigarette?"*

2) *"The last time you used an e-cigarette, did it contain nicotine?"*

Overall, the estimated percentage reporting electronic cigarette use in the past 12 months was **13.7%** (95% CI: 12.3% to 15.2%).

- There was a significant difference in electronic cigarette use between men and women (17.0% vs. 10.7%, respectively).

- There was a significant difference in electronic cigarette use between age groups, with younger adults more likely to use electronic cigarettes than older adults (Figure 4.1.5). About 23.3% of adults aged 18 to 29 smoked electronic cigarettes in the past 12 months compared to 3.1% of adults aged 65 and older.

- There was also a significant difference in electronic cigarette use between regions in Ontario (Figure 4.1.5).

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[9] The HSI is more meaningful among daily smokers than current smokers because a sizeable proportion of the latter are occasional smokers or smokers attempting to quit.

Change between 2020 and 2022

▪ In 2022, the estimated percentage reporting electronic cigarette use in the past 12 months (13.7%) was not significantly different from the 2020 estimate (15.2%).

▪ There were also no changes among men and women, and among age subgroups.

▪ No regional change between 2020 and 2022 in electronic cigarette use was evident among adults.

Figure 4.4.1 Electronic Cigarette use in the past 12 months by Sex, Age and Region, Aged 18+, 2022 (N=2650)
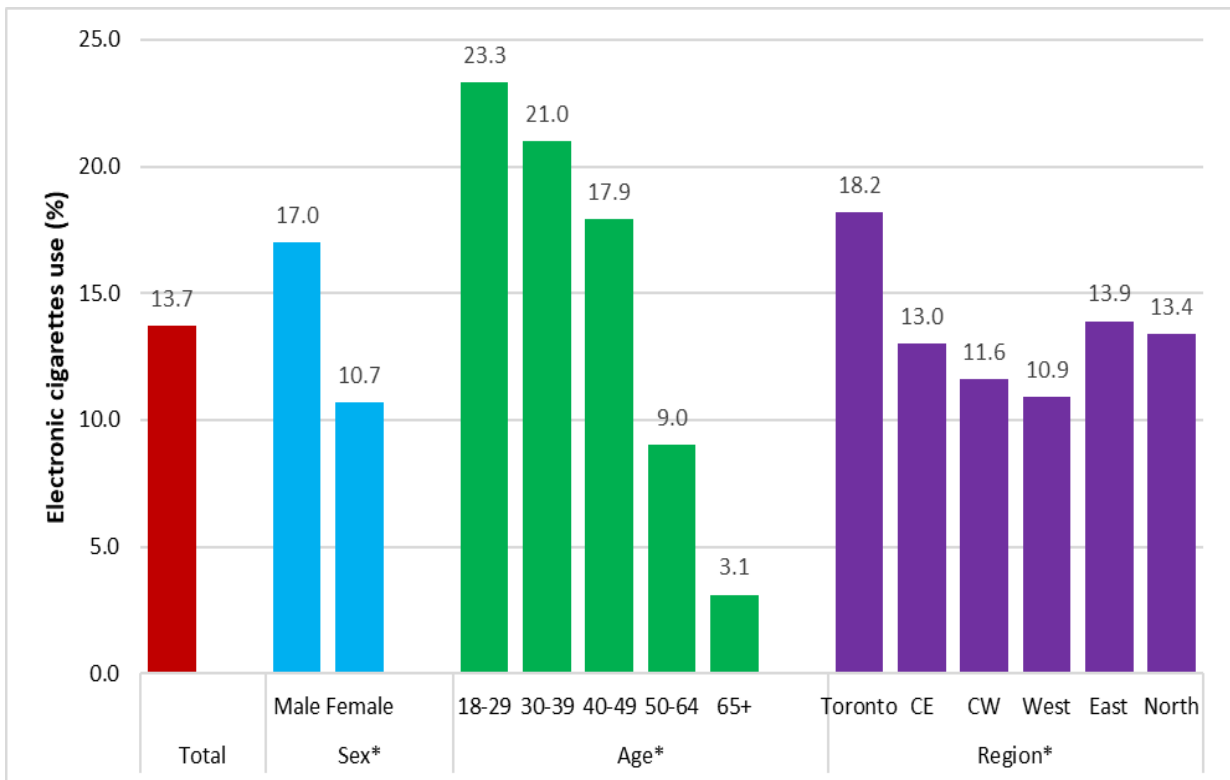
Note: CE: Central East; CW: Central West; *: Statistically significant differences between estimates, (p<0.05).

5. CANNABIS and OTHER DRUGS

5.1 Cannabis Use

Overall, an estimated **54.1%** (95% CI: 52.1 to 56.2) of adults used cannabis at least once in their lifetime, while **32.9%** (95% CI: 30.9% to 34.8%) used it in the 12 months before the survey.

Frequency of cannabis use

Overall, **23.4%** of adults used cannabis once a month or more frequently. Among past year cannabis users, 28.8% used less than once a month and 71.2% used once a month or more frequently.

- There was a significant difference in cannabis use in the past 12 months between men and women (35.7% vs. 30.3%, respectively).

- There were also significant differences in cannabis use in the past 12 months between age groups, with young adults more likely to use cannabis in the past 12 months than older adults (Figure 5.1.2).

- There were no significant difference in cannabis use in the past 12 months between regions in Ontario (Figure 5.1.2).

Change between 2020 and 2022

- There was no significant change in past-year cannabis use between the 2020 and 2022 surveys (31.7% in 2020 and 32.9% in 2022).

- There were also no significant changes in cannabis use in the past 12 months among men and women, or among age subgroups except for adults aged 50 to 64 (increased from 25.2% in 2020 to 30.3% in 2022).

- No changes in cannabis use were evident among regions.

Figure 5.1.1 Cannabis use in the past 12 months by Sex, Age and Region, Aged 18+, 2022 (N=2650)
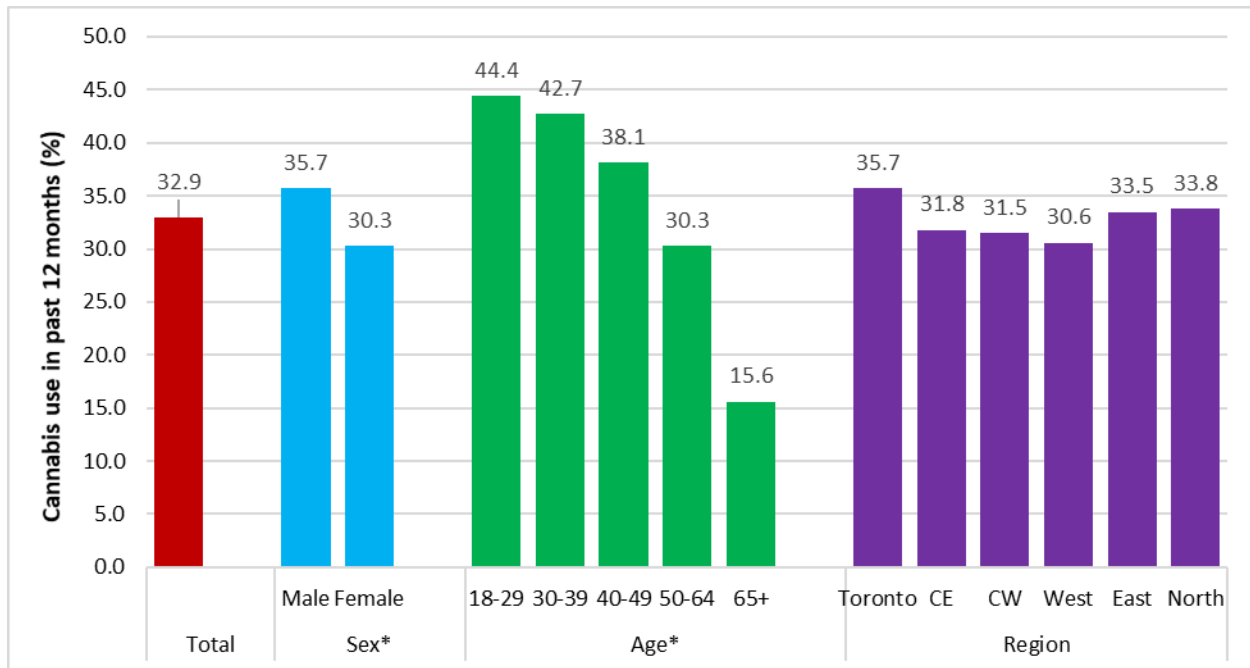
Note: CE: Central East; CW: Central West; *: Statistically significant differences between estimates, (p<0.05).

5.1.1. Cannabis Use Problems (ASSIST–CIS)

The Cannabis Involvement Score (CIS) of the World Health Organization's *Alcohol, Smoking and Substance Involvement Screening Test* (ASSIST V3.0) was used to assess cannabis use problems in the past 3 months.

The ASSIST–CIS consists of a 6-item screener (addressing frequency of use, strong desire to use, legal or financial problems from use, lack of control over one's own use, failure to meet expectations, and having someone express concern about using) and a protocol for scoring responses (see Table 5.1.1).

The ASSIST–CIS score ranges in value from 0 to 39, captures aspects of harmful/hazardous use, abuse and dependence, and provides three categories to assess the risk of experiencing health and other problems: 1) *low risk* (scores of 0–3) indicating a pattern of use associated with a low risk of experiencing problems; 2) *moderate risk* (scores of 4–26) indicating a pattern of use associated with a moderate risk of experiencing

problems; and 3) *high risk* (scores of 27 or more) indicating a pattern of use that is associated with a high risk of experiencing problems and is likely to lead to dependency. In this report, we used a summed score of 4 or more to estimate the percentage of respondents who present a moderate to high risk of experiencing cannabis use problems.

Overall, an estimated **19.4%** (95% CI: 17.4% to 21.6%) of adults and **64.4%** (95% CI: 59.9% to 68.7%) of past year cannabis users met the criteria for **moderate to high risk** of cannabis use problems.

- There was a significant difference in cannabis use problems between men and women (23.3% vs. 16.2%, respectively).

- There were also significant differences in cannabis use problems between age groups, with younger adults more likely to experience cannabis use problems compared to older adults (Figure 5.1.2).

- However, there were no differences in cannabis use problems between regions in Ontario (Figure 5.1.2).

Among **past year users,** men were more likely to experience cannabis problems than women (73.0% vs. 56.5%, respectively).

- There were significant increases in cannabis use problems among those 40 to 49 years old (increased from 18.7% in 2020 to 26.1% in 2022) and those aged 50 to 64 years (increased from 13.4% in 2020 to 19.0% in 2022).

- There was a significant increase in cannabis use problems in the Toronto region (increased from 14.7% in 2020 to 21.2% in 2022). No changes in cannabis use problems were found in other regions.

Change between 2020 and 2022

- Between 2020 and 2022, there was a significant increase in cannabis use problems among the total sample (16.4% in 2020 and 19.4% in 2022).

- There were also no significant changes in cannabis use problems among men and women.

Among **past year cannabis users**, there was a significant increase in experiencing cannabis use problems (increased from 55.5% in 2020 to 64.4% in 2022).

- There was also a significant increase in cannabis use problems among men (62% in 2020 to 73.0% in 2022).

- There was a significant increase in cannabis use problems among those aged 30 to 39 years (50.6% in 2020 to 67.7% in 2022), among those aged 50 to 64 years (increased from 52.9% in 2020 to 65.5% in 2022).

- There was a significant increase in cannabis use problems among adults residing in the Toronto region (increased from 47.9% in 2020 to 69.1% in 2022).

Figure 5.1.2 Percentage Reporting Cannabis Use Problems in the Past Three Months by Sex, Age and Region, Aged 18+, 2022 (N=1668)
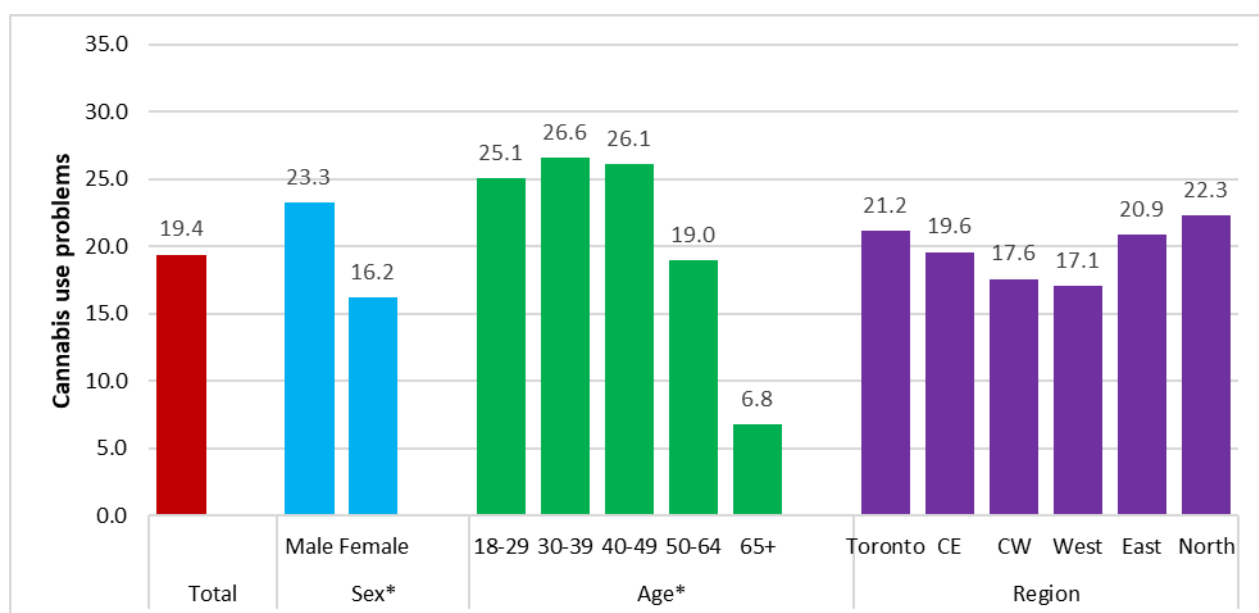
Note: CE: Central East; CW: Central West; *: Statistically significant differences between estimates, ($p<0.05$).

