

**The Relationship between Geographical Location,  
Indigenous Status and Socio-Economic Status and  
Adolescent Drug Use**

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## **ABSTRACT**

Adolescence is a time of great changes, a time where experimentation and exploration is expected and when the values of authority figures are examined and challenged.

Adolescents will experiment and push the boundaries of all aspects of their life in order to find their own place and identity in a world that has changed its expectations of them.

Use of drugs is one of the ways that they do this. Australian adolescents grow up in a society where alcohol and tobacco is an acceptable part of daily life. Their use of drugs is at least on par with and in some cases exceeds that of the general population.

The overall goals of this research were to gain more information on drug use of Australian adolescents, using existing data sets. This research examined, using a number of different age groups, the differences in adolescent drug use between urban and rural Australia for lifetime use, use in the last year and use in the last month using the 2002 edition of the Australian School Student Alcohol and Drug (ASSAD) survey series in conjunction with the 2001 National Drug Strategy Household Survey (NDSHS). It also used these data sets to investigate differences between Indigenous adolescents and non-Indigenous adolescents and whether there were any differences in adolescent drug use across socio-economic status groups.

Four hypotheses were developed. The first was that rural adolescents are more likely than urban adolescents to use licit drugs and the second was that urban adolescents are more likely than rural adolescents to use illicit drugs. Thirdly, that Indigenous adolescents are more likely than non-Indigenous adolescents to use both licit and illicit drugs and the fourth was that adolescents from low socio-economic status (SES) groups are more likely than adolescents from high SES groups to use licit and illicit substances. The data offered little support for any of the hypotheses. The hypothesis on rural adolescents being more likely to use licit drugs was supported by the ASSAD survey

data but not the NDSHS. All other hypotheses were not supported by either of the data sets.

While there are aspects of the information from the two data sets that are contradictory making it difficult to prove or disprove the hypotheses formulated for this research, they highlighted a number of aspects of adolescent drug use. The first of these is that this research supports the premise that rural adolescent drug use rates are converging with urban drug use rates for younger adolescents. It also highlighted that there are a large number of rural school students who are using alcohol and cannabis. The ASSAD data also confirmed other Australian research showing that Indigenous adolescents are less likely than their non-Indigenous counterparts to use alcohol. Both data sets confirmed previous research by indicating that adolescents from the high SES groups are more likely than their counterparts in the lower SES groups to consume alcohol.

Further investigation is needed to find out why the data sets did not substantiate each other and to gain further insight into the consumption of alcohol by Indigenous adolescents and adolescents from the higher socio-economic status groups. Increasing the samples of Indigenous people in both of the data sets and lobbying the Australian Bureau of Statistics to increase their sample for the Indigenous Social Survey to include 12-14 year olds should give more information on Indigenous adolescents that could be used in research and prevention activities.

**Keywords: Adolescents, Drug use, Indigenous, Urban/Rural**

## STATEMENT OF ORIGINALITY

This dissertation has not been submitted for credit for any other degree, or part thereof:

Signed: .....

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### **Australian Secondary School Alcohol And Drugs Survey**

I would like to gratefully acknowledge the help of Dr Vicki White and the staff of the Victorian Cancer Council's Centre for Behavioural Research in Cancer for collating the data required from the Australian Secondary School Alcohol and Drugs survey for this research.

### **National Drug Strategy Household Survey**

The National Drug Strategy Household Survey data set was supplied by the Social Science Data Archives as a Confidentialised Unit Record File. I would like to acknowledge the original investigators of the data, the Australian Institute of Health and Welfare and the Commonwealth Department of Health and Aged Care and declare that those who carried out the original analysis and collection of the data bear no responsibility for the analysis and interpretation of the data in this report.

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## **LIST OF ACRONYMS AND ABBREVIATIONS**

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
ASSAD	Australian Secondary School Alcohol and Drug survey
ASSDA	Australian Social Science Data Archive
CATI	Computer Assisted Telephone Interviewing
CCDs	Census Collector Districts
NDS	National Drug Strategy
NDSHS	National Drug Strategy Household Survey



## INTRODUCTION

Adolescence is a time of great changes, a time where experimentation and exploration is expected and when the values of authority figures are examined and challenged.

Bonomo (2004) maintains that it is a time when an adolescent undergoes substantial changes whilst they explore their sense of identity and self worth, gain intellectual maturity, adapt to society's imperatives and get ready for adult roles.

Ryder, Salmom and Walker (2001) maintain that adolescence is a time when young people are attempting to change from dependence on parents and other authority figures to independence. This means that they will examine and explore what they believe to be adult behaviour, including the use of tobacco, alcohol and other drugs. Paglia and Room (1999) reviewed the literature on youth drug use and made a number of observations including:

- experimentation with drugs is normal;
- most who do try them do not have a problem with their use;
- use initiated in adolescence tends to decline in the twenties.

They maintain that this is part of the "maturing out" process, which comes with the acceptance of more adult roles and all the added responsibilities that come with these roles (Paglia & Room, 1999 p 9). Adolescents will experiment and push the boundaries of all aspects of their life in order to find their own place and identity in a world that has changed its expectations of them. Use of drugs is one of the ways that they do this.

One avenue of research has shown that adolescents who have experimented with drugs may in fact be psychologically healthier than adolescents that have problematic drug use or are abstainers. Hogan, Mankin, Conway and Fox (1970) found that college cannabis users were more likely to be socially adept, have a broader range of interests

and be more adventuresome than college students who did not use cannabis. In comparison, non-users were narrower in their interests, more over controlled and more deferential to authority. This research is supported by research published twenty years later by Shedler and Block (1990) who continued with the longitudinal study started by Block and Block (Block & Block, 1980; Block, Block & Keyes, 1988). Their research followed a number of kindergarten children to age 14 and showed that there was

. a number of psychological characteristics that were apparent in kindergarten that correlated to drug use in early adolescence. On the basis of information collected at age 18, Shedler and Block (1990) divided the adolescents into three groups, frequent users, experimenters and abstainers. They found that frequent users were more alienated, had less impulse control and higher rates of distress than experimenters. Abstainers were more anxious, and lacking in social skills compared to experimenters. Differences were also found in their earlier assessment at age 7 and 11. Abstainers were anxious and inhibited and frequent users were insecure, not able to form healthy relationships and emotionally distressed as children compared to experimenters.

Shedler and Block (1990) suggested that their finding that “some drug experimentation was not psychologically destructive” (Shedler & Block, 1990 p 628) might sit badly with some and directly opposed the clinical view that all drug use is dangerous. They stated that their findings did not mean that drug use might improve an adolescent’s psychological health, but that for adolescents generally some experimentation “apparently does not have psychologically catastrophic implications” (Shedler & Block, 1990 p 628).

It seems to be expected that adolescents will at some time experiment with at least the licit drugs, tobacco and alcohol, and even cannabis is becoming more commonly acceptable for experimentation. Sellman and Deering (2002) suggest that generally alcohol, tobacco and cannabis are the first drugs to be tried by adolescents, with amphetamines, stimulants, hallucinogens and opioids used after mid adolescence if at all. Younger adolescents may also use inhalants (Sellman & Deering, 2002).

Although it is common for adolescents to use alcohol and other drugs, it is only a small percentage of adolescents that have problems with their use. About 5% of adolescents will become dependent and a further 10-15% will have other problems associated with their drug use when they become adults, with girls more likely to have problems with drug abuse and dependence in early adolescence and boys more likely to have problems in late adolescence (Sellman & Deering, 2002). The research by Sellman and Deering (2002) reinforces the concept that most adolescents will at least try licit drugs, some adolescents will try illicit drugs at least once in their lifetime, and that such experimentation is normative.

Australian adolescents grow up in a society where alcohol and tobacco is an acceptable part of daily life, although the social norms for tobacco are changing. Their use of drugs is at least on par with, and in some cases exceeds that of the general population. This information is collected in national surveys like the Australian School Student Alcohol and Drug (ASSAD) survey series and the National Drug Strategy Household Survey (NDSHS) series.

### **Adult drug use and their attitudes towards drug use**

The current statistics show that Australians commonly use tobacco, alcohol and cannabis (AIHW, 2002). In 2001, 23% of Australians aged 14 years and over had in the

last 12 months used tobacco, 82% had consumed alcohol, 13% had used cannabis, 3.4% had used amphetamines and 2.9% had used ecstasy or designer drugs. These percentages increase when examining the use of a particular drug at least once in a lifetime, with 49% who had used tobacco, 90% alcohol, 33% cannabis, 8.9% amphetamines and 6.1% ecstasy or designer drugs (AIHW, 2002).

The number of people who believed that the use of alcohol was acceptable increased to three-quarters of Australians aged 14 years or older in 2001 from two-thirds of Australians in 1998 while the acceptability of regular use of tobacco did not change between these two times and stayed at around 40%, (AIHW, 2002). The use of certain illicit drugs is also becoming more acceptable and part of the norm for some Australians. In 1995, around 2% of Australians considered regular use of ecstasy by adults to be acceptable. However when asked, in 2004, about the acceptability of ecstasy use by adults just over 4% of Australians believed that regular use of ecstasy was acceptable (AIHW, 1999, 2005).

The Australian Institute of Health and Welfare (AIHW, 2003) reported on the drug use of a number of special populations including metropolitan and non-metropolitan, and Indigenous populations. Australians living in a major city were slightly more likely to have ever used any illicit drug than Australians outside of a major city (19%, 17% respectively) although the percentage was the same (17%) in both populations for having used any illicit drug in the last 12 months. Australians outside major cities were slightly more likely to have used alcohol and tobacco (92%, 90% for alcohol, 53%, 48% for tobacco). Both urban and rural populations had the same proportion reporting having ever used cannabis and having used it in the last 12 months (33%, 13% respectively). However rural Australians aged 14 years and over were slightly less



likely to have ever tried any illicit drug excluding cannabis that their urban counterparts (17%, 19%) or have tried any illicit drug excluding cannabis in the last 12 months (7%, 9%) (AIHW, 2003).

Statistics for Indigenous peoples are less reliable than statistics for the whole population due to a number of factors. These include the accuracy of Indigenous peoples being identified in surveys, the unreliability of population estimates for Indigenous peoples and concerns regarding the applicability of the survey methods for Indigenous peoples, including cultural considerations like differing interpretations for concepts and definitions and literacy issues for self administered questionnaires (AIHW, 2003).

In spite of this potential unreliability, the evidence shows that Indigenous peoples have poorer health than non-Indigenous Australians (AIHW, 2003). They are more likely to have ever used tobacco (62%, 49%), cannabis (50%, 33%) and any other illicit drug (25%, 18%). Their use in the last 12 months for all drugs except alcohol is around two times that of non-Indigenous people (50%, 23% tobacco, 27%13% cannabis, 13%, 8% other illicit drugs). Although the proportion of Indigenous peoples that have ever consumed alcohol is the same as non-Indigenous people (91%), fewer Indigenous peoples have consumed alcohol in the last 12 months (79%, 83% respectively) (AIHW, 2003). In contrast, Indigenous peoples (49%) are more likely than non-Indigenous Australians (34%) to have consumed alcohol at risky levels in the last year. A higher proportion of Indigenous males (56%) than Indigenous females (42%) are more likely to have consumed alcohol at risky levels in the last year compared to non-Indigenous males (39%) and females (30%). There could be a number of reasons to explain the difference between Indigenous and non-Indigenous alcohol use in the last year. One reason could be that some Indigenous peoples live in alcohol free communities and so

although they have consumed alcohol at least once in their lifetime, they are now living in place that does not allow the consumption of alcohol so have not consumed alcohol in the last year. Another reason could be a methodological reason in that only a small proportion of the survey population identified themselves as someone from Indigenous descent (around 400 out of just under 27,000 (AIHW, 2003)). As such, further investigation with a larger sample is needed to verify the lower alcohol use in the last year, the higher propensity to drink at risky levels and the larger gender differences for risky drinking for Indigenous adults.

### **Information on Australian adolescent drug use**

The Australian Secondary School Alcohol and Drugs (ASSAD) Survey has collected information on secondary students' use of tobacco and alcohol every three years since 1984. Since 1996, questions on pain relievers, sleeping tablets and illicit substances such as cannabis, hallucinogens, ecstasy and opioids have been included. The researchers found, in 2002, that around 66% of 17 years olds having ever used tobacco (White & Hayman, 2004a) and around 55% of boys and 46% of girls aged 17 years have ever consumed alcohol (White & Hayman, 2004b). Cannabis was the most commonly used illicit drug with 25% of students aged 12-17 years saying that they had used cannabis sometime in their life. Nearly 6% of students had some experience with amphetamines, 5% had used ecstasy at some time and 21% had used inhalants (White & Hayman, 2004c).

The ASSAD survey series is a school-based survey. This method for collecting data on adolescent drug use is problematic for several reasons including the fact that the method does not allow the sampling of the entire adolescent population, as the adolescents who have dropped out of school or who are truant are not included.

The National Drug Strategy Household Survey (NDSHS) also collects information on Australians from the age of 14 years and as this is a household survey, the NDSHS collects information from both school students and non school adolescents. In 2001, around 25% of 14-19 year olds had ever smoked tobacco and around 75% had consumed alcohol. Just under a third of this age group had ever used cannabis, with 25% using within the last 12 months and 5% using ecstasy and 6% using amphetamines within the last 12 months (AIHW, 2003). The NDSHS, although allowing for the sampling of out of school adolescents, has the problem that it only samples private dwellings and as such, adolescents that live in boarding houses, military establishments and university halls of residence are not included in the survey.

Research has shown that drug use amongst adolescents that drop out of school could be higher than adolescents that remain at school (Adlaf, Zdanowicz & Smart, 1996; Baer, Peterson & Wells, 2004; Lenning, 1996; Yates, MacKenzie, Pennbridge & Cohen, 1988). Lenning (1996) found in his research that street or at risk adolescents have far higher rates of drugs use than those found in the general adolescent population.

Whilst much of the research on out of school adolescents and drug use has sampled at risk or homeless adolescents, the Centers for Disease Control (1994) in the United States of America and research in Australia by Tressider, Macaskill, Bennett and Nutbeam (1997) concentrated on different populations of adolescents. The Centres for Disease Control used data from the Youth Risk Behaviour Survey, which is a household survey and included an over-sampling of out of school adolescents and Tressider et al., (1997) used the Commonwealth Employment Service register to obtain their data. Both sets of researchers found that their out of school adolescents populations had higher rates of drug use than their in school counterparts.

The Centers for Disease Control (1994) reported that out of school adolescents were significantly more likely to smoke cigarettes, use alcohol, cannabis or cocaine than their in school counterparts. Tressider et al., (1997) compared their data with information on 16 year olds in the New South Wales Schools Drug and Alcohol survey and found that the out of school population had significantly higher rates of weekly tobacco and cannabis use and that out of school males also had a significantly higher rates of binge drinking than the in school group.

### **Reasons, Causes and Influences of Adolescent Drug Use**

Most researchers acknowledge that it is not one single cause that affects an adolescent's use of drugs and look for combinations of influences in their research. A large body of research exists looking into the reasons, causes and influences on the use and abuse of drugs. There are both internal and external influences and although these will affect each adolescent differently, the influences could also be affected by the geographical location, socio-economic grouping or ethnicity and as such increase or decrease the effects of these influences on the adolescent.

Spooner, Hall and Lynskey (2001) examined the social determinants of youth drug use and found that drug use is affected by a number of macro-environmental factors including economic, social and physical environment factors. They looked at the wider concept of developmental health of which drug use was only one element. They found that widening economic gaps have increased the feelings of relative deprivation and that individualism and libertarianism and physical environmental factors such as policies that move on or prohibit youth congregating together in public places have resulted in youth alienation and a sense of powerlessness. A number of factors including boredom and lack of facilities and services can contribute to the reasons that young people want

to congregate in public places. This desire does not dissipate just because they are asked to move on by the police, instead they move to places that are less visible.

Spooner et al., (2001) maintain that this move can expose them to individuals that are involved in drug marketing and thus increasing their access to drugs.

Gordon and Caltabiano (1996) looked at leisure boredom as a predictor of leisure time usage of urban and rural adolescents and found that urban adolescents had more leisure opportunities but that the more leisure opportunities and facilities available, the more likely the person is to experience leisure boredom. The more opportunities they experience, the higher the likelihood that they will tire of them and expect just as many different opportunities to replace them. Gordon and Caltabiano (1996) found that while rural adolescents reported more leisure boredom, it was the urban adolescents that reported less leisure satisfaction. They concluded that perhaps individuals with fewer opportunities and facilities learn to make do and enjoy what is available and “take more responsibility for their leisure experiences by creating their own enjoyment” (Gordon & Caltabiano, 1996 p 892).

Whilst the macro-environmental aspects of the adolescents’ environment can have detrimental effects on their decisions to use drugs, there are also a number of social factors that effect drug use. “Substance ab/use is not an isolated behaviour”, (Spooner et al., 2001 p 45) it involves a number of risk behaviours including lower academic achievement and aspirations, risky sexual behaviour, antisocial behaviour and poor self concepts. Sutherland and Shepherd (2001) investigated a number of social aspects and their influence on adolescent drug use as a function of age. Included in their research were the influence of factors such as whether the adolescent had been in trouble with the police, whether they had been suspended from school, their academic achievements

and expectations, their religious beliefs, family structure and family and peer influences. They found that many of the relationships were age sensitive. They also found that children that had been in trouble with police were nearly four and an half times more likely to use drugs, over three times more likely to use tobacco and one and an half times as likely to use alcohol. The differences between the adolescents that had been in trouble with the police and those that had not, increased with age for illicit drug use and tobacco use but decreased for alcohol use.

Sutherland and Shepard (2001) also found that drug use contributed to a number of behaviours that caused adolescents to be suspended from school with the proportion suspended increasing with age. They found that the relationship between the adolescents that were suspended and the ones that were not remained constant for cigarette use, converged after age 15 years for alcohol use but diverged over all the age range for illicit drug use indicating that there might be a normative influence of alcohol but also showing a strong relationship between suspension and illicit drug use for the older children. Sutherland and Shepard (2001) maintained that although they didn't investigate the question that it was probable that early substance use contributed to suspension in older children.

Perceptions of low academic achievement also had a strong association with drug use with low achievers two and an half times more likely to have used illicit drugs, twice as likely to smoke tobacco and nearly one and an half times more likely to drink alcohol. Religious belief was found to be a strong protective factor against all substance use. These findings confirmed those of Albrecht, Amey and Miller (1996) who found that adolescents with higher grade point average, those who viewed themselves to be above average intelligence and those who had plans for the future had lower drug use rates.

Sutherland and Shepard (2001) concluded that adolescent drug use is a complex situation which involves a number of different relationships and that “adolescent substance use increases with age and that the rate of increase is mediated by differing social variables” (Sutherland & Shepherd, 2001 p 457).

There is a large body of research that has investigated the influence of family and peers on adolescents’ use of drugs. Beman (1995) maintains that families have a major influence on whether an adolescent will use drugs. He suggested a number of reasons why this correlation was so strong including that:

- the adolescent is simply modelling the adult behaviour he/she sees;
- children learn from adult family members what is socially appropriate and if they use drugs and alcohol regularly then they are sending the message that this is normal behaviour; and
- the adolescent may start to use drugs and alcohol in order to escape or cope with their situation if they have a parent that is abusing drugs.

Adolescents also look at their peers and their attitudes towards drug use. Sutherland and Shepherd (2001) hypothesise that for substances that are perceived to be of minor importance, peer influence is stronger than family influence but for substances perceived to be more harmful that family influence is stronger. The adolescent perception of their peers’ attitudes to drug use especially in relation to alcohol use is also a strong influence. The more that adolescents think their peers drink, the more likely they themselves will drink. Although actual peer behaviour is important, Beck and Treiman (1996) discovered that perceptions of peer attitudes about drinking alcohol was more important than their peers’ approving of their drinking. This was especially the case for binge drinking. They also mentioned that their findings suggests that

adolescent alcohol use was not motivated by a need for peer approval or to be considered as part of a particular group but because they perceive that alcohol use and the level of that use to be normal behaviour in their particular set of peers.

Curran, Chassin and Stice (1997) investigated the relationship between adolescent alcohol use and peer alcohol use. They wanted to find out if adolescents who have alcohol drinking friends are more likely to drink alcohol or if alcohol drinking adolescents are more likely to gravitate towards a peer group that matches their behaviour. They concluded that the relationship was bi-directional and that their research was support for both “peer selection and peer socialisation processes in the prediction of adolescent and peer alcohol use over time” (Curran et al., 1997 p 137).

