ALERTING THE COMMUNITY TO THE LINK BETWEEN ILLICIT DRUGS AND MENTAL ILLNESS

DEVELOPMENTAL RESEARCH

QUALITATIVE AND QUANTITATIVE RESEARCH REPORT

Prepared for Australian Government Department of Health and Ageing

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Commercial-in-Confidence

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1 EXECUTIVE SUMMARY

1.1 Background to the Research

Mental health is becoming an increasingly prominent issue in Australia, and one which has been linked with the use of illicit drugs. The National Drug Strategy Household Survey of 2004 demonstrated greater incidence of both high and low level psychological distress among those who had used an illicit drug in the previous month than those who had not. In addition to this, comorbidity[1] between mental health and substance use disorders is widespread.

In 2006, the Australian Government announced a funding package to improve services for those with a mental illness which included the '*Alerting the Community to the Links Between Illicit Drugs and Mental Illness*' initiative and the development of a related communications campaign. This campaign will aim to raise awareness of the connections between illicit drug use and the development of mental health problems, and to emphasise the importance of seeking treatment and / or intervention for mental health problems, illicit drug use or both, as early as possible.

To inform the development of the campaign, research among the target audiences of youth and young adults, their parents and the broader community was commissioned. The research sought to ascertain current levels of awareness of issues relating to illicit drug use and mental health issues among these target groups, as well as their perceptions and experiences relating to each of these areas. Further, the research was required to fully understand the issues faced by the target audiences and identify messages which will resonate across the groups.

The findings in this report reflect the opinions and attitudes of the research participants and not the Australian Government. The Department is mindful of the stigma attached to mental health issues and works to promote communications which adhere to the Australian Government's Mindframe Media guidelines for communications regarding mental illness which are managed by SANE Australia.

[1] Simultaneous incidence of one or more diseases or disorders

1.2 Research Methodology

The research was conducted in two stages. Firstly, a qualitative stage involving 25 mini-groups and nine depth interviews. Thirteen mini-groups were conducted amongst 15-24 year olds, 12 groups amongst adults aged 25-39 years and parents of children aged 15-39, and nine depth interviews with sufferers of mental illness aged 15-39. Fieldwork was conducted from 15-29 November 2006.

Following this a quantitative stage was conducted. This involved a national telephone survey of 1,700 people aged 15 to 24. Fieldwork was conducted between 15 February and 22 March 2007.

1.3 Key Findings

Perceptions of Mental Health

In the qualitative research perceptions of mental health tended to vary according to knowledge and experience of mental health or illicit drugs problems. For many, with little knowledge or no previous experience of people with mental health problems, the topic tended to be either frightening or uncomfortable. At the other end of the scale, those who suffered from a mental health problem or had been affected by family that had, tended to immediately associate the topic with being stigmatised, feeling outcast and a need for support.

Other factors affecting perceptions of mental health included both age and exposure to the media. Younger people often found the topic both frightening and fascinating at the same time. Many of these only had the media's portrayal of certain conditions on which to base their perceptions. Within this context, some mental health problems such as 'depression', 'anxiety' and 'stress' were perceived as more common and a symptom that someone is experiencing rather than a state which consumes them. In contrast, conditions with more medical sounding names such as 'schizophrenia', 'bi polar', and 'psychosis' were perceived as being more extreme and more all consuming.

The quantitative research found that mental health problems are extremely undesirable among young people aged 15-24 years and were ranked much more negatively than physical health problems, relationship problems and problems with study / university / school.

Awareness and Experience of Mental Health Problems

When measured in the quantitative research, depression (61%) and schizophrenia (52%) were the conditions that 15-24 years olds were most likely to spontaneously associate with mental health problems. More than one in ten (13%) of survey respondents claimed to have experienced mental health problems in the last year. Among these, depression was by far the most common problem (75%), followed by anxiety (22%).

Treatment Services

It was broadly perceived that there were not many readily accessible treatment options available for mental health problems. That said, the qualitative research indicated that many people were reluctant to seek help for a mental health problem until the issue being experienced had become a 'serious' problem and therefore perceived as requiring expert assistance. Therefore, few had knowledge of what treatment options were available. When

quantified it was found that only half (53%) of respondents who had not experienced a mental health problem in the past year spontaneously said they would seek help from a health professional. Of those who had experienced a mental health problem in the past year, most (77%) had sought help for their problem, the majority (86%) doing so from a health professional.

Causes and Severity

Mental health problems were typically linked with a number of possible factors. While no single element was seen to be the greatest contributor, there is a strong belief that personality type and family history made some people more susceptible to developing mental health problems than others.

The primary difference identified between mental health problems and mental illness was one of severity. Mental illnesses were perceived to be more severe, more permanent and more all consuming than mental health problems. They were seen as resulting in *considerable* loss of control rather than *some* loss of control as is the case with mental health problems.

1.4 The Link Between Mental Health Problems and Illicit Drugs

Awareness and Knowledge

There was a high degree of acceptance by research participants that there is some association between the use of illicit drugs and mental health problems. For many, this was a well established fact. Either they had seen or heard of examples of illicit drug usage leading to mental health problems or they believed there was widely available 'documented evidence'. There was also a strong belief that the association could work either way – that taking illicit drugs could lead to mental health problems and that those with mental health problems were potentially more likely to resort to illicit drug taking.

Across the qualitative sample, it was believed that for illicit drugs to lead to mental health problems, the individual in question likely had an 'at risk' personality or there was something specific in the drug that had a negative effect upon them. It was also commonly believed and accepted, even among those with mental health problems who claimed to be taking drugs, that taking drugs could exacerbate problems and illnesses.

The quantitative research found a very strong relationship between self-reported mental health problems and drug use in the last year. Users of every illicit drug were significantly more likely

to have experienced a mental health problem in the last year than those who used no illegal drug. In particular, ice, speed and cocaine users were the most likely to have had a recent mental health problem. Further, while two-thirds (67%) of the total sample knew of someone with a mental health problem, this was significantly higher among those who had used illicit drugs in the past year than those that had not.

Specific Drugs and Specific Mental Problems

Throughout the research, it was consistently found that different drugs were more readily associated with different mental health problems or illnesses. Further, it was not only drugs such as ice and heroin that were strongly linked to mental health issues – other illicit drugs which are perceived to be less dangerous were clearly linked to mental health issues as well. Schizophrenia and depression were perceived to be the mental health problems most likely to be caused by illicit drug use. When broken down by drug type, schizophrenia and depression were equally linked for marijuana and ice, with depression linked more strongly than schizophrenia to ecstasy, heroin and speed.