Table 5.1.1 Percentage Reporting Cannabis Involvement Score Indicators (ASSIST-CIS), Overall and Past Year Cannabis Users, Aged 18+, 2022

ASSIST ITEMS	Response Weight and Response Category	Total[1] (N=1698)	Past year Cannabis Users[2] (N=539)
ASSIST Q1. How often have you used cannabis, marijuana or hash during the past 3 months? Abuse indicator	0. Never	73.2	14.5
	2. Once or twice	5.5	17.4
	3. Monthly	5.7	18.0
	4. Weekly	8.2	26.0
	6. Daily or almost daily	7.6	24.1
	Mean (SE)	1.06 (.05)	3.37 (.09)
ASSIST Q2. During the past 3 months, how often have you had a strong desire or urge to use cannabis, marijuana or hash? Dependence indicator	0. Never	84.8	51.5
	3. Once or twice	5.9	18.8
	4. Monthly	†1.9	†6.2
	5. Weekly	†2.4	†7.7
	6. Daily or almost daily	5.0	15.9
	Mean (SE)	.67 (.04)	2.15 (.11)
ASSIST Q3. During the past 3 months, how often has your use of cannabis, marijuana or hash led to health, social, legal or financial problems? Abuse and harmful use indicator	0. Never	96.4	88.4
	4. Once or twice	†1.6	†5.2
	5. Monthly	†1.4	†4.6
	6. Weekly	†	†
	7. Daily or almost daily	0	0
	Mean (SE)	.17 (.03)	.55 (.08)
ASSIST Q4. During the past 3 months, how often have you failed to do what was normally expected of you because of your use of cannabis, marijuana or hash? Abuse indicator	0. Never	96.5	88.5
	5. Once or twice	†2.4	†7.9
	6. Monthly	†1.1	†3.6
	7. Weekly	0	0
	8. Daily or almost daily	0	0
	Mean (SE)	.19 (.03)	.61 (.09)
ASSIST Q5. Has a friend, relative, a doctor or anyone else ever expressed concern about your use of cannabis, marijuana or hash? Abuse and dependence indicator	0. Never	95.4	85.3
	3. Yes, not past 3 months	†2.5	†8.0
	6. Yes, past 3 months	†2.1	†6.7
	Mean (SE)	.2 (.03)	.64 (.08)
ASSIST Q6. Have you ever tried and failed to control, cut down or stop using cannabis, marijuana or hash? Dependence indicator	0. Never	95.2	84.8
	3. Yes, not past 3 months	†2.5	†8.0
	6. Yes, past 3 months	†2.3	†7.2
	Mean (SE)	.2 (.03)	.67 (.09)

Notes: [1]ASSIST-CIS items were asked only of a random subsample of respondents (N=1,698); [2]Analysis based on unconditional subclass of past year cannabis users (N=539); all analyses are sample design adjusted; † Estimate unstable or suppressed.
Def'n: The ASSIST–CIS (WHO) screener measures risk of experiencing cannabis use problems.
Source: *CAMH Monitor*, Centre for Addiction and Mental Health

5.1.2. Cannabis Use for Medical Purposes

The survey asked respondents about their use of cannabis to treat medical problems. The question asked was: "In the past 12 months, have you ever used cannabis to treat pain, nausea, glaucoma, multiple sclerosis, or any other medical condition?" Response options were *yes* or *no*.

Overall, an estimated **14.2%** (95% CI: 12.8% to 15.7%) of adults, and **43.7%** (95% CI: 40.1% to 47.3%) of past year cannabis users, reported using cannabis for medical purposes.

Among the **total sample:**

- There was no significant difference in cannabis use for medical purposes between men and women (13.7% vs. 14.7%, respectively).

- There were also significant differences in cannabis use for medical purposes between age groups. Younger adults were more likely to engage in cannabis use for medical purposes compared to older adults (Figure 5.1.3).

- There were no differences in cannabis use for medical purposes between regions in Ontario (Figure 5.1.3).

Among **past year cannabis users:**

- There was a significant difference in cannabis use for medical purposes between men and women (38.6% vs. 49.0%, respectively).

- There were significant differences in cannabis use for medical purposes between age groups, with older adults more likely to use cannabis for medical purposes compared to younger adults (Figure 5.1.4).

- There were no differences in cannabis use for medical purposes between regions in Ontario (Figure 5.1.4).

Change between 2020 and 2022

- There was no significant change in cannabis use for medical purposes among adults (13.1% in 2020 and 14.2% in 2022).

- There were also no significant changes in cannabis use for medical purposes among men and women.

- There was a significant increase in cannabis use for medical purposes among adults aged 50 to 64 (increased from 12.8% in 2020 to 17.0% in 2022).

- There were no significant changes in cannabis use for medical purposes among regions in Ontario.

Among **past year cannabis users**, there was no significant change in cannabis use for medical purposes (41.5% in 2020 vs. 43.7% in 2022). Similarly, the percentages remained stable among men and women, among age subgroups and regions in Ontario.

Figure 5.1.3 Percentage Reporting Cannabis Use for Medical Purposes by Sex, Age and Region, Aged 18+, 2022 (N=2613)
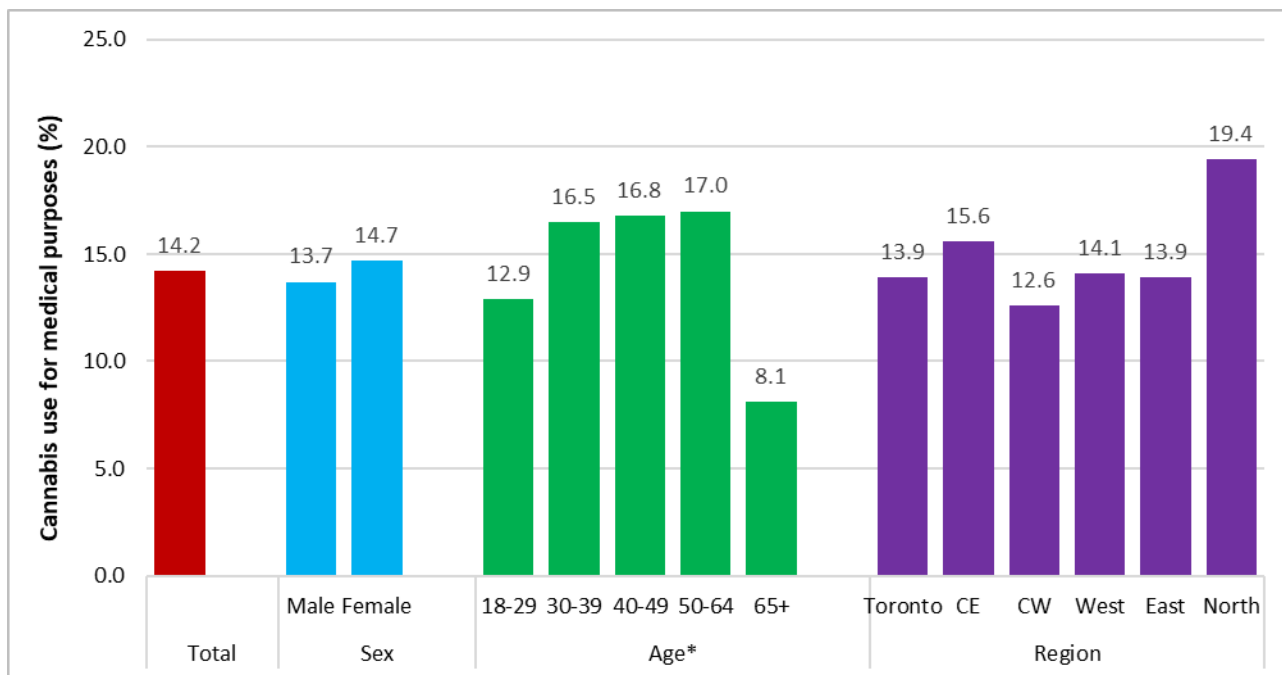
Note: CE: Central East; CW: Central West; *: Statistically significant differences between estimates, (p<0.05).

Figure 5.1.4 Percentage Reporting Cannabis Use for Medical Purposes, among past year cannabis users by Sex, Age and Region, Aged 18+, 2022 (N=846)
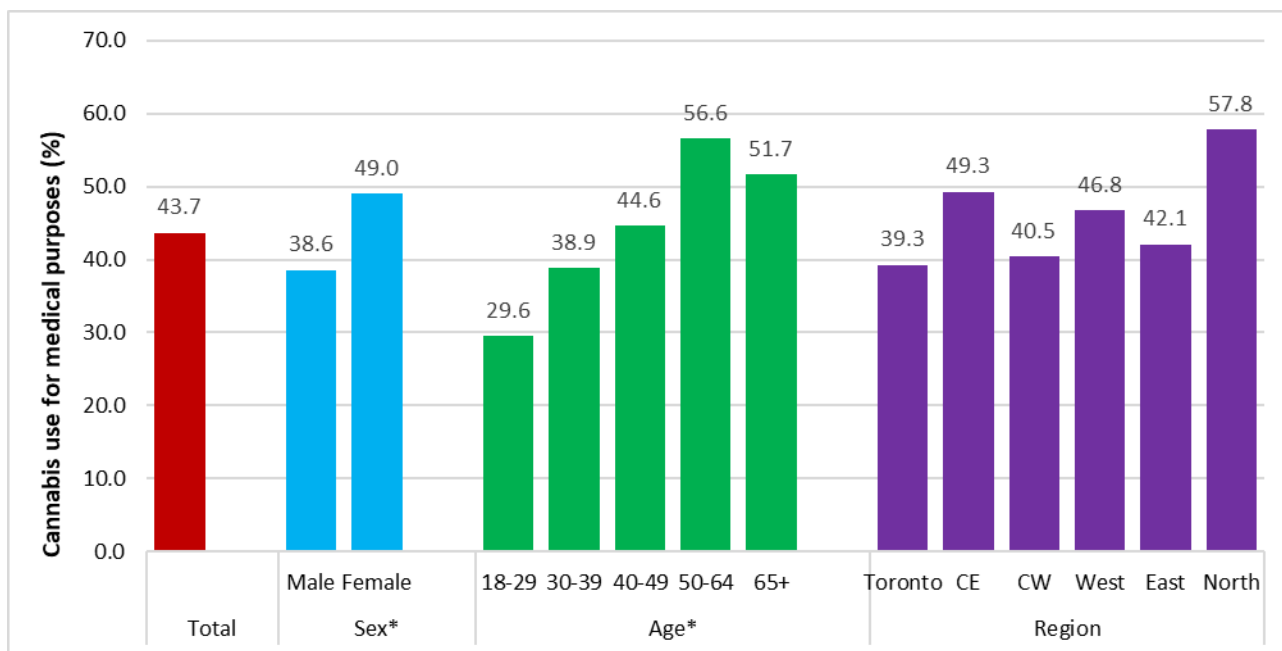
Note: CE: Central East; CW: Central West; *: Statistically significant differences between estimates, (p<0.05).

5.1.3. Modes of Use and Perceived Risk of Cannabis Use

The survey asked past year cannabis users about the ways they used cannabis in the past 12 months. Each of the six questions begins with the wording: "*In the past 12 months did you ....*" followed by:

(1) ...smoke cannabis in a joint?
(2) ...use it in a vaporizer or e-cigarette?
(3) ...smoke cannabis in a pipe, bong or waterpipe?
(4) ...use it in a food product or edibles (such as a brownie, cookie, candy)
(5) ...have a drink that contained cannabis (such as a tea)
(6) ...use cannabis as a tincture, cream or lotion on your skin or as a patches?

- In 2022, the most common modes of using cannabis were using it in a food product (67.3%), followed by smoking it in a joint (66.3%), using it in a vaporizer or e-cigarette (38.0%), and smoking it in a pipe, bong or waterpipe (35.3%) (Figure 5.1.5).

- The least common modes of use were using cannabis as a drink (e.g., tea) (21.5%) and as a tincture or lotion (18.1%).

- There was a significant difference between men and women (40.7% vs. 29.7%, respectively) who reported using cannabis in a pipe, bong or waterpipe (Figure 5.1.6).

- There was also a significant difference between men and women who reported using cannabis as a drink (25.8% vs. 16.9%, respectively) (Figure 5.1.6).

Change between 2020 and 2022

- Between 2020 and 2022, there was a significant decrease in percentage reporting use of cannabis in a pipe, bong or waterpipe (40.5% in 2020 to 35.3% in 2022) (Figure 5.1.5).

- There were no significant changes between 2020 and 2022 in other modes of cannabis use.

Figure 5.1.5 Modes of Cannabis Use in the Past Year, Cannabis Users Aged 18+, 2020-2022 (N=615)
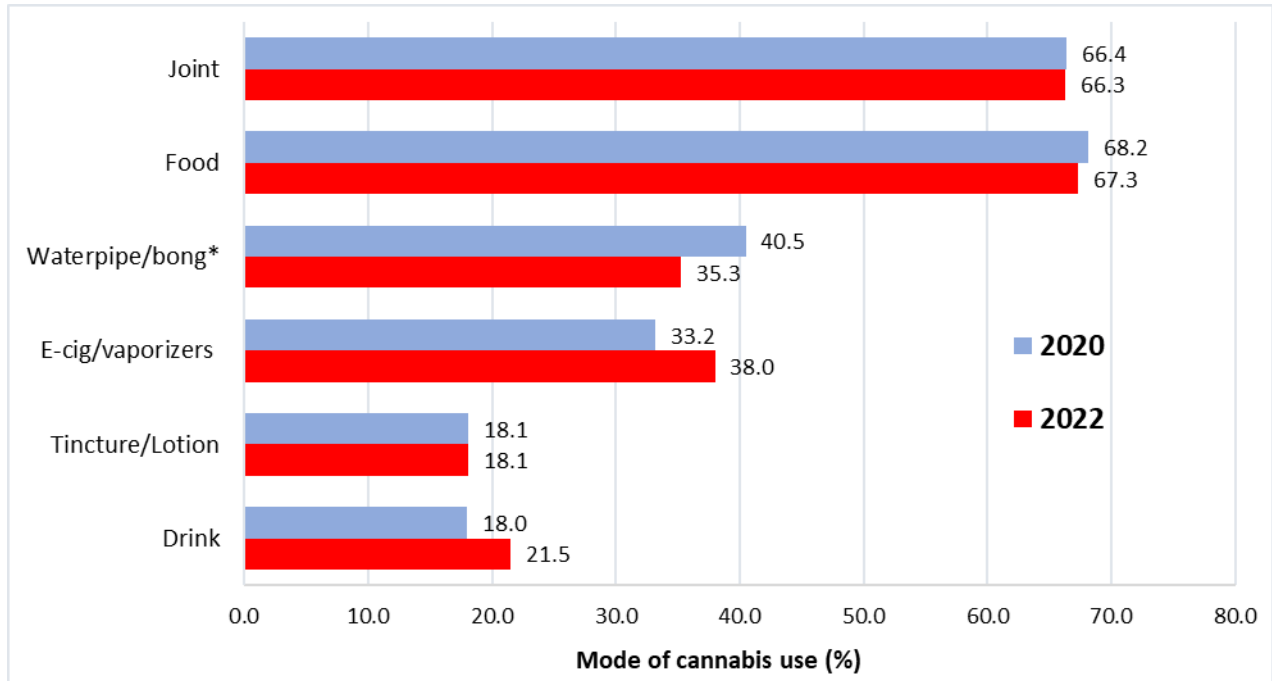
Figure 5.1.6 Modes of Cannabis Use in the Past Year by Sex, Cannabis Users Aged 18+, 2022 (N=851)

Notes: *Statistically significant sex differences (p<.05), CAMH Monitor 2022
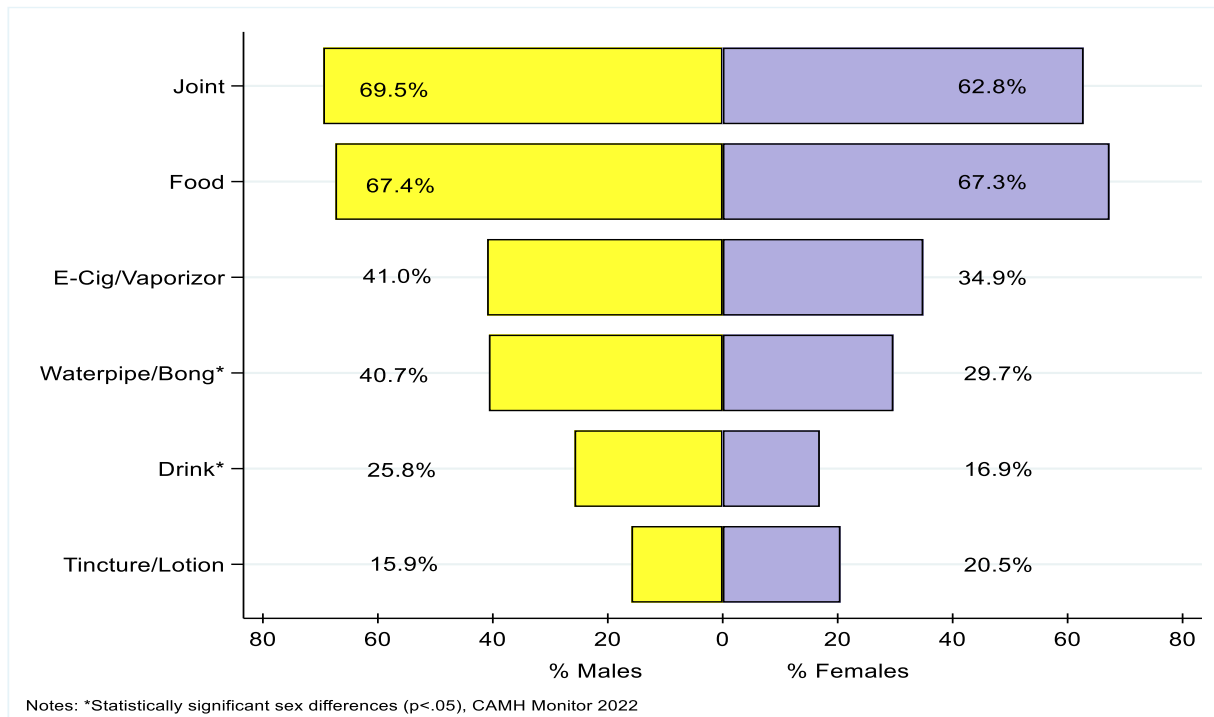
Perceived risk of cannabis use

The survey asked about the risk perception of cannabis use compared to tobacco use. Respondents were asked whether they think smoking cannabis is less harmful, the same, or more harmful than smoking tobacco. In Figure 5.1.7, we present the percentage of adults who believe smoking cannabis is "less harmful," "the same," or "more harmful".