Would these social variables have similar effect on rural adolescents as they would on urban adolescents, or on adolescents from low socio-economic groups compared to their counterparts in the higher socio-economic groups? Adolescents from lower socio-economic groups could have greater incentive to get higher grades and have concrete plans for their future so that they improve their situations. Rural adolescents could strive for higher grades, avoid situations that would bring them to the notice of the police and have plans to either move into the city to get away from their hometown, or obtain qualifications in a profession so they can go back and help improve the services and facilities in their hometown.

On the other hand, could the diversity of the adolescent population as a whole mean that the above factors would have similar influence on adolescents regardless of their location or socio-economic group or ethnicity? Peters, Oetting and Edwards (1992) maintain that although rural communities differ in social structures, services and facilities from urban communities, the causes and influences that makes adolescents



susceptible to drug use are not any less likely to be present in rural societies. Whether the adolescent is in a rural or urban setting “a strong and caring family with solid values does much to protect a youth from the more serious forms of drug involvement” (Peters et al., 1992 p 26).

Another aspect of peer influence that could affect rural and perhaps Indigenous adolescents more than urban and non-Indigenous adolescents is one highlighted by Edwards (1992). She commented that because of the smaller numbers of rural adolescents, a few adolescent that use drugs could make up a significant proportion of the peer group and have a greater effect on the behaviour of that peer group than they would have in a much larger urban population where it is easier to have a number of different peer groups. Although Edwards’ (1992) research was on urban and rural differences, this rationale could also apply to Indigenous adolescents for a number of reasons. One reason could be that there are a large proportion of Indigenous peoples that live in rural and remote communities (ABS, 2004) and as such the effect mentioned in the above research could also affect them. Another reason could be that Indigenous adolescents could find themselves in the minority in the urban schools and if they have peer groups that consist solely of Indigenous friends then the effect of having only a small number of that group who used drugs could have a larger effect than if Indigenous adolescents were part of a larger peer group.

The effect of parental/authority figure influence could also be magnified because of the smaller populations in rural areas. As mentioned previously, Beman (1995) maintains that families have a major influence on whether an adolescent will use drugs and that this influence could lead to the adolescent simply modelling the adult behaviour he/she sees. Even a small number of adults who use drugs in a rural population could look as

if a large proportion of adults use drugs. As such, adolescents could see this behaviour as being normal and socially appropriate and emulate the behaviour.

There is always debate about what influences have the most prominence in adolescent drug use with researchers differing in their opinions on which have the most effect.

Randolph (2004) in her review looked at the changing nature of risk factors to see if their influence changed depending on the stage of adolescent development and if they shifted over time. She discovered five change-based mechanisms that effect adolescent drug use:

- a) changes due to historical periods, where societal norms or values have changed over time and effect the approval or disapproval of adolescent drug use.
- b) changes in the influences of risk and protective factors in relation to the different stages of development, for instance peers have little influence over younger children or preteens but have much greater influence when the adolescent gets older (Sutherland & Shepherd, 2001)
- c) the progression to harder drugs from softer ones or the Gateway theory, this mechanism relates to time as an element in the progression of substance use that occurs for some adolescents. Research has found that age of first use of drugs can affect the use of harder drugs later in adolescence. Welt and Barnes (1985) concluded that the use of a particular drug makes the use of the next drug in sequence more likely and that “alcohol use precedes all other drug use.” (Welte & Barnes, 1985 p. 497);
- d) the building of connecting risk factor over time, this is different from c) in that it doesn't necessarily mean that there is a progression in severity and it also includes risk factor beyond the choice of drug. O'Donnell, Hawkins and Abbott's (1995)

antisocial model is one such chain as it describes the development of antisocial behaviour by providing temporal links between perceived opportunities for antisocial activities, interaction with antisocial others and rewards for antisocial behaviour;

- e) cumulative risk, the co-occurrence of risk factors and their cumulative effect on substance abuse. A number of researchers have researched this phenomenon and have found that risk factors have an interactive effect rather than an additive effect. Newcomb and Felix-Ortiz (1992) identified seven risk factors that are positively related to drug use: low educational ambition, lack of perceived future opportunities, deviant behaviour, lack of community support, perceived adult drug use, perceived peer drug use, and the availability of drugs. Newcomb, Maddahian and Benler (1986) found that the risk of daily cannabis use more than doubled for adolescents that had seven or more risk factors compared with those that had only six risk factors.

Randolph's (2004) research looked at the risk factors in adolescent drug use and how these factors changed over time. She found that the five time related mechanisms showed "that risk factors associated with adolescent substance use are dynamic in that their relationship to substance use among teenagers changes over time" (Randolph, 2004 p 43). She concluded that these mechanisms are useful as a way to understand the dynamic nature of risk factors associated with drug use among adolescents.

### **Differences in Drug Use for Urban and Rural Areas**

The data on differences between Australian metropolitan and non metropolitan populations' drug use, reported by the AIHW mentioned previously, is corroborated by the research performed by Hall, Teesson, Lynskey and Degenhardt (1999) who found

that adults in rural areas in Australia were more likely to use alcohol and tobacco than urban adults but less likely to use illicit substances. On the other hand, for students, White, Hayman, Wakefield and Hill (2003) found that there was little difference between metropolitan and rural students in their analysis of tobacco smoking trends among Victorian secondary school students. They discovered that this similarity was mainly due to the smokers aged 14 and above which shows similar trends, but for the 12-13 year age group there was a difference between the two areas with urban students more likely than the rural students of the same age to smoke tobacco. When controlling for differences in school type and for gender, these differences did not continue into the older age groups.

Although there is not a large amount of research on the differences between urban and rural adolescent drug use in Australia, there is research performed in America and other countries that could give some indication of trends that might be expected in Australia. This research concludes that although rural living used to be a protective factor for adolescent drug use it would appear that this protection has disappeared in recent years with rural adolescent drug use rates converging with urban drug use rates (Albrecht, et al., 1996; Alvarez, et al., 1989; Beauvais & Segal, 1992; Cockerham, 1977; Edwards, 1992; Forsyth & Barnard, 1999; French & Pichall-French, 1998; Sandi, Diaz, & Uglade, 2002).

Cronk and Sarvela (1997) in their secondary analysis of the Monitoring the Future data set found that although alcohol use rates for rural adolescents were similar to urban adolescents in 1992, that rural males were more likely to binge drink and drink alcohol daily than their urban counterparts. Their analysis also showed that over the sixteen years that the Monitoring the Future survey data was collected that although rural

adolescent drug use was lower than urban adolescents' to begin with, the rates had converged by the end of the survey series. This result was despite the decline in overall use for most drugs.

Cronk and Sarvela (1997) maintained that there were two trends in the differences between the urban and rural students. The first is that, for the licit substances, rural students had similar or higher use for the whole time period. This is most apparent for binge drinking and smoking at least 30 cigarettes a day. The second contrast between the groups is for cannabis and cocaine use where prevalence in urban areas exceeds that in rural areas in 1976 but this difference is much reduced by 1992. Cronk and Sarvela (1997) suggested a number of reasons why the rates were converging including that drug availability had changed in rural areas, that prevention efforts were less effective in rural areas or that the protective factors that helped in keeping the rates of drug use down in rural areas have changed in the 16 year period. They also suggested that it could also be that urban youth have reduced levels of drug use because of the success of the prevention activities that promote a greater knowledge of the problems associated with drug use.

Peters et al., (1992) maintain that the isolation of small rural towns that once contributed to rural protection against a number of problems including drug use has decreased with the increase of technology. Easier access to communication systems including mobile phones, satellite television, DVDs and computers and faster transport has contributed to a reduction of the isolation leading to rural adolescents becoming more like their urban counterparts.

Oetting and Beauvais (1990) concluded in their research that there is no protection from drug use by living in a rural area, the availability and choice of drugs in rural regions

were similar to urban areas as are the prevalence rates for having ever used specific drugs. This finding was also corroborated by Peters et al., (1992) who found similar levels of drug use in both rural and urban eighth and twelfth graders. They stated that generally younger adolescents from small rural towns are less likely to use drugs than those in larger rural towns or urban areas but that this difference disappears for older adolescents. They found that generally rural adolescents were just as likely to experiment with drugs, regularly use the same drug and the frequency of use was not different. They concluded “ the myth of the idyllic small country town that is synonymous with a *clean and wholesome*, drug free environment is just that – a myth” (Authors' emphasis Peters, et al., 1992 pp 22-23).

Another aspect that needs to be considered when looking at the differences between rural and urban populations is that areas will not be homogeneous and that classifying an area either rural or urban will cover a magnitude of differences. Rural areas will differ in their characteristic to each other, as will urban areas.

Peters et al., (1992) maintained that there was a wealth of differences between the rural areas in that some had problems with drug use that were far greater than urban areas and some had much lower rates of drug use. As mentioned previously, they also highlighted the fact that in rural settings with the much smaller population of adolescents only a small number of adolescents that are using drugs could have a number of effects. As well as having a greater effect on their peer group because of the smaller numbers of adolescents, they can also distort the overall percentage of adolescents using drugs making it seem like there is a much larger problem than it is (i.e. if five adolescents in a group of ten are using drugs then that is 50% of that population using drugs, but if five adolescents in a group of 100 are using drugs then that is only 5% of that population

taking drugs).

### **Aspects of rural living that could effect substance use**

Living in small rural environments where everyone knows each other can have both advantages and disadvantages. Murray and Berends (1998) mention that some of the rural participants in their research said that they believed that they had better quality education as teachers know all the students and that the schools were smaller. A disadvantage is that transgressions are remembered and could affect adolescent chances for employment.

Edwards (1992) maintains that while living in a rural environment does not protect people from the problems of society, a protective factor for young rural children, which could delay their exposure to drugs, is the fact that everyone knows each other.

Undesirable behaviour of children such as buying inhalant substances or getting drunk is more likely to be observed by someone who knows them and be reported to their parents.

It used to be a common belief that rural living was healthier than living in a big city (AIHW, 1998). Whilst there are some advantages of living in the country, there are a number of disadvantages not least of which are social isolation and the difficulty in accessing health services, both of which can affect developmental health. Most Australian governments' youth policies talk about the importance of ensuring that young people have ready access to services including health, transport, recreation, housing and employment. Spooner et al., (2001) noted that studies of young people in rural areas have shown that they feel their location is a disadvantage to service provision.

The AIHW noted in their publication *Health in Rural and Remote Australia* (1998) that there are a number of factors that can add to the health disadvantage in rural communities including:

- geographic isolation and problems of access to care;
- shortage of health care providers and health services
- socio-economic disparities;
- small sparsely distributed populations; and
- Indigenous health needs

These factors and a number of other factors that would relate to mental health, social and community disadvantage could have an impact on the use of drugs in these communities. The other factors include the lack of recreational activities, effects of climatic changes on the livelihood of the communities, the physical isolation and the lack of proper transportation, lack of employment and educational opportunities and entrenched social divisions.

As mentioned previously, rural populations are not a homogenous group. Edwards (1992) mentions that differing rural towns can have similar population numbers but are nothing alike in their characteristics. They can vary widely in socio-economic conditions, ethnic mixes and balance, stability, degree of isolation from a variety of services. Even minor differences such as predominantly farm versus rural but non-farming, ethnic balance and history of a community could have an effect on adolescent drug use (Edwards, 1992).

The higher proportion of Indigenous peoples in rural areas could also have an effect on the rates of substance use. National statistics for rural and urban Indigenous peoples are available from the Indigenous Social Survey run by the Australian Bureau of Statistics.



These statistics show that a significant number of Indigenous people aged 15 years and over live in rural and remote locations. New South Wales and Queensland have the largest population of Indigenous peoples but Northern Territory have the largest representation of Indigenous peoples in their total population (ABS, 2004). As mentioned previously, Indigenous peoples' rates of substance use are higher than non-Indigenous people so as such could this then cause rural adolescents rates of substance abuse to be higher than urban adolescent.

### **Indigenous substance use in other countries**

Research also shows that Australia is not the only country that has high Indigenous drug use rates. In research that looked at patterns over a twenty-five year period of drug use for American Indian youth in the eighth, tenth and twelfth grade, it was found that the rates of drug use for all drugs were higher for American Indians than for non-Indians especially for cannabis use (Beauvais, Jumper-Thurman, Helm, Plested, & Burnside, 2004).

Although American Indian youth have much higher rates of drug use than non Indian youth the trends over time are similar with large increases in the early 1980s followed by a gradual decline until around 1992 when the rates started to rise again. Inhalants are the one exception where American Indians' use was very high for a number of years, but has now dropped to a level comparable to that of other non-Indian youth (Beauvais et al., 2004).

### **Indigenous Australians' substance use**

Finding information on Australian Indigenous adolescent substance use is difficult in that most of the data collected is for particular groups in a particular State or Territory. Dunne, Yeo and Keane (2000) and Forero, Bauman, Chen and Flaherty (1999)

examined Queensland primary school students and New South Wales secondary school students respectively. Gray, Morfitt, Ryan and Williams (1997) examined young Indigenous people in Albany Western Australia and Lowe et al., (2004) research examined tobacco use among Indigenous secondary school students in North Queensland.

Dunne et al., (2002) found that for the primary students there were no significant differences between the students of Indigenous descent and non-Indigenous students in their use of tobacco and alcohol. Although they found no overall difference, they found that smoking for both Indigenous and non-Indigenous students was more prevalent in remote communities than in metropolitan areas. Conversely, the prevalence of alcohol consumption was higher in metropolitan areas than the rural communities for both Indigenous and non-Indigenous students.

Forero et al., (1999) found that Indigenous secondary school students were more likely to use drugs and would maintain a higher use of the substance than non-Indigenous students. They also found that more Indigenous students than their counterparts would smoke tobacco weekly (31%, 21% respectively). Although the percentage that consumed alcohol regularly was similar for both Indigenous and non-Indigenous students, the former were seven times more likely to believe that they were heavy drinkers. Over 50% of Indigenous, secondary school students reported hazardous drinking compared to 34% of students who were not from Indigenous descent.

Gray et al., (1997) collected information on a variety of drug use for Indigenous adolescents in Albany but was only able to report comparisons for alcohol and tobacco use as there was no studies of illicit drug use among non-Indigenous people that were directly comparable to their study population. They found that for tobacco use that

there were similar proportions of Indigenous and non-Indigenous adolescents that had smoked tobacco in the last year, but there were a larger proportion of the former group of adolescents that has smoked tobacco in the last month or last week. For alcohol, the non-Indigenous adolescents were more likely to have consumed alcohol in the last year, month and week. Nearly 45% of Indigenous adolescents aged 15-17 years in this study used cannabis frequently and 37% were occasional users, 48% had sniffed solvents at least once in their lifetimes.

Similar to the Indigenous adults, these researchers found that Indigenous adolescents are more likely to smoke tobacco and use illicit drugs than are non-Indigenous adolescents. Alcohol consumption by the adolescents was one area where the researchers did not agree. Although none of the researchers found that more Indigenous adolescents consumed alcohol than non-Indigenous adolescents, some of the researchers found that the rates were similar for both groups and others found that Indigenous alcohol use was lower than non-Indigenous alcohol use.

#### **Substance use by people in different socio-economic status groups**

Johnston et al., (2004) looked at whether family socio-economic status affected adolescent drug use. They found that although by the twelfth grade there was very little difference in drug use between the adolescents in the different socio economic groups, there were differences for eighth grade students. They had two explanations for this phenomenon, one that by grade twelve; the students in the higher socio-economic groups had just caught up with their peers in the lower groups. The other explanation is that there are more of adolescents in the lower socio-economic groups that leave school early and that out of school adolescent have higher drug use rates. It could mean that by

the twelfth grade students in the lower socio-economic groups that use drugs have simply dropped out of school and so are not monitored in the survey.

Oetting and Beauvais (1990) also found what they considered to be the most important factor of their research that the highest rates of drug use amongst adolescents are among those who are part of economically disadvantaged minorities who live in ghettos, barrios and Indian reservations. They also found that this disadvantage didn't translate to the same minorities when they lived in other environments.

A number of researcher have looked at licit drug use by people in the different socio-economic status groups and found that in England that there was a higher proportion of people in the lower socio-economic status group that smoke tobacco (Marmot, 1997).

Marmot also found in his study of civil servants that the higher the grade of worker, i.e. the more senior the worker, the greater the possibility that they would consume alcohol, although there was little difference between the grades for heavy drinking. Casswell, Pledger and Hooper (2003) also found that frequency of drinking by both men and women was affected most clearly by income with those with a higher income drinking more often. This relationship persisted over teenage and young adult years. In contrast to Marmot's finding that there were little or no difference for heavy drinking between the grades of civil servants, Neumark, Rehav and Jaffe (2003) found that it was the respondents with average or above average income, those with at least a high school education, and non-manual laborers, who were 30–60% less likely compared with the respective lower SES groups to report binge drinking.

It would seem from the research that there are conflicting impressions on how socio-economic status can affect drug use. For tobacco, it would seem that the more economically disadvantaged people would smoke this drug. For illicit drug use, more

younger students in lower socio-economic groups would use these substances than their counterparts in the higher socio-economic groups, but this difference would disappear for older students. Conversely, for alcohol, it would seem that higher income earners are more likely to consume alcohol. None of the research cited above is from Australia, only one involving adolescents, and as such, it could be problematic to generalise these results to Australian adolescents.

### **Objectives of this research project**

The overall goals of this research were to gain more information on drug use of Australian adolescents, using existing data sets. The Australian School Student Alcohol and Drug (ASSAD) survey series and the National Drug Strategy Household Survey (NDSHS) series are typically analysed to show overall, national rates of adolescent drug use. Although these data sets collect data on locality, Indigenous descent and socio-economic status, this information has not been used to explore the differences in drug use between adolescents in rural and urban areas, Indigenous and non Indigenous adolescents or adolescents in differing socio-economic groups.

There is not a large amount of research on the differences between urban and rural adolescent drug use in Australia or national information on drug use by Indigenous adolescents either using these data sets or other data. Information that is available seems to concentrate on adolescent drug use in particular areas or states rather than national adolescent drug use analysed by geographical location and for national Indigenous adolescents drug use.

This research examined, using a number of different age groups, the differences in adolescent drug use between urban and rural Australia for lifetime use, use in the last year and use in the last month using the 2002 edition of the ASSAD survey series in

conjunction with the 2001 NDSHS. It also used these data sets to investigate differences between Indigenous adolescents and non-Indigenous adolescents and whether there were any differences in adolescent drug use across socio-economic status groups.

Four hypotheses were generated for this research. The first two were developed to explain any difference in drug use between urban and rural adolescents. Hall et al., (1999) maintained that for Australian adolescents, rural adolescents are more likely than urban adolescents to use licit drugs and urban adolescents are more likely than rural adolescents to use illicit drugs. As such hypothesis<sup>1</sup> - that a higher proportion of rural adolescents than urban adolescents will use licit substance - and hypothesis<sup>2</sup> - that a higher proportion of urban adolescents than rural adolescents will use illicit substances - were generated to examine this premise in this research.

Although the research for Indigenous adolescents is undecided on whether Indigenous adolescents are more likely than non-Indigenous adolescents to consume alcohol, they do agree that Indigenous adolescents are more likely than non-Indigenous adolescents to use tobacco and illicit drugs. It was decided that despite the contradictory results for alcohol consumption that the hypothesis for Indigenous drug use would look at both licit and illicit drugs together and hypothesis<sup>3</sup> - that a higher proportion of Indigenous adolescent than non-Indigenous adolescents will use licit and illicit substances - was developed.

The research on the effect socio-economic status (SES) has on drug use is also contradictory and many of the researchers did not have adolescents in their samples. The secondary analysis on the “Monitoring the Future” survey series seems to believe that the adolescents in the lower SES groups are more likely the adolescents in the

higher SES groups to use drugs and that any convergence between the groups in later adolescents could be explained by the likelihood of students in the lower SES groups leaving school early. As such, hypothesis<sup>4</sup> - that a higher proportion of adolescents from low socio-economic status (SES) groups than adolescents from high SES groups will use licit and illicit substances – was generated to examine the effects that socio-economic status will have on adolescents' propensity to use drugs.