Influence of Mental Health Problems on Drug Use

Both stages of research indicated that the potential for mental health problems had considerable influence on whether people would use drugs. However, this varied by drug, with ice and heroin having the greatest influence on acceptance or rejection on the basis of mental health issues when measured in the quantitative research. Further, a key finding from the qualitative research was the distinction made between short and long-term mental health symptoms in regard to use of illicit drugs. Short-term symptoms were perceived to be an expected and relatively accepted side-effect of drug use, the equivalent of a hangover from alcohol. It was commonly believed that these were very different than longer term mental health problems, meaning that many may not recognise if their perceived short term symptoms are becoming more problematic.

Mental health problems were seen as just one of many possible negatives that can occur from illicit drug use. However, while opinions on illicit drug use are strongly divided, it was apparent in the qualitative research that no one wanted to develop or suffer from mental health problems. This suggests that if the link between mental health problems and illicit drug use could be made successfully, particularly for those who accept and manage short term effects, the possibility of mental health problems could become a strong deterrent to illicit drug taking.

1.5 Identifying Illicit Drug / Mental Health Segments

From the qualitative research six possible archetypes emerged in relation to mental health problems and drug usage - 'Jeopardized', 'Bullet-proofs', 'Percentage Players', 'That's Me', 'Too Scarys' and 'Positive Alternatives'. Using attitudinal statements derived from these archetypes, the subsequent quantitative study created a statistically robust attitudinal segmentation. Six different segments of young people aged 15-24 years were identified. While not identical to the qualitative segmentation, the quantitative results bore a relatively strong relationship to the archetypes originally hypothesised and although based purely on attitudes, these segments were very good predictors of drug usage levels and of mental health problems.

'Positive Alternatives' – 33%

Attitudinally, this segment is not interested in drugs. They have low incidence of both drug use and mental health problems. Whilst they have little exposure to mental health problems amongst people they know, the risk of mental health problems was seen as a strong deterrent to using illicit drugs.

'Too Scarys' – 16%

This segment was characterised by the strong perception that they would be personally susceptible to mental health problems if they used drugs, and are frightened of the link between the two. While they have low reported drug use, they have a greater incidence of mental health problems such as anxiety, depression and stress when compared to other segments and are sympathetic of those with mental health problems. The risk of mental health problems is a very strong influence on their decision not to use drugs.

'Intolerant Deniers' – 14%

Similar to the 'Too Scary' segment, 'Intolerant Deniers' have a higher incidence of mental health problems than others. However, this segment is very unsympathetic to those with mental health problems. Not being interested in drugs, they have a relatively low incidence of drug use. While scared of the link between drug use and mental health problems, they have a minimal understanding of the associations. As they consider it only applicable to heavy drug users, they do not feel personally susceptible.

'Sceptics' – 14%

This segment is characterised by being the only group sceptical of the link between drug use and mental health problems. They have relatively low incidence of mental health problems, and are somewhat interested in drugs. With very low exposure to, and understanding of mental health problems, they do not feel personally susceptible and are not scared of the link.

'Bullet Proofs' – 14%

This segment is very interested in drugs, regardless of any negative effects. While they have relatively low incidence of mental health problems themselves, they appear supportive of those who do have problems. They are characterised by not feeling at all personally susceptible to the mental health effects of drugs although they accept that there is a link. They are simply not scared of it as they do not think it will happen to them.

'Jeopardized' – 9%

This segment is the most interested in drugs, regardless of effects. They are the most likely to have used drugs, and the most likely to have mental health problems such as anxiety and depression. While they feel very susceptible to mental health effects of drugs and accept there is a link between drug use and mental health problems, they are not scared of it and ignore it.

1.6 Summary of Conclusions

Both stages of research found that the link between illicit drug use and mental health problems is strong and credible and has strengthened since 2000. Further, there was a strong relationship between self-reported mental health problems and recent illicit drug use. Communication of the risk of mental health problems is likely to be a very strong deterrent to using illicit drugs amongst young people.

BACKGROUND AND METHODOLOGY

2 BACKGROUND

2.1 Overview

Mental health is becoming an increasingly prominent issue in Australia, and one which has been linked with the use of illicit drugs. The National Drug Strategy Household Survey of 2004 demonstrated that of those who had used an illicit drug in the previous month, 14 percent had experienced a high level of psychological distress, compared to 6.9 percent of those who had not. Equally, of those who had not used an illicit drug in the previous month, 70 percent had only experienced a low level of psychological distress, compared to 50 percent of those who had used an illicit drug.

In addition to this, comorbidity[2] between mental health and substance use disorders is widespread. The 1997 National Survey of Mental Health and Wellbeing indicated that one in four people with an anxiety, affective or substance use disorder also had at least one other mental disorder. It is entirely possible that the link between the two issues is multi-directional, in that substance abuse may directly or indirectly increase the likelihood of mental illness or vice versa, or that there are common factors which increase the risk of both disorders.[3]

In early 2006, the Council of Australian Governments recognised that mental health is a major problem for the Australian community and noted that additional resources were required from all governments to address the issues. This included a renewed focus on promotion, prevention and early detection and intervention, including reducing the impact on mental health of substance abuse. Supporting this commitment, the Australian Government announced a $1.9 billion funding package to improve services and support for those with a mental health problem, their families and carers. The '*Alerting the Community to the Links Between Illicit Drugs and Mental Illness*' measure was part of this package and a communications campaign is to be developed. The aims of this campaign are threefold:

- to augment awareness of the connections between illicit drug use and the development of mental health problems among the target audience (at this stage, primarily teenagers and young adults aged 15-24 years) and the general population; and
- to emphasise the importance of seeking treatment and / or intervention for mental health problems, illicit drug use or both, as early as possible.

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[2] Simultaneous incidence of one or more diseases or disorders

[3] Refer to Ross, J. *'Illicit drug use in Australia: Epidemiology, use patterns and associated harm'*, National Drug & Alcohol Research Centre (2nd Edition, draft), 2007

2.2 The Need for Research

In order to inform the development of the campaign, the Department of Health and Ageing determined that a program of research among the target audience of youth and young adults, their parents and the broader community was required. Broadly the research was needed to ascertain current levels of awareness of issues relating to illicit drug use and mental health issues among these target groups, as well as their perceptions and experiences relating to each of these areas.

Further, the research was required to fully understand the issues faced by the target audiences and identify messages which will resonate across the groups. A clear understanding of the perceived link between drug and mental health issues was required to ensure the campaign is credible and has impact among the target audience.

There was also a need to explore any differences between the perceptions of those with mental health problems and those who had experienced mental illness. As it is possible that mental health problems may develop into mental illness, it was deemed crucial to develop an understanding of differences between mental health problems and mental illness in order to inform a successful campaign.

3 RESEARCH OBJECTIVES

The overall objective of this research was to inform the development of the communications strategy of '*Alerting the Community to the Links Between Illicit Drugs and Mental Illness'*, by identifying the key messages and the best methods of communicating with the target audiences.