- In 2022, 39.4% of respondents perceived that smoking cannabis was less harmful than smoking tobacco, 41.4% perceived the risk of smoking cannabis and smoking tobacco to be the same, and 19.1% perceived smoking cannabis as more harmful than smoking tobacco.

Change between 2020 and 2022

- There was no significant change between 2020 and 2022 in perception of cannabis use compared to tobacco use among adults (Figure 5.1.7).

Figure 5.1.7 Perceived Risk of Cannabis Use compared to Tobacco among adults Aged 18+, 2020-2022
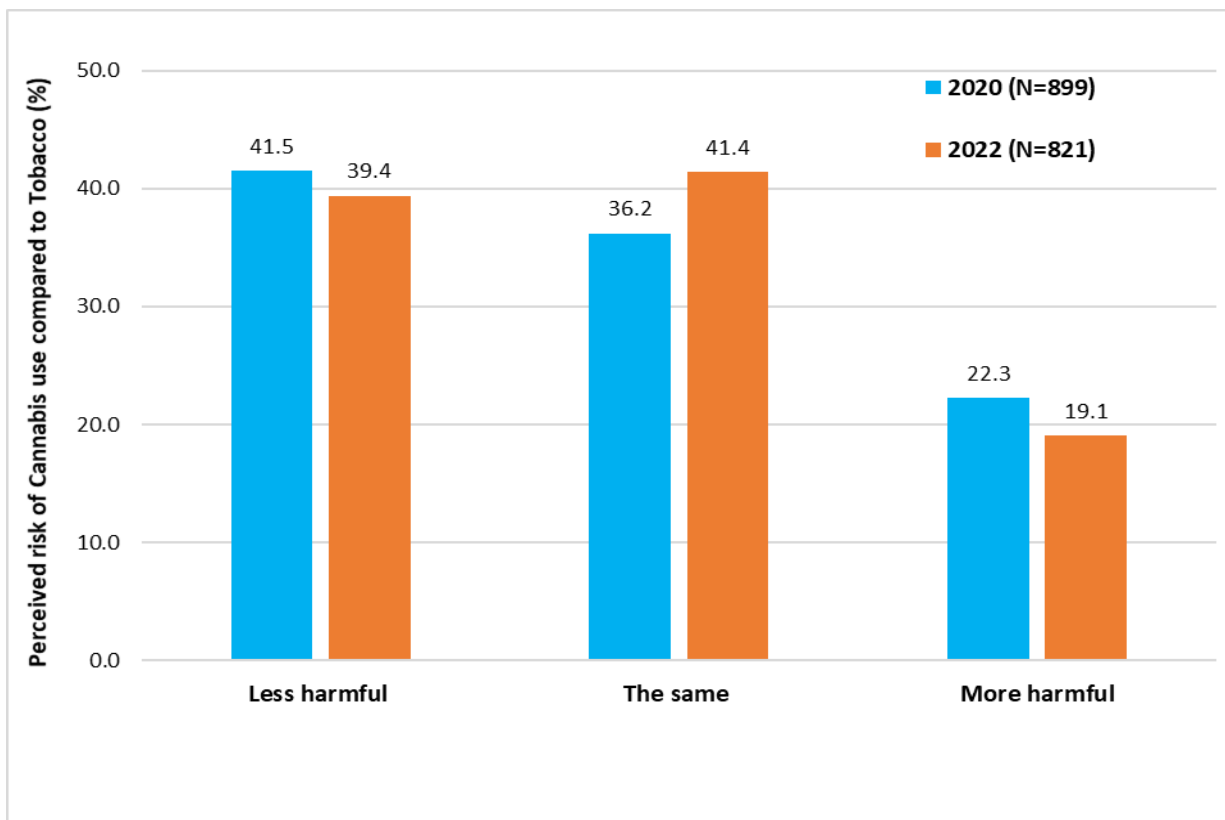
Note: No significant differences in perceived risk between 2020 and 2022.

5.2 Cocaine Use

Overall, an estimated **15.1%** (95% CI: 13.7% to 16.6%) of adults used cocaine in their lifetime, and **3.0%** (95% CI: 2.4% to 3.7%) used it in the past 12 months before the survey.

- There was a significant difference in **past year use** of cocaine between men and women (4.0% vs. 2.1%, respectively).

- There was also a significant difference in **lifetime use** of cocaine between men and women (17.2% vs. 13.1%, respectively).

- There were significant differences in lifetime use of cocaine between age groups and between regions (Figure 5.2.1).

Change between 2020 and 2022

- There was no significant change in **past year** use of cocaine among adults (3.7% in 2020 and 3.0% in 2022). Similarly, the percentages remained stable among men. Percentage estimates among women, age groups and region were not stable due to small sample size.

- There was no significant change in **lifetime** use of cocaine among adults (14.7% in 2020 and 15.1% in 2022). Similarly, the percentages remained stable among men.

- There was a significant change in **lifetime** use of cocaine only among adults aged 40 to 49 (increased from 15.5% in 2020 to 20.8% in 2022).

- There were no significant changes in **lifetime** use of cocaine between regions in Ontario.

Figure 5.2.1 Lifetime Cocaine Use by Sex, Age and Region, Aged 18+, 2022 (N=2635)
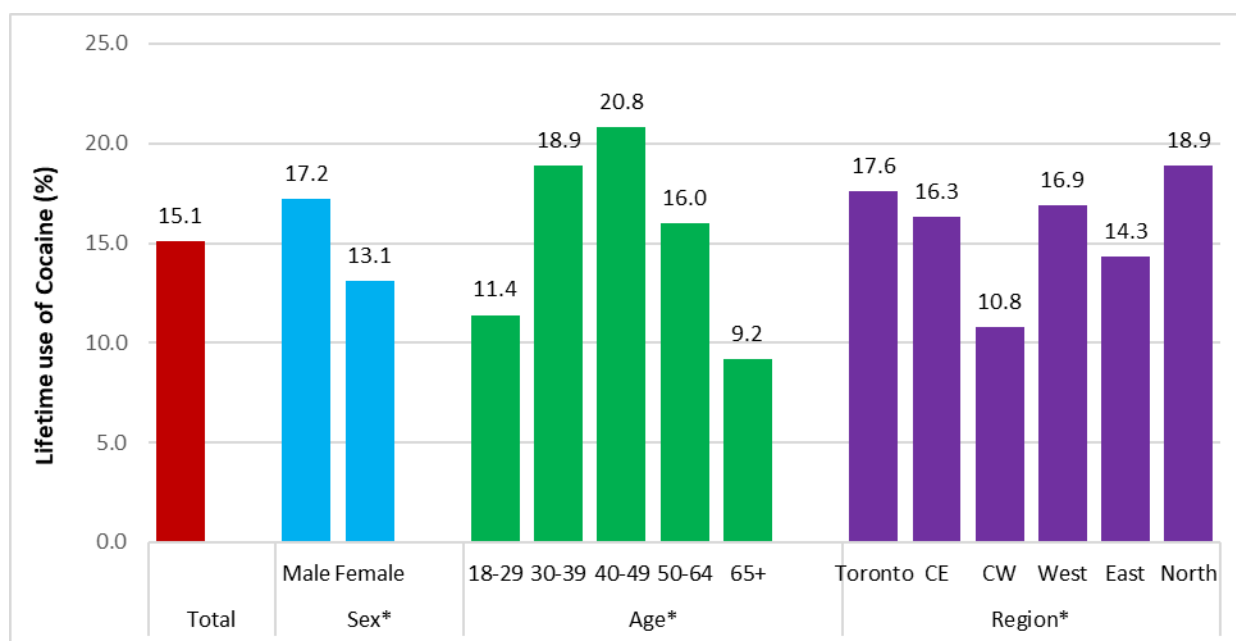
Note: CE: Central East; CW: Central West; *: Statistically significant differences between estimates, (p<0.05)

5.3 Use of Prescription Opioid Pain Relievers

The survey asked respondents about their use of prescription opioid pain relievers, such as Percocet™, Demerol™, Tylenol™ #3 or other pain relievers with codeine that are usually obtained through a prescription from a doctor.

Any past year use (i.e., medical or nonmedical) of prescription opioid pain relievers was assessed by the item: "*In the past 12 months how often, if at all, have you used any pain relievers (such as Percocet, Demerol, Tylenol #3 or other products)?*" Responses were recoded as *any past year use* (coded 1) versus *no use* (coded 0).

Any past year nonmedical use of prescription opioid pain relievers was assessed by the item: "*During the past 12 months, how often did you use pain relievers without a prescription or without a doctor telling you to take them?*" Responses were recoded as *any nonmedical past year use* (coded 1) versus *no use* (coded 0).

- Overall, an estimated **31.3%** (95% CI: 29.0% to 33.8%) of adults reported **any use** of prescription pain relievers in the past year, and **18.0%** (95% CI: 16.0% to 20.1%) reported **any nonmedical use.**

- There were no significant differences in any past year use and nonmedical use of pain relievers between men and women, age groups and regions (Figure 5.3.1 and Figure 5.3.2).

Change between 2020 and 2022

- Past year **use of any prescription opioid** in 2022 (31.3) was not significantly different from 2020 (32.7%). There were also no significant changes among men and women, age groups and regions.

- Past year **nonmedical use** of prescription opioid pain relievers in 2022 (18.0%) was not significantly different from 2020 (17.8%). Similarly, estimates of nonmedical use remained stable among men and women, among age subgroups and regions in Ontario.

Figure 5.3.1 Past Year Use of Any Prescription Opioid Pain Relievers by Sex, Age and Region, Aged 18+, 2022 (N=1680)
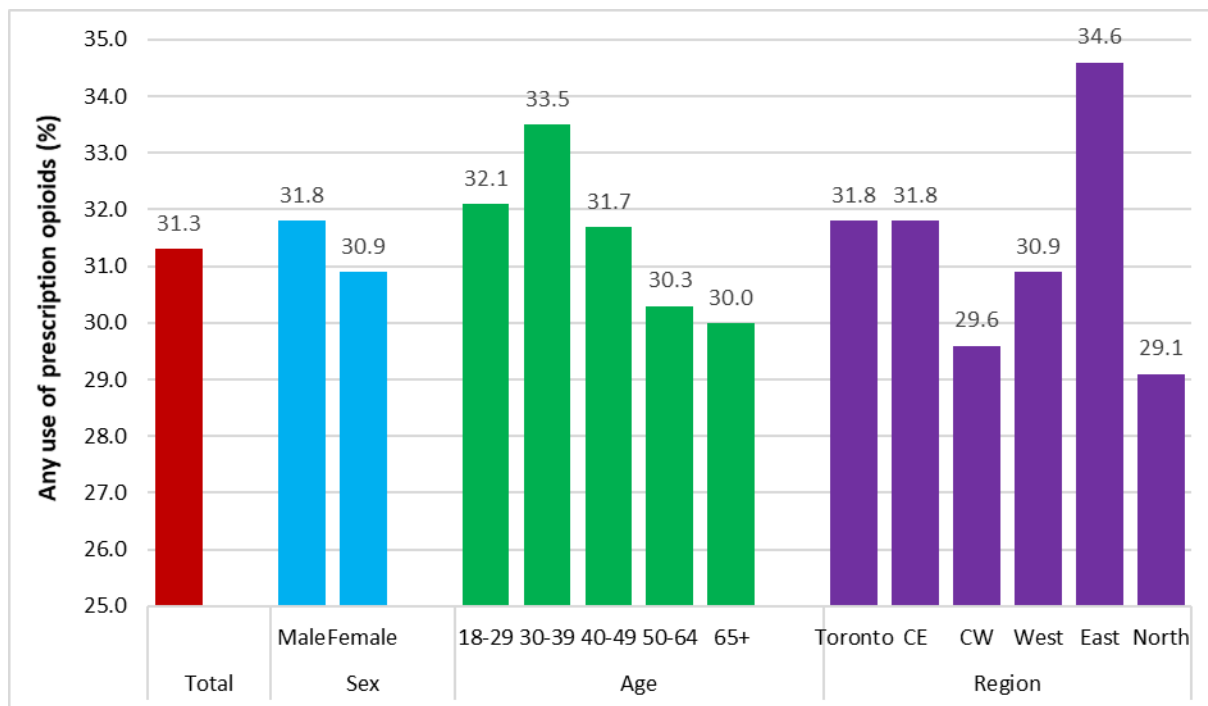
Note: CE: Central East; CW: Central West.