Accordingly the four hypotheses that will be examined in this research are:

- Hypothesis<sup>1</sup> that a higher proportion of rural adolescents than urban adolescents will use licit substance.
- Hypothesis<sup>2</sup> that a higher proportion of urban adolescents than rural adolescents will use illicit substances.
- Hypothesis<sup>3</sup> that a higher proportion of Indigenous adolescent than non-Indigenous adolescents will use licit and illicit substances.
- Hypothesis<sup>4</sup> that a higher proportion of adolescents from low socio-economic status (SES) groups than adolescents from high SES groups will use licit and illicit substances.

Three timeframes were examined for each of these hypotheses. These looked at whether adolescents had at least once in their lifetime used a substance, whether they had used the particular substance in the last year or in the last month. Cross tabulations were used to obtain proportions and Chi squared analyses were used to examine whether there were significant differences between the different populations of adolescents.





## **METHODOLOGY**

### **Australian School Student Alcohol and Drugs survey series**

The Australian Secondary Students' Alcohol and Drug (ASSAD) survey series currently has seven surveys in a series monitoring the use of tobacco, alcohol and other substances among adolescents throughout Australia. ASSAD arose from a three yearly survey of secondary school students' use of tobacco and alcohol commencing in 1984. In 1996, the survey was expanded to include questions on the use of illicit and over the counter substances.

In 2002, the target population included all students in years 7 to 12 across Australia in schools that had at least 100 pupils. A stratified two-stage probability sample was used. The schools were stratified by the three education sectors (government, Catholic and independent) and randomly selected from each sector. Out of 558 secondary schools selected, 363 schools participated in the study, giving an overall response rate of 65%. Twenty students from each year for years 7 to 10 and 40 students from years 11 & 12 were surveyed in each school. Following the protocol used in past surveys, members of the research team administered the pencil-and-paper questionnaire (see Appendix One for sample of survey questionnaire) to groups of up to 20 students on the school premises. The questionnaires were anonymous and teachers' presence during the survey was discouraged.

The questionnaire collected background information which included information on suburb or town, postcode, year level, age, gender, date of birth, how much money they have available to spend on themselves, main language spoken at home and whether they are of Indigenous descent. It asked a number of questions on the use of tobacco, alcohol and other drugs including:

- whether the student had used the substance at least once in their life;
- whether the student had used the substance in the last year, month or week.
- in the case of a student identifying that they had used cannabis, ecstasy, amphetamines, and hallucinogens in the last year, they were also asked what other substances they used at the same time.

The substances covered and descriptions given to the students are:

- pain killers/ analgesics - Disprin', Panadol' or 'Aspro';
- steroids – muscles or roids without a doctor's prescription to make you better at sport, increase muscle size or improve your general appearance;
- cannabis - marijuana, grass, hash, cannabis, dope, weed, mull, pot or a joint;
- opiates – heroin, smack, horse, skag or other opiates (narcotics) such as methadone, morphine or pethadine,
- amphetamines - speed, uppers, MDA, Ritalin, 'Dex', Dexamphetamine, ox blood;
- cocaine - crack;
- hallucinogens - LSD, 'acid', 'trips', Magic Mushrooms, Datura, Angel's Trumpet,
- ecstasy/designer drugs - XTC, E, MDMA, Eccci, X; and
- inhalants - deliberately sniffed (inhaled) from spray cans or sniffed things like glue, paint, petrol or thinners in order to get high or for the way it makes you feel.

A total of 23,417 students aged between 12 and 17 years of age across the country answered the questionnaire in 2002. Data from 986 students outside this age range were excluded from the analysis as the numbers in each age and gender group were too small to ensure reliable estimates. Seventeen per cent of students surveyed were absent from school on the school day preceding the survey. As students that are absent from school are more likely to have injected drugs at least sometime in their lifetime, it is

likely that these data underestimate the true prevalence of alcohol drinking, smoking and taking of illicit and over the counter drugs among secondary school students and the rates could have been higher if those absent on the day of the survey had been included (White & Hayman, 2004c). Table 1 presents the number of students in each gender and age group between 12 and 17 years answering questions (White & Hayman, 2004b).

**Table 1: Number of students surveyed in 2002 by age and gender.**

Gender	Age (years)						
	12	13	14	15	16	17	12-17
Male	1401	2317	2390	2375	1819	1344	11646
Female	1471	2287	2248	2197	1995	1573	11771
Total	2872	4604	4638	4572	3814	2917	23417

Source: Australian Secondary School's Alcohol and Drugs survey

### **National Drug Strategy Household Survey series**

The 2001 National Drug Strategy Household Survey is the seventh in a series of national household surveys to examine current awareness, attitudes and behaviour related to drugs and drug problems, usage of drugs, and to assess changes in these attitudes and usage over the period 1985-2001. The six earlier studies are Social Issues in Australia, 1985, the National Campaign Against Drug Abuse Social Issues Survey, 1988, the National Campaign Against Drug Abuse Social Issues Survey, 1991, the National Campaign Against Drug Abuse Social Issues Survey, 1993, the National Drug Strategy Household Survey, 1995 and the National Drug Strategy Household Survey, 1998. A supplement was also carried out targeting the urban Aboriginal and Torres Strait Islander populations in 1994 (see Appendix Two for a sample of survey questions).

In 2001, the sampling procedure was a stratified multi-stage sample with 15 strata. The ACT was one stratum, with two strata for each other state or territory - one for capital city and one for rest of state. Three different collection methodologies were employed.

1. Face-to-face interviews: This sample was designed to result in 2000 face-to-face interviews across the eight capital cities.
2. Drop and collect interviews (Capital Cities only): This sample was designed to result in 16,000 completed questionnaires. Sampling in WA and SA was designed to result in the proportion of 20,000 interviews reflecting their population share, Tasmania, ACT and NT were over sampled aiming for 1,000 responses in each area, and the remaining sample was divided between NSW, Victoria and Queensland according to size of population in each state.
3. CATI (Computer Assisted Telephone Interviewing): This sample was designed to result in 2000 CATI interviews across the 15 strata, with the number of interviews per strata proportional to population. Phone numbers were randomly selected from a white pages listing, discarding any numbers drawn from previously sampled Census Collector Districts (CCDs).

A sealed section of the questionnaire allowed respondents to indicate their usage of each drug without the interviewer being aware of their answers. In addition, self-completion questionnaires were administered to two supplementary samples. Table 2 presents the number of respondents aged 14 to 24 years by age and gender who participated in the survey.

**Table 2: Number of respondents aged 14 –24 years by age and gender in 2001**

Gender	Age (years)											
	14	15	16	17	18	19	20	21	22	23	24	14-24
<b>Males</b>	166	174	187	191	173	164	171	138	170	174	165	1873
<b>Females</b>	145	192	217	205	238	194	203	207	225	246	231	2303
<b>Total</b>	311	366	404	396	411	358	374	345	395	420	396	4176

Source: National Drug Strategy Household Survey 2001, Australian Social Science Data Archives

Background variables collected included state, urban/rural (information available is aggregated to capital city/rest of state), sex, age, marital status, Indigenous status, country of birth, language spoken at home, employment status, occupation, educational attainment, income and household descriptions. As with the previous surveys in the series, the 2001 survey questionnaire asked people aged 14 years and above about their degree of concern regarding various social issues and drugs. The substance covered were: tobacco/cigarettes, alcohol, pain killers/ analgesics, tranquillisers, steroids, barbiturates, marijuana, heroin, methadone, other opiates, amphetamines, cocaine, hallucinogens including LSD, ecstasy/designer drugs and inhalants.

A number of questions were asked about each substance. For tobacco, respondents were asked to indicate if they had ever smoked a full cigarette and at what age, if they had smoked at least 100 cigarettes, whether they had ever smoked on a daily basis, when they had stopped smoking and if they had ever smoked cigars or a pipe. For alcohol, respondents were asked to indicate whether they had ever had a full serve of alcohol and at what age, if they have had a drink of alcohol in the last year, what type of alcohol they usually used and how many standard drinks they have had in the last week. For illicit substances, respondents were asked to indicate if they had used the substance at least once in their life, had used in the last year, month and week, how often in the

last week they had used a substance, whether they used other substances at the same time, where they got the substance from and by what method they used the substance. Both datasets were used in order to gain a more comprehensive view of adolescent drug use. As the ASSAD survey series only surveys adolescents that are currently in schools, it was felt that this could underestimate the rates of adolescent drug use because it does not allow the sampling of the entire adolescent population, as the adolescents who have dropped out of school or who are truant are not included. Research has shown that drug use amongst these adolescents could be higher than adolescents that remain at school (Adlaf, et al., 1996; Baer, et al., 2004; Lenning, 1996; Yates, et al., 1988). Therefore, the 2001 National Drug Strategy Household Survey was used to obtain information on adolescents that might not necessarily be attending school. The other advantage of using the Household Survey was that it was not restricted to adolescents and included older ages, which gave the opportunity to look at older adolescents, and those who are in their early twenties. An advantage of using the ASSAD survey was the large number of respondents included in the survey, with over 23, 000 secondary students nationally completing the survey in 2002. This compared to the 1,450 14-17 year olds and 2,700 people aged 18-24 years in the NDSHS.

#### **Statistical analysis of the ASSAD Survey data**

Secondary analysis was performed on the ASSAD data using SPSS. This data covers school students aged 12–17 years. To ensure that disproportionate sampling of any State, school type, age level and gender grouping did not bias the prevalence estimates, data were weighted to bring the achieved sample into line with the population distribution. The prevalence estimates were based on these weighted data. Information about the enrolment details of male and female students in each age group at

government, Catholic and independent schools was obtained from the Australian Bureau of Statistics (ABS, 2003). Using 95% confidence intervals, the prevalence estimates reported here are within 2.6% or better of the true population values (White & Hayman, 2004c). The data were separated out into two groups for the urban/rural analysis with the students in the larger rural cities like Newcastle and Wollongong classified as urban. This categorisation was slightly different to how location information was categorised for the NDSHS, where the location variable in the public access computer file is categorised to capital city and rest of state. Indigenous information was supplied in response to a question, which asked if the student was of Indigenous descent. The question had four options

- No
- Yes – Aboriginal descent
- Yes – Torres Strait Islander descent
- Yes – both Aboriginal and Torres Strait Islander.

For the analysis, the last three categories were recoded to form one single category for Indigenous descent. Analysis for the socio-economic segment which used socio-economic status (SES) groups to differentiate the different groups of adolescents was performed using a SEIFA Quintiles variable. Percentages of students were calculated for drugs use at least once in their lifetime, for use in the last year and last month. Chi squared analyses were used to examine whether there were significant difference between the different populations of students.

Because the ASSAD study used a two-stage sampling procedure, the sample was less efficient than a simple random sample of the same size. The school sample is a complex sample design--selecting schools and then students within the schools - so the

students are not independent. Strictly speaking analysis should have been performed by a statistical package that would take into account the fact that the students in the sample are not independent and there would use a procedure that takes this clustering into account (increasing the size of confidence intervals or standard errors). Analysis was in fact done by SPSS, which does not take into this into account, however this makes little difference to the findings at the  $p < .001$  level and  $p < .01$  significance levels (personal correspondence with Dr V. White, Centre for Behavioural Research in Cancer dated 21 December 2004).

#### **Statistical analysis of the National Drug Strategy Household Survey data**

Secondary analysis of the 2001 sample was performed with SPSS. Only data from ages 14-24 years were included in the analysis. This survey was designed to provide (within each geographic stratum) a close-to-random sample of households with an unbiased selection of respondents from each household. However, the samples required weighting to correct for imbalances arising in the design and execution of the sampling. Each respondent was assigned a weight designed to counteract this imbalance overall.

- The disproportionate sampling by region meant that it was necessary to attach lower weights to respondents from relatively over-sampled regions and higher weights to respondents from relatively under-sampled regions.
- Households were selected with equal probability, meaning that the probability of selection of an individual was inversely proportional to the number of persons aged 14+ in the household, this probability being taken into account in the calculation of the individual's weight, so that respondents in households of different sizes were represented in their due proportions.



- Cooperation could not be obtained from all selected households, or from all selected respondents. These non-cooperators were not necessarily typical of the populations being sampled. (Roy Morgan Research, 2002)

A number of different weights were calculated as part of the weighting process including a household size, demographic or non-response and a within-sample-and-stratum relative weight. Three combined weights were also calculated: within-sample absolute weight; combined-sample absolute weight and combined-sample absolute weight (excluding CATI sample). The combined-sample absolute weight was used for the analysis in this report as suggested by the AIHW in their technical documentation that is part of the Australian Social Science Data Archives. The prevalence estimates in the research were based on these weighted data.

The NDSHS dataset supplied by the Australian Social Science Data Archives is a public use Confidentialised Unit Record File, which has already aggregated the locality information to ensure confidentiality of the dataset and has a variable that has the following categories:

<b>Urban</b>	<b>Rural</b>
Brisbane	Rest of Queensland
Sydney	Rest of New South Wales
Melbourne	Rest of Victoria
Hobart	Rest of Tasmania
Adelaide	Rest of South Australia
Perth	Rest of Western Australia
Darwin	Rest of Northern Territory
Australian Capital Territory	

This variable was used to obtain data on the two geographical areas of urban/rural with all capital cities and the Australian Capital Territory classified as urban and all the other categories categorised as rural as shown above. Indigenous information was supplied in response to a question, which asked if the respondent was from Indigenous descent.

The question was similar to that of the ASSAD survey with four options

- No
- Yes – Aboriginal descent
- Yes – Torres Strait Islander descent
- Yes – both Aboriginal and Torres Strait Islander.

For the analysis, the last three categories were recoded to form one single category for Aboriginal and Torres Strait Islander descent. Analysis for the socio-economic segment that used socio-economic status (SES) groups to differentiate the different groups of adolescents was performed using a SEIFA Quintiles variable. Only the data for respondents aged 14-24 years old were used for the analysis. The data were aggregated into two age groups of 14-17 years and 18-24 years. Cross tabulations were used to obtain proportions for this survey and Chi squared analyses were used to examine whether there were significant differences between the different populations of adolescents.

## RESULTS

### Urban rural differences

Tables 3 and 4 show that hypothesis<sup>1</sup> - that a higher proportion of rural adolescents than urban adolescents will use licit substances - is supported by the Australian Secondary Student Alcohol and Drug (ASSAD) survey data but not the National Drug Strategy Household Survey (NDSHS) data. Hypothesis<sup>2</sup>, - that a higher proportion of urban adolescents than rural adolescents will use illicit substances - is not supported by either data set and in fact, the converse may be true.

Results from the ASSAD survey show that 51% of rural students have ever smoked tobacco compared to 44% of urban students ( $\chi^2 (1) = 94.91 p < .001$ ). Also more rural students than urban students continue to smoke tobacco with one third smoking in the last year ( $\chi^2 (1) = 40.57 p < .001$ ) and one fifth in the last month ( $\chi^2 (1) = 24.62 p < .001$ ) compared to 29 % of urban students smoking in the last year and 17% in the last month (Table 3).

Rural students are also more likely than urban students to have consumed alcohol with 92% of rural and 86% of urban students ever having consumed alcohol ( $\chi^2 (1) = 214.93 p < .001$ ), and 78% of rural students and 70% of urban students have consumed alcohol in the last year ( $\chi^2 (1) = 181.12 p < .001$ ) and 56% of rural students and 45% of urban students consuming alcohol in the last month ( $\chi^2 (1) = 232.93 p < .001$ ).

Contrary to what was hypothesised, more rural students than urban students having used any illicit drugs with 29% having ever used illicit drugs ( $\chi^2 (1) = 10.58 p = .001$ ), 24% have used in the last year ( $\chi^2 (1) = 41.68 p < .001$ ) and 14% in the last month ( $\chi^2 (1) = 30.03 p = .001$ ). This pattern changes, however, when cannabis is removed from the group of illicit substances, with the numbers of students who have tried illicit substances excluding cannabis similar for both groups. About 10% of adolescents

regardless of their location are likely to have tried an illicit substance at least once in their lifetime, 8% in the last year and 2% in the last month.

**Table 3: Prevalence of lifetime use, use in the last year and in the last month of licit and illicit drugs among Australian secondary school students aged 12-17 years by geographical location in 2002.**

	Urban (%)	Rural (%)	$\chi^2$ value (df)	p value (n=22958)
Ever smoked a cigarette	44	51	94.91 (1)	< .001
Smoked a cigarette in last year	29	33	40.57 (1)	< .001
Smoked a cigarette in last month	17	20	24.62 (1)	< .001
Ever drank alcohol	86	92	214.93 (1)	< .001
Drank alcohol in last year	70	78	181.12 (1)	< .001
Drank alcohol in last month	45	56	232.93 (1)	< .001
Ever tried any illicit substances	27	29	10.58 (1)	.001
Used any illicit substances in last year	21	24	41.68 (1)	< .001
Used any illicit substances in last month	11	14	30.03(1)	.001
Ever tried any illicit substances excluding cannabis	11	10	0.19 (1)	.657
Used any illicit substances excluding cannabis in last year	8	8	0.86 (1)	.353
Used any illicit substances excluding cannabis in last month	2	2	0.35 (1)	.552

Source: Australian School Students' Alcohol and Drugs survey – Centre for Behavioural Research in Cancer.

As can be seen from Table 4, which show data from the NDSHS, almost 50% of rural 18-24 year old adolescents are likely to have smoked at least 100 cigarettes compared to 39% of their urban counterparts ( $\chi^2 (2) = 11.24 p = .004$ ). More urban than rural 18 - 24 year olds have tried any illicit substance excluding cannabis at least once in their lifetime, or in the last year or month. The differences between the urban and rural populations gradually decrease over the three time frames with 36% of urban 18-24 year olds having ever used illicit drugs excluding cannabis compared to 29% of rural 18 - 24 year olds ( $\chi^2 (1) = 12.62 p < .001$ ), 22% compared to 18% for use in last year ( $\chi^2 (1) = 15.41 p < .001$ ) and 11% compared to 9% for use in the last month ( $\chi^2 (1) = 8.56 p = .003$ ). Also, more urban 18-24 year old adolescents have used any illicit substance in the last year ( $\chi^2 (1) = 8.59 p = .003$ ) compared to rural adolescents of the same age. Consumption of alcohol in 18-24 year olds is similar for both groups with

around 97% having consumed alcohol in their lifetime and 90% having consumed alcohol in the last year. The NDSHS data show that similar numbers of urban and rural 14 – 17 year old adolescents use both licit and illicit drugs.

**Table 4: Prevalence of lifetime use, use in the last year and in the last month of licit and illicit drugs among Australian adolescents aged 14-17 and 18 – 24 years by geographical location in 2001.**

	Urban (%)	Rural (%)	$\chi^2$ value (df)	p value
	<b>14-17 years</b>		<b>(n= 1477)</b>	
Ever smoked a cigarette	53	56	2.45 (2)	.294
Smoked at least 100 cigarette	46	47	0.25 (1)	.620
Ever drank alcohol	88	92	3.27 (2)	.194
Consumed alcohol in last year	67	73	0.60 (1)	.742
Ever tried any illicit substances	32	37	3.94 (1)	.047
Used any illicit substances in last year	23	23	0.06 (1)	.807
Used any illicit substances in last month	12	13	0.42(1)	.515
Ever tried any illicit substances excluding cannabis	13	14	0.04 (1)	.839
Used any illicit substances excluding cannabis in last year	9	8	0.21(1)	.648
Used any illicit substances excluding cannabis in last month	4	4	0.35	.553
	<b>18-24 years</b>		<b>(n= 2699)</b>	
Ever smoked a cigarette	76	80	3.78 (2)	.151
Smoked at least 100 cigarette	39	48	11.24 (2)	.004
Ever drank alcohol	96	98	6.04 (2)	.049
Consumed alcohol in last year	89	92	1.09 (1)	.296
Ever tried any illicit substances	61	60	0.06 (1)	.802
Used any illicit substances in last year	38	35	8.59 (1)	.003
Used any illicit substances in last month	22	23	2.42 (1)	.120
Ever tried any illicit substances excluding cannabis	36	29	12.62 (1)	< .001
Used any illicit substances excluding cannabis in last year	22	18	15.41 (1)	< .001
Used any illicit substances excluding cannabis in last month	11	9	8.56	.003

Source: National Drug Strategy Household Survey 2001, Australian Social Science Data Archives

### Indigenous differences

Hypothesis<sup>3</sup>, which states that a higher proportion of Indigenous adolescents than non-Indigenous adolescents will use licit and illicit substances, was not supported by either dataset and in fact there is some evidence to the contrary. Table 5 show data from the ASSAD survey for use of licit and illicit substances at least once in their lifetime, use in

the last year and use in the last month for Indigenous and non-Indigenous students aged 12-17 years.