More specifically, the individual objectives of the research were to fully explore:

- Awareness, knowledge, beliefs and perceptions of:
  - positive mental health, mental health problems and mental illness;
  - symptoms and possible causes or risk factors of mental health problems and illness as well treatment options and services;
  - seeking help or accessing services;
- Perceptions and beliefs about mental health problems including perceived susceptibility (individual or others), perceived severity, any stigma or widely held beliefs or prejudices;
- Key barriers and potential motivators to seeking help or accessing services;
- Awareness and knowledge of the potential impact of illicit drug use on mental health;
- The extent to which any links are made between illicit drug use and mental health problems, in terms of awareness, knowledge, perceptions and beliefs; and
- Investigate and identify a preliminary segmentation of the youth audience with respect to attitudes to drugs and mental health issues.

In terms of communication issues, specifically to:

- Explore ways in which to successfully communicate with the target audience in terms of credible and motivating messages and methods of communication, and whether there were any specific communication issues;
- Identify whether there were separate issues for Indigenous and NESB populations, and therefore different communications requirements; and
- Provide guidelines to the Department as to ideal ways in which to develop the communications strategy for the campaign.

These objectives guided the initial qualitative research. Quantitative research among 15-24 years olds followed this initial phase. The quantitative research phase was used to quantify the findings from the qualitative research and to test and refine the preliminary segmentation of the target audience.

Note that this report contains the findings of both the qualitative and quantitative research. In order to attribute the source of the data or information, the qualitative and quantitative research is clearly separated in each section.

4 QUALITATIVE METHODOLOGY

4.1 Research Program

The qualitative research program included 25 mini-group discussions and 9 individual in-depth discussions. The mini-groups were conducted among the following target audiences:

1. Teenagers and young adults aged 15-24 years with experience to varying degrees of illicit drug, alcohol and tobacco use. This sample included participants who had experienced difficult times due to mental health problems or illicit drug use and those who had not. Psychographic segments established in previous research[4] were used to define drug use behaviour.

2. Adults aged 25-39 years who are regular illicit drug users, and those who are not regular illicit drug users but who use occasionally or know others who use regularly. This sample included users of a range of illicit drugs including injecting drug users, marijuana users and 'party' drug users, and participants who had experienced difficult times due to mental health problems or illicit drug use.

3. Parents of teenagers and young adults aged 15-24 years. This sample included parents with children who had experienced difficult times due to mental health problems or illicit drug use and those who had not. Psychographic segments were used to determine drug behaviour of the reference child.

4. Parents of adults aged 25-39 years who are regular illicit drug users. This sample included participants whose children had experienced difficult times due to mental health problems. Regular use of a broad range of drugs was represented.

5. Teenagers and young adults aged 15-24 years from culturally and linguistically diverse (CALD) and Indigenous backgrounds. Arabic and Chinese were selected as the target groups for the CALD research, as these represent the largest language groups outside of English in Australia. Indigenous groups were held in both metropolitan and regional areas to ensure geographic representation. This sample included participants who had experienced difficult times due to mental health problems or illicit drug use.

6. Members of the general population who did not fall into any of the target groups.

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[4] Clark, G., Scott, N., and Cook, S. '*Formative research with young Australians to assist in the development of the National Drugs Campaign*', Blue Moon Research and Planning, June 2003

The 9 in-depth interviews were conducted with teenagers and young adults aged 15-24 years and older adults aged 25-39 years with a diagnosed mental illness. This sample included research participants with diagnosed psychotic and non-psychotic illnesses such as clinical depression and significant anxiety. These interviews were undertaken by a clinical psychologist.

4.2 The Qualitative Sample

The qualitative sample is outlined below.

Table 1: Group Discussion Sample

GROUP	SEGMENT	AGE	ISSUES	TYPOLOGY	LOCATION	STATE
1	Teens and young adults	15-17	None	Thrill seeker	Sydney	NSW
2		15-17	Mental health	Reality swapper	Melbourne	VIC
3		15-17	Drugs	Other	Regional	QLD
4		18-20	None	Reality swapper	Brisbane	QLD
5		18-20	Mental health	Other	Sydney	NSW
6		18-20	Drugs	Thrill seeker	Regional	VIC
7		21-24	None	Other	Brisbane	QLD
8		21-24	Mental health	Thrill seeker	Melbourne	VIC
9		21-24	Drugs	Reality swapper	Regional	NSW
10	Older adults	25-39	Mental health	Regular drug (injectors)	Sydney	NSW
11		25-39	Mental health	Occ. drug	Melbourne	VIC
12		25-39	No mental health issues	Regular drug (non injectors)	Brisbane	QLD
13		25-39	No mental health issues	Occ. drug	Regional	NSW
14	Parents of teens and young adults	Kids 15-17	None	Mix	Melbourne	VIC
15		Kids 18-20	Mental health		Brisbane	QLD
16		Kids 21-24	Drugs		Sydney	NSW
17		Mix	Mental health & drugs		Regional	QLD
18	Parents of older adults	Offspring aged 25-39	Mental health	N/a	Melbourne	VIC
19			Drugs		Brisbane	QLD
20	General population	25-39	None	N/a	Sydney	NSW
21		40+	None		Regional	VIC
22	NESB (Chinese)	15-19	Mental Health	Mix	Melbourne	VIC
23	NESB (Arabic)	20-24	Drugs	Mix	Sydney	NSW
24	Indigenous	15-19	Drugs	Mix	Sydney	NSW

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25	Indigenous	20-24	Mental Health	Mix	Regional	NSW

Table 2: In-depth Interview sample

GROUP	SEGMENT	AGE	LOCATION
1	Teens and young adults	15-17	Metro
2		15-17	Regional
3		18-20	Metro
4		18-20	Regional
5		21-24	Metro
6		21-24	Regional
7	Older adults	25-39	Metro
8		25-39	Regional
9		25-39	Metro

Across the sample, quotas were applied to ensure representation of:

- different types of mental health problem and mental illness;
- different types of drugs being used;
- socio-economic background;
- education level;
- employment status; and
- living circumstances.

The sample was segmented deliberately to separate the 'issues' of mental health and drugs during recruitment. This allowed for exploration of these issues in isolation prior to any discussion of the link between them.

4.3 Recruitment of Group Participants

Illicit Drugs

A range of methods was used during recruitment. Firstly, the recruitment of teenagers, young adults and parents of this group were recruited according to psychographic segments using accredited commercial recruitment companies. A questionnaire (Appendix B) enabling the

identification of the 'Thrill Seekers' and 'Reality Swappers' psychographics segments from other typologies was used to screen respondents.

Respondents who openly admitted to illicit drug use were initially identified through a screening question on types of drug used. For the more difficult to recruit groups, a process of snowballing was used. Recruiters asked recruited participants to ask friends and others they knew who may fit the required criteria to also participate in the research. The recruitment process was then explained and once recruited we asked others if they knew of a similar person who might meet our criteria, and so on.