Figure 5.3.2 Past Year Nonmedical Use of Prescription Opioid Pain Relievers by Sex, Age and Region, Aged 18+, 2019 (N=1680)
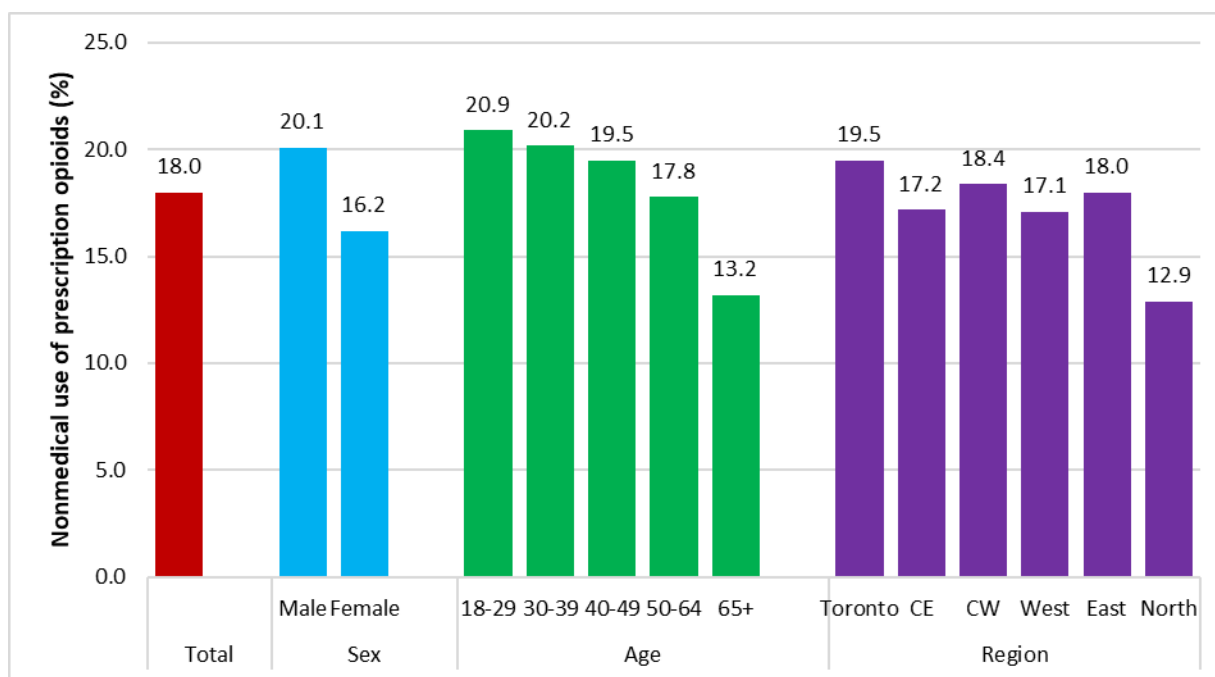
Note: CE: Central East; CW: Central West.

6. IMPAIRED AND DISTRACTED DRIVING

6.1. Driving after Drinking

Overall, an estimated **3.9%** (95% CI: 3.0% to 5.1%) of adults with a valid driver's licence reported driving after drinking alcohol – **driving after consuming two or more alcoholic drinks in the previous hour** – at least once during the past 12 months.

- There was a significant difference in percentages of men and women who reported driving after drinking alcohol (6.0% vs. 2.0%, respectively) (Figure 6.1.1). Estimates for age and region groups were suppressed.

Change between 2020 and 2022

- There was no significant change in the percentage who reported driving after drinking alcohol between 2020 (4.5%) and 2022 (3.9%).

- Estimates for driving after drinking alcohol remained stable among men and women. Estimates for age groups and regions were suppressed due to small sample size (i.e., unreliability).

Figure 6.1.1 Past Year Driving after Drinking by Sex, Age and Region, Ontario Licensed Drivers Aged 18+, 2022 (N=1471)
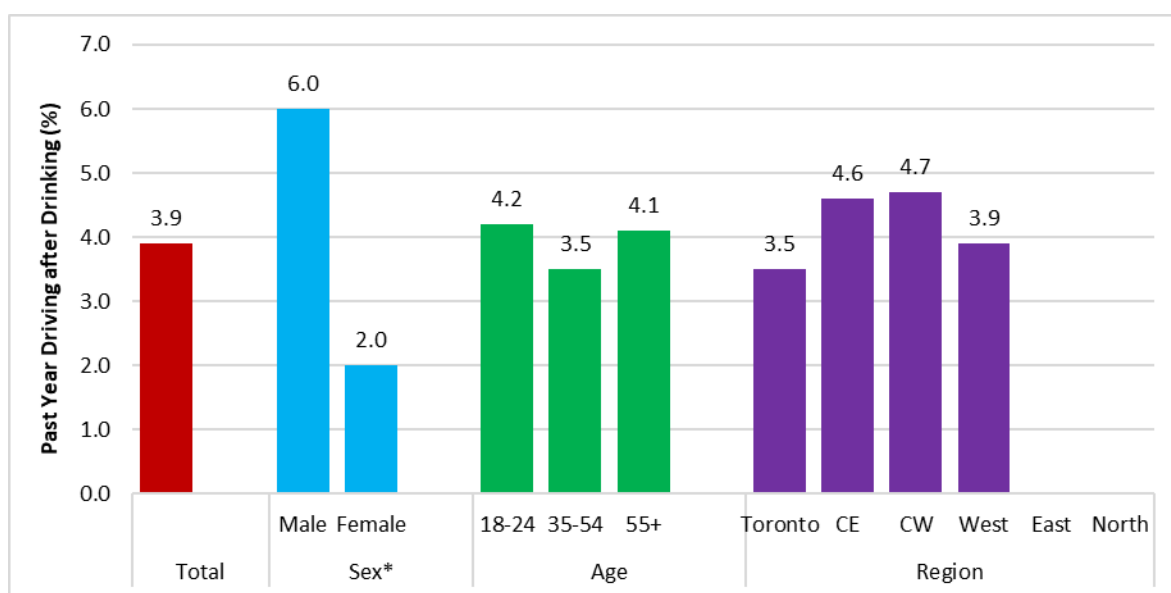
Note: CE: Central East; CW: Central West; *: Statistically significant differences between estimates, (p<0.05).

6.2 Driving after Cannabis Use

Overall, an estimated **2.5%** (95% CI: 2.2% to 4.3%) of adults with a valid driver's licence reported **driving within one hour of consuming cannabis** at least once during the past 12 months.

- There was no significant difference in the percentages of men and women who reported driving within one hour of consuming cannabis at least one time (2.9% vs. 2.1%).

Change between 2020 and 2022

- There were no significant changes in percentages reported driving within one hour of consuming cannabis at least one time between 2020 (2.4%) and 2022 (2.5%).

- There were also no significant changes in percentages reported driving within one hour of consuming cannabis among men and women.

6.3 Texting While Driving

Overall, an estimated **23.5%** (95% CI: 21.2% to 25.9%) of Ontario adults with a valid driver's licence reported texting while driving at least once during the **past 12 months**. Notably, **18.4%** (95% CI: 16.3% to 20.6%) of licensed drivers reported texting while driving at least once in the **past 30 days**.

- There were no significant differences in percentages reporting texting while driving at least once during the **past 12 months** between men and women, age groups and regions (Figure 6.3.1).

- Younger adults were more likely to report texting while driving at least once during the **past 30 days** compared to older adults (Figure 6.3.2).

Change between 2020 and 2022

- Overall, there was no significant change in the percentage reporting texting while driving at least once during the **past 12 months** between 2020 (26.5%) and 2022 (23.5%).

- Among men, there was a significant decrease in percentages reported texting while driving at least once during the **past 12 months** between 2020 (28.7%) and 2022 (21.3%). There were no significant changes among women and among age groups.

- Among adults residing in Toronto, there was a significant decrease in the percentage who reported texting while driving at least once during the **past 12 months** (26.7% in 2020 to 17.1% in 2022).

- With regard to texting while driving at least once during the **past 30 days**, there were significant decreases between 2020 and 2022 overall (21.6% in 2020 vs. 18.4% in 2022), among men (22.9% in 2020 vs. 16.6% in 2022), and among those who reside in Toronto (21.5% in 2020 vs. 13.1% in 2022). No significant changes were evident among women, age groups, or other regions.

Figure 6.3.1 Percentage Reporting Texting while Driving in the Past Year by Sex, Age and Region, Ontario Licensed Drivers Aged 18+, 2022 (N=1464)
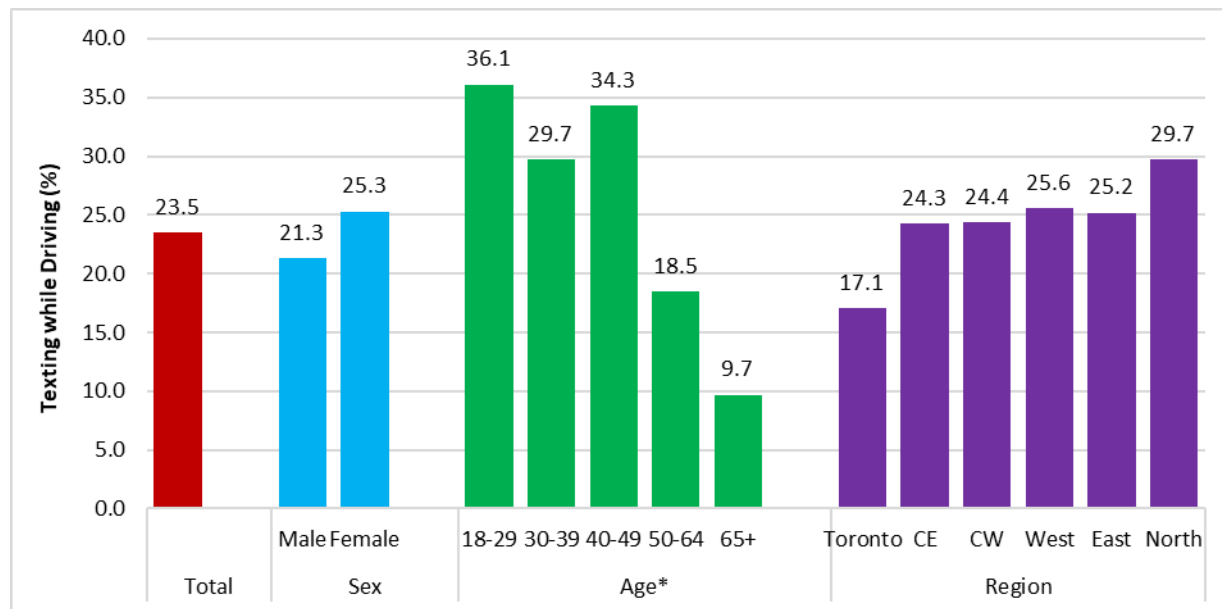
Note: CE: Central East; CW: Central West; *: Statistically significant differences between estimates, (p<0.05).

Figure 6.3.2 Percentage Reporting Texting while Driving (at least once) in the Past 30 Days by Sex, Age and Region, Ontario Licensed Drivers Aged 18+, 2019 (N=1464)
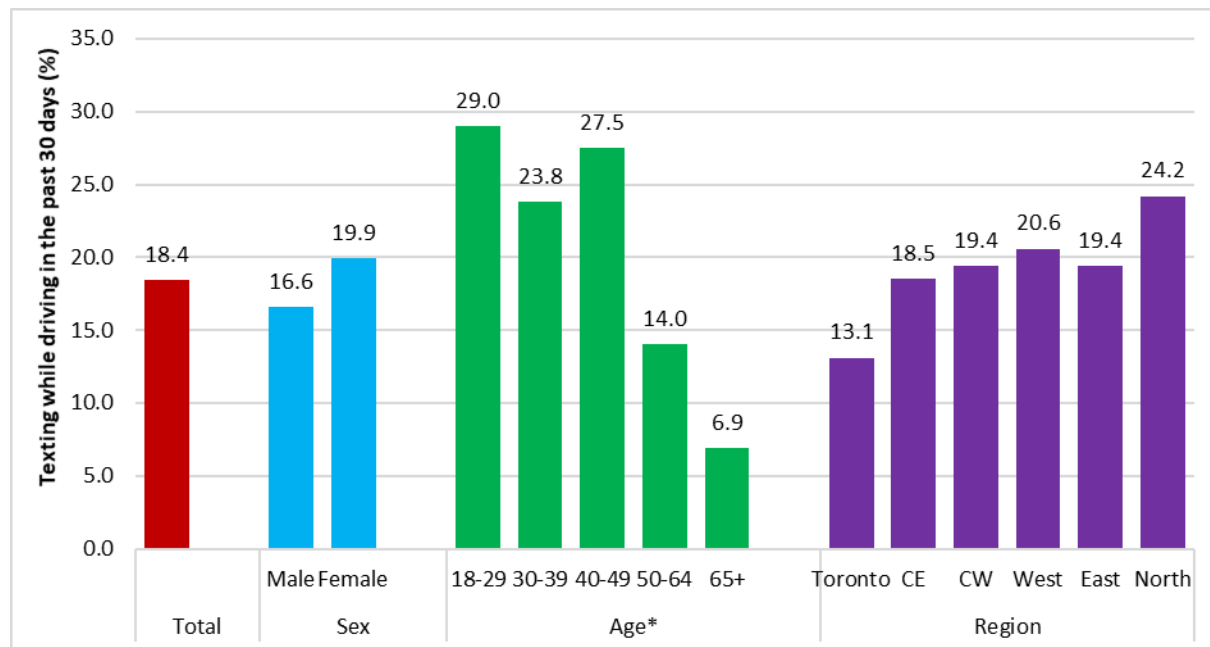
Note: CE: Central East; CW: Central West; *: Statistically significant differences between estimates, (p<0.05).

7. MENTAL HEALTH

7.1 Psychological Distress

The *Kessler 6-Item Psychological Distress Scale (K6)* was used to detect nonspecific psychological distress (symptoms of anxiety and depression) using the following symptoms:

"*In the past 30 days how often did you....*":
- *feel nervous*
- *feel hopeless*
- *feel restless or fidgety*
- *feel so depressed that nothing could cheer you up*
- *feel that everything was an effort*
- *feel worthless*

Response categories are on a 5-point frequency scale ranging from (1) "*None of the time*" to (5) "*All of the time.*" Responses to each of the six items were rescaled to a 0–4 scale for summation.

A summated score ranging from 0 to 24 was computed for respondents who answered all six items. Higher scores indicate higher levels of psychological distress.

For this report, we used two cut-off scores: (1) a score of **8 or higher** (out of 24) to estimate the percentage experiencing a *moderate-to-serious* level of psychological distress (henceforth, called moderate psychological distress) (Galea et al., 2007); and (2) a cut-off score of **13 or higher** to estimate the percentage experiencing *serious* psychological distress (Kessler et al., 2003).

Psychological Distress Symptoms

The three most common symptoms experienced by respondents "*most of the time"* or *"all of the time"* during the past 30 days were: feeling that everything was an effort (16.3%), feeling restless or fidgety (15.0%), and feeling nervous (13.0%) (Figure 7.1.1).

Figure 7.1.1 **Percentage Reporting Symptoms of Psychological Distress (K6) "Most of the Time" or "All of the Time" in the Past Month, Aged 18+, 2022 (N=1696)**

Note: Error bars represent 95% confidence intervals
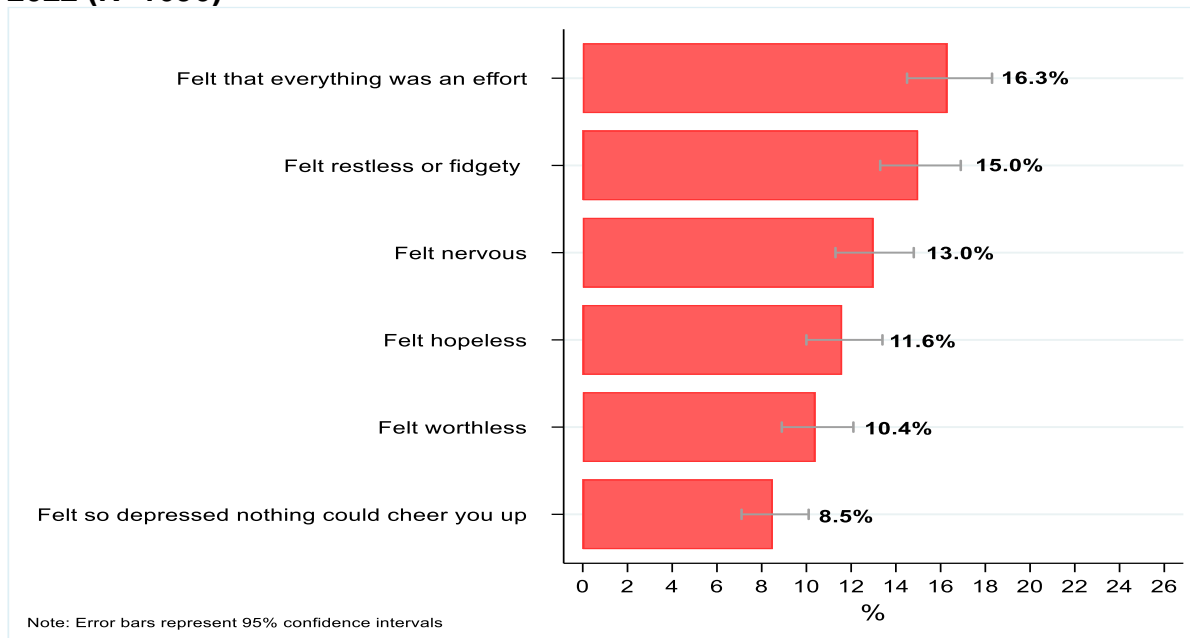
There were significant differences between men and women in feeling that everything was an effort (12.6% vs. 19.4%, respectively), feeling restless (12.0% vs. 17.5%), feeling nervous (9.8% vs. 15.6%) and feeling worthless (8.4% vs. 12.0%) (Figure 7.1.2).