Contrary to the hypothesis, fewer Indigenous students have ever used alcohol with 84% of Indigenous students compared to 89% of non-Indigenous students ( $\chi^2 (1) = 18.46$   $p < .001$ ). There are also less Indigenous students (67%) compared to non-Indigenous students (74%) that have consumed alcohol in the last year ( $\chi^2 = 19.99$  (df = 1)  $p < .001$ ) whilst similar numbers of Indigenous and non-Indigenous students have consumed alcohol in the last month ( $\chi^2 (1) = 0.73$   $p = .392$ ).

For the other substances, for lifetime use, use in the last year and month, Indigenous students aged 12-17 years were more likely than their non-Indigenous counterparts to use drugs. Whilst more Indigenous students than their non-Indigenous counterparts smoke tobacco and use any illicit substances, Indigenous students are twice more likely than non-Indigenous students to use any illicit drug excluding cannabis at least once in their life (18% compared to 10%) and in the last year (14%, 7%) and around 2.5 times more likely to have used in the last month (10%, 4%).

**Table 5: Prevalence of lifetime use, use in the last year and in the last month of licit and illicit drugs among Australian school students aged 12-17 years by Indigenous status in 2002.**

	Indigenous (%)	Non Indigenous (%)	$\chi^2$ value (df)	p value (n = 22621)
Ever smoked a cigarette	54	46	25.03 (1)	< .001
Smoked a cigarette in last year	37	30	20.49 (1)	< .001
Smoked a cigarette in last month	25	17	25.03 (1)	< .001
Ever drank alcohol	84	89	18.46(1)	< .001
Drank alcohol in last year	67	74	19.99(1)	< .001
Drank alcohol in last month	48	50	0.73(1)	.392
Ever tried any illicit substances	35	28	18.81(1)	< .001
Used any illicit substances in last year	29	22	27.08(1)	< .001
Used any illicit substances in last month	21	12	69.88(1)	< .001
Ever tried any illicit substances excluding cannabis	18	10	42.68(1)	< .001
Used any illicit substances excluding cannabis in last year	14	7	60.40(1)	< .001
Used any illicit substances excluding cannabis in last month	10	4	98.44(1)	< .001

Source: Australian School Students' Alcohol and Drugs survey – Centre for Behavioural Research in Cancer.

Table 6 shows NDSHS data for use of licit and illicit substances at least once in their lifetime, use in the last year and use in the last month for Indigenous and non-Indigenous adolescents' aged 14-17 and 18-24 years. As can be seen in Table 6 over half of Indigenous 14-17 year old adolescents have smoked at least 100 cigarettes compared to 17% of non Indigenous 14-17 year olds ( $\chi^2 (1) = 8.75 p = .003$ ). Table 6 also show that there are no statistical differences in the number of Indigenous and non-Indigenous 14-17 year old and 18-25 year old adolescents who consumed alcohol and illicit substances.

**Table 6: Prevalence of lifetime use, use in the last year and in the last month of licit and illicit drugs among Australian adolescents aged 14-17 and 18 –24 years by Indigenous status in 2001.**

	Indigenous (%)	Non Indigenous (%)	$\chi^2$ value (df)	p value
<b>14-17 year olds (n =1466)</b>				
Ever smoked a cigarette	72	53	3.02 (2)	.221
Smoked at least 100 cigarette	53	17	8.75 (1)	.003
Ever drank alcohol	83	90	3.51 (2)	.173
Consumed alcohol in last year	71	69	1.24 (2)	.538
Ever tried any illicit substances	51	30	1.76 (1)	.185
Used any illicit substances in last year	25	23	0.21(1)	.644
Used any illicit substances in last month	14	12	0.21 (1)	.650
Ever tried any illicit substances excluding cannabis	15	11	1.24 (1)	.266
Used any illicit substances excluding cannabis in last year	9	8	0.972(1)	.324
Used any illicit substances excluding cannabis in last month	3	4	0.75 (1)	.387
<b>18 –24 year olds (n = 2699)</b>				
Ever smoked a cigarette	80	75	2.78 (2)	.249
Smoked at least 100 cigarette	58	41	1.57 (2)	.455
Ever drank alcohol	97	96	3.06 (2)	.217
Consumed alcohol in last year	93	90	0.81 (1)	.368
Ever tried any illicit substances	66	57	3.02 (1)	.082
Used any illicit substances in last year	45	37	1.40 (1)	.237
Used any illicit substances in last month	30	23	2.37 (1)	.124
Ever tried any illicit substances excluding cannabis	41	32	0.96 (1)	.329
Used any illicit substances excluding cannabis in last year	23	21	0.03 (1)	.860
Used any illicit substances excluding cannabis in last month	6	11	0.63(1)	.428

Source: National Drug Strategy Household Survey 2001, Australian Social Science Data Archives

### Socio-economic differences

Tables 7 - 8 show that hypothesis<sup>4</sup> - a higher proportion of adolescents from low socio-economic status (SES) groups than adolescents from high SES groups will use licit and illicit substances - is not supported by either of the data sets.

More students in the lower socio economic groups than the higher groups have ever smoked tobacco ( $\chi^2 (4) = 43.39 p < .001$ ). This changes when looking at the other two time frames where more students in the mid high group compared to students in the



other four groups have smoked tobacco in the last year ( $\chi^2 (4) = 10.70 p = .030$ ) and around 20% of all students have smoked tobacco in the last month.

For alcohol, although differences between the students for all time periods are statistically significant, it is the students in the mid to high SES groups rather than the students in the lower groups who are more likely to have consumed alcohol. More students in the high SES group compared to the four other groups have ever consumed alcohol ( $\chi^2 (4) = 95.78 p < .001$ ), more students in the mid high SES group compared to the four other groups have used in the last year ( $\chi^2 (4) = 63.70 p < .001$ ) and more students in the mid SES group compared to the four other groups have consumed alcohol in the last month ( $\chi^2 (4) = 54.47 p < .001$ ).

More students in the low mid SES group compared to the four other groups have ever used any illicit substance ( $\chi^2 (4) = 14.78 p = .005$ ). The students in the low mid and high mid SES groups are more likely than students in the other three SES groups to have used illicit substances in the last year ( $\chi^2 (4) = 12.37 p = .015$ ). Around 14% of students have used any illicit substances in the last month.

When cannabis is removed from the group of illicit substances, about 10% of all students, regardless of their socio-economic status, are likely to have tried an illicit substance at least once in their life ( $\chi^2 (4) = 3.71 p = .446$ ) and around 8% have used in the last year ( $\chi^2 (4) = 7.29 p = .121$ ) and around 4% in the last month ( $\chi^2 (4) = 2.51 p = .643$ ).

**Table 7: Prevalence of lifetime use, use in the last year and in the last month of licit and illicit drugs among Australian secondary school students aged 12-17 years by socio economic status in 2002.**

<b>Socio-economic status</b>	<b>Low (%)</b>	<b>Low mid (%)</b>	<b>Mid (%)</b>	<b>High mid (%)</b>	<b>High (%)</b>	<b><math>\chi^2</math> value (df = 4)</b>	<b>p value (n = 22958)</b>
<b>Ever smoked a cigarette</b>	47	48	47	46	42	43.439	< .001
<b>Smoked a cigarette in last year</b>	31	30	31	33	30	10.70	.030
<b>Smoked a cigarette in last month</b>	19	17	19	19	18	8.379	.079
<b>Ever drank alcohol</b>	84	89	89	89	90	95.78	< .001
<b>Drank alcohol in last year</b>	71	75	76	78	75	63.70	< .001
<b>Drank alcohol in last month</b>	47	51	53	47	49	54.47	< .001
<b>Ever tried any illicit substances</b>	27	30	27	27	29	14.82	.005
<b>Used any illicit substances in last year</b>	22	25	23	25	24	12.37	.015
<b>Used any illicit substances in last month</b>	13	14	13	14	13	5.62	.230
<b>Ever tried any illicit substances excluding cannabis</b>	11	11	10	10	11	7.29	.121
<b>Used any illicit substances excluding cannabis in last year</b>	8	9	9	8	8	3.71	.446
<b>Used any illicit substances excluding cannabis in last month</b>	5	5	4	4	4	2.51	.643

Source: Australian School Students' Alcohol and Drugs survey – Centre for Behavioural Research in Cancer.

For the NDSHS data, more 18 - 24 year old adolescents in the mid high SES than their counterparts in the other four SES groups have ever drank alcohol ( $\chi^2 (8) = 16.41 p = .037$ ). Around 45% of 18 - 24 year old adolescents in the high SES have tried any illicit substance in the last year ( $\chi^2 (4) = 22.35 p < .001$ ) compared to 33% -38% of 18-24 year olds in the other four groups and nearly a quarter of this group of 18-24 year olds have used any illicit substance except cannabis in the last year compared to around 20% of this age group in the other four SES groups ( $\chi^2 (4) = 14.02 p = .007$ ). Around half of 18 – 24 year old adolescents in the low SES have smoked at least 100 cigarettes ( $\chi^2(8) = 17.85 p = .022$ ).

**Table 8: Prevalence of lifetime use, use in the last year and in the last month of licit and illicit drugs among Australian secondary school students aged 14 –17 and 18 – 24 years by socio economic status in 2001.**

Socio-economic status	Low (%)	Low mid (%)	Mid (%)	High mid (%)	High (%)	$\chi^2$ value (df = 4)	p value
<b>14-17 year olds (n = 1477)</b>							
Ever smoked a cigarette	54	51	57	53	54	8.66 (8)	.372
Smoked at least 100 cigarette	54	42	43	45	49	2.84 (8)	.584
Ever drank alcohol	87	88	91	90	93	10.72 (8)	.218
Consumed alcohol in last year	67	67	70	66	75	10.72 (8)	.218
Ever tried any illicit substances	33	28	28	29	34	1.63 (4)	.803
Used any illicit substances in last year	17	22	22	26	27	2.79 (4)	.594
Used any illicit substances in last month	11	12	11	13	14	0.53 (4)	.971
Ever tried any illicit substances excluding cannabis	13	10	10	9	14	2.66 (4)	.616
Used any illicit substances excluding cannabis in last year	8	7	7	7	11	0.95 (4)	.917
Used any illicit substances excluding cannabis in last month	3	5	4	2	4	6.29 (4)	.178
<b>18 –24 year olds (n = 2699)</b>							
Ever smoked a cigarette	76	73	76	73	76	6.44 (8)	.598
Smoked at least 100 cigarette	46	41	45	37	40	17.85 (8)	.022
Ever drank alcohol	95	94	96	98	97	16.41 (8)	.037
Consumed alcohol in last year	89	89	90	91	92	6.19 (8)	.186
Ever tried any illicit substances	57	57	56	51	61	9.73 (4)	.045
Used any illicit substances in last year	36	33	38	33	43	22.35 (4)	< .001
Used any illicit substances in last month	25	20	23	21	25	6.05	.196
Ever tried any illicit substances excluding cannabis	32	32	32	34	32	5.62 (4)	.229
Used any illicit substances excluding cannabis in last year	20	19	20	21	24	14.02(4)	.007
Used any illicit substances excluding cannabis in last month	10	10	11	9	12	8.367	.079

Source: National Drug Strategy Household Survey 2001, Australian Social Science Data Archives



## DISCUSSION

This document presents an analysis of adolescent drug use using the 2002 survey of the Australian Secondary School Alcohol and Drug (ASSAD) survey series in conjunction with the 2001 National Drug Strategy Household Survey (NDSHS). This research investigated, using a number of different age groups, the differences in adolescent drug use between those in urban and rural Australia including use of both illicit and licit drugs for a number of different time frames (i.e. used at least once in their lifetime, used in the last year and used in the last month). The data sets were also used to look at the Indigenous adolescents' lifetime use and use in the last year and the last month of both illicit and licit drugs and drug use in these time frames for adolescents in differing socio-economic status (SES) groups.

The hypotheses examined in this research are:

- Hypothesis<sup>1</sup> that a higher proportion of rural adolescents than urban adolescents will use licit substances.
- Hypothesis<sup>2</sup> that a higher proportion of urban adolescents than rural adolescents will use illicit substances.
- Hypothesis<sup>3</sup> that a higher proportion of Indigenous adolescents than non-Indigenous adolescents will use licit and illicit substances.
- Hypothesis<sup>4</sup> that a higher proportion of adolescents from low socio-economic status (SES) groups than adolescents from high SES groups will use licit and illicit substances.

As mentioned in the results section of this research, the data did not offer much support for the hypotheses developed on geographical location, Indigenous status or socio-economic status differences in adolescents' use of licit and illicit drugs. Hypothesis<sup>1</sup> was supported by the ASSAD survey data but not the NDSHS. The ASSAD data

showed more rural students than urban students had ever consumed alcohol or smoked tobacco, or used these substances in the last year or month. For the NDSHS, more rural than urban 18-24 year olds had smoked more than 100 cigarettes but there was no difference between rural and urban adolescents aged 18-24 year for consumption of alcohol. For the 14-17 year old adolescents in the NDSHS, there were no differences between the urban and rural populations for consumption of alcohol or for smoking tobacco.

Hypothesis<sup>2</sup>, Hypothesis<sup>3</sup> and Hypothesis<sup>4</sup> were not supported by either dataset. For Hypothesis<sup>2</sup>, the ASSAD data showed that although more rural students than urban used any illicit substance at least once in their lifetime, in the last year and in the last month, when cannabis was removed from the group of illicit substance, there were no differences between the two groups of students. For the 14-17 year old adolescents in the NDSHS, there were no differences between urban and rural adolescents. For the 18-24 year olds, more urban than rural adolescents in that age group used any illicit drugs excluding cannabis.

For Hypothesis<sup>3</sup>, the ASSAD data showed that non-Indigenous student were more likely than Indigenous students to have ever consumed alcohol and to have consumed it in the last year. For the NDSHS data, the only difference between Indigenous and non-Indigenous adolescents in both age groups was that, more Indigenous than non-Indigenous 14-17 year old adolescents smoked over 100 cigarettes. For Hypothesis<sup>4</sup>, the ASSAD data, showing that it was students in the mid to high SES groups rather than the students in the lower groups who are more likely to have consumed alcohol. For NDSHS, more 18 - 24 year old adolescents in the mid high SES group than their counterparts in the other four SES groups have ever consumed alcohol in their lifetime and used illicit substances in the last year.

### **Urban/Rural differences**

This research with the exception of the older age group in the NDSHS would support the premise proposed by overseas researchers that although rural living used to be a protective factor for adolescent drug use this has disappeared in recent years with rural adolescent drug use rates converging with urban drug use rates (Albrecht, et al., 1996; Alvarez, et al., 1989; Beauvais & Segal, 1992; Cockerham, 1977; Cronk & Sarvela, 1997; Edwards, 1992; Forsyth & Barnard, 1999; French & Picthall-French, 1998; Sandi, et al., 2002). The NDSHS data for 14-17 year olds supports the premise because there was no differences found between rural and urban adolescents aged 14-17 years old for smoking tobacco, consuming alcohol or using illicit drugs. However, for the older age group in this survey, more urban than rural 18-24 year olds are likely to have used illicit substances excluding cannabis at least once in their lifetime, in the last year and in the last month. One reason why in the older age group, urban adolescents are more likely to use illicit drugs than their rural counterparts could simply be that rural adolescents that use illicit drugs have by age 18 years finished their schooling and could have moved away from their rural home towns into the city. One of the social risk factors that has been studied is the role of families in influencing adolescents to use drugs (Beman, 1995; Newcomb & Felix-Ortiz, 1992; Newcomb, et al., 1986; Peters, et al., 1992). Research has found that adolescents from dysfunctional families or who have poor relationships with parents are more susceptible to becoming drug users and are more likely to move away from home.

As well as showing that more rural students smoke tobacco and consume alcohol, the ASSAD data also shows that more rural students than their urban counterparts have used any illicit substances (which include cannabis) at least once in their lifetime, used in the last year and in the last month. When cannabis is excluded from the group of

illicit substances, there is an equal likelihood that adolescents from the different geographical locations would have used these substances at least once in their lifetime or used them in the last year or in the last month. As the only difference between these two groups of substances is the inclusion or exclusion of cannabis, this seems to imply that rural students are more likely to use cannabis than their urban counterparts.

The fact that a greater number of rural secondary school students use alcohol and cannabis is a cause for concern in that rural adolescents are probably more prone to be in situations where accidents can occur and the use of alcohol and cannabis could affect their abilities to avoid these situations. One example mentioned by Peters et al., (1992) is the greater propensity for rural adolescents to have to drive more often and for longer distances than their urban counterparts due to the lack of reliable public transport and the distances between home and school, home and friends and home and entertainment opportunities. Alcohol and cannabis have been found to affect one's ability to drive, although they have different effects on the person with alcohol being associated with aggression and speeding and cannabis with distortion of judgement and the persons sense of time and motion, the effect when used in conjunction is "worse for either substance used alone" (Peters, et al., 1992 p 26). Peters et al., (1992) maintain that the "relative lack of traffic on rural roads and the distances travelled often lead to driving at high speed" (Peters et al., 1992 p 26) and as such rural adolescents have a greater potential to be involved in accidents. The consumption of alcohol and/or cannabis could only exacerbate the situation leading to an even greater possibility of injury and death. Whilst more research is needed to investigate why the NDSHS data did not show similar results for rural adolescents' consumption of alcohol and cannabis, one way to help address this issue could be to include more rural messages in the new National



Illicit Drug Campaign. For example: including scenario that is obviously in a rural setting depicting the dangers of cannabis use and driving.

Another aspect highlighted by the ASSAD data is that more rural adolescents than urban adolescents have smoked tobacco in all three of the timeframes examined. The NDSHS, also showed that more rural 18-24 year olds than rural 18-24 year olds having smoked over 100 cigarettes. This research supported Cronk and Sarvela's (1997) secondary analysis of the Monitoring the Future data set in which they found that rural students had similar or higher use of alcohol and tobacco for the whole time period (1976 –1992). This is most apparent for binge drinking and smoking at least 30 cigarettes a day. In contrast, this research does not support the research by White et al., (2003) who found that there was little difference in the prevalence of smoking between students from metropolitan or rural areas of Victoria. As White et al., (2003) were also using the ASSAD data set, it could be expected that both these research projects would have similar findings. One reason that they are not similar could be the fact that White et al (2003) only used the Victorian data rather than the National data. This raises the question of the heterogeneity of areas that can be classified as rural or urban and that classifying an area either rural or urban will cover a multitude of differences (Edwards, 1992; Peters, et al., 1992). The locality data on both of the data sets were classified into a variable that only had two categories (urban and rural). For the ASSAD data, the categorisation was that capital cities and other large urban cities were classified as urban and the rest of the state was classified as rural. For the NDSHS, the classification was based on a variable that had categories that delineated the data into either the capital city or the rest of that state/territory with Australian Capital Territory being classified as completely urban. As such, the data sets used in this research were not measuring exactly the same thing, the NDSHS data had the larger urban cities in the rest of state

categories, which were classed as rural, rather than in the urban category as is the case with the ASSAD survey. Also, the fact that there are only two categories would not take into account the differences that can exist within the categories. It is possible that adolescent drug use in the inner city would be different to adolescent drug use in the outer regions of the capital cities. There could also be vast difference between rural areas and as such could have different effects on adolescent drug use.

While more information is needed on national adolescent drug use so that results can be generalised nationally and although it is more difficult to compare too many categories, it might be useful to have more categories than just two for geographical location. It would also be useful if these categories could be based on characteristics other than just whether an adolescent is living in the capital city or the rest of the state/territory. One possibility would be to use a classification similar to the Australian Bureau of Statistics' Remoteness Structure which has six categories which are: major cities; inner regional; outer regional; remote; very remote and migratory. Although, because of the sampling frames used for both of the data sets used in this research, probably the only categories needed will be major cities, inner regional and outer regional. This research was unable to do this, as the locality data in the NDSHS had been confidentialised on the computer file available from the Australian Social Science Data Archive to just capital city and rest of state information. To keep the two data sets comparable, the ASSAD data was also categorised in a similar fashion. Further investigation into the availability of a remoteness indicator or other geographical breakdown would be valuable especially as the 2004 edition of the survey will be added to the Data Archives in the very near future and suggestions given to the Australian Institute of Health and Welfare could be investigated and included in the computer file.