Participants with more serious drug use, such as intravenous drug users, were recruited via organisations that offer support and assistance to the target audience.

Mental health

Group participants with indicators of mental health problems were identified using a battery of behavioural statements based on a mix of the K10 symptom scale and previous research. Recruitment for the in-depth interviews with participants with diagnosed mental illnesses was completed through organisations that offer assistance and support for this target group.

All screening questionnaires used in recruitment can be found in Appendix B.

4.4 Parental Permission

Parental or guardian permission was sought for participation in the research for all respondents under the age of 18 years.

4.5 Ethical Considerations

The Department provided phone numbers for appropriate support services in case respondents requested help during or at the conclusion of the groups. A practicing clinical psychologist was included in the project team to undertake the interviews with participants with mental illnesses and to provide advice on the conduct of the research.

4.6 Discussion Coverage

Semi-structured discussion guides were developed for use in all discussion groups and in-

depth interviews. The discussion guide was approved by the Research and Marketing Group of the Department prior to use and is appended (Appendix A). Based on this guide, the order of questioning within each group depended on whether respondents were recruited into a group focussing on mental health or on drugs.

4.7 Group Size and Duration

Each group lasted for approximately 2 hours and each in-depth interview for between 40-60 minutes. The group discussions comprised 4-5 respondents.

4.8 Timing of Qualitative Fieldwork

All qualitative fieldwork was undertaken between 15 and 29 November 2006.

5 QUANTITATIVE METHODOLOGY

5.1 Research Approach

The quantitative component of the study was based on 1,700 telephone interviews with people aged 15–24 years across Australia. The sample was drawn at random within each region from the Electronic White Pages. Respondents were identified using the next-birthday technique where there was more than one eligible person resident in the household. Parental permission was obtained prior to the interview for those aged 15-17 years.

Quotas were established for the sample on age, gender and region (State and Territory, capital city and regional areas). The results were post-weighted by age, sex and region to match the 2001 Australian Bureau of Statistics (ABS) Census population profile.

5.2 Quantitative Sample

The following sample (unweighted) was achieved.

Table 3: Quantitative sample characteristics

	No. of Interviews (n=1700)
Region	
Capital City	1072
Non-Capital City	628
State / Territory	
NSW	492
Victoria	440
Queensland	298
South Australia	137
WA	152
Tasmania	43
ACT	24
NT	14
Gender	

Male	827
Female	873
Age	
15-17	571
18-20	562
21-24	567

5.3 Pilot Test

A pilot test of 30 interviews was conducted prior to the main fieldwork. This resulted in some modifications to the questionnaire to improve the flow of the questions. The final questionnaire is appended (Appendix A).

5.4 Timing of Quantitative Fieldwork

All interviews for the main survey were conducted between 15 February and 22 March 2007.

5.5 Test of Statistical Significance

Tests of significance were conducted between sub-groups in the 2007 survey and between the results of the 2000 survey[5] and the 2007 survey to identify statistically significant differences. In this report, differences between groups that are reported as 'significant' mean that a statistically significant difference has been identified at a 95% confidence level.

[5] Reporting in this survey can be found in Clark, G., Scott, N., and Cook, S. '*Formative research with young Australians to assist in the development of the National Drugs Campaign*', Blue Moon Research and Planning, June 2003

6 RELATED REPORT

Throughout this document, findings on illicit drug use are compared with similar research completed in 2000 titled *'Formative research with young Australians to assist in the development of the National Illicit Drugs Campaign'*[6]. This research was the basis for the psychographic segments used to construct the qualitative sample for the research. Data from this research is at times used for comparison in the quantitative findings.

[6] Clark, G., Scott, N., and Cook, S. Blue Moon Research and Planning, June 2003.

DETAILED FINDINGS

7 PERCEPTIONS OF MENTAL HEALTH

7.1 Awareness, Knowledge and Beliefs

Spontaneous associations of mental health

The sample for the qualitative research was highly targeted to ensure representation within the group discussions of people with drug issues and mental health issues, as well as participants without experience of either. From this initial research, it was found that associations with mental health problems varied according to four experiential groupings:

- those who are not affected by mental health problems who do not take drugs;
- those who are not affected by mental health problems who do take drugs;
- those who are affected by mental health problems personally; and
- those who are affected by mental health problems because of a member of a family.

The first of these, those who are not affected by mental health problems and who do not use drugs tended to think spontaneously of extreme examples of mental illness. Associations were of people in straight jackets in mental institutions, those who hear voices, those who suffer from depression and homeless people.

> *"People who can't look after themselves, who can't function in society."*

> *"Being locked in a ward somewhere, receiving shock treatment."*

This group was typically not very knowledgeable about the subject of mental health, which they found somewhat scary and uncomfortable. Most admitted that they did not like to think about mental health problems.

The next group, those not affected by mental health problems but who used drugs, often appeared to be quite knowledgeable about specific mental health illnesses (such as schizophrenia, bi-polar, depression and bulimia). Some had acquaintances or friends, or knew about people who had been affected by mental health problems. Interestingly, many were often aware that they themselves may be at risk. For many within this group, mental health was a topic they found frightening.

"Being trapped in a world you can't get out of, feeling down."

"Being really depressed, when you can't listen to anyone else and no one can talk you out of it."

The third group identified, those within the qualitative sample who suffered from mental health problems personally, were aware that they were affected and saw their condition as being quite a common one. Their spontaneous associations related to family issues, medication and a sense of being misunderstood. While they were able to distinguish between 'mental health problems' and 'mental illness', they saw the whole area as a complex and varied one. Many were acutely aware of the effect their mental health problems had upon their family and friends.

"It's hard to generalise because it's always such a personal thing."

"Tears, rage, sadness, hurt, destructive behaviour, myself, loneliness, misunderstanding."

People in the final grouping, those who were affected because a member of the family has mental health problems, were keenly aware of the unhelpful labelling that society adopts in this context. Their immediate associations related to stigma, feeling outcast and a need for support. The specific mental health problems they spontaneously thought of were depression and mood swings. This group felt that the whole topic area was one which is easily misunderstood and can be poorly handled by individuals in society. They often felt helpless in their situation.

"Being shunned, misunderstood, outcast."

"Families torn apart and can't cope."

Other factors affecting perceptions of mental health

Beyond these broad experiential groups, a number of other factors were identified that affected perceptions of mental health problems. Age was one such factor. Younger people often found the topic of mental health both scary and fascinating at the same time.