7.1.1   Moderate Psychological Distress

An estimated **34.7%** (95% CI: 32.3% to 37.2%) of adults met the criteria for **moderate psychological distress** (a score of 8 or higher) during the past 30 days.

- There was a significant difference in moderate psychological distress between men and women (29.9% vs. 38.6%, respectively).

- There were also significant differences in moderate psychological distress between age

groups, with young adults more likely to experience moderate psychological distress than older adults (Figure 7.1.3).

- There were no differences in moderate psychological distress between regions in Ontario (Figure 7.1.3).

Change between 2020 and 2022

- Overall, there was no significant change in the percentage reporting moderate psychological distress between 2020 (33.8%) and 2022 (34.7%).

- There were also no significant changes in moderate psychological distress among men and women, age groups and regions.

Figure 7.1.2 Percentage Reporting Symptoms of Psychological Distress (K6) "Most of the Time" or "All of the Time" in the Past Month by Sex, Aged 18+, 2022 (N=1820)

	% Males	% Females
Felt that everything was an effort*	12.6%	19.4%
Felt restless or fidgety*	12.0%	17.5%
Felt nervous*	9.8%	15.6%
Felt hopeless	10.1%	12.9%
Felt worthless*	8.4%	12.0%
Felt so depressed nothing could cheer you up	7.6%	9.3%

Note: *Significant sex difference (p<.05)
Source: 2022 CAMH Monitor
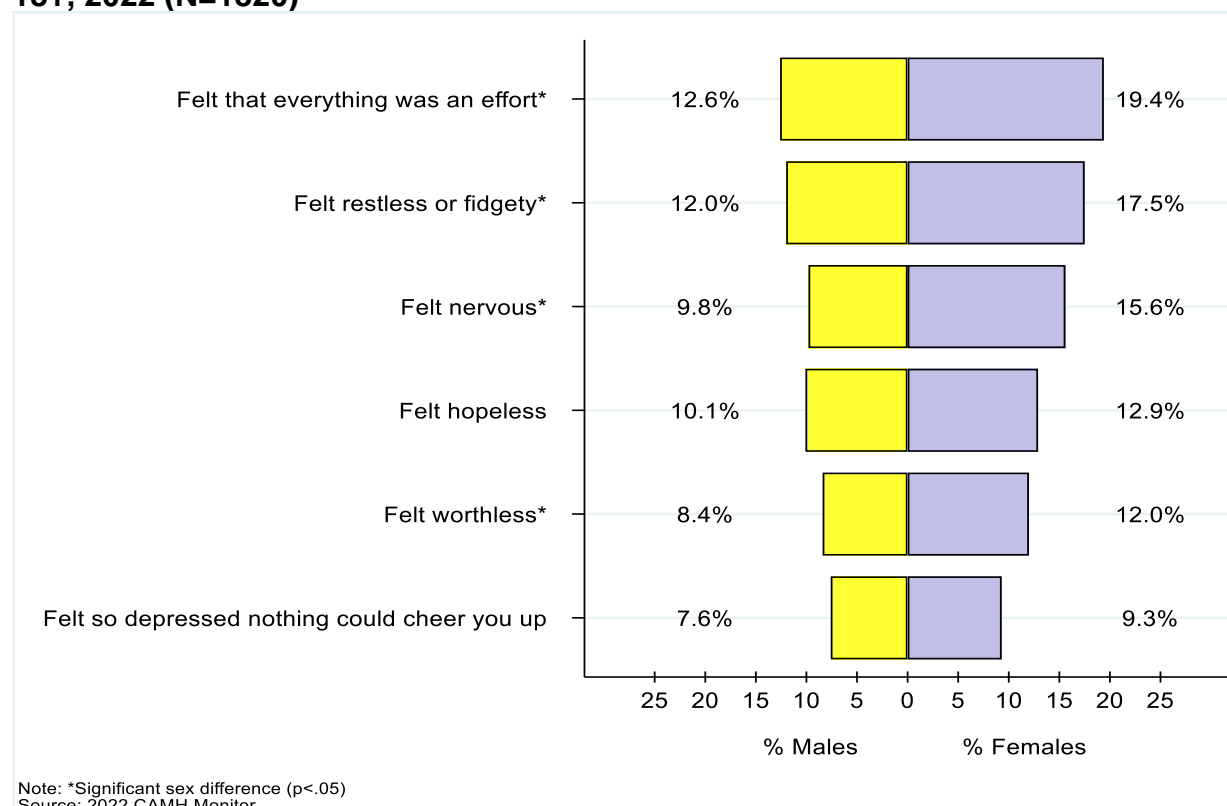
Figure 7.1.3 Percentage Reporting Moderate-to-Serious Psychological Distress (K6/8+) in the Past Month by Sex, Age and Region, Aged 18+, 2022 (N=1696)
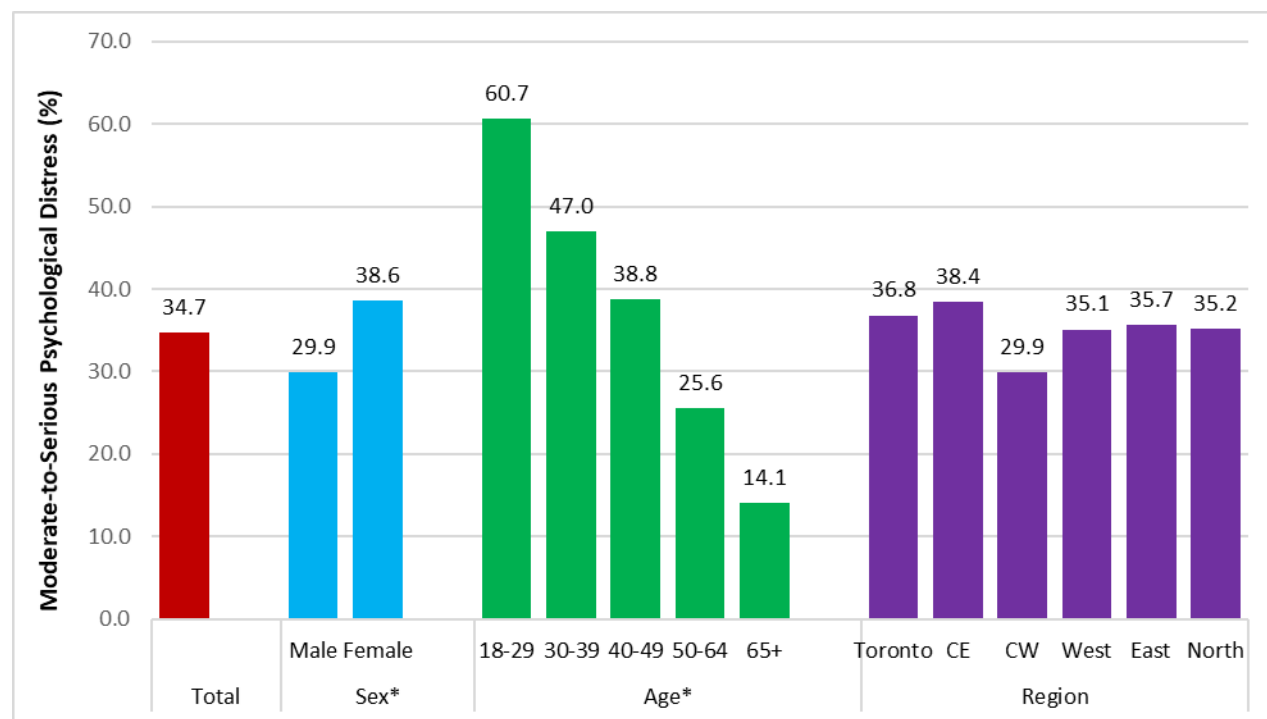
7.1.2 Serious Psychological Distress

- An estimated **14.9%** (95% CI: 13.1% to 16.8%) of adults met the criteria for **serious psychological distress** (a score of 13 or higher) during the past 30 days.

- There was a significant difference in serious psychological distress between men and women (12.4% vs. 16.9%, respectively).

- There were also significant differences in serious psychological distress between age groups, with young adults more likely to experience serious psychological distress than older adults (Figure 7.1.3).

- There were no differences in serious psychological distress between regions in Ontario (Figure 7.1.3).

Change between 2020 and 2022

- Overall, there was no significant change in the percentage reporting serious psychological distress between 2020 (13.5%) and 2022 (14.9%).

- There were also no significant changes in serious psychological distress among men and women, age groups and regions.

Figure 7.1.4 Percentage Reporting Serious Psychological Distress (K6/13+) in the Past Month by Sex, Age and Region, Aged 18+, 2019 (N=1696)
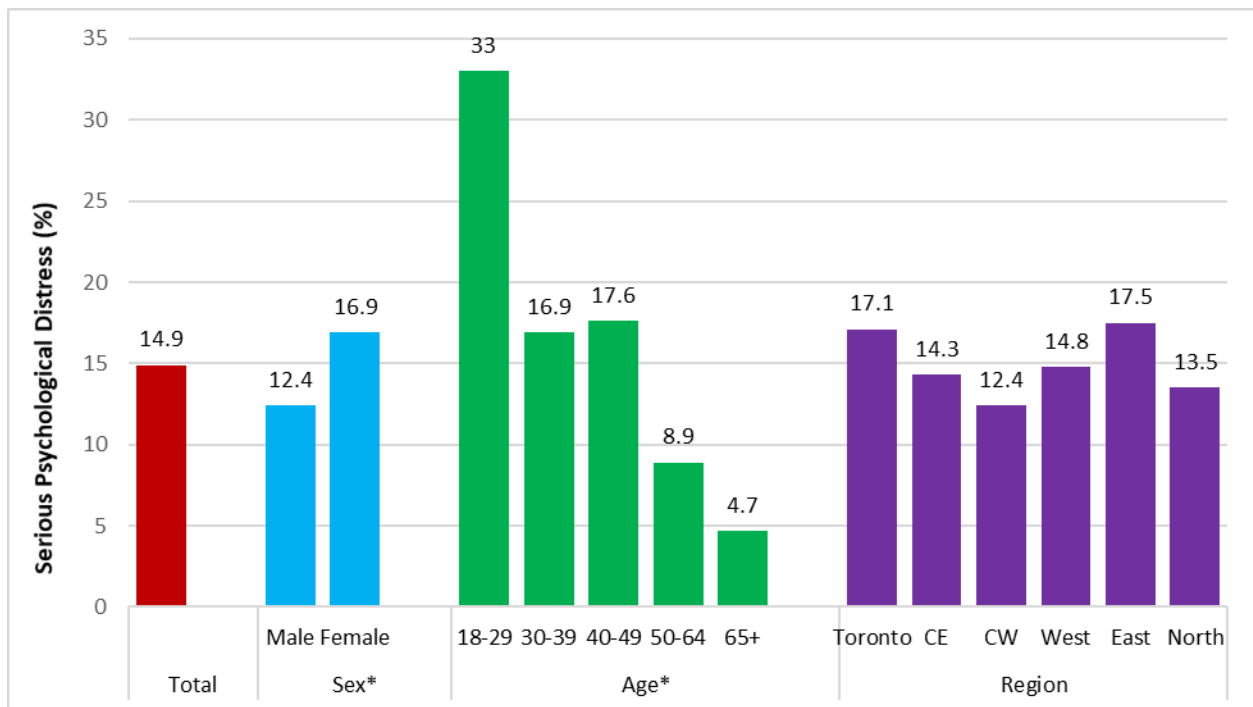
7.2 Prescription Medication for Anxiety and Depression

Anxiety and depression are some of the most prevalent mental health conditions experienced by adults. For monitoring purposes, we assess the percentage reporting having used prescription medication to treat anxiety (anxiolytics) and depression (antidepressants) during the 12 months before the survey.

The following questions were asked:
 1) *In the past 12 months, have you taken any prescription medication to treat anxiety or panic attacks?*
 2) *In the past 12 months, have you taken any prescription medication to treat depression?*

7.2.1 Antianxiety Medication

An estimated **20.4%** (95% CI: 18.4% to 22.4%) of adults used a prescribed medication to treat anxiety– anxiolytics – during the 12 months before the survey.

- There was a significant difference in the percentage reporting use of antianxiety medication between men and women (16.5% vs. 23.5%, respectively).

- There was no significant difference in antianxiety medication use between age groups.

- There were significant differences in antianxiety medication use between regions in Ontario, with adults who reside in the North more likely to use antianxiety medication in the past 12 months compared to those adults residing in the Central West region (Figure 7.2.1).

Change between 2020 and 2022

- Overall, there was no significant change in reports of antianxiety medication use between 2020 (19.4%) and 2022 (20.4%).

- There were also no significant changes in use of antianxiety medication among men and women.

- There was a significant increase in use of antianxiety medication among adults 65 years or older (increased from 12.8% in 2020 to 18.6% in 2022). However, the estimates for antianxiety medication use remained stable among other age groups.

- There was a significant change in antianxiety medication use among adults who reside in the North (increased from 22.4% in 2020 to 32.7% in 2022). However, the estimates for antianxiety medication use remained stable among other regions in Ontario.