### **Indigenous differences**

Hypothesis<sup>3</sup> cannot be fully supported by either data set, as the NDSHS data showed that the only difference found for both age groups was that, more Indigenous than non-Indigenous 14-17 year old adolescents smoked over 100 cigarettes. The ASSAD data showed that non-Indigenous students were more likely than Indigenous students to have ever consumed alcohol and to have consumed it in the last year. Despite this, the ASSAD data does show that Indigenous adolescents have higher drug use rates than non-Indigenous adolescents for all drugs except alcohol and as such could support the well documented view that Indigenous people are more likely than non-Indigenous people to use these drugs (Beauvais, et al., 2004; Forero, et al., 1999; Gray, et al., 1997; Wallace Jr, et al., 2003).

The ASSAD data found that non-Indigenous students were more likely than Indigenous students to have consumed alcohol at least once in their lifetime and in the last year. The likelihood of Indigenous and non-Indigenous students of having consumed alcohol in the last month is the same. The lower proportion of Indigenous adolescents who have consumed alcohol is consistent with the finding from Gray et al., (1997) who collected information on a variety of drug use for Indigenous adolescents in Albany where they found that adolescents of Indigenous descent were less likely to have consumed alcohol in the last year, month and week. This is in direct contrast to overseas research that shows that Indigenous peoples are more likely than their non-indigenous counterparts to consume alcohol (Beauvais, et al., 2004; Beauvais & Segal, 1992).

As mentioned previously, statistics for Aboriginal and Torres Strait Islanders can be unreliable due to a number of factors including the accuracy of Indigenous being identified in surveys and the unreliability of population estimates for these people.

Only 996 Indigenous students out of over 22,000 students in the survey identified themselves as Indigenous peoples in the 2002 ASSAD survey and only 113 out of 4179 participants identified themselves as Indigenous peoples in the NDSHS. As such, this data should be treated with caution and further investigation of the findings in this research should be undertaken to verify the lack of differences between Indigenous and non-Indigenous adolescents from the NDSHS.

The results from the ASSAD survey on the use of alcohol also need to be investigated further to see if this finding can be substantiated. The AIHW (2003) data mentioned previously showed that although the proportion of Indigenous people that have ever consumed alcohol is the same as the proportion among non-Indigenous people, less Indigenous people have consumed alcohol in the last 12 months and as such partially supports the information found from the ASSAD data.

One aspect of alcohol consumption behaviour that was not investigated in this research is consumption of alcohol at risky levels. Forero et al (1999) found that although there was no difference between Indigenous and non-Indigenous adolescents for consumption of alcohol in the last week, there were differences in the probability of alcohol consumption at hazardous levels, with more Indigenous adolescents than non-Indigenous adolescents likely to consume alcohol at hazardous levels. This research is supported by the information available from the AIHW (2003) mentioned previously in that Indigenous peoples are more likely than non-Indigenous Australians to have consumed alcohol at risky levels in the last year. Further investigation using both data sets could include examining whether there are differences between Indigenous and non-Indigenous adolescents consumption of alcohol at risky or hazardous levels. Another aspect that needs to be taken into account would be any differences in Indigenous alcohol use that is related to where a person lives. The research that Dunne

et al (2000) completed in far north Queensland found that the prevalence of alcohol consumption was higher in metropolitan areas than the rural communities for both Indigenous and non-Indigenous students. Further research that also takes into account not just, whether there are difference between Indigenous and non-Indigenous adolescents but the difference between rural and urban Indigenous populations would be beneficial. This research was unable to do this because of the low number of Indigenous adolescents identified in the surveys especially the NDSHS.

### **Socio-Economic Status**

Hypothesis<sup>4</sup>, which asserted that a higher proportion of adolescents from low socio-economic status (SES) areas than adolescents from high SES areas will use licit and illicit substances, is not supported for the ASSAD data. Although the differences between the groups for both smoking and consuming alcohol licit drugs are significant, the fact that it is students in the high SES groups that are more likely to consume alcohol and the fact there is no difference between the groups for the use of any illicit drugs excluding cannabis means that this hypothesis could not be supported by this data set. NDSHS data also did not support Hypothesis<sup>4</sup> for the 14-17 year old age group as there are no differences between the groups for any drugs. For 18-24 year old in the NDSHS, adolescents in the higher SES groups are more likely than adolescent in the other four groups to consume alcohol and use any illicit drugs so Hypothesis<sup>4</sup> is not supported for this age group.

The finding that adolescents from the high SES groups are more likely to consume alcohol is corroborated by the research mentioned previously by Marmot (1997), Casswell et al., (2003) and Neumark et al., (2003). These researchers all found that people in the higher SES group or with higher incomes were more likely to consume alcohol. Research into the factors that can effect whether an adolescent will use drugs

has looked into the effect of income on an adolescent's propensity to use drugs (Albrecht, et al., 1996; Beman, 1995). Beman (1995) found that adolescent employment is a risk factor leading to substance use, in that adolescents who are employed are "more susceptible to substance abuse than those who do not work" (Beman, 1995 p 205). Whilst there is just as much likelihood that adolescents in the lower SES groups are working as the ones in the higher SES groups, Albrecht et al., (1996) suggested one reason that the adolescents in the higher SES groups are more likely to use drugs. They found that higher amounts of individual income, especially from a source other than from a job are associated with higher levels of alcohol and illicit drug use. They found that around a quarter of the teens with less than \$10 a week from a source other than a job would have consumed alcohol compared to around 40% of those with non-employment income of \$75 and higher. As it seems more likely that adolescents from the higher SES groups than ones from the lower groups would have more discretionary money and as such would be more likely to consume alcohol and use illicit drugs.

As expected, the analysis for this research found that there are many more adolescents that have tried both licit and illicit substances at least once in their life, than there are adolescents that have used these substances in the last year or month. This is consistent with the finding of other researchers (Paglia & Room, 1999; Reid, Lynskey, & Copeland, 2000; Sellman & Deering, 2002; Shedler & Block, 1990) that maintain that much of adolescent drug use is experimentation which will tend to decline in the twenties and that only a small proportion of adolescents will go on to regularly use illicit drugs. However, the number of 18-24 year olds that have used illicit drugs in the last year is still around twice that of the general population of around 17% (AIHW,

2002), which could mean that adolescents' experimentation phase with drugs is lengthening.

Another explanation could be, as mentioned previously, the use of some illicit drugs has become more acceptable and part of the norm for some Australians. Data from the AIHW has shown that over the last ten years that the use of ecstasy has become more acceptable. In 1995, around 2% of people considered regular use of ecstasy by adults to be acceptable and in 2004 just over 4% believed that regular use of ecstasy was acceptable (AIHW, 1999, 2005). As this cohort of 18-24 year olds have grown up with the premise that use of certain drugs are consider to be normal behaviour, it could mean that a larger proportion of this cohort will continue to use drugs throughout their life as they do not consider using these drugs as a way of testing their boundaries during adolescence but as a normal way of life.

The data available on adolescents' drug use comes from cross-sectional surveys, which are carried out in regular intervals rather than surveys that follow a cohort of individuals throughout the different stages of their life. As such, it is harder to determine if the current social acceptance of some drugs is having an effect on the drug use of this particular cohort of 18-24 year olds or the experimentation stage is just lengthening. The only way to verify this would be to re-survey the 18-24 year old respondents that completed the NDSHS survey in 2001.

Throughout this research, the two data sets whilst sometimes showing a small number of similar results have also shown a number of inconsistencies, especially when comparing the ASSAD survey and the younger age group in the NDSHS. Both datasets are collected information using self report questionnaires, they have overlapping populations, although collected from different sources, one from only school students and the other from households in Australia which includes school students and as such,

it was expected that these data sets would corroborate each other more than they actually did in this analysis.

Some of the reasons that this did not happen have been mentioned previously including the small differences in the categorisation of the urban/rural indicator and the fact there are very small numbers of Indigenous people identified in the samples. Other reasons could be the differences in the number of people included in the samples, with the ASSAD survey having such a larger number of participants than the NDSHS and that there could also be differences in the composition of the people that refused to complete the surveys. More analysis of both data sets is needed to investigate if the differences between the two datasets are methodological differences or if the differences are actual differences between the two samples of adolescents.

One important outcome from this research is the importance of not relying on one specific type of data to answer questions on adolescent drug use. Although there are a number of methodological problems arising from surveys and the sampling populations of each dataset (which are outlined below), they are two of the most important data sources for adolescent drug use and as such should be used to investigate adolescent drug use. It is also important given the difference found between the two data sets that other sources of information are investigated to give a more complete view of drug use by adolescents in Australia. Further information from different populations could include:

- remote communities;
- schools that include more Indigenous adolescents including the smaller school in rural communities;
- out of school adolescents using data gathered from source other than homeless studies;



- adolescents living in hostels, temporary housing and caravan parks.

### **Limitations of the data**

As mentioned previously the data from the ASSAD survey series is collected through schools. This method for collecting data does not allow the sampling of the entire adolescent population, as the adolescents who have dropped out of school or who are truant are not included. The NDSHS although allowing for the sampling of out of school adolescents has the problem that it only samples private dwellings and as such, adolescents that live in boarding houses, military establishments, university halls of residence and correctional facilities are not included in the survey.

Another problem with both data collection methods is the reliability and validity of the information that is collected by self report questionnaires. Reid et al., (2000) mention in their research that there could be an effect on the report because of the illegal nature of illicit drugs and cost and implications of the use of these substances. They also point out aspects of self reporting that could affect the data collection for both surveys used in this research. They pointed out that self reports can be affected by the people that are present at time of collection (i.e. if parents or authority figures are present, adolescents are less likely to report drug use and the converse is true if friends or peers are present). The data from both surveys was divided into capital and major cities (urban) and rest of state (rural) information. As neither of the surveys sampled from remote communities, this research was not able to obtain information on the effect living in a remote community would have on adolescents propensity to use drugs. Further research that includes remote communities would be advantageous to ensure that a more rounded picture of adolescent drug use and especially relevant to gaining more information on drug use by Indigenous adolescents.

As mentioned earlier there are a number of concerns when using Indigenous data. The Australian Institute of Health and Welfare have mentioned a number of limitations for the use of Indigenous data. These include:

- the accuracy of the identification of people of Indigenous descent;
- uncertainties about population estimates; and
- the appropriateness of the survey methods used including cultural considerations like differing interpretations for concepts and definitions and literacy issues for self administered questionnaires which can affect how an Indigenous person completes the questionnaire (AIHW, 2003).

Although, the ABS is collecting data on drug use with the Indigenous Social Survey, information is collected for ages 15 + years and so doesn't have information on the younger groups adolescents. Identification as an Indigenous peoples was also raised by Forero et al., (1999) who mentioned that there are problems with the rates of self-identification of Indigenous. The added disadvantage of using the ASSAD survey was that using schools as collection points for information means that this survey is only gaining information on those older students that have elected to remain at school. Forero et al., (1999) mentioned that the proportion of Indigenous not in the school system is very high and the retention rates for the older ages is relatively low. The ASSAD researchers also commented that information was collected from mainstream schools, that smaller schools (less than 100 enrolments) and special schools are excluded (private correspondence from Dr V White dated 27 January 2004). As such, the ASSAD data is restricted to the Indigenous students that attend the larger schools. There are a number of ways that more information could be collected on Indigenous adolescents using the existing data collection series. Increasing the sample to include 12-14 year old adolescents in the Indigenous Social Survey will increase the capacity of

this survey to give information on adolescents. Over sampling the Indigenous population for the NDSHS and ASSAD would also help increase the numbers of Indigenous people answering that survey although these surveys would still not have data on remote Indigenous populations as the sampling frames used do not cover these areas. Another idea would be to include a supplementary survey on health issues in the Census to be answered by Indigenous people. This would also help in overcoming the collection issues mentioned by the AIHW (2003), in that the Australian Bureau of Statistics employ specially trained collection personnel to collect the information from Indigenous peoples for the Census.

In spite of all the above difficulties, these two data sets are perhaps two of the best sources of information of national adolescent drug use in Australia and further investigation of both data sets is essential to understanding adolescent drug use in Australia. The National Drug Strategy Household Survey series has recently released data from the 2004 survey, this survey will be a vital source of information for adolescents as the sample used was the largest for the series and they have collected data for 12-13 year old for the first time in the series.

### **Conclusions**

While there are aspects of the information from the two data sets that are contradictory making it difficult to prove or disprove the hypotheses formulated for this research, they highlighted a number of aspects of adolescent drug use. The first of these is that for younger adolescents, this research supports the premise that the protective factor for adolescent drug use of living in a rural area has disappeared with rural adolescent drug use rates converging with urban drug use rates. It also highlighted that a large number of rural school students are using alcohol and cannabis.

The ASSAD data also confirmed other Australian research on the fact that Indigenous adolescents are less likely to use alcohol than their non-Indigenous counterparts.

Although this confirmed data on Indigenous adults' consumption of alcohol in the last year, it is in direct contrast to overseas research that shows alcohol use among Indigenous peoples is higher than non-Indigenous people. Both data sets also confirmed the research by Casswell, et al., (2003) and Neumark et al., (2003) by finding that adolescents from the high SES groups are more likely to consume alcohol than their counterparts in the lower SES groups.

Further investigation is needed to find out why the data sets did not substantiate each other and to gain further insight into the consumption of alcohol and cannabis by rural adolescents and the consumption of alcohol by Indigenous adolescents and adolescents from the higher socio-economic status groups. Using another indicator to distinguish between urban and rural populations that allows for the heterogeneity of the areas will help in gaining information on whether geographical location is a factor in drug use.

Increasing the samples of Indigenous people in both of the data set and lobbying the Australian Bureau of Statistics to increase their sample for the Indigenous Social Survey to include 12-14 year old should give more information on Indigenous adolescents.

The overall goals of this research were to gain a more comprehensive view of adolescent drug use using existing data sets. Information on the relationship of geographical location, Indigenous and socio-economic status and adolescent drugs use was explored. Although none of the hypotheses constructed were fully supported by both datasets, a number of interesting aspects to adolescent drug use were discovered around the consumption of alcohol by rural adolescents, adolescent in the high socio-economic status group and Indigenous adolescents and suggestions for further research into the relationships were proposed.

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**APPENDIX ONE: AUSTRALIAN SCHOOL STUDENTS ALCOHOL  
AND DRUG SURVEY**

# SURVEY

Please do not write your name on this paper.

- The information you give is private and will only be seen by the people putting all the answers together.
- Answer *every* question you can.
- If you can't answer a question or if you do not want to answer a question, leave it out and go on to the next one.
- For most questions, there is a choice of answers. Pick the one that's true for you and tick the box next to it.
- If you make a mistake or wish to change your answer, cross out the mistake and tick the new response.
- Some questions ask you to write a short answer in the space provided.

Office use only

STATE 1	SCHOOL ID	PCODE	LEVEL	CAMPUS
PATTERN	SCHSEX	STRATA	TEACH	DAY
ORDER 2	INITIALS		DATE	MONTH YEAR 2002

1. (a) What suburb or town do you live in? \_\_\_\_\_

(b) What is the postcode of your address? \_ \_ \_ \_

2. What year level are you in?

1  Year 7

4  Year 10

2  Year 8

5  Year 11

3  Year 9

6  Year 12

3. How old are you **now**?

10  10

15  15

11  11

16  16

12  12

17  17

13  13

18  18

14  14

19  19 and over

4. What sex are you?

1  Male

2  Female

5. What is your date of birth? \_ \_ / \_ \_ / 19 \_ \_

6. During a normal week, how much money do you have available to spend on yourself (eg from pocket money, part-time job)?

1  None

2  Less than \$10

3  \$11 - \$20

4  \$21 - \$40

5  \$41 - \$60

6  \$61 - \$80

7  Over \$80

7. **At school work**, do you consider yourself:

1  A lot above average?

2  Above average?

3  Average?

4  Below average?

5  A lot below average?

8. (a) Were you at school on the last school day?

1  Yes **Go to QUESTION 9**

2  No **Go to QUESTION 8(b)**

(b) If **No**: Why were you away?

1  You were ill or had some other health problem

2  Study day or other school-related activities

3  Family reasons

4  Other (*specify*) \_\_\_\_\_

9. Are you of Aboriginal or Torres Strait Islander descent?

1  No

2  Yes - Aboriginal descent

3  Yes - Torres Strait Islander descent

4  Yes - both Aboriginal and Torres Strait Islander descent

10. What is the main language spoken at home? *Tick only **one** box.*

1  English

2  Another language only (*specify which language*) \_\_\_\_\_

3  English and another language  
(*specify the other language*) \_\_\_\_\_

**THE NEXT FEW QUESTIONS ARE ABOUT SMOKING CIGARETTES.**

11. At the present time, do you consider yourself:

- 1  A heavy smoker?
- 2  A light smoker?
- 3  An occasional smoker?
- 4  An ex-smoker?
- 5  A non-smoker?

12. Have you **ever** smoked even part of a cigarette?

- 1  No
- 2  Yes, just a few puffs
- 3  Yes, I have smoked fewer than 10 cigarettes in my life
- 4  Yes, I have smoked more than 10 but fewer than 100 cigarettes in my life
- 5  Yes, I have smoked more than 100 cigarettes in my life

13. Have you smoked cigarettes in the last **twelve months**?

- 1  Yes
- 2  No

14. Have you smoked cigarettes in the last **four weeks**?

- 1  Yes
- 2  No

15. This question is about the number of cigarettes you had during the last **seven days**, including yesterday.

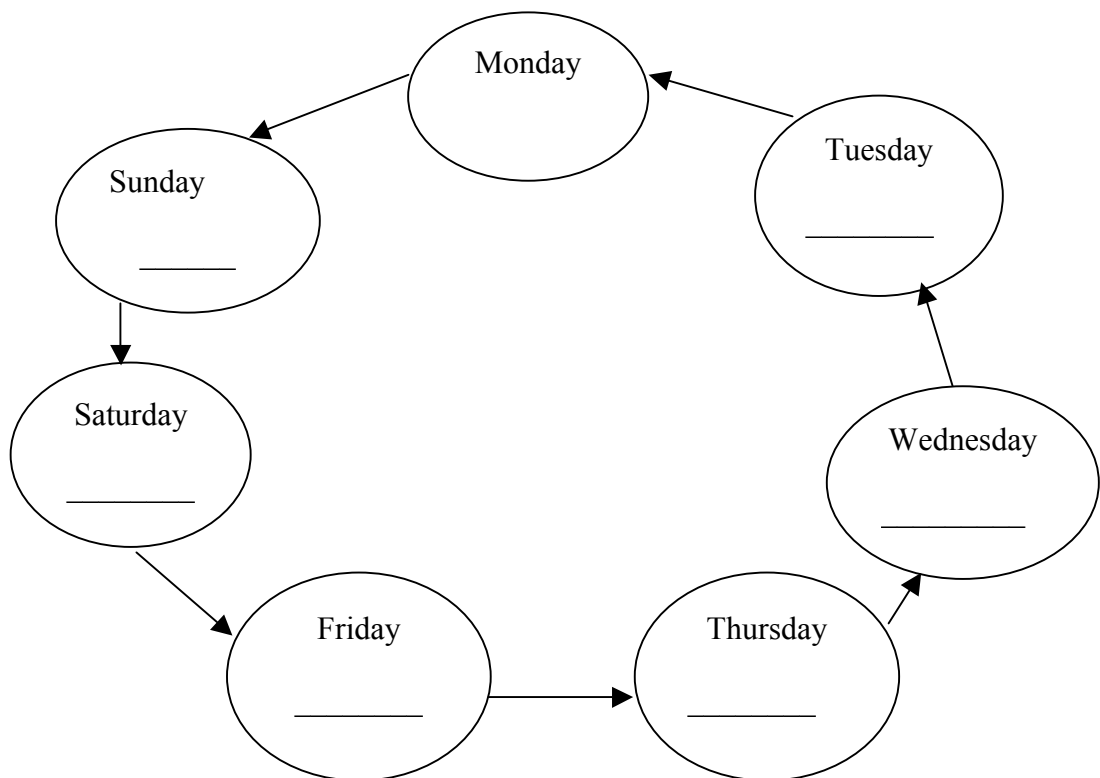
*Put a tick near **yesterday**. Then in the space provided, write the number of cigarettes you had yesterday. If you didn't smoke any cigarettes, put in '0'.*

*Start filling in the spaces beginning with yesterday, and follow the arrows.*

**Answer for every day of the week.**

*Write the number of cigarettes you smoked each day in the circle.*

*Put '0' for each day you didn't smoke any cigarettes.*



16. Do you think you will be smoking cigarettes this time next year?

- 1  Certain **not** to be smoking
- 2  Very **unlikely** to be smoking
- 3  **Unlikely** to be smoking
- 4  Can't decide how likely
- 5  Likely to be smoking
- 6  Very likely to be smoking
- 7  Certain to be smoking

17. Have you ever smoked even part of a cigar?

- 1  No  
2  Yes, a few puffs but not as much as one cigar  
3  Yes, I have smoked at least one cigar in my life

**QUESTIONS 18, 19 AND 20 ARE ONLY FOR THOSE WHO HAVE SMOKED A CIGARETTE IN THE PAST WEEK. IF YOU HAVE NOT SMOKED A CIGARETTE IN THE PAST WEEK, GO TO QUESTION 21.**

18. (a) What brand of cigarettes do you usually smoke?