The way that mental health problems are treated in the media can also affect perceptions. In this context many thought of movies such as 'A Beautiful Mind' and 'One Flew Over the Cuckoos Nest'. Those who had first hand knowledge and experience of mental health problems demonstrated a far greater depth of understanding of the issues. Finally, the type of

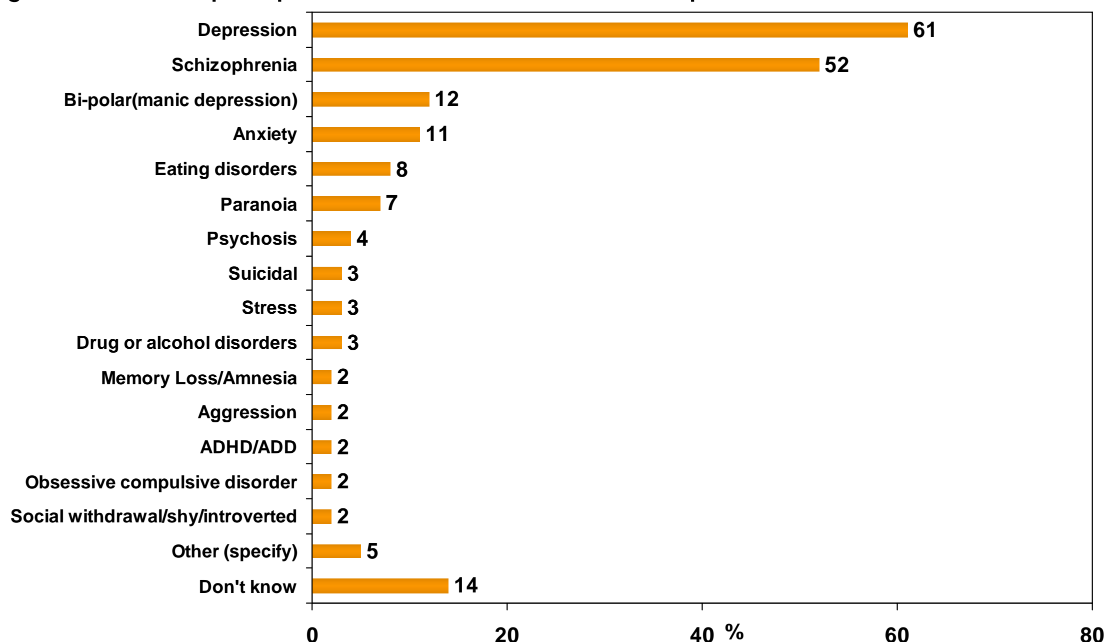
condition which people suffered from could also affect perceptions, with some conditions considered to be much more 'consuming' than others.

Within this context some mental health conditions emerged as possibly more 'acceptable' than others. These included conditions with more common sounding names such as 'depression', 'anxiety' and 'stress'. These were perceived to be common to many people and a symptom that someone is experiencing rather than a state which consumes them. In contrast, conditions with more medical sounding names such as schizophrenia, bi-polar, psychosis and obsessive compulsive disorders tended to be seen as less 'acceptable'. These were perceived as being more extreme and more all consuming.

7.2 Awareness and Experience of Mental Health Problems

When measured in the quantitative research, depression and schizophrenia were the conditions that 15-24 years olds are most likely to spontaneously associate with mental health problems. As shown in Figure 1, three-fifths (61%) of the sample spontaneously associated depression with mental health problems and half (52%) associated schizophrenia with mental health problems. Note that this question measures unprompted awareness of mental health problems and doesn't provide any insight into what young people understand about these conditions.

Figure 1 : Total unprompted awareness of mental health problems

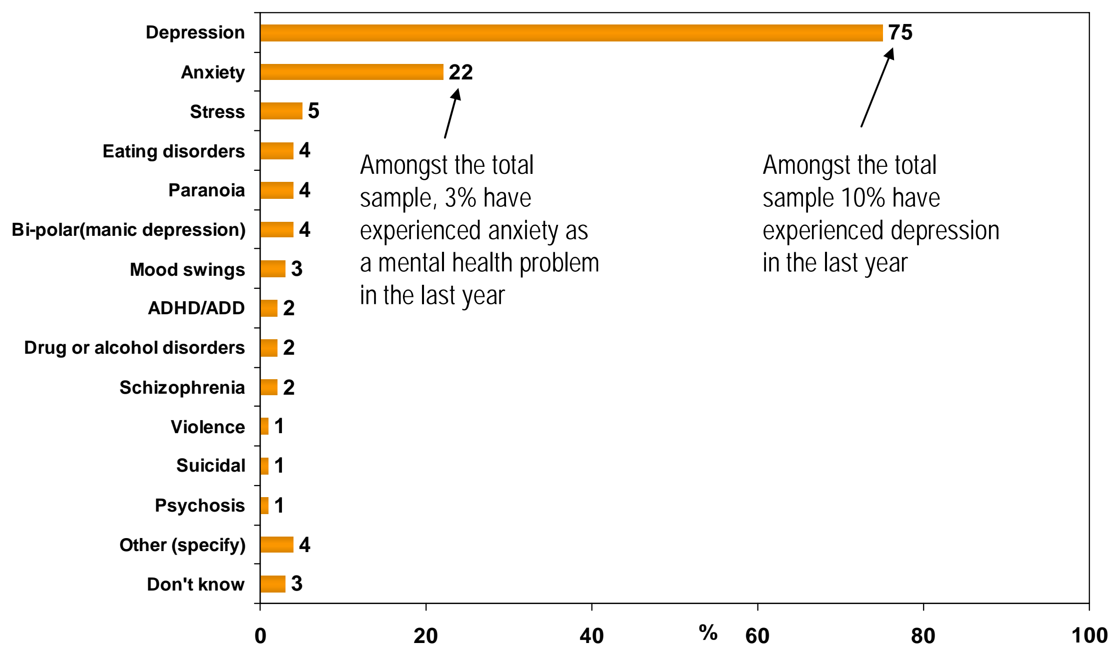


Base: Total Sample (1700) Note: The scale is not to 100%.

In an associated question, more than one in ten (13%) respondents claimed to have experienced any mental health problems in the last year. They were more likely to be female (17%) than male (10%), and older (15% of 21-24 year olds, 13% of 18-20 year olds and 11% of 15-17 year olds).

As shown in Figure 2 below, amongst those who had experienced mental health problems in the last year, depression was by far the most common problem (75%), followed by anxiety (22%). Note that this question was unprompted and that "mental health conditions" are as interpreted by respondents.

Figure 2: Mental health problems experienced



Base: Experienced mental health problems in last year (216)

7.3 Accessing Treatment Services

Within the qualitative research, many perceived that there were not many readily accessible treatment options available in relation to mental health problems. Services that were available were considered to be mainly for extreme cases or for 'the middle classes who can afford them', with the majority perceiving that treatment options for mental health conditions were generally out of their reach.