Figure 7.2.1 **Past Year Use of Prescription Medication to Treat Anxiety /Panic Attacks by Sex, Age and Region, Aged 18+, 2022 (N=1685)**
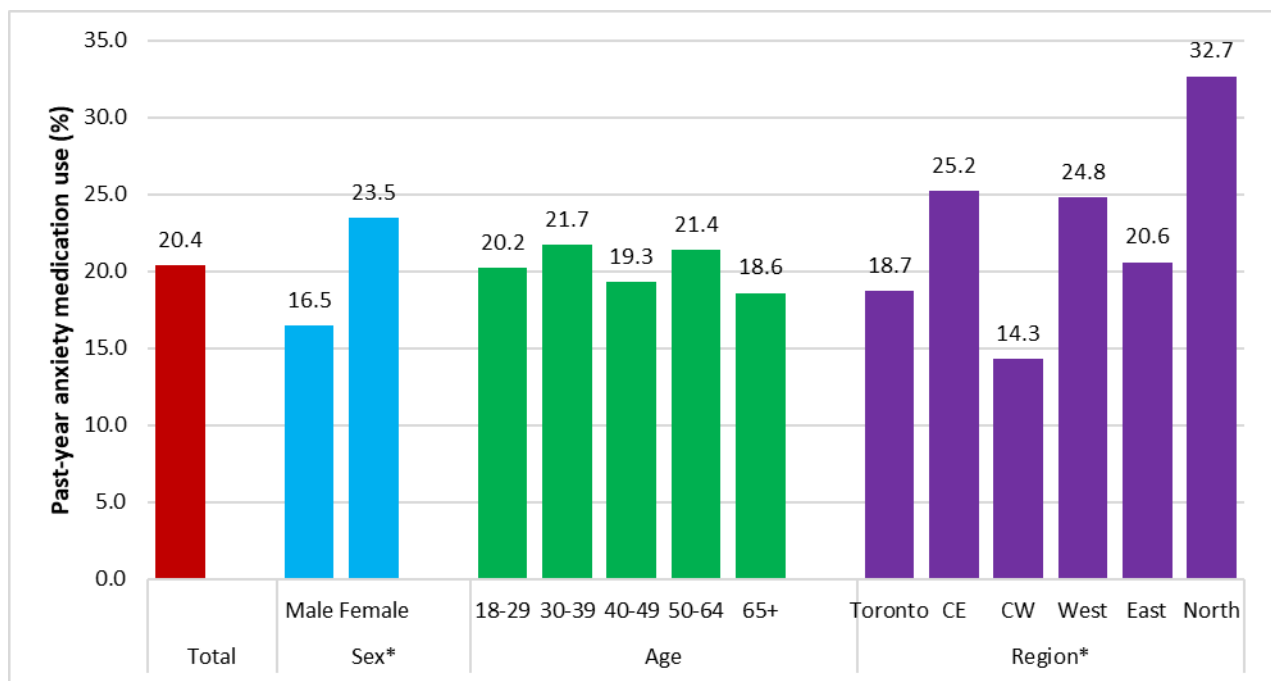
7.2.2. Antidepressant Medication

An estimated **17.3%** (95% CI: 15.5% to 19.3%) of adults used a prescribed medication for depression – antidepressants – during the 12 months before the survey.

- There was a significant difference in reports of antidepressant use between men and women (13.1% vs. 20.8%, respectively).

- There was no significant difference in use of antidepressants between age groups (Figure 7.2.2).

- There were significant differences in use of antidepressants between regions in Ontario, with adults reside in the North (23.7%) more likely to use antidepressants in the past 12 months compared to those adults residing in the Central West region (14.7%) or Toronto (14.5%) (Figure 7.2.1).

Change between 2020 and 2022

- Overall, there was no significant change in antidepressant use between 2020 (16.1%) and 2022 (17.3%).

- There were also no significant changes in antidepressant use among men and women.

- There was a significant change in antidepressants use among adults 65 years or older (increased from 10.8% in 2020 to 16.1% in 2022). However, the estimates for antidepressant use remained stable among other age groups.

- The estimates for antidepressant use remained stable among regions in Ontario.

Figure 7.2.2 Past Year Use of Prescription Medication to Treat Depression by Sex, Age and Region, Aged 18+, 2022 (N=1685)
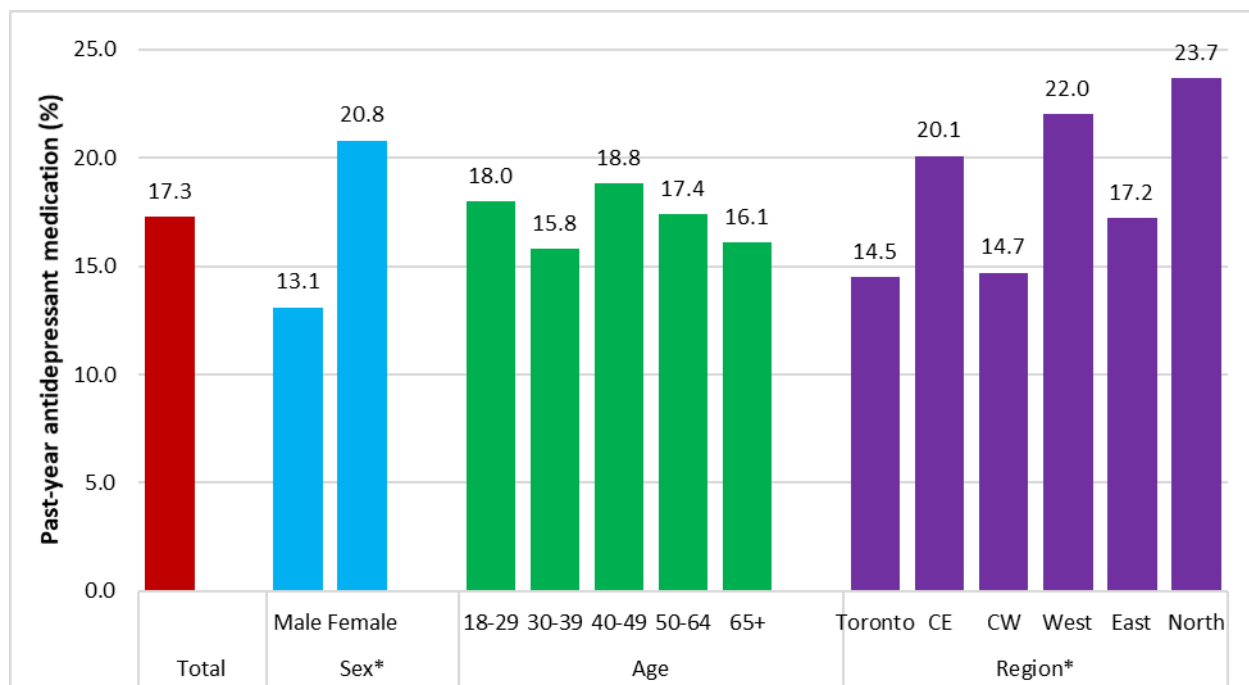
7.3 . Mental Health-Related Quality Of Life

Mental Health-Related Quality of Life were assessed by two measures: 1) the percent reporting *fair or poor mental health*, defined as the percentage rating their mental health as fair or poor, and 2) the percent reporting *frequent mental distress days*, defined as the percentage reporting 14 or more mentally unhealthy days during the past 30 days. The following items were asked in the survey:

1) *In general, would you say your overall mental health is excellent, very good, good, fair, or poor?*

2) *Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days in the last 30 days was your mental health not good?*

Self- Rated Fair/Poor Mental Health

An estimated **31.8%** (95% CI: 29.9% to 33.8%) of adults rated their mental health as fair or poor.

- There was a significant difference in percentages reporting fair or poor mental health between men and women (29.4% vs. 34.0%, respectively).

- There was a significant difference in self-rated fair or poor mental health between age groups. Younger adults were more likely to report fair or poor mental health compared to older adults (Figure 7.3.1).

- There were no significant differences in self-rated fair or poor mental health between regions in Ontario (Figure 7.3.1).

Change between 2020 and 2022

- Overall, there was a significant change in self-rated fair or poor mental health between 2020 (26.2%) and 2022 (31.8%).

- There was also a significant change in self-rated fair or poor mental health among men (increased from 20.8% in 2020 to 29.4% in 2022). However, it remained stable among women (31.2% in 2020 and 34.0% in 2022).

- There was a significant change in self-rated fair or poor mental health among 18 to 29 years old (increased from 35.2% in 2020 to 49.3% in 2022), and 50 to 64 years old (increased from 23.4% in 2020 and 28.9% in 2022). However, the estimates for fair or poor mental health remained stable among other age groups.

- There were also significant changes in self-rated fair or poor mental health estimates among adults who reside in Toronto (increased from 25.9% in 2020 to 34.9% in 2022), and the Central East region (increased from 26.0% in 2020 to 32.4% in 2022). The estimates for fair or poor mental health remained stable among other regions in Ontario.

Figure 7.3.1 Percentage Reporting Fair or Poor Mental Health by Sex, Age and Region, Aged 18+, 2019 (N=2604)
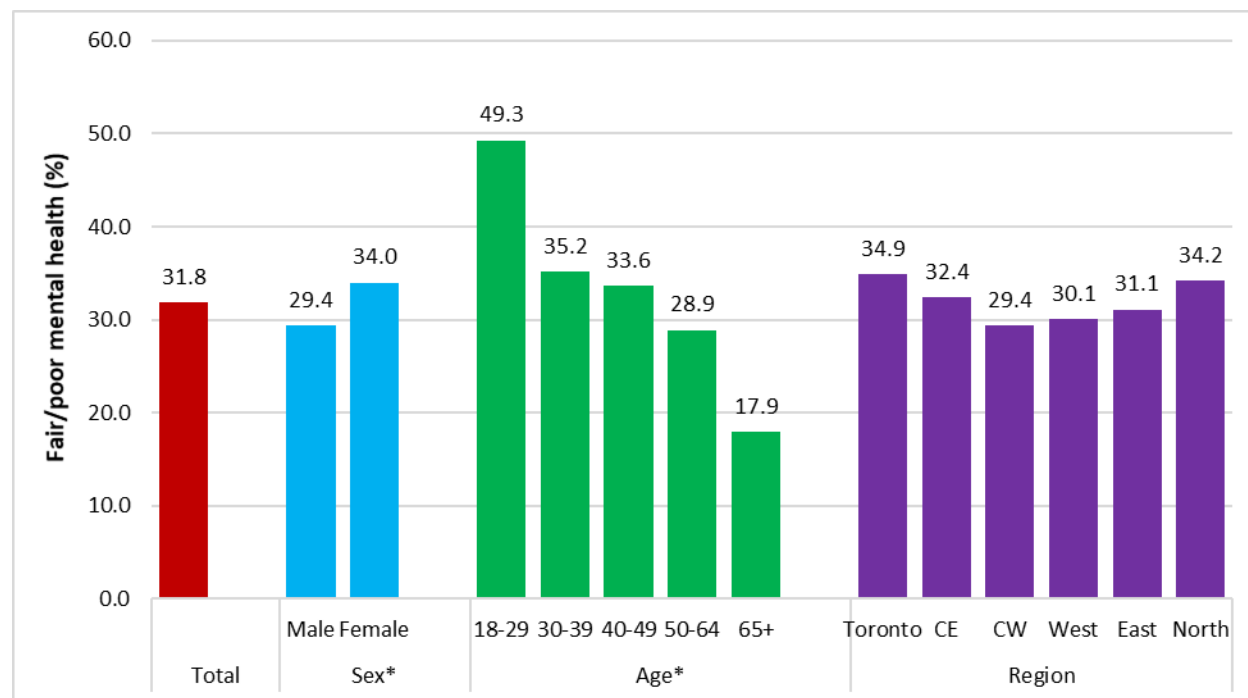
Note: CE: Central East; CW: Central West; *: Statistically significant differences between estimates, ($p<0.05$)

7.3.2 Frequent Mental Distress Days

Overall, an estimated **19.3%** (95% CI: 17.3% to 21.4%) of adults experienced **frequent mental distress days** (14+ days) in the past 30 days.

- There was a significant difference in estimates of frequent mental distress days between men and women (14.9% vs. 22.9%, respectively).

- There was a significant difference in estimates of frequent mental distress days between age groups. Younger adults were more likely to experience frequent mental distress days compared to older adults (Figure 7.3.2).

- There were no significant differences in estimates of frequent mental distress days between regions in Ontario (Figure 7.3.1).

Change between 2020 and 2022

- There was no significant change in estimates of frequent mental distress days between 2020 (16.8%) and 2022 (19.3%).

- There were no significant changes in estimates of frequent mental distress days among men and women.

- There was a significant change in estimates of frequent mental distress days among 30 to 39 years old (increased from 17.0% in 2020 to 24.4% in 2022). However, the estimates for frequent mental distress days remained stable among other age groups.

- There was also a significant change in frequent mental distress days among adults who reside in the East region (increased from 13.3% in 2020 to 20.7% in 2022). The estimates for frequent mental distress days remained stable among other regions in Ontario.

Figure 7.3.2 **Percentage Reporting Frequent Mental Distress Days (14+) in the Past 30 Days by Sex, Age and Region, Aged 18+, 2022 (N=1676)**
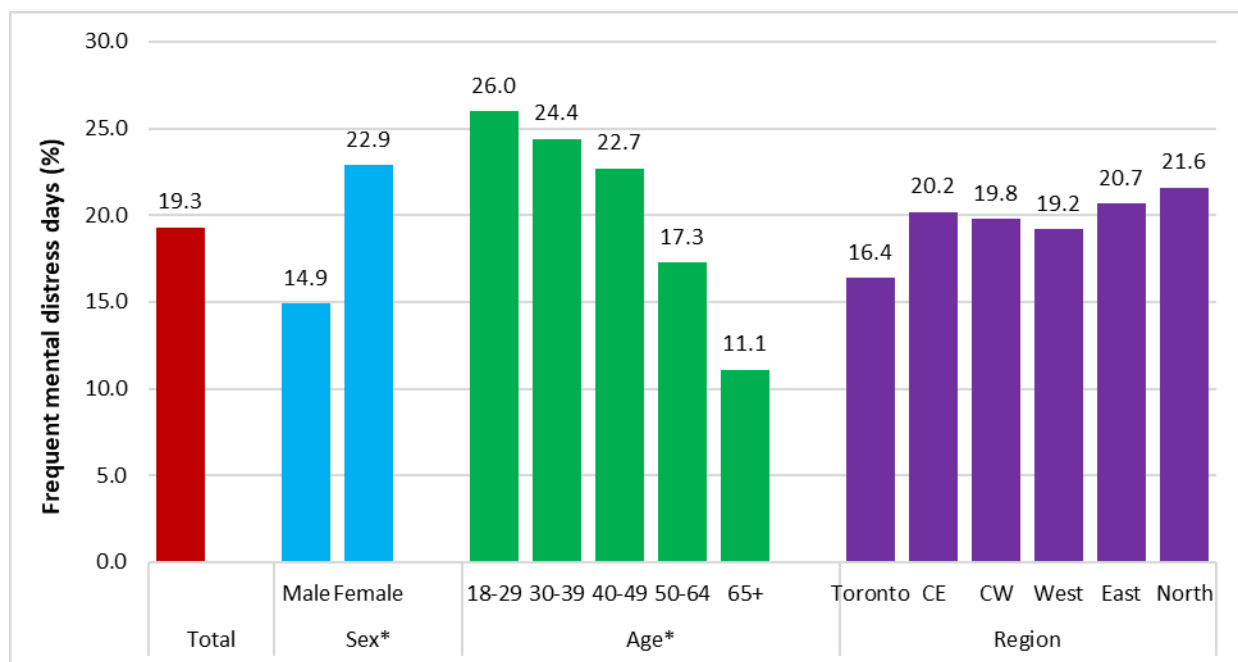
Note: CE: Central East; CW: Central West; *: Statistically significant differences between estimates, (p<0.05)

7.4 Suicidal Ideation and Suicide Attempt

Suicidal ideation and attempts were assessed by asking the following items: (1) *"In the past 12 months, did you ever seriously consider attempting suicide?"* and (2) *"In the past 12 months, did you actually attempt suicide?"* Response options to both questions were *yes* or *no*.

Overall, an estimated **7.7%** (95% CI: 6.5% to 9.2%) of adults reported that they seriously contemplated suicide during the 12 months before the survey. Less than 0.5% of adults reported attempting suicide in the past year. Estimates for suicide attempts were suppressed due to unreliability.