*Tick the box near the brand you **usually** smoke. If that brand is not listed here, tick the box next to "Other" and write the name of the brand in the space provided.*

- 01  Alpine  
02  Benson & Hedges  
03  Dunhill  
04  Escort  
05  Fortune  
06  Holiday  
07  Horizon  
08  Longbeach  
09  Marlboro  
10  Peter Jackson  
11  Sterling  
12  Stradbroke  
13  Vogue  
14  Wills Super Mild  
15  Winfield  
16  Freedom  
\*\*  Other (*specify*) \_\_\_\_\_

*You should have ticked only **one** box.*



(b) Do the cigarettes you usually smoke come from packets of...?

- 1  20s?
- 2  25s?
- 3  30s?
- 4  35s?
- 5  40s?
- 6  50s?

*You should have ticked only **one** box.*

19. (a) Where, or from whom, **did you get the last** cigarette that you smoked?

*Fill in the space beside "Other" if you can't find your answer.*

*Tick only **one** box.*

**I didn't buy it ....**

- 01  My parent(s) gave it to me
- 02  My brother or sister gave it to me
- 03  I took it from home without my parent(s) permission
- 04  Friends gave it to me
- 05  I got someone to buy it for me
- \*\*  Other (*specify*)  
\_\_\_\_\_

**OR I bought it ....**

- 51  At a hotel, pub, bar, tavern, RSL Club
- 52  At a supermarket
- 53  At a newsagency
- 54  At a milk bar or delicatessen
- 55  At a convenience store (eg Food Plus)
- 56  At a tobacconist/tobacco shop
- 57  At a take-away food shop
- 58  At a petrol station
- 59  Through the Internet
- \*\*  Other

(*specify*) \_\_\_\_\_

*You should have ticked only **one** box.*

(b) If you bought your last cigarette, was it from a coin-operated (vending) machine?

- 1  Yes
- 2  No

20. (a) Sometimes people break open a packet of cigarettes and sell single cigarettes. In the last **four weeks**, have you **bought** cigarettes that were **not in a full packet** (for example, buying one or more cigarette(s) at a time)?

1  Yes *Go to QUESTION 20(b)*

2  No *Go to QUESTION 21*

(b) Thinking of the last time you **bought** cigarettes that were **not in a full packet**, who did you buy the cigarette(s) from?

1  I bought the cigarette(s) at a shop

2  I bought the cigarette(s) from a friend or relative

3  I bought the cigarette(s) from someone else

**THESE QUESTIONS ARE FOR EVERYONE AND ARE ABOUT DRINKING ALCOHOL - BEER, WINE, WINE COOLERS, ALCOHOLIC SODAS, SPIRITS, LIQUEURS, ALCOHOLIC APPLE CIDER, SHERRY OR PORT.**

21. At the present time, do you consider yourself:

1  A non-drinker?

2  An occasional drinker?

3  A light drinker?

4  A party drinker?

5  A heavy drinker?

22. Have you **ever** had even part of an alcoholic drink?

1  No

2  Yes, just a few sips

3  Yes, I have had fewer than 10 alcoholic drinks in my life

4  Yes, I have had more than 10 alcoholic drinks in my life

23. Have you had an alcoholic drink in the last **twelve months**?

1  Yes

2  No

24. Have you had an alcoholic drink in the last **four weeks**?

1  Yes

2  No

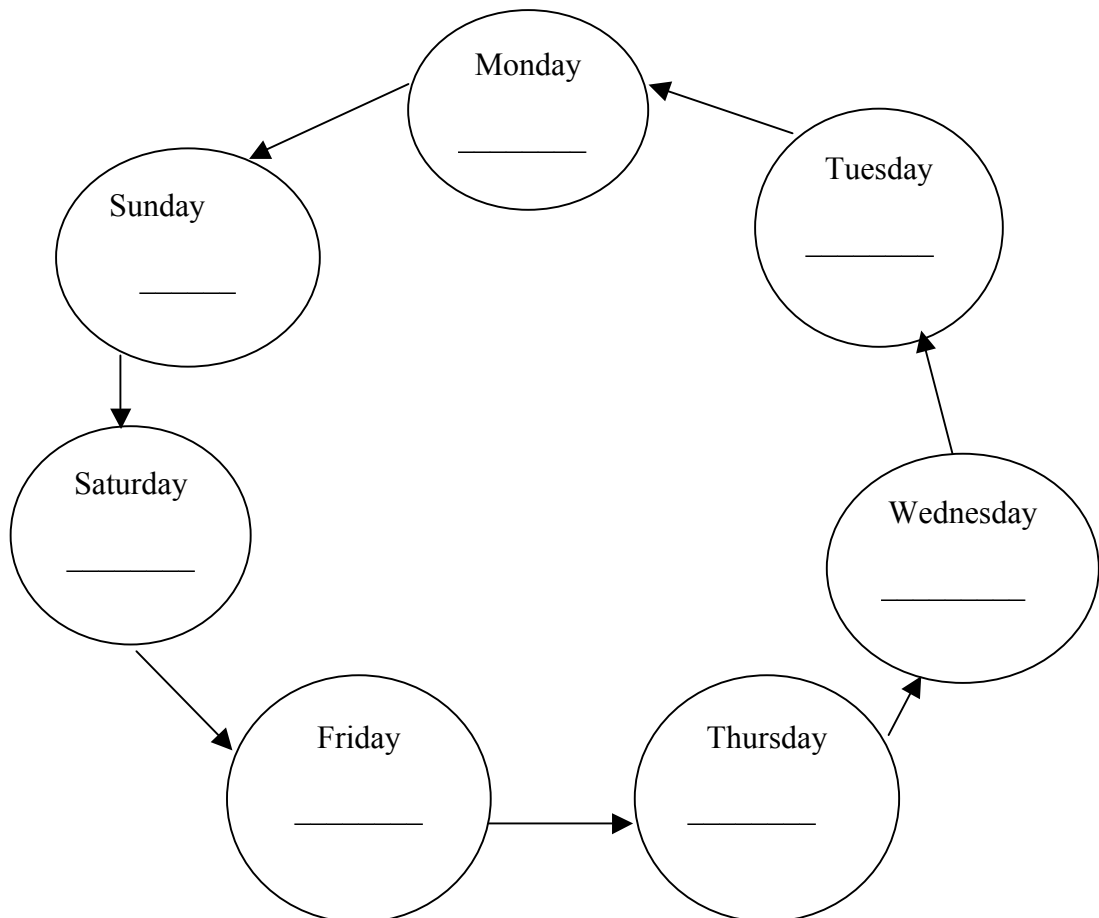
25. This question is about the number of alcoholic drinks you had during the last **seven days**, including yesterday.

*Put a tick near **yesterday**. Then in the space provided, write the number of alcoholic drinks you had yesterday. If you didn't have any alcoholic drinks, put in '0'. Start filling in the spaces beginning with yesterday, and follow the arrows.*

**Answer for every day of the week.**

*Write the number of alcoholic drinks you had each day in the circle.*

*Put '0' for each day you didn't drink any alcoholic drinks.*



**QUESTIONS 26, 27, 28 AND 29 ARE FOR ANYONE WHO HAS HAD AN ALCOHOLIC DRINK.**

**IF YOU HAVE NEVER HAD AN ALCOHOLIC DRINK, GO TO QUESTION 30.**

26. What alcoholic drink do you usually have?

*Tick the box near the drink you **usually** have. If that drink is not listed here, tick the box next to "Other" and write the name of the drink in the space provided.*

01  Ordinary beer

02  Low alcohol beer

03  Wine

04  Wine Cooler (eg West Coast Coolers)

05  Champagne or sparkling wine (eg Spumante, Passion Pop)

06  Alcoholic Apple Cider (eg Strongbow)

07  Alcoholic sodas (eg Two Dogs)

08  Premixed spirits (eg Bacardi Breezer, Lemon Ruski, UDL Drinks, Sub Zero)

09  Spirits (eg rum, brandy, whisky, gin, vodka)

10  Liqueurs (eg Tia Maria, Kahlua, Midori, etc)

\*\*  Other (*specify*) \_\_\_\_\_

*You should have ticked only **one** box.*

27. Where, or from whom, **did you get** your **last** alcoholic drink?  
*Fill in the space beside "Other" if you can't find your answer.*

*Tick only **one** box.*

**I didn't buy it ....**

- 01  My parent(s) gave it to me
- 02  My brother or sister gave it to me
- 03  I took it from home without my parent(s) permission
- 04  Friends gave it to me
- 05  I got someone to buy it for me
- \*\*  Other (*specify*)  
\_\_\_\_\_  
—

**OR I bought it ....**

- 51  At a hotel, pub, bar, tavern, RSL Club
- 52  At a licensed liquor store or supermarket
- 53  At a walk-in bottle-shop at a pub or hotel
- 54  At a drive-in bottle-shop
- 55  At a restaurant
- 56  At a dance venue/dance party
- 57  At a nightclub
- 58  At a sporting event
- 59  At a sports club (eg Leagues, surfing, football)
- 60  Through the Internet
- 61  By phone, fax, mail order
- \*\*  Other  
(*specify*) \_\_\_\_\_

*You should have ticked only **one** box.*

28. **Where did you drink your last alcoholic drink?**  
*Fill in the space beside "Other" if you can't find your answer.*

*Tick only **one** box.*

**I drank it ....**

- 01  At a beach, park or recreation area  
 02  At a hotel, pub, bar, tavern or RSL club  
 03  At a dance venue/dance party  
 04  At a nightclub  
 05  At a party  
 06  At a restaurant  
 07  At a sporting event  
 08  At a sports club (eg Leagues, surfing, football)  
 09  On school grounds during school hours  
 10  On school grounds after hours  
 11  At my home  
 12  At my friend's home  
 13  In a car  
 \*\*  Other (*specify*) \_\_\_\_\_

*You should have ticked only **one** box.*

29. Think back over the last **two weeks**. How many times, if any, have you had the following number of alcoholic drinks on any one occasion when you have been drinking in the last two weeks?

				3-6	7-9	10 +
	None	Once	Twice	times	times	times
(i) 11 or more drinks in a row	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
(ii) 7 or more drinks in a row	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
(iii) 5 or more drinks in a row	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

**THE NEXT QUESTIONS ARE FOR EVERYONE AND ARE ABOUT OTHER THINGS YOU MIGHT USE.**

For **each** substance, tick the box which shows how many times you have used the substance during the specified time period. There should only be **one** tick for **each** line of boxes.

30. How many times, if ever, have you used or taken pain killers/analgesics such as Disprin, Panadol or Aspro, **for any reason**:

	None	Once or twice	3-5 times	6-9 times	10-19 times	20-39 times	40+ times
(i) In the <b>last week</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(ii) In the <b>last four weeks</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iii) In the <b>last year</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iv) In your <b>lifetime</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>

31. How many times, if ever, have you used or taken sleeping tablets, tranquillisers or sedatives, such as Valium, Serepax or Rohypnol (rohies, barbs) **other than for medical reasons**:

	None	Once or twice	3-5 times	6-9 times	10-19 times	20-39 times	40 + times
(i) In the <b>last week</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(ii) In the <b>last four weeks</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iii) In the <b>last year</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iv) In your <b>lifetime</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>

32. (a) How many times, if ever, have you smoked or used marijuana/cannabis (grass, hash, dope, weed, mull, yarndi, ganga, pot, a bong, a joint):

	None	Once or twice	3-5 times	6-9 times	10-19 times	20-39 times	40 + times
(i) In the <b>last week</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(ii) In the <b>last four weeks</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iii) In the <b>last year</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iv) In your <b>lifetime</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>

*If you have NOT used marijuana/cannabis in the last year, go to*

**QUESTION 33.**

- (b) In the **last year**, did you use any other substance or substances **on the same occasion that you used** marijuana/cannabis?

*Tick **all** that apply.*

- 01  I did not use any other substance on the same occasion
- 02  Ecstasy (XTC, E, MDMA, ecci, X, bickies)
- 03  Amphetamines (eg speed, uppers, goey, MDA, dex, dexies, dexamphetamines, ox blood, methamphetamine, ice)
- 04  Hallucinogens (eg LSD, acid, trips, magic mushrooms)
- 05  Pain killers/analgesics
- 06  Sedatives/tranquillisers/sleeping tablets
- 07  Alcohol
- 08  Tobacco
- \*\*  Other (*what substance?*) \_\_\_\_\_

*You should have ticked **all** that apply.*

- (c) When you use cannabis (marijuana) do you usually:

*Tick only **one** box*

- 1  Smoke it as a joint (reefer, spliff)?
- 2  Smoke it from a bong or a pipe?
- 3  Eat it (eg in hash cookies)?
- 4  Other (*specify*) \_\_\_\_\_

*You should have ticked only **one** box.*

- (d) Do you usually use cannabis (marijuana) by yourself or with others?

- 1  By myself
- 2  With others
- 3  By myself and with others about equally often



(e) **Where did you last use cannabis?**

Fill in the space beside "**Other**" if you can't find your answer

**I used it....**

- 01  At a hotel, pub, bar, tavern or RSL club
- 02  At a dance venue, dance party, rave
- 03  At a nightclub
- 04  At a party
- 05  At my home
- 06  At my friend's home
- 07  At a sports club (eg Leagues, surfing, football)
- 08  At the beach
- 09  In a park
- 10  In a car
- 11  On school grounds during school time
- 12  On school grounds after hours
- \*\*  Other (*specify*) \_\_\_\_\_

*You should have ticked only **one** box.*

33. How many times, if ever, have you used or taken steroids, (muscle, roids, or gear) **without a doctor's prescription** in an attempt to make you better at sport, to increase muscle size or to improve your general appearance:

	None	Once or twice	3-5 times	6-9 times	10-19 times	20-39 times	40+ times
(i) In the <b>last week</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(ii) In the <b>last four weeks</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iii) In the <b>last year</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iv) In your <b>lifetime</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>

34. How many times, if ever, have you deliberately sniffed (inhaled) from spray cans or sniffed things like glue, paint, petrol or thinners in order to get high or for the way it makes you feel:

**This does not include sniffing white-out, liquid paper, textas or pens.**

	None	Once or twice	3-5 times	6-9 times	10-19 times	20-39 times	40+ times
(i) In the <b>last week</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(ii) In the <b>last four weeks</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iii) In the <b>last year</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iv) In your <b>lifetime</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>

35. (a) How many times, if ever, have you used or taken amphetamines (eg speed, uppers, MDA, goey, dex, dexies, dexamphetamine, ox blood, methamphetamine, ice) other than for medical reasons:

	None	Once or twice	3-5 times	6-9 times	10-19 times	20-39 times	40 + times
(i) In the <b>last week</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(ii) In the <b>last four weeks</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iii) In the <b>last year</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iv) In your <b>lifetime</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>

*If you have NOT used amphetamines in the last year, go to*

**QUESTION 36(a).**

- (b) In the **last year**, did you use any other substance or substances **on the same occasion that you used amphetamines** (eg speed, uppers, MDA, goey, dex, dexies, dexamphetamine, ox blood, methamphetamine, ice)?

*Tick **all** that apply.*

- 01  I did not use any other substance on the same occasion  
 02  Ecstasy (XTC, E, MDMA, ecci, X, bickies)  
 03  Marijuana/cannabis  
 04  Hallucinogens (eg LSD, acid, trips, magic mushrooms)  
 05  Pain killers/analgesics  
 06  Sedatives/tranquillisers/sleeping tablets  
 07  Alcohol  
 08  Tobacco  
 \*\*  Other (*what substance?*) \_\_\_\_\_

*You should have ticked **all** that apply*

36. (a) How many times, if ever, have you used or taken ecstasy or XTC (E, MDMA, ecci, X, bickies):

	None	Once or twice	3-5 times	6-9 times	10-19 times	20-39 times	40 + times
(i) In the <b>last week?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(ii) In the <b>last four weeks?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iii) In the <b>last year?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iv) In your <b>lifetime?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>

***If you have NOT used ecstasy in the last year, go to QUESTION 37.***

- (b) In the **last year**, did you use any other substance or substances **on the same occasion that you used** ecstasy (XTC, E, MDMA, ecci, X, bickies):

*Tick **all** that apply.*

- 01  I did not use any other substance on the same occasion  
 02  Marijuana/cannabis  
 03  Amphetamines (eg speed, uppers, goey, MDA, dex, dexies, dexamphetamines, ox blood, methamphetamine, ice)  
 04  Hallucinogens (eg LSD, acid, trips, magic mushrooms)  
 05  Pain killers/analgesics  
 06  Sedatives/tranquillisers/sleeping tablets  
 07  Alcohol  
 08  Tobacco  
 \*\*  Other (*what substance?*) \_\_\_\_\_

*You should have ticked **all** that apply.*

37. How many times, if ever, have you used or taken cocaine:

	None	Once or twice	3-5 times	6-9 times	10-19 times	20-39 times	40 + times
(i) In the <b>last week</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(ii) In the <b>last four weeks</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iii) In the <b>last year</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iv) In your <b>lifetime</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>

38. How many times, if ever, have you used or taken heroin (smack, horse, skag, hammer, H), or other opiates (narcotics) such as methadone, morphine or pethidine **other than for medical reasons:**

	None	Once or twice	3-5 times	6-9 times	10-19 times	20-39 times	40 + times
(i) In the <b>last week?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(ii) In the <b>last four weeks?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iii) In the <b>last year?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iv) In your <b>lifetime?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>

39. (a) How many times, if ever, have you used or taken hallucinogens (eg LSD, acid, trips, magic mushrooms, datura, angel's trumpet):

	None	Once or twice	3-5 times	6-9 times	10-19 times	20-39 times	40 + times
(i) In the <b>last week?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(ii) In the <b>last four weeks?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iii) In the <b>last year?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iv) In your <b>lifetime?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>

*If you have NOT used hallucinogens in the last year, go to QUESTION*

40.

(b) In the **last year**, what forms of hallucinogens did you use?

*Tick all that apply.*

- 1  Tablets
- 2  Paper tabs
- 3  Liquids
- 4  Magic mushrooms
- 5  Datura / Angel's trumpet
- 6  Other (*please write in*) \_\_\_\_\_

- (c) In the **last year**, did you use any other substance or substances **on the same occasion that you used** hallucinogens (eg LSD, acid, trips, magic mushrooms, datura, angel's trumpet)?

*Tick **all** that apply.*

- 01  I did not use any other substance on the same occasion
- 02  Ecstasy (XTC, E, MDMA, ecci, X, bickies)
- 03  Amphetamines (eg speed, uppers, goey, MDA, dex, dexies, dexamphetamines, ox blood, methamphetamine, ice)
- 04  Marijuana/cannabis
- 05  Pain killers/analgesics
- 06  Sedatives/tranquillisers/sleeping tablets
- 07  Alcohol
- 08  Tobacco
- \*\*  Other (*what substance?*) \_\_\_\_\_

*You should have ticked **all** that apply.*

**THESE QUESTIONS ARE FOR EVERYONE.**

40. **During 2001** (last year), did you have any lessons or parts of lessons at school that were about **smoking**?
- 1  No, not even part of a lesson
- 2  Yes, part of a lesson
- 3  Yes, one lesson
- 4  Yes, more than one lesson
41. **During 2001** (last year), did you have any lessons or parts of lessons at school that were about **drinking**?
- 1  No, not even part of a lesson
- 2  Yes, part of a lesson
- 3  Yes, one lesson
- 4  Yes, more than one lesson

42. **During 2001** (last year), did you have any lessons or parts of lessons at school that were about **illicit drugs** such as marijuana, ecstasy, heroin, amphetamines, hallucinogens, cocaine?