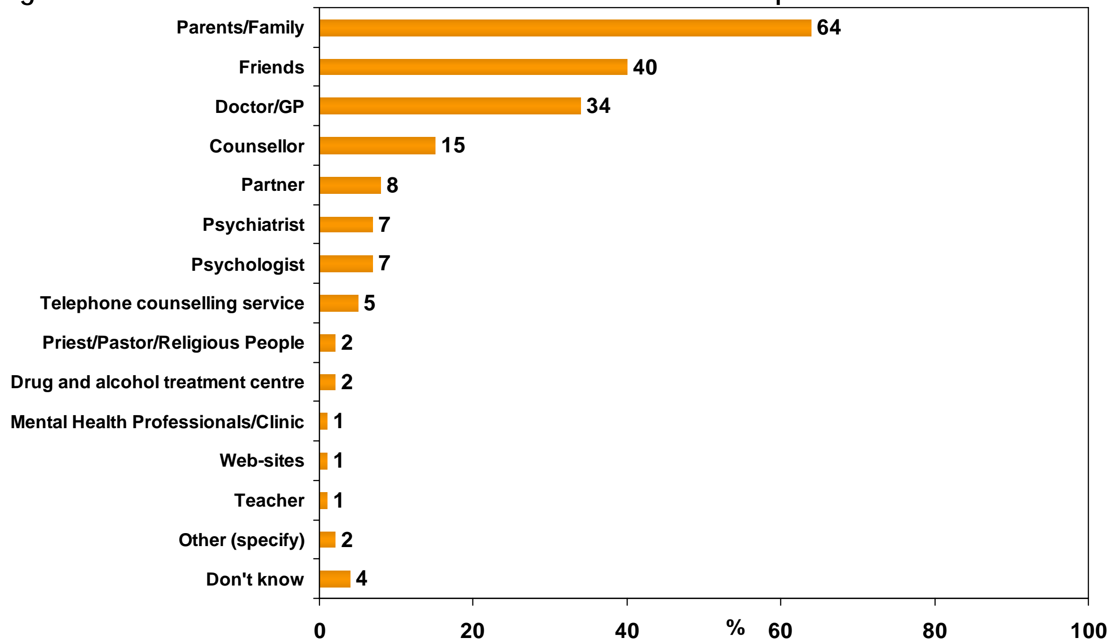
Overall, it was thought that a treatment option would only be available once a problem had become fully developed, that is, when the problems could no longer be dealt with by the family alone and experts were required. Further to this, some participants in the qualitative research recounted stories of inadequate community services, people being turned away or dealt with inappropriately when they did try and seek help.

Among the qualitative sample, most of those affected by mental health problems appeared reluctant to seek help. A number of reasons accounted for this reluctance. Partly it was because they thought the condition would be short term, and partly because they did not want to admit that the problem existed at all. Also because it is not a black and white subject, it was apparent that many could not initially determine when the issue they were experiencing had become a 'serious' problem and therefore warranted expert assistance (in their perception). In addition, many were typically not aware of effective solutions and did not know how to understand or rectify the problems they might have. This reluctance to seek help was apparent within the qualitative research for both sufferers and those around them such as their family.

This general lack of knowledge of where to access treatment options and services prior to acceptance of a more serious problem was also apparent within the quantitative research. Respondents who had not experienced a mental health problem in the last year had very little awareness of where to seek help. Most (64%) envisaged that if they did ever have a mental health problem, they would be likely to talk to family and friends about it. Only 53% (nett) would seek help from a health professional, most likely a GP (see Figure 3).

There was a lack of motivation to seek assistance for problems due to an unwillingness to accept the potential seriousness of their problems, lack of knowledge of the treatment services available to them, a perception that services were only available for extreme causes or those who could afford them and negative peer experiences of services.

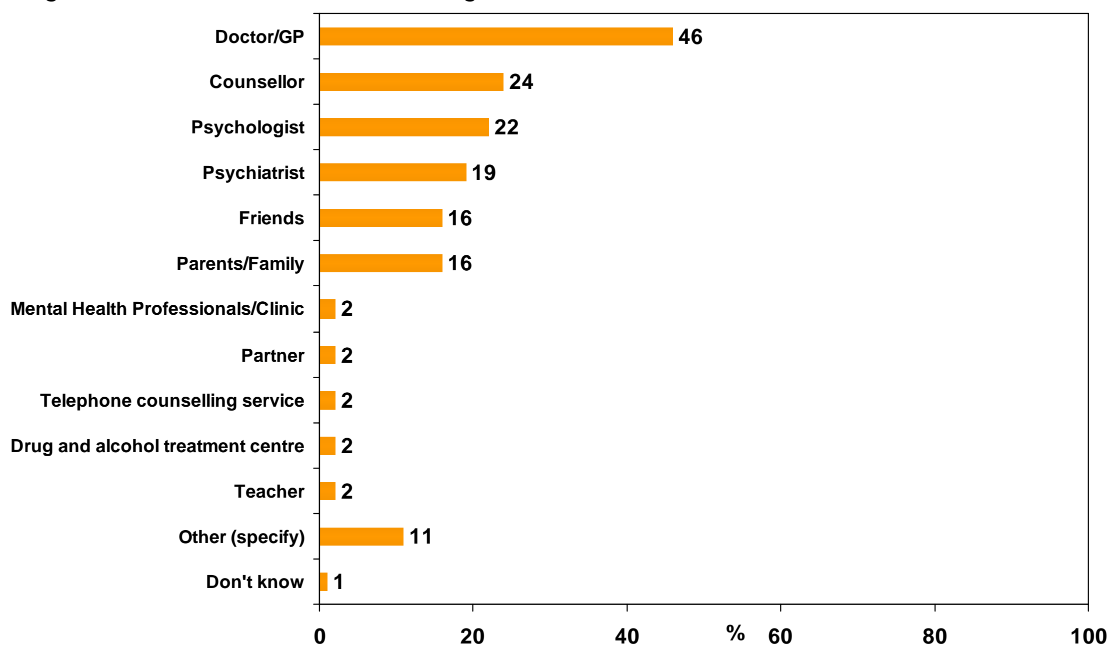
Figure 3 : Perceived sources of assistance for a mental health problem



Base: Not had mental health problem in last year (1522) Note: A health professional was defined as doctor/GP, counsellor (incl. telephone), psychiatrist, psychologist, drug and alcohol treatment centre, mental health professionals.

Of the 216 respondents who had experienced a mental health problem in the past year, most (77%) had sought help for their problem. As detailed in Figure 4, of those who sought help, 86% (nett) went to a health professional – most commonly a GP.

Figure 4 : Sources of treatment sought



Base: Sought help in last year for a mental health problem (165). Note: A health professional was defined as

bluemoon

doctor/GP, counsellor (incl. telephone), psychiatrist, psychologist, drug and alcohol treatment centre, and mental health professionals.