- There was a significant difference in the percentage of respondents reporting suicidal ideation between men and women (5.6% vs. 9.4%, respectively).

- There was a significant differences in the percentage of respondents reporting suicidal ideation between age groups. Younger adults were more likely to contemplate suicide compared to older adults (Figure 7.4.1).

- There were no significant differences in the percentage of respondents reporting suicidal ideation between regions in Ontario (Figure 7.4.1).

Change between 2020 and 2022

- The percentage reporting suicidal ideation remained stable between the 2020 (7.7%) and 2022 (7.7%) surveys.

- There were also no significant changes in reports of suicidal ideation among men and women, age groups and regions in Ontario.

Figure 7.4.1 Percentage Reporting Suicidal Ideation in the Past Year by Sex and Age, Aged 18+, 2022 (N=1678)
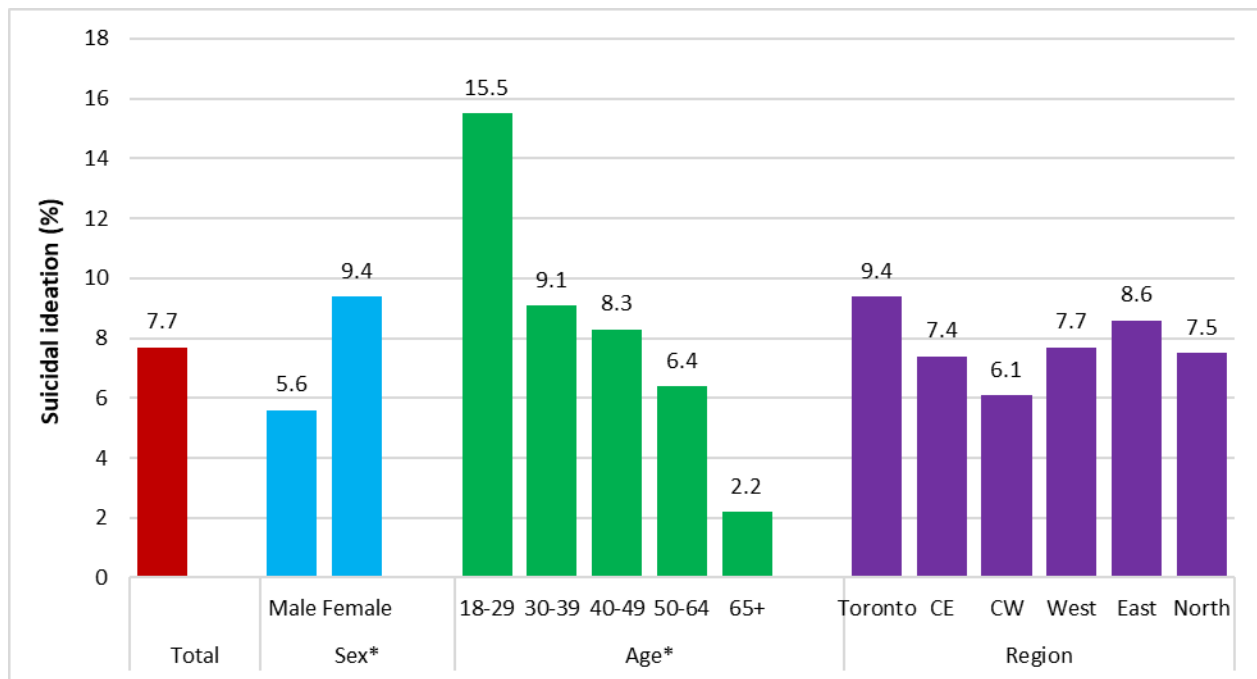
Note: CE: Central East; CW: Central West; *: Statistically significant differences between estimates, (p<0.05)

8. PHYSICAL AND OVERALL HEALTH

8.1 Self-Rated Health

Perceived or self-rated health is one of the most frequently used indicators of a person's current health status. This global assessment of health status has been shown to be a reliable measure and a valid predictor of physical health and emotional well-being (McDowell, 2006), as well as future morbidity and mortality (Idler & Benyamini, 1997).

The following items were asked in the survey:

(1) In general, would you say your overall health is excellent, very good, good, fair, or poor?

(2) Now thinking about your physical health, which includes physical illness and injury, for how many days in the last 30 days, was your physical health not good?

In this report, we present two measures of self-rated health: 1) the percent reporting *fair or poor health*, defined as the percentage rating their overall health as fair or poor in general, and 2) the percent reporting *frequent physically unhealthy days*, defined as the percentage reporting **14 or more** physically unhealthy days during the past 30 days.

8.1.1 Self-Rated Fair/Poor Health

An estimated **19.2%** (95% CI: 17.6% to 20.8%) of adults rated their overall health as fair or poor.

- There was no significant difference in the percentages reporting fair or poor overall health between men and women (17.9% vs. 20.3%, respectively).

- There were significant differences in the percentages reporting fair or poor overall health between age groups. Older adults were more likely to report fair or poor overall health compared to younger adults (Figure 8.1.1).

- There were no significant differences in the percentages reporting fair or poor overall health between regions in Ontario (Figure 8.1.1).

Change between 2020 and 2022

- There was a significant increase in the percentage reporting fair or poor overall health between the 2020 (16.3%) and 2022 (19.2%) surveys.

- There was also a significant change in the percentage reporting fair or poor overall health among women (increased from 16.4% to 20.3% in 2022). However, the percentage estimate remained stable among men.

- There was also a significant change in the percentage reporting fair or poor overall health among those 65 years or older (increased from 17.7% to 23.2% in 2022). However, no changes were evident among other age groups.

- There was a significant change in reports of fair or poor overall health among adults who reside in Toronto (increased from 14.2% to 20.5% in 2022). However, no changes in overall health were evident among other regions in Ontario.

Figure 8.1.1 Percentage Reporting Fair or Poor Health by Sex, Age and Region, Aged 18+, 2022 (N=2639)
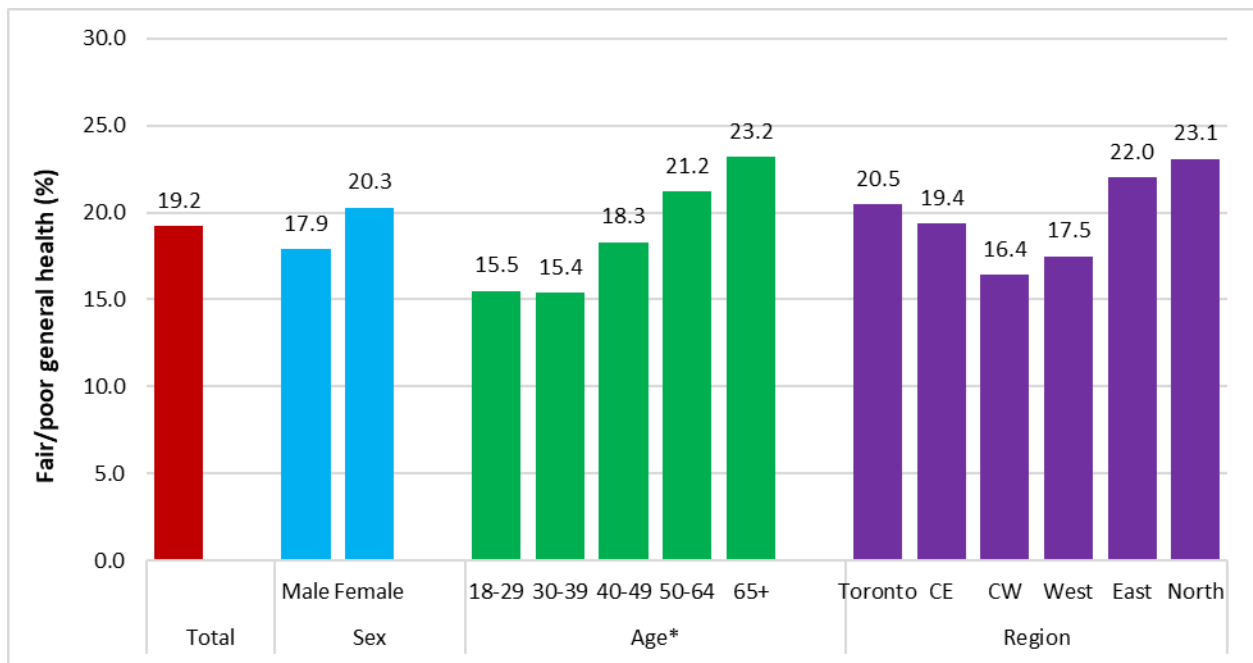
Note: CE: Central East; CW: Central West; *: Statistically significant differences between estimates, (p<0.05)

8.1.2 Frequent Physically Unhealthy Days

Overall, an estimated **14.3%** (95% CI: 12.7% to 16.2%) of adults experienced frequent physically unhealthy days (14+ days) in the past 30 days.

- There was a significant difference in estimates of frequent physically unhealthy days between men and women (10.9% vs. 17.2%, respectively).

- There was a significant difference in estimates of frequent physically unhealthy days between age groups. Older adults were more likely to experience physically unhealthy days than younger adults (Figure 8.1.2).

- There were no significant differences in estimates of frequent physically unhealthy days between regions in Ontario (Figure 8.1.2).

Change between 2020 and 2022

- There was no significant change in the estimate of frequent physically unhealthy days between the 2020 (12.4%) and 2022 (14.3%) surveys.

- There was no significant change in estimates of frequent physically unhealthy days among men and women.

- There was a significant change in estimates of frequent physically unhealthy days among 40 to 49 years old adults (increased from 11.5% to 20.1% in 2022). However, no changes were evident among other age groups.

- There was a significant change in estimates of frequent physically unhealthy days among adults who reside in the East (increased from 9.5% to 16.1% in 2022). However, no

changes in estimates of frequent physically unhealthy days were evident among other regions in Ontario.

Figure 8.1.2 **Percentage Reporting Frequent Physically Unhealthy Days (14+) in the Past 30 Days by Sex, Age and Region, Aged 18+, 2019 (N=1680)**
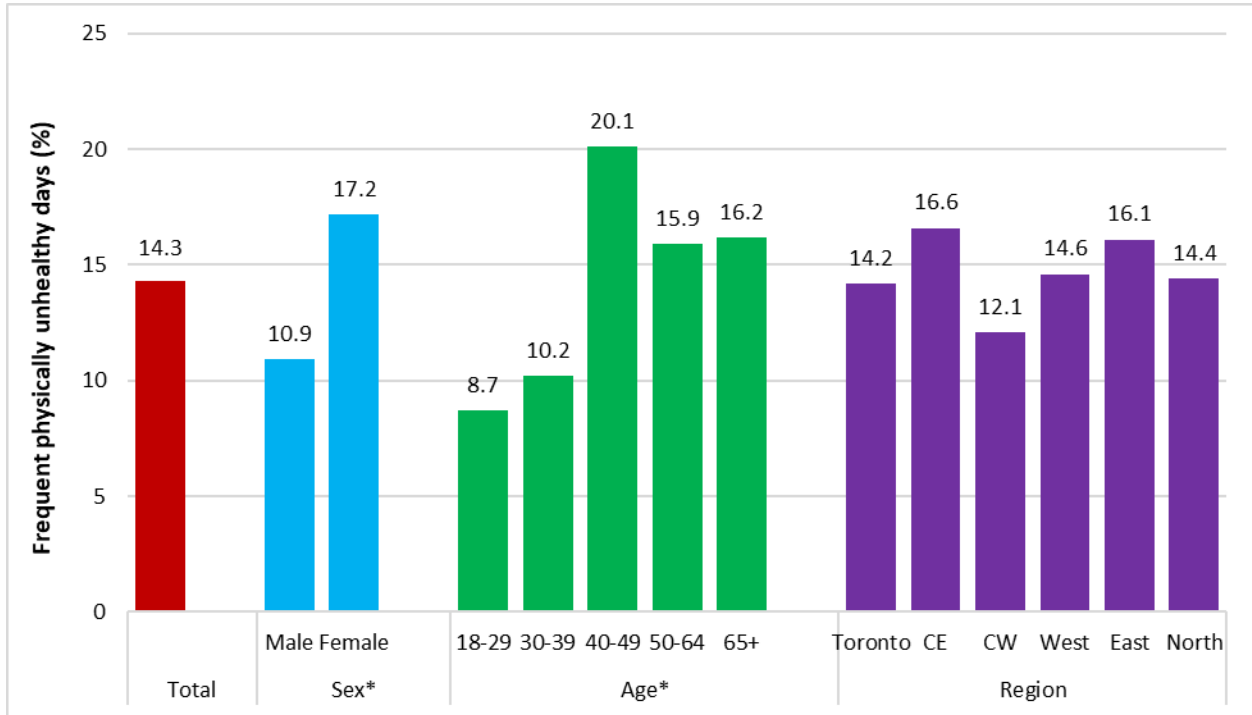
Note: CE: Central East; CW: Central West; *: Statistically significant differences between estimates, (p<0.05)

9. CONCLUSIONS

The main purpose of the CAMH Monitor (CM) study is to monitor substance use and their attributable harms, and indicators of mental health and overall health concerns among adults in Ontario. Since 1977, the CM has been providing evidence based information for designing and targeting prevention and health promotion programs, for public health and social policy planning and making, and evaluating the effectiveness of policies and programs at the population level, and disseminating relevant and timely information to health professionals, policy makers and the general public.

The CM2022 report presents the key findings of the 2022 cycle of the CM covering a wide range of topics including substance use (alcohol, tobacco, cannabis and other drugs and their attributable harms), and indicators of health and mental health concerns (self-rated poor health, psychological distress, use of antianxiety and antidepressant medication and mental health-related quality of life indicators) as well as impaired and distracted driving among adults. In addition, the report presents the changes in main indicators compared to the previous cycle in 2020 to provide more context during the COVID-19 pandemic. Comparisons to the 2019 pre-pandemic survey estimates are provided in the appendix (Table 11-A1).

Data Limitations

Although cross-sectional surveys are the most feasible means to establish and monitor substance use and mental health concerns in the general population, those interpreting *CAMH Monitor* (CM) data should consider the following limitations. Given the present study employed non-probability sampling to recruit the participants, there might be a potential for selection bias, limiting the generalizability of the study findings. Although selection bias cannot be completely eliminated, it is minimized by matching those who complete the survey to the characteristics of the population using quotas,

which were embedded within the questionnaire such that those who completed the survey approximated the distributions in the Census.

The CM data are also based on self-reports, which cannot be readily verified. However, reviews of self-report methods for alcohol and drug use suggest that although surveys tend to underestimate true usage, they are still regarded as the best available means to estimate such individual behaviours in the population (Harrison et al., 1993; Turner et al., 1992). Moreover, the CM is a cross-sectional survey, which administered at just one point in time and do not examine the same individuals at different time points such that it is impossible to identify the causes of individual change and the temporal ordering of the effects (e.g., whether unemployment causes drug use or whether drug use causes unemployment). There might also be confounding bias as the comparison between percentage estimates are not adjusted to potential confounders.

Despite these limitations, monitoring studies excel at identifying the extent of and change in various health behaviours and measures in the general population. Surveillance studies identify which groups of the population are at the greatest risk for significant health concerns; identify areas requiring more research; and identify changes that may have implications for future service and programming needs.

Key findings in 2022

The present study summarize statistically significant associations within- and between sex, age and region variables and substance use and other health indicators.