- 1  No, not even part of a lesson
- 2  Yes, part of a lesson
- 3  Yes, one lesson
- 4  Yes, more than one lesson

*Remember, **last** year was 2001.*

**THE NEXT FEW QUESTIONS ARE ABOUT SOME OTHER TOPICS.**

43. You only get skin cancer if you get burnt often.

- 1  True
- 2  False

44. Most skin cancer is caused by ultraviolet radiation (UVR) from the sun.

- 1  True
- 2  False

45. **During 2001** (that is **last year**), did you have any lessons or parts of lessons at school that were about **skin cancer** or **protection from the sun**?

- 1  No, not even part of a lesson
- 2  Yes, part of a lesson
- 3  Yes, one lesson
- 4  Yes, more than one lesson

46. Over the **last** summer, did you get sunburn that was sore or tender the next day?

- 1  Yes, just once
- 2  Yes, 2 or 3 times
- 3  Yes, 4 or more times
- 4  No, not at all

47. (a) Have you **ever** had severe sunburn, which has blistered?

- 1  Yes ***Go to QUESTION 47(b)***
- 2  No ***Go to QUESTION 48***

(b) **If yes**, how long ago was the last time you were severely sunburnt?

- 1  Last summer
- 2  1 to 2 years ago
- 3  More than 2 years ago

48. What type of hat do you most often wear on a sunny day in summer?

- 1  Wide brimmed hat
- 2  Narrow brimmed hat
- 3  Legionnaire hat
- 4  Cap
- 5  Sun-visor
- 6  Other (*what kind?*) \_\_\_\_\_
- 7  None



49. What is the SPF (Sun Protection Factor) of the sunscreen you usually use on a sunny day in summer?
- 1  I don't use sunscreen
  - 2  SPF 12 or lower
  - 3  SPF 15
  - 4  SPF 30+
  - 5  Can't remember / don't know
50. Suppose your skin was exposed to **strong** sunshine at the **beginning** of summer with no protection at all. If you stayed in the sun for 30 minutes, would your skin:
- 1  Just burn or go red
  - 2  Burn or go red first, then tan afterwards
  - 3  Just tan
  - 4  Nothing would happen because I was born with dark skin
51. Do you like to get a suntan?
- 1  No
  - 2  Yes, a light tan
  - 3  Yes, a moderate tan
  - 4  Yes, a dark tan
  - 5  Yes, a very dark tan

52. **Thinking about sunny days in summer, when you are outside for an hour or more between 11 am and 3 pm, how often would you:**

	Never	Rarely	Sometimes	Usually	Always
(i) Wear a hat?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
(ii) Wear clothes covering most of your body (including arms and legs)?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
(iii) Deliberately wear less or briefer clothing so as to get some sun on your skin?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
(iv) Wear maximum protection sunscreen (SPF 30+)?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
(v) Wear sunglasses?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
(vi) Stay mainly in the shade?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

**Thinking about sunny days in summer between 11 am and 3 pm:**

	Never	Rarely	Sometimes	Usually	Always
(vii) How often would you spend most of the time <b>inside</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

# APPENDIX TWO: NATIONAL DRUG STRATEGY HOUSEHOLD SURVEY

<b>OFFICE USE ONLY:</b>	<b>DROP &amp; COLLECT</b>
CCD No. <input style="width: 100%;" type="text"/>	ROTATION: <input style="width: 20px;" type="text" value="1"/> <input style="width: 20px;" type="text" value="1"/>
Date: <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 40px;" type="text" value="2001"/>	
Day                      Month                      Year	
Household ID Number: <input style="width: 100%;" type="text"/>	



## 2001 National Drug Strategy Household Survey

### What is the purpose of this form?

The National Drug Strategy Household Survey has been conducted since 1985. This is the seventh occasion that information from households on drug awareness, attitudes and behaviour has been collected. We would like you to complete this questionnaire by yourself.

The questionnaire is for your use only. Your answers will help the Department of Health and Aged Care to effectively examine important health and social issues and certain behaviour relating to tobacco, alcohol and drug use.

### How confidential is the information you give?

Completely confidential!! When you have completed this form, please seal it in the envelope provided and give it back to the Roy Morgan Research fieldworker who will return it sealed to the survey team for processing. The survey is managed by the Australian Institute of Health & Welfare (AIHW), on behalf of the Department. Only the survey team will have access to your form and once the survey data is compiled your form will be destroyed. Your name and address will never be linked with any of the information you provide.

Section 29 of the AIHW Act prohibits the release of information about individuals collected in the survey.

**Please be as honest and as accurate as possible. If you do not wish to answer any question for any reason, you do not have to do so. Participation in this survey is entirely voluntary.**

### How to complete this form:

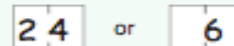
- Please complete this form carefully using black ballpoint pen (not felt). Alternatively use blue pen.

Most questions only require you to answer by marking the appropriate box or boxes with a cross like this:



Please do not mark any areas outside the box.

- Other questions will require a numeric answer and can be filled in like this:



Please do not cross the number 7. Please make sure to write only one number in each box.

- Other questions will ask you to write your answer in the box provided. Please ensure that you print your answers like this:

Last year I travelled to Bali on a Holiday

- If you make a mistake, completely shade out the box and cross the appropriate one.



- If you see an instruction like this (**skip to**), you should follow the direction exactly. For example (skip to Y1) means that you should miss all the questions after the one you have just answered, until you come to the question marked Y1. If you do not see the skip to, just answer the next question.



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## A note for all, but particularly, for our younger respondents.

The answers you give in this survey will be used by researchers to help in understanding what people think about tobacco, alcohol and other drugs and how widely drugs are used. You might feel embarrassed about giving honest answers. You might even be afraid that the researchers will be able to identify you, or that the answers will be shown to your parents. This will not, and cannot, happen.

All survey forms have codes entered onto them and the researchers will not know who you are. Your answers will be added to everyone else's (perhaps up to 20,000 people) before the researchers get to see them. When all the answers are collected, researchers will then be able to report, for example, that "most young people do not smoke" or that "less than half of all young women drink alcohol". Your answers will simply become part of a much bigger pool of answers.

The only researchers who will get to see the pool of answers are those who are looking at health or social issues relating to drug use. They must meet strict guidelines before the Australian Institute of Health and Welfare or the Department of Health and Aged Care will let them look at the answers you provide. Your answers will help in planning health and other services for the community.

Remember, your name and address will never be linked with any of the information you provide.

## Section A - Perceptions

A1. When people talk about "a drug problem", which are the first two drugs you think of?

(Cross only one drug category in each column)

	1st drug?	2nd drug?
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>
Tea/coffee/caffeine	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates (e.g. Barbies, Barbs, Downers, Reds, Purple hearts)	<input type="checkbox"/>	<input type="checkbox"/>
Tranquillisers, Sleeping Pills (e.g. Benzos, Temazzies, Tranks, Sleepers, Valium, Serapax, Serries, Mandrax, Mandies, Rohypnol, Rowies)	<input type="checkbox"/>	<input type="checkbox"/>
Pain killers, Analgesics (e.g. Aspirin, Paracetamol, Mersyndol)	<input type="checkbox"/>	<input type="checkbox"/>
Steroids (e.g. Roids, Juice)	<input type="checkbox"/>	<input type="checkbox"/>
Inhalants/Solvents/Aerosols/Glue/Petrol (e.g. Laughing Gas, Whippits, Nitrous, Snappers, Poppers, Pearlers, Rushamines, Locker Room, Bolt, Bullet, Rush, Climax, Red Gold)	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana/Hashish/Cannabis Resin (e.g. Pot, Grass, Weed, Reefer, Joint, MaryJane, Acapulco Gold, Rope, Mull, Cone, Spliff, Dope, Skunk, Bhang, Ganja, Hash, Chronic)	<input type="checkbox"/>	<input type="checkbox"/>
Naturally Occurring Hallucinogens (e.g. Blue Meanies, Gold Tops, Mushies, Magic Mushrooms, Datura, Angel's Trumpet)	<input type="checkbox"/>	<input type="checkbox"/>
LSD/Synthetic Hallucinogens/Psilocybin/ PCP (e.g. Acid, Trips, Wedges, Windowpane, Blotter, Microdot, Angel Dust, Hog, Loveboat)	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines/Speed (e.g. Crystal, Whizz, Goey, Gogo, Zip, Uppers, Ice, Amphet, Meth, Ox Blood, Leopards Blood, MDA, Bromo MDA, MDEA, Methylamphetamine, Eve, Shabu)	<input type="checkbox"/>	<input type="checkbox"/>
Heroin (e.g. Hammer, Smack, Horse, H, Boy, Junk)	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine (e.g. Coke, Crack, Flake, Snow, White Lady/Girl, Happy Dust, Gold Dust, Toot, Scotty, Charlie, Cecil, C, Freebase)	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy/Designer Drugs (e.g. XTC, E, Ex, Ecci, E and C, Adam, MDMA, PMA, GHB)	<input type="checkbox"/>	<input type="checkbox"/>
Kava	<input type="checkbox"/>	<input type="checkbox"/>
Drugs other than listed	<input type="checkbox"/>	<input type="checkbox"/>
None/Can't think of any/any more	<input type="checkbox"/>	<input type="checkbox"/>



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**THE FOLLOWING SECTIONS CONTAIN QUESTIONS WHICH DEAL WITH ACTIVITIES WHICH MAY BE AGAINST THE LAW.**

**We remind you that only our survey team have access to your form, and once the survey data is compiled, your form will be destroyed.**

**Your name and address will never be linked with any of the information you provide.**

**Answers are completely confidential.**

**You may telephone 1800 656 856 (a free call) to speak to an officer from the Australian Institute of Health and Welfare, who will confirm the data process for you.**

**If you do not wish to answer any question for whatever reason, you do not have to. Participation in this survey is entirely voluntary.**

**THANK YOU FOR YOUR PATIENCE AND YOUR HELP WITH THIS SURVEY**

Just as a reminder, this survey is conducted under the AIHW Act, which prohibits the release of information about individuals collected from this survey. The information you provide in the following sections may appear to be self-incriminating, however, your individual information cannot be revealed and you will not be identified from the responses you provide.

## Section D

**FOR THIS SURVEY, THE TERM "NON-MEDICAL PURPOSES" MEANS DRUGS USED:**

1. either alone or with other drugs in order to induce or enhance a drug experience;
2. for performance (e.g. athletic) enhancement; or
3. for cosmetic (e.g. body shaping) purposes

**D1. In the past 12 months, have you been offered or had the opportunity to use any of the following?**

(Answer yes or no for each drug type)

	Yes	No
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Pain killers, Analgesics for <u>non-medical purposes</u> (e.g. Aspirin, Paracetamol, Mersyndol)	<input type="checkbox"/>	<input type="checkbox"/>
Tranquillisers, Sleeping Pills for <u>non-medical purposes</u> (e.g. Benzos, Temazzies, Tranks, Sleepers, Valium, Serapax, Serries, Mandrax, Mandies, Rohypnol, Rowies)	<input type="checkbox"/>	<input type="checkbox"/>
Steroids for <u>non-medical purposes</u> (e.g. Roids, Juice)	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates for <u>non-medical purposes</u> (e.g. Barbies, Barbs, Downers, Reds, Purple Hearts)	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana/Hashish/Cannabis Resin (e.g. Pot, Grass, Weed, Reefer, Joint, MaryJane, Acapulco Gold, Rope, Mull, Cone, Spliff, Dope, Skunk, Bhang, Ganja, Hash, Chronic)	<input type="checkbox"/>	<input type="checkbox"/>
Heroin (e.g. Hammer, Smack, Horse, H, Boy, Junk)	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines/Speed (e.g. Crystal, Whizz, Goey, Gogo, Zip, Uppers, Ice)	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine (e.g. Coke, Crack, Flake, Snow, White Lady/Girl, Happy Dust, Gold Dust, Toot, Scotty, Charlie, Cecil, C, Freebase)	<input type="checkbox"/>	<input type="checkbox"/>
Naturally Occurring Hallucinogens (e.g. Blue Meanies, Gold Tops, Mushies, Magic Mushrooms, Datura, Angel's Trumpet)	<input type="checkbox"/>	<input type="checkbox"/>
LSD/Synthetic Hallucinogens/Psilocybin/PCP (e.g. Acid, Trips, Wedges, Windowpane, Blotter, Microdot, Angel Dust, Hog, Loveboat)	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy/Designer Drugs (e.g. XTC, E, Ex, Ecce, E and C, Adam, MDMA, PMA, GHB)	<input type="checkbox"/>	<input type="checkbox"/>
Inhalants/Solvents/Aerosols/Glue/Petrol (e.g. Laughing Gas, Whippits, Nitrous, Snappers, Poppers, Pearlers, Rushamines, Locker Room, Bolt, Bullet, Rush, Climax, Red Gold)	<input type="checkbox"/>	<input type="checkbox"/>
Kava	<input type="checkbox"/>	<input type="checkbox"/>

**D2. How difficult or easy would it be for you to get some of the following drugs, if you wanted some?**

(Mark one box for each drug type)

	Probably impossible	Very difficult	Fairly difficult	Fairly easy	Very easy	Don't know
Marijuana/Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LSD/Naturally Occurring Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy/Designer Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines/Speed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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## Section E

**E1. About what proportion of your friends and acquaintances smoke tobacco?**  
(Mark one response only)

- All   
Most   
About half   
A few   
None

**E2. In the last 12 months, have you or any other member of your household smoked at least one cigarette, cigar or pipe of tobacco per day in the home?**  
(Mark one response only)

- Yes, inside the home   
No, only smoke outside the home   
No-one at home regularly smokes

**E3. Have you personally ever tried smoking cigarettes or other forms of tobacco?**

- Yes  (Continue)    No  (Skip to E22)

**E4. Have you ever smoked a full cigarette?**

- Yes  (Continue)    No  (Skip to E22)

**E5. About what age were you when you smoked your first full cigarette?**

Age in years:

**E6. Would you have smoked at least 100 cigarettes (manufactured or roll your own), or the equivalent amount of tobacco in your life?**

- Yes  (Continue)    No  (Skip to E22)

**E7. Have you ever smoked on a daily basis?**  
(Mark one response only)

- Yes, I smoke daily now  (Skip to E9)  
Yes, I used to smoke daily, but not now  (Continue)  
No, never smoked daily  (Skip to E10)

**E8. About what age were you when you stopped smoking daily?**

Age in years:

**E9. At what age did you first start smoking daily?**

Age in years:  (If now smoke daily skip to E12)

**E10. How often do you now smoke cigarettes, pipes or other tobacco products?**

- Daily   
At least weekly (not daily)  (Skip to E12)  
Less often than weekly   
Not at all, but I have smoked in the last 12 months  (Skip to E16)  
Not at all and I have not smoked in the last 12 months  (Continue)

**E11. About what age were you when you last smoked?**

Age in years:  (If not smoked in last 12 months skip to E22)

**E12. How often, if at all, do you now smoke manufactured cigarettes?**

Daily  → How many per day?

or

At least weekly (but not daily)  → How many per week?

or

Less often than weekly  → How many per month?

or

Not at all

**E13. How often, if at all, do you now smoke roll-your-own cigarettes?**

Daily  → How many per day?

or

At least weekly (but not daily)  → How many per week?

or

Less often than weekly  → How many per month?

or

Not at all



E14. How often, if at all, do you now smoke cigars or pipes?

- Daily   
At least weekly (not daily)   
Less often than weekly   
Not at all

E15. During the past 12 months, did you want to or try to stop or cut down on your use of tobacco, but found that you couldn't?

- Yes  No

E16. In the last 12 months, have you:  
(Mark all that apply)

- Successfully given up smoking  
(for more than a month)   
Tried to give up unsuccessfully   
Changed to a brand with lower  
tar or nicotine content   
Tried to change to a brand with  
lower tar or nicotine content,  
but was unsuccessful   
Reduced the amount of tobacco  
you smoke in a day   
Tried to reduce the amount of tobacco  
smoked in a day, but was unsuccessful   
None of these  (Skip to E19)

E17. Which of the following motivated you to try giving up, cutting down or changing to a lower tar or nicotine brand?

(Mark all that apply)

- Health warnings on cigarette packets   
Government advertisements on TV, press  
or radio advertising by pharmaceutical  
companies for products such as  
nicotine gum, patches or Zyban   
Tobacco Information Line  
(ie phone number on cigarette packet)   
QUIT line   
I wanted to get fit   
I was pregnant or planning to start a family   
I think it was affecting my health or fitness   
My doctor advised me to give up   
Family and/or friends asked me to quit   
I was worried it was affecting the health  
of those around me   
It was costing too much   
Smoking restrictions in public areas  
(e.g. restaurants, sporting venues,  
public transport etc.)   
Smoking restrictions in the work place   
Other

E18. In the last 12 months, on average how much do you think you have cut down on your cigarette smoking?

(Mark one response only)

- Have not cut down   
By about 1 to 5 cigarettes per day   
By about 6 to 10 cigarettes per day   
By about 11 to 15 cigarettes per day   
By about 16 to 20 cigarettes per day   
By more than 20 cigarettes per day   
Don't smoke cigarettes

E19. Are you planning on giving up smoking?

(Mark one response only)

- No, I have already given up   
Yes, within 30 days   
Yes, after 30 days, but within the next 3 months   
Yes, but not within the next 3 months   
No, I am not planning to give up

## Reminder:

Please cross inside the box, like this:



If you see a (skip to) after the box you have just marked, go straight to the question indicated.



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**E20. During the past 12 months, have you done any of the following?**

(Mark all that apply)

- Discussed smoking and health at home
- Rung the "QUIT" line
- Asked your doctor for help to quit
- Used nicotine gum, nicotine patch or nicotine inhaler
- Used a smoking cessation pill (Zyban)
- Bought a product other than nicotine patch, gum or pill to help you quit
- Read "How to Quit" literature
- Done something else to help you quit
- None of the above
- Don't know

**E21. During the past 12 months, has anybody at your house been trying to get you to quit smoking?**

(Mark all that apply)

- Yes – Parent
- Yes – Child
- Yes – Sibling (brother or sister)
- Yes – Partner/spouse
- Yes – Friend/flatmate
- Yes – Other person
- No one trying to get me to quit
- Not applicable (live alone)

ALL PLEASE ANSWER

**E22. At the present time, do you consider yourself:**

(Mark one response only)

- A non-smoker
- An ex-smoker
- An occasional smoker
- A light smoker
- A heavy smoker
- A chain smoker

**E23. Have you come across unbranded loose tobacco (also called chop chop) sold in plastic bags or rolled into unbranded cigarettes?**

Yes  (Continue)    No  (Skip to F1)

**E24. Have you ever smoked it?**

Yes  (Continue)    No  (Skip to F1)

**E25. How often do you smoke this type of tobacco?**

(Mark one response only)

- Every day
- Some days
- Only occasionally
- No longer use it  (Skip to F1)

**E26. Would you say that when you smoke, you:**

(Mark one response only)

- Only smoke this type of tobacco
- Mainly smoke this type of tobacco
- Smoke this type of tobacco about half of the time
- Smoke this type of tobacco less than half of the time
- Occasionally smoke this type of tobacco



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## Section F

F1. About what proportion of your friends and acquaintances consume alcohol?

(Mark one response only)

- All   
 Most   
 About half   
 A few   
 None

F2. Have you ever tried alcohol?

- Yes   
 No  (Skip to F20)

F3. Have you ever had a full serve of alcohol?  
 (eg. a glass of wine, a whole nip of spirits, a glass of beer, etc.)

- Yes   
 No  (Skip to F20)

F4. At what age were you when you had your first full serve of alcohol?

Age in years:

F5a. Have you had an alcoholic drink of any kind in the last 12 months?

- Yes  (Skip to F6)  
 No  (Continue)

F5b. About what age were you when you last had an alcoholic drink?