7.4 Symptoms and Causes

The qualitative research found that mental health problems were typically linked with a number of possible factors. Commonly mentioned factors included:

- family problems;
- genetic connection;
- negative events, such as the break-up of a relationship, loss of work, and so on;
- drug use/abuse; and
- personality traits

While no single element was seen to be the greatest contributor, there is a strong belief that certain groups of people are more susceptible to developing mental health problems in relation to drug taking than others. This in turn was perceived to be strongly linked to personality type and family history. This was supported by the quantitative survey. Some 25% believed their 'personality makes them more susceptible to drug-related mental health problems' and 41% believed that if they were to use drugs they would be 'more likely than most to develop a drug related mental health problem'. These findings are shown in Figure 11 which is discussed further in Section 10.

> *"Certain personality types are more susceptible than others – like people with addictive personalities."*

> *"He's got this obsessive compulsive problem and it's gradually become worse – his father had the same thing, always cleaning, washing things …"*

> *"You need to be someone who is more susceptible to schizophrenia, or have a trigger which sets it off."*

In this context, existing mental health or drug issues within a family situation were also spontaneously identified as a significant contributor to both subsequent drug usage and mental health problems. Many within the qualitative research openly discussed the mental

health or drug issues being faced by different members of their family, as well as openly recounting their early lives.

> *"I'm a compulsive gambler and my daughter is a drug addict. My daughter had a pact with me she said, 'you give up the gambling and I'll give up my drugs'. She stopped but I couldn't. But as soon a she realised I was gambling again she started taking drugs again, which I think is a bit pathetic."*

> *"When you grow up in a family that drinks in order to solve its problems then that becomes the norm."*

> *"I mean I was sexually abused and shit like that … would I do drugs if that didn't happen to me? I dunno … maybe I would have, maybe I wouldn't have."*

In contrast, potential impact on family and friends was also identified as one of the greatest concerns of those suffering from mental health problems. Interestingly, while sufferers claimed to be keenly aware of the impact of their behaviour on friends and family, those who were close to them often felt this was not the case.

> *"He's threatened to commit suicide – he's always talking about it, how he was going to drive the Monaro off a cliff – he wanted to take me with him … sometimes it makes you want to do it too."*

> *"They don't think about how it affects the family, the whole family."*

7.5 Comparisons of Mental Health and Mental Illness

Across the broader qualitative sample, most identified a difference between mental health 'problems' and mental 'illness', although many found it difficult to articulate what that difference was without further thought. Essentially, mental 'illness' was seen as more severe, more permanent and more all consuming than mental health problems. Mental illness was perceived as resulting in *considerable* loss of control rather than *some* loss of control as is the case with mental health problems.

The qualitative sample of people with diagnosed mental illnesses included sufferers of psychosis, depression, anxiety and paranoia. Their mental health illnesses had been attributed to a mix of factors including drug usage, genetic connection and environmental factors such as family problems.

Overall, a number of core beliefs emerged among those affected by mental illness. Many felt that 'once you've got it, you've got it', as mental illnesses were believed to be very difficult to eradicate successfully on a long-term basis. There was a strong sense among the broader community that people with a family history of mental illness would have a much greater probability of developing mental health illnesses themselves and should be made aware of possible causes.

8 THE LINK BETWEEN ILLICIT DRUG USE AND MENTAL HEALTH PROBLEMS

8.1 Awareness and Knowledge

The concept that illicit drug use could have an impact on mental health was accepted by all within the qualitative sample. For many, this concept had credibility on a rational level as illicit drugs were believed to change the state of mind of the user due to their chemical makeup, and therefore could potentially create a chemical imbalance in the brain. Many believed the more a person got into drugs the greater his or her susceptibility to mental health problems. Further, there was a strong belief that the association could work either way – that taking illicit drugs could lead to mental health problems and that those with mental health problems were more likely to resort to illicit drug taking.

However, the perceived effect and role of illicit drugs was considered to vary according to which issue affected an individual first. In circumstances when use of illicit drugs was considered to lead to mental health problems, this was typically attributed to two main reasons: either the individual in question was perceived to have a personality particularly at risk of developing mental health problems anyway, or there was something particular in the drug that had a bad effect upon them. Only within these situations did the majority believe that illicit drugs can contribute to mental health problems.

On the other hand, it was a common belief that when someone had mental health problems they were already likely to experience some of the short term problems that people associated with drug use, such as mood swings, depression and so on. It was perceived that while some people with mental health problems may be under the misconception that certain drugs might help them to feel better, they may not be making appropriately balanced or rational decisions, and the drugs were most likely making their condition worse. Further, it was thought that these people may be unaware that the drugs they were taking were creating the very conditions from which they were trying to escape.

Despite these commonly held beliefs, many of the people who identified as having mental health problems within the qualitative research claimed that they were aware of how the illicit drugs they took could have a negative affect upon them, and how that contributed to their condition. This attitude toward drugs and mental health problems was reflected clearly in the qualitative sample of people with diagnosed mental health illnesses. While all claimed to be fully aware of the risks involved in drug taking, behaviour towards drugs was polarised. There were some who tried to avoid drugs completely and others who kept taking drugs as an

escape from the way in which their illness made them feel.

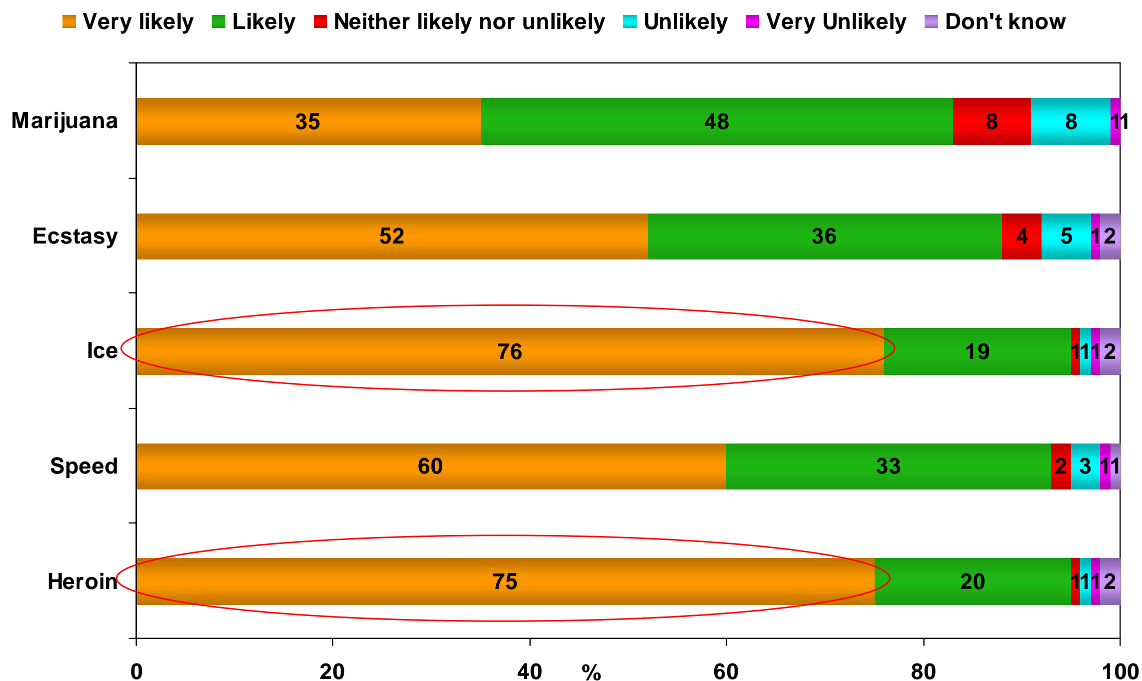
Despite this, the majority of the qualitative sample with mental illnesses believed that taking drugs could exacerbate their illness, including some who claimed to use drugs in order to avoid confronting their problems. Even among this latter group of those with mental health illnesses who continued to use drugs, there was a strong belief that it was appropriate and beneficial to communicate the link that existed between illicit drugs and mental health issues among the broader community.