Men were more likely than women to report daily drinking, higher number of drinks consumed weekly, weekly binge drinking, drinking hazardously or harmfully, symptoms of

alcohol dependence, current smoking, past year electronic cigarette use, lifetime- and past year cannabis use, moderate to high risk cannabis use problems, cannabis use for medical purposes, lifetime and past year cocaine use, and past year driving after drinking two or more drinks in the previous hour.

Women were more likely than men to report moderate to serious psychological distress, serious psychological distress, fair/poor self rated mental health, frequent mental distress days, use of anxiety and depression medications, suicidal ideation and frequent physically unhealthy days.

Adults aged 18 to 29 years old were more likely than their older counterparts to report drinking hazardously or harmfully, symptoms of alcohol dependence, past year e-cigarette use, past year cannabis use, cannabis use problems, cannabis use for medical purposes among the total sample, texting while driving in the past year and 30 days, moderate and serious psychological distress, serious psychological distress, fair or poor mental health, frequent mental distress days, and suicidal ideation.

Adults aged 65 years and older were more likely than their younger counterparts to report higher number of cigarettes smoked daily, cannabis use for medical purposes among cannabis users, fair or poor overall health and frequent physically unhealthy days in the past 30 days.

Significant regional differences were observed for **current smoking and average number of cigarettes smoked daily** (both were highest in the North), **past year electronic cigarette use** (highest in Toronto), **lifetime cocaine use** (highest in the North), **past year use of antianxiety and antidepressant medications** (highest in the North).

Overall changes between 2020 and 2022

Three indicators show evidence of total sample increases between the past two survey cycles. **Moderate to high risk of cannabis use problems** increased significantly between 2020 and 2022, from 16.4% to 19.4%. This increase was evident especially among men who use cannabis, those users aged 30 to 39, 50 to 64 years old and those living in Toronto.

There was a significant increase in **fair or poor mental health** between 2020 and 2022, from 26.2% to 31.8%. This increase was evident especially among men, those aged 18 to 29 years, 50 to 64 years old and those residing in Toronto and Central East regions.

There was also a significant increase in **fair or poor general health** between 2020 and 2022, from 16.3% to 19.2%. This increase was evident especially among women, those aged 65 years and older and respondents residing in Toronto.

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11. APPENDIX

Comparisons between the 2019 pre-pandemic estimates and those from 2020 and 2022 are provided in Table 11-A1. Overall, the results show increases in estimates for most indicators between 2019 and 2020 (Nigatu, Elton-Marshall, Rehm, & Hamilton, 2021). Most of those increases remained evident between the 2019 and 2022 estimates.

Table 11-A1 Substance Use, Mental Health & Well-Being Indicators, 2019-2022 CAMH Monitor

Indicator	2019 (N=2,827)			2019 (adjusted)			2020 (N=3,033)			2020 (adjusted)			2022 (N=2,650)			2022 (adjusted)		
	Tot %	M %	W %	Tot %	M %	W %	Tot %	M %	W %	Tot %	M %	W %	Tot %	M %	W %	Tot %	M %	W %
Alcohol																		
Percentage drinking alcohol - past 12 months	**79.9**	81.3	78.7	**81.7**	83.1	80.5	**80.4**	80.8	80.0	**79.6**	80.3	79.0	**80.4**	82.1	78.8	**79.8**	81.6	78.3
Percentage drinking daily - total sample - among drinkers	**5.6** **7.1**	7.3 9.0	4.1 5.2	**5.8** **7.4**	7.8 9.6	4.1 5.4	**9.7** **12.1**	12.0 14.9	7.6 9.5	**9.8**[a] **12.1**[a]	12.2[b] 14.7[b]	7.6[c] 9.7[c]	**9.2** **11.4**	11.3 13.8	7.3 9.2	**9.1**[e] **12.2**[e]	11.4[f] 13.7[f]	7.2[g] 9.1[g]
Average number of drinks consumed weekly - among drinkers (mean)	**4.6**	6.0	3.2	**4.5**	5.9	3.2	**6.7**	8.7	4.8	**6.6**[a]	8.6[b]	4.8[c]	**6.3**	8.0	4.7	**6.3**[e]	8.1[f]	4.7[g]
Percentage consuming 5 or more drinks on a single occasion weekly (weekly binge drinking) - total sample - among drinkers	**6.0** **7.5**	8.6 10.6	3.6 4.5	**5.8** **7.0**	8.6 10.2	3.3 4.1	**11.3** **14.1**	15.9 19.6	7.1 8.9	**11.4**[a] **14.3**[a]	15.7[b] 19.5[b]	7.4[c] 9.3[c]	**10.7** **13.3**	15.1 18.4	6.8 8.6	**10.9**[e] **13.7**[e]	15.2[f] 18.8[f]	7.1[g] 9.2[g]
Percentage reporting hazardous or harmful drinking (AUDIT 8+) - total sample - among drinkers	**13.2** **16.6**	18.7 23.3	8.1 10.4	**13.0** **15.4**	18.3 21.7	8.1 9.8	**21.2** **26.8**	26.9 33.8	16.0 20.3	**21.2**[a] **27.2**[a]	26.8[b] 34.2[b]	16.1[c] 20.5[c]	**20.1** **25.3**	25.7 31.6	15.0 19.3	**20.3**[e] **26.0**[e]	25.9[f] 32.4[f]	15.2[g] 19.9[g]
Percentage reporting symptoms of alcohol dependence (based on the AUDIT) - total sample	**7.4**	9.7	5.2	**7.1**	9.3	5.1	**13.9**	17.1	11.0	**13.8**[a]	16.8[b]	11.0[c]	**14.1**	18.0	10.7	**14.3**[e]	17.9[f]	11.0[g]
Tobacco																		
Percentage currently smoking cigarettes	**16.3**	20.4	12.5	**14.9**	18.3	11.8	**17.2**	19.3	15.3	**18.1**[a]	20.2	16.0[c]	**17.7**	19.9	15.7	**18.6**[e]	21.1[f]	16.1[g]
- smoking daily	**12.2**	15.1	9.6	**10.7**	12.5	9.0	**12.4**	13.1	11.7	**13.4**[a]	14.3	12.3[c]	**12.3**	12.9	11.8	**13.2**[e]	14.1	12.3[g]
Average number of cigarettes smoked daily - among smokers (mean)	**11.2**	11.9	10.1	**10.5**	10.4	9.2	**9.0**	8.1	10.1	**9.6**	8.7	9.7	**8.9**	8.2	9.8	**9.2**	8.4	9.1
Percentage of daily smokers reporting high nicotine dependence - among daily smokers	**13.6**	18.7	6.2	**11.9**	13.9	5.2	**7.8**	6.2	9.4	**8.1**	5.1[b]	9.1	**9.4**	8.7	10.1	**9.6**	6.9[f]	10.0

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Indicator	2019 (N=2,827)			2019 (adjusted)			2020 (N=3,033)			2020 (adjusted)			2022 (N=2,650)			2022 (adjusted)		
	Tot %	M %	W %	Tot %	M %	W %	Tot %	M %	W %	Tot %	M %	W %	Tot %	M %	W %	Tot %	M %	W %
Percentage reporting electronic cigarette use - past 12 months	**12.8**	14.3	11.4	**12.1**	13.5	10.9	**15.2**	17.4	13.0	**15.1**[a]	17.3[b]	13.0	**13.7**	17.0	10.7	**14.0**	17.2[f]	11.1
Cannabis																		
Percentage using cannabis in lifetime	**53.1**	57.9	48.6	**54.4**	58.7	50.4	**53.0**	53.4	52.6	**52.3**	52.9[b]	51.5	**54.1**	56.9	51.7	**54.0**	57.3	50.8
Percentage using cannabis - past 12 months	**25.6**	31.5	20.1	**25.5**	31.0	20.5	**31.7**	33.9	29.7	**31.4**[a]	33.4	29.2[c]	**32.9**	35.7	30.3	**33.0**[e]	36.1[f]	30.0[g]
Percentage reporting moderate to high risk of cannabis use problems (ASSIST-CIS 4+) - total sample - among users	**13.6** **57.9**	19.0 63.6	8.7 49.2	**13.1** **52.0**	17.6 56.0	8.8 49.3	**16.4** **55.5**	18.9 62.0	14.0 48.9	**16.2**[a] **54.3**	18.9 60.2	13.6[c] 49.7	**19.4**[d] **64.4**[d]	23.3 73.0[¶]	16.2 56.5	**20.4**[e] **64.3**[e]	24.7[f] 72.2[f]	16.2[g] 57.2
Percentage using cannabis for medical purposes - past 12 months	**10.5**	13.1	8.2	**10.1**	12.1	8.2	**13.1**	12.6	13.5	**13.3**[a]	12.8	13.6[c]	**14.2**	13.7	14.7	**15.9**[e]	15.9[f]	15.7[g]
Cocaine																		
Percentage using cocaine in lifetime	**11.3**	15.5	7.5	**10.8**	14.4	7.3	**14.7**	17.0	12.6	**14.9**[a]	17.2	12.8[c]	**15.1**	17.2	13.1	**15.2**[e]	17.7	13.0[g]
Percentage using cocaine - past 12 months	**1.9**	2.5	1.3	**1.9**	2.5	1.3	**3.7**	4.5	3.0	**3.5**[a]	4.3	2.7	**3.0**	4.0	2.1	**3.0**	4.0	2.0
Prescription Opioid Pain Relievers																		
Percentage reporting any use (medical or nonmedical) of prescription opioid pain relievers - past 12 months	**24.5**	23.2	25.6	**23.2**	21.7	24.7	**32.7**	31.1	34.2	**33.3**[a]	32.0 [b]	34.7[c]	**31.3**	31.8	30.9	**31.9**[e]	32.9[f]	31.5[g]
Percentage using prescription opioid pain relievers for nonmedical purposes - past 12 months	**5.3**	5.5	5.2	**5.1**	5.0	5.4	**17.8**	19.1	16.6	**17.8**[a]	18.9[b]	16.7[c]	**18.0**	20.1	16.2	**18.3**[e]	20.7[f]	16.4[g]
Driving[1]																		
Percentage of drivers who drove after drinking two or more drinks in the previous hour - past 12 months	**3.9**	5.4	2.4	**3.7**	5.5	2.2	**4.4**	7.0	2.0	**4.4**	6.8	2.0	**3.9**	6.0	2.0	**4.0**	5.9	2.3
Percentage of drivers who drove after using cannabis in the previous hour - past 12 months	**3.1**	4.7	1.6	**3.0**	4.4	1.7	**2.4**	2.9	2.0	**2.6**	3.2	1.8	**2.5**	2.9	2.1	**2.8**	3.3	2.0
Percentage of drivers who reported texting while driving - past 12 months	**27.1**	27.6	26.7	**28.4**	28.5	27.8	**26.5**	28.8	24.3	**25.2**	27.8	22.8[c]	**23.5**	21.3[¶]	25.3	**23.1**[e]	22.2[f]	23.3
Mental Health																		

Indicator	2019 (N=2,827)			2019 (adjusted)			2020 (N=3,033)			2020 (adjusted)			2022 (N=2,650)			2022 (adjusted)		
	Tot %	M %	W %	Tot %	M %	W %	Tot %	M %	W %	Tot %	M %	W %	Tot %	M %	W %	Tot %	M %	W %
Percentage reporting moderate to serious psychological distress during the past 30 days (K6/8+)	**17.7**	16.0	19.3	**16.4**	14.3	18.8	**33.7**	30.0	37.5	**34.1**[a]	30.3[b]	37.8[c]	**34.7**	29.9	38.6	**35.4**[e]	31.1[f]	39.6[g]
Percentage reporting serious psychological distress during the past 30 days (K6/13+)	**6.8**	5.1	8.3	**6.0**	4.1	8.0	**13.4**	11.4	15.6	**13.9**[a]	11.8[b]	15.9[c]	**14.9**	12.4	16.9	**15.3**[e]	13.3[f]	17.5[g]
Percentage using prescribed antianxiety medication - past 12 months	**13.9**	10.4	16.9	**13.5**	10.4	16.4	**19.4**	16.4	22.3	**19.4**[a]	16.1[b]	22.3[c]	**20.4**	16.5	23.5	**20.6**[e]	17.4[f]	23.9[g]
Percentage using prescribed antidepressant medication - past 12 months	**11.8**	8.9	14.4	**11.5**	8.5	14.2	**16.1**	12.2	19.9	**16.2**[a]	12.1	19.9[c]	**17.3**	13.1	20.8	**17.3**[e]	13.4[f]	20.9[g]
Percentage reporting fair or poor mental health in general	**12.9**	11.8	14.0	**12.1**	10.4	13.6	**26.2**	20.8	31.2	**26.5**[a]	21.2[b]	31.3[c]	**31.8**[d]	29.4[¶]	34.0	**32.2**[e]	30.1[f]	34.3[g]
Percentage reporting frequent mental distress days (14+) during the past 30 days	**13.3**	9.5	16.8	**12.6**	8.4	16.5	**16.8**	12.3	21.1	**17.0**[a]	12.9[b]	21.0[c]	**19.3**	14.9	22.9	**19.5**[e]	15.6[f]	23.2[g]
Percentage reporting suicidal ideation - past 12 months	**3.9**	2.7	4.9	**3.6**	2.4	4.9	**7.7**	7.4	7.9	**7.5**[a]	7.8[b]	7.5[c]	**7.7**	5.6	9.4	**8.0**[e]	6.1[f]	9.8[g]
Physical Health																		
Percentage reporting fair or poor health in general	**13.7**	15.4	12.1	**12.2**	13.5	10.9	**16.3**	16.3	16.4	**17.3**[a]	17.5[b]	17.1[c]	**19.2**[d]	17.9	20.3[§]	**19.9**[e]	19.1[f]	20.8[g]
Percentage reporting frequent physically unhealthy days (14+) during the past 30 days	**12.2**	11.3	13.0	**11.5**	10.2	12.6	**12.4**	10.0	14.7	**12.9**	10.9	14.8	**14.3**	10.9	17.2	**14.8**[e]	11.4[f]	17.6[g]

Notes:

[a]: Significant change between 2019 and 2020 adjusted estimates among total sample (Tot)

[b]: Significant change between 2019 and 2020 adjusted estimates among men (M)

[c]: Significant change between 2019 and 2020 adjusted estimates among women (W)

[d]: Significant change between 2020 and 2022 unadjusted estimates among total sample (Tot); [¶]: among men (M), and [§]: among women (W)

[e]: Significant change between 2019 and 2022 adjusted estimates among total sample (Tot)

[f]: Significant change between 2019 and 2022 adjusted estimates among men (M)

[g]: Significant change between 2019 and 2022 adjusted estimates among women (W) at p<0.05; [1]estimates are based on licensed drivers.

1) The 2019 telephone sample was weighted for household size, region, age and sex. In contrast, the 2020 and 2022 samples were from a web panel and thus the weights for 2020 & 2022 did not include adjustments for household size because individuals were approached directly. The quota targets for some socio-demographic characteristics by region were applied as closely as possible in obtaining this sample. The final weight adjusts the sample to the region proportions and the population figures for each age group and gender. The pooled sample (2019, 2020 and 2022) was used to compare estimates over time and the corresponding weights from each individual survey year were used in analyses (i.e., weights were not averaged or adjusted).

2) The percentages were adjusted using regression modelling and a marginal standardization method in Stata, with the estimates proportionally adjusted according to a weight for each level of the confounding factors age, sex, education, region, immigration status and survey year. Marginal probabilities obtained from logit models reflect a weighted average over the distribution of the confounders and are equivalent to estimates obtained by standardizing to the total population (Muller & MacLehose, 2014).

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