Age in years:  (If non-drinker in past 12 months skip to F20)

F6. In the last 12 months, how often did you have an alcoholic drink of any kind?  
 (Mark one response only)

- Every day   
 5 to 6 days a week   
 3 to 4 days a week   
 1 to 2 days a week   
 2 to 3 days a month   
 About 1 day a month   
 Less often   
 No longer drink  (Skip to F9)

F7. What type of alcohol do you usually drink?

(Mark all that apply)

- Cask wine   
 Bottled wine   
 Regular Strength Beer  
 (greater than 4% Alc/Vol)   
 Mid Strength Beer (3% to 3.9% Alc/Vol)   
 Low Alcohol Beer (1% to 2.9% Alc/Vol)   
 Premixed spirits in a can  
 (e.g. UDL, Jim Beam and Cola)   
 Bottled spirits and liqueurs  
 (e.g. scotch, brandy, vodka, rum,  
 Kahlua, Midori, Baileys etc.)   
 Premixed bottles (e.g. Bacardi Breezer,  
 Sub-Zero, Lemon Ruski/Stolis)   
 Cider   
 Home brewed beer   
 Fortified wine, port, vermouth, sherry, etc.   
 Other

F8. Where do you usually drink alcohol?

(Mark all that apply)

- In my home   
 At a friend's house   
 At private parties   
 At raves/dance parties   
 At restaurants/cafés   
 At licensed premises (e.g. pub/club)   
 At School, TAFE, University, etc.   
 At my workplace   
 In public places (e.g. parks)   
 In a car or other vehicle   
 Somewhere else

F9. In the last 12 months have you...

(Mark all that apply)

- Reduced the amount of alcohol  
 you drink at any one time?   
 Reduced the number of  
 times you drink?   
 Switched to drinking more  
 low-alcoholic drinks than  
 you used to?   
 Stopped drinking alcohol   
 None of the above  (Skip to F11)



**F10. What was the main reason for doing that?**  
(Mark one response only)

- Health reasons (eg. weight, diabetes, avoid hangover)
- Life style reasons (eg. work/study commitments, less opportunity, young family)
- Social reasons (eg. believe in moderation, concerned about violence, avoid getting drunk)
- Pregnant and/or breastfeeding
- Taste/enjoyment (eg. prefer low alcohol beer, don't get drunk)
- Drink driving regulations
- Financial reasons
- Peer pressure
- Other

If you no longer drink alcohol (at F6) – Skip to F13

**EXAMPLE OF STANDARD DRINKS**

The number of standard drinks in each container is shown by the number in bold under each one.

								
<b>1.5</b>	<b>1</b>	<b>0.8</b>	<b>1.5</b>	<b>1</b>	<b>0.8</b>	<b>1</b>	<b>0.7</b>	<b>0.5</b>
375ml Full Strength Beer 4.9% Alc/Vol	375ml Mid Strength Beer 3.5% Alc/Vol	375ml Light Beer 2.7% Alc/Vol	375ml Full Strength Beer 4.9% Alc/Vol	375ml Mid Strength Beer 3.5% Alc/Vol	375ml Light Beer 2.7% Alc/Vol	285ml Middy* Full Strength Beer 4.9% Alc/Vol	285ml Middy* Mid Strength Beer 3.5% Alc/Vol	285ml Middy* Light Beer 2.7% Alc/Vol
								
<b>1.5</b>	<b>1.5</b>	<b>1</b>	<b>24</b>	<b>1</b>	<b>1.8</b>	<b>7</b>	<b>36</b>	
375ml Pre-mix Spirits 5% Alc/Vol	340ml Alcoholic Soda 5.5% Alc/Vol	30ml Spirit Nip 40% Alc/Vol	750ml Bottle of Spirits 40% Alc/Vol	100ml Standard Serve of Wine 12% Alc/Vol	180ml Average Restaurant Serve of Wine 12% Alc/Vol	750ml Bottle of Wine 12% Alc/Vol	4 Litres Cask Wine 12% Alc/Vol	

\* NSW, WA, ACT = Middy; VIC, QLD, TAS = Pint; NT = Harbin; SA = Schearer



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F11. On a day that you have an alcoholic drink, how many standard drinks do you usually have?

(Mark one response only)

- 13 or more drinks
- 11 – 12 drinks
- 7 – 10 drinks
- 5 – 6 drinks
- 3 – 4 drinks
- 1 – 2 drinks

F12. When you have an alcoholic drink, how often do you do any of the following?

(Mark one response for each row below)

	Always	Most of the time	Sometimes	Rarely	Never
Count the number of drinks you have	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deliberately alternate between alcoholic and non-alcoholic drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Make a point of eating while consuming alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quench your thirst by having a non-alcoholic drink before having alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Only drink low alcohol drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limit the number of drinks you have in an evening (e.g. when driving)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Refuse an alcoholic drink you are offered because you really don't want it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F13. Please record how often in the last 12 months you have had each of the following number of standard drinks in a day?

(Mark one response for each row below)

	Every day	5 – 6 days a week	3 – 4 days a week	1 – 2 days a week	2 – 3 days a month	About 1 day a month	Less often	Never
20 or more standard drinks a day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 – 19 standard drinks a day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 – 10 standard drinks a day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 – 6 standard drinks a day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 – 4 standard drinks a day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1 – 2 standard drinks a day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



F14. Please mark the day of the week that is today.  
(Mark one response only)

- Monday
- Tuesday
- Wednesday
- Thursday
- Friday
- Saturday
- Sunday

F15. How many alcoholic drinks did you have yesterday?

Number of drinks:

None  (Skip to F17)

### EXAMPLE ONLY

F16. How many nips, cans, bottles or glasses did you have yesterday? For each of the following drinks, please summarise your own usage.

HERE IS AN EXAMPLE OF HOW TO ANSWER:

	Cans	Small Bottles (300 – 375 ml)	Large Bottles (750ml)	Large Glass (425 ml)	Medium Glass (285 ml)	Small Glass (100 – 200ml)	Nips	English Pint Glass	Other (write in)
Cask wine									
Bottled wine						2			
Regular Strength Beer (greater than 4% Alc/Vol)		1						2	

Yesterday, this person had 2 glasses of bottled wine, 1 small bottle of Regular Strength Beer and 2 English pints of Regular Strength Beer.

**Notes -**

- Small Bottles (300 – 375 ml) – e.g. Stubbies, echos, half-bottles of wine, premixed spirit bottles, cider bottles, etc.
- Large Glass (425 ml) – e.g. 15 oz, schooners in NSW, pints in SA, etc.
- Medium Glass (285 ml) – e.g. 10 oz, middies in NSW, pots in VIC and QLD, schooners in SA, handles in NT, etc.
- Small Glass (100 – 200 ml) – e.g. Wine, champagne glass, small beer glass (7 oz, butchers, ponies) etc.
- Nips – e.g. Full measures of spirits, shot and shooter glasses, port and sherry glasses, etc.

**The example above shows you how to complete the table for F16 on the next page.**



R1078

F16. How many nips, cans, bottles or glasses did you have yesterday? For each of the following drinks, please summarise your own usage.

	Cans	Small Bottles (20)–275 ml	Large Bottles (750ml)	Large Glass (225 ml)	Medium Glass (225 ml)	Small Glass (10)–200ml	Nips	Other (write in)		
								1	2	3
Cask wine				<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
Bottled wine		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
Regular Strength Beer (greater than 4% Alc/Vol)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
Mid Strength Beer (3% to 3.9% Alc/Vol)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
Low Alcohol Beer (1% to 2.9% Alc/Vol)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
Home brewed beer		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
Premixed spirits in cans (e.g. UDL, Jim Beam and Cola)	<input type="text"/>			<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
Bottled spirits and liqueurs (e.g. Vodka, Rum, Gin, Kahlua)		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Premixed bottles (e.g. Lemon Ruski/Stolis, Bacardi Breezer)		<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
Cider	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
Fortified wine, port, vermouth, sherry, etc		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (please write in)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4 <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

4

Office Use Only

An example of how to complete this question is shown on the previous page.

OFFICE USE ONLY:



R1075

16

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F17. In the past 12 months, about how often have you been unable to remember afterwards what happened while you were drinking?  
(Mark one response only)

- Every day
- 5 to 6 days a week
- 3 to 4 days a week
- 1 to 2 days a week
- 2 to 3 days a month
- About 1 day a month
- Less often but at least once
- Never

F18. During the past 12 months, did you want to or try to stop or cut down on your use of alcohol but found that you couldn't?

- Yes
- No

F19. Have you ever found that you drank alcohol much more often in larger amounts than you intended?

- Yes
- No

ALL PLEASE ANSWER

F20. At the present time do you consider yourself:  
(Mark one response only)

- A non-drinker
- An ex-drinker
- An occasional drinker
- A light drinker
- A social drinker
- A heavy drinker
- A binge drinker

Just as a reminder, this survey is conducted under the AIHW Act, which prohibits the release of individuals' information collected from this survey. The information you provide in the following sections may appear to be self-incriminating, however, your individual information cannot be revealed and you will not be identified from the responses you provide.

## Section G

FOR THIS SURVEY, THE TERM "NON-MEDICAL PURPOSES" MEANS DRUGS USED:

1. either alone or with other drugs in order to induce or enhance a drug experience;
2. for performance (e.g. athletic) enhancement; or
3. for cosmetic (e.g. body shaping) purposes

The term illicit drug and illegal drug are used interchangeably to describe each of the following:

- Any drug which is illegal to possess or use;
- Any legal drug used in an illegal manner, for example:
  - A drug obtained on prescription but given to another person to use;
  - Glue or petrol which is sold legally, but is used in a manner that is not intended, such as inhaling fumes; or
  - Stolen pharmaceuticals sold on the black market (e.g. Pethidine).

G1. About what proportion of your friends and acquaintances use Pain killers/Analgesics for non-medical purposes?  
(e.g. Aspirin, Paracetamol, Mersyndol)  
(Mark one response only)

- All
- Most
- About half
- A few
- None

G2. Have you ever used Pain Killers/Analgesics for non-medical purposes?

- Yes  (Continue) No  (Skip to H1)

G3. About what age were you when you first used Pain Killers/Analgesics for non-medical purposes?

Age in years:

G4. Have you used Pain Killers/Analgesics for non-medical purposes in the last 12 months?

- Yes  (Continue) No  (Skip to H1)

G5. During the past 12 months, did you want to or try to stop or cut down on your use of Pain Killers/Analgesics for non-medical purposes, but found that you couldn't?

- Yes  No

G6. Have you used Pain Killers/Analgesics for non-medical purposes in the last month?

- Yes  (Continue) No  (Skip to G8)



G7. Have you used Pain Killers/Analgesics for non-medical purposes in the last week?

Yes  No

G8. In the last 12 months, how often did you use Pain Killers/Analgesics for non-medical purposes?  
(Mark one response only)

Every day   
Once a week or more   
About once a month   
Every few months   
Once or twice a year

G9. Where do/did you usually obtain Pain Killers/Analgesics for non-medical purposes?  
(Mark one response only)

Friend or acquaintance   
Brother or sister   
Parent   
Spouse or partner   
Other relative   
Dealer on the street   
Dealer delivers to my home   
Visit to the dealer's house   
Dealer at another location   
Doctor shopping/forged script   
Steal it   
Buy at a shop/retail outlet  
(e.g. chemist, supermarket, etc.)   
Other

G10. Where do/did you usually use Pain Killers/Analgesics for non-medical purposes?  
(Mark all that apply)

In my own home   
At a friend's house   
At private parties   
At raves/dance parties   
At restaurants/cafes   
At licensed premises (e.g. pubs, clubs)   
At School, TAFE, University etc   
At my workplace   
In public places (e.g. parks)   
In a car or other vehicle   
Somewhere else

G11. Which of the following did you use at the same time, on at least one occasion that you used Pain Killers/Analgesics for non-medical purposes?  
(Mark all that apply)

Alcohol   
Marijuana/Cannabis   
Heroin   
Cocaine/Crack   
Tranquillisers/Sleeping Pills   
Anti-depressants   
Barbiturates   
Amphetamines/Speed   
Ecstasy/Designer Drugs   
Other   
Not used any of the  
above at the same time  
as Pain Killers/Analgesics for  
non-medical purposes

G12. What drug would you mostly use when Pain Killers/Analgesics for non-medical purposes are not available?  
(Mark one response only)

Alcohol   
Marijuana/Cannabis   
Heroin   
Cocaine/Crack   
Tranquillisers/Sleeping Pills   
Anti-depressants   
Barbiturates   
Amphetamines/Speed   
Ecstasy/Designer Drugs   
Other   
No other drug





## Section H

H1. About what proportion of your friends and acquaintances use Tranquillisers/Sleeping Pills for non-medical purposes?

(e.g. Benzos, Temazzies, Tranks, Sleepers, Valium, Serapax, Mandrax, Mandies, Rohypnol, Rowies)

- All   
 Most   
 About half   
 A few   
 None

H2. Have you ever used Tranquillisers/Sleeping Pills for non-medical purposes?

Yes  (Continue)    No  (Skip to J1)

H3. About what age were you when you first used Tranquillisers/Sleeping Pills for non-medical purposes?

Age in years:

H4. Have you used Tranquillisers/Sleeping Pills for non-medical purposes in the last 12 months?

Yes  (Continue)    No  (Skip to J1)

H5. During the past 12 months, did you want to or try to stop or cut down on your use of Tranquillisers/Sleeping Pills for non-medical purposes, but found that you couldn't?

Yes     No

H6. Have you used Tranquillisers/Sleeping Pills for non-medical purposes in the last month?

Yes  (Continue)    No  (Skip to H8)

H7. Have you used Tranquillisers/Sleeping Pills for non-medical purposes in the last week?

Yes     No

H8. In the last 12 months, how often did you use Tranquillisers/Sleeping Pills for non-medical purposes?

(Mark one response only)

- Every day   
 Once a week or more   
 About once a month   
 Every few months   
 Once or twice a year

H9. Where do/did you usually obtain Tranquillisers/Sleeping Pills for non-medical purposes?

(Mark one response only)

- Friend or acquaintance
- Brother or sister
- Parent
- Spouse or partner
- Other relative
- Dealer on the street
- Dealer delivers to my home
- Visit to the dealer's house
- Dealer at another location
- Doctor shopping/forged script
- Steal it
- Other

H10. Where do/did you usually use Tranquillisers/Sleeping Pills for non-medical purposes?

(Mark all that apply)

- In my own home
- At a friend's house
- At private parties
- At raves/dance parties
- At restaurants/cafes
- At licensed premises (e.g. pubs, clubs)
- At School, TAFE, University etc
- At my workplace
- In public places (e.g. parks)
- In a car or other vehicle
- Somewhere else

H11. Which of the following did you use at the same time, on at least one occasion that you used Tranquillisers/Sleeping Pills for non-medical purposes?

(Mark all that apply)

- Alcohol
- Marijuana/Cannabis
- Heroin
- Cocaine/Crack
- Anti-depressants
- Pain killers/Analgesics
- Barbiturates
- Amphetamines/Speed
- Ecstasy/Designer Drugs
- Other

Not used any of the above at the same time as Tranquillisers/sleeping pills for non-medical purposes



H12. What drug would you mostly use when  
Tranquillisers/Sleeping Pills for non-medical  
purposes are not available?  
(Mark one response only)

- Alcohol
- Marijuana/Cannabis
- Heroin
- Cocaine/Crack
- Anti-depressants
- Pain killers/Analgesics
- Barbiturates
- Amphetamines/Speed
- Ecstasy/Designer Drugs
- Other
- No other drug

There is no Section I

### Reminder:

Please cross inside the box, like this:



If you see a (skip to) after the box  
you have just marked, go straight to  
the question indicated.

## Section J

J1. About what proportion of your friends and  
acquaintances use Steroids for non-medical  
purposes?  
(e.g. Roids, Juice)

- All
- Most
- About half
- A few
- None

J2. Have you ever used Steroids for non-medical  
purposes?

- Yes  (Continue) No  (Skip to K1)

J3. About what age were you when you first used  
Steroids for non-medical purposes?

Age in years:

J4. Have you used Steroids for non-medical purposes  
in the last 12 months?

- Yes  (Continue) No  (Skip to K1)

J5. During the past 12 months, did you want to or try to  
stop or cut down on your use of Steroids for  
non-medical purposes but found that you couldn't?

- Yes  No

J6. Have you used Steroids for non-medical purposes  
in the last month?

- Yes  (Continue) No  (Skip to J8)

J7. Have you used Steroids for non-medical purposes in  
the last week?

- Yes  No

J8. In the last 12 months, how often did you use  
Steroids for non-medical purposes?  
(Mark one response only)

- Every day
- Once a week or more
- About once a month
- Every few months
- Once or twice a year



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**J9. Where do/did you usually obtain Steroids for non-medical purposes?**  
(Mark one response only)

- Friend or acquaintance
- Brother or sister
- Parent
- Spouse or partner
- Other relative
- Dealer on the street
- Dealer delivers to my home
- Visit to the dealer's house
- Dealer at another location
- At gyms/sporting clubs/fitness centres
- Doctor shopping/forged script
- Steal it
- Other

**J10. Where do/did you usually use Steroids for non-medical purposes?**  
(Mark all that apply)

- In my own home
- At a friend's house
- At private parties
- At raves/dance parties
- At restaurants/cafes
- At licensed premises (e.g. pubs, clubs)
- At School, TAFE, University etc
- At my workplace
- In public places (e.g. parks)
- In a car or other vehicle
- At gyms/sporting clubs/fitness centres
- Somewhere else

**J11. How have you used Steroids for non-medical purposes?**  
(Mark all that apply)

- Swallowed
- Injected

**J12. Which of the following did you use at the same time, on at least one occasion that you used Steroids for non-medical purposes?**  
(Mark all that apply)

- Alcohol
- Marijuana/Cannabis
- Heroin
- Cocaine/Crack
- Tranquillisers/Sleeping Pills
- Anti-depressants
- Pain killers/Analgesics
- Barbiturates
- Amphetamines/Speed
- Ecstasy/Designer Drugs
- Other
- Not used any of the above at the same time as Steroids for non-medical purposes

**J13. What drug would you mostly use when Steroids for non-medical purposes are not available?**  
(Mark one response only)

- Alcohol
- Marijuana/Cannabis
- Heroin
- Cocaine/Crack
- Tranquillisers/Sleeping Pills
- Anti-depressants
- Pain killers/Analgesics
- Barbiturates
- Amphetamines/Speed
- Ecstasy/Designer Drugs
- Other
- No other drug

## Section K

**K1. About what proportion of your friends and acquaintances use Barbiturates for non-medical purposes?**  
(e.g. Barbies, Barbs, Downers, Red, Purple Hearts)

- All   
Most   
About half   
A few   
None

**K2. Have you ever used Barbiturates for non-medical purposes?**

Yes  (Continue) No  (Skip to L1)

**K3. About what age were you when you first used Barbiturates for non-medical purposes?**

Age in years:

**K4. Have you used Barbiturates for non-medical purposes in the last 12 months?**

Yes  (Continue) No  (Skip to L1)

**K5. During the past 12 months, did you want to or try to stop or cut down on your use of Barbiturates for non-medical purposes, but found that you couldn't?**

Yes  No

**K6. Have you used Barbiturates for non-medical purposes in the last month?**

Yes  (Continue) No  (Skip to K8)

**K7. Have you used Barbiturates for non-medical purposes in the last week?**

Yes  No

**K8. In the last 12 months, how often did you use Barbiturates for non-medical purposes?**  
(Mark one response only)

- Every day   
Once a week or more   
About once a month   
Every few months   
Once or twice a year

**K9. Where do/did you usually obtain Barbiturates for non-medical purposes?**  
(Mark one response only)

- Friend or acquaintance   
Brother or sister   
Parent   
Spouse or partner   
Other relative   
Dealer on the street   
Dealer delivers to my home   
Visit to the dealer's house   
Dealer at another location   
Doctor shopping/forged script   
Steal it   
Other

**K10. Where do/did you usually use Barbiturates for non-medical purposes?**  
(Mark all that apply)

- In my own home   
At a friend's house   
At private parties   
At raves/dance parties   
At restaurants/cafes   
At licensed premises (e.g. pubs, clubs)   
At School, TAFE, University etc   
At my workplace   
In public places (e.g. parks)   
In a car or other vehicle   
Somewhere else