8.2 Acceptance of the Link Between Mental Health and Illicit Drug Use

As indicated above, there was a high degree of acceptance by research participants that there are links between illicit drug use and mental health problems. Although not always able to articulate what the link was, for many it was well established. Either they had seen or heard of examples of illicit drug usage leading to mental health problems or they believed there was widely available 'documented evidence'.

The quantitative research indicates that while ice and heroin, in particular, were seen to be strongly linked to mental health issues, the perception of a link is not limited to just these drugs. Over 80% perceived that even regular use of marijuana and ecstasy, which are perceived to be less dangerous, was likely to lead to serious mental health problems (Figure 5 below).

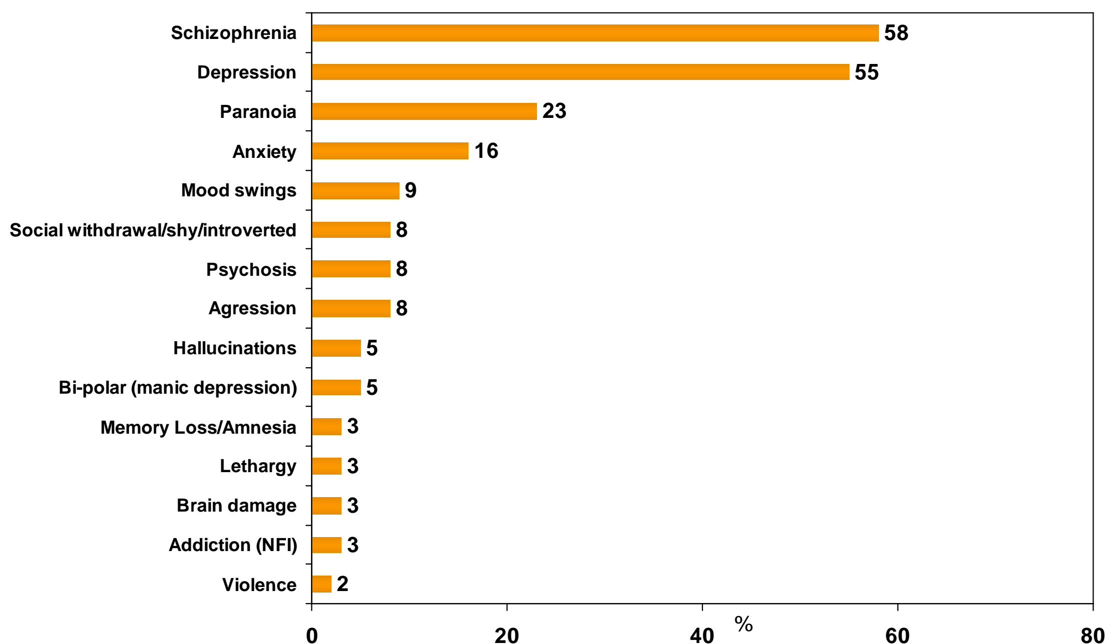
Figure 5 : Likelihood regular drug use would lead to mental health problems



Base: Total Sample (1700)

For each drug very likely or likely to cause mental health problems, respondents were asked unprompted which mental health problem/s each drug is likely to cause. Figure 6 has combined the mental health problems perceived to be caused by all drugs likely to cause health problems. Schizophrenia and depression were perceived to be the mental health problems most likely to be caused by illicit drug use. When broken down by drug type, there was some difference in perceived prevalence of these conditions. Schizophrenia and depression were equally linked for marijuana and ice, with depression linked more strongly than schizophrenia to ecstasy, heroin and speed.

Figure 6 : Mental health problems most likely to be linked to drug use (unprompted)



Base: Total Sample

Note: Scale is not to 100% Only 2% + has been presented.

8.3 Perceived Impact of Specific Drugs on Mental Health

Throughout the research, it was consistently found that different drugs were more readily associated with different mental health problems or illnesses. Table 4 illustrates general findings from the qualitative research.

Table 4: Specific drugs and mental health conditions

DRUG	SHORT TERM USE	LONG TERM USE
Marijuana	Anxiety, paranoia	Depression, schizophrenia, paranoia
Speed	Depression, anxiety	Psychotic behaviour
Ice	Psychotic behaviour	Psychotic behaviour, paranoia, delusion
Ecstasy[7]	Depression, anxiety	?
Heroin[8]	Depression?	Depression?

When quantified, it was found that the majority of teenagers and young adults perceived that illicit drug use could cause some kind of mental health problem. When drug perception statements were asked for marijuana, ice, speed and ecstasy, it was found that for each drug at least:

- 87% agreed that they make a person paranoid;
- 90% agreed that they can change a user's personality over the long term;
- 85% agreed that they can make a person depressed in the long term;
- 78% agreed that they can trigger schizophrenia; and
- 82% agreed that they can cause anxiety.

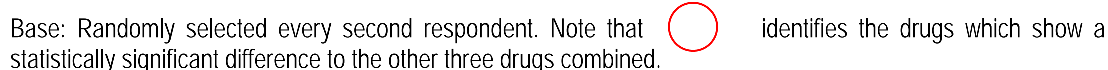
As shown in Table 5, ice and speed have very similar image profiles and are more likely than other drugs to be associated with being addictive and causing aggression. These drugs, along with ecstasy, are considered to share the attributes of not knowing what is in the drug and increasing anxiety. However, ecstasy is also much more likely to be seen as 'a fun drug' than the other drugs (although to a much lower level than the negative associations). Marijuana is different to the other three drugs in that it is more likely to 'make a person lazy and lethargic', help relaxation, is a good drug to share with friends and can help a person cope with mental health problems. While these positive associations towards marijuana are at a lower level than the negative associations it is still concerning that there is a perception that marijuana use could help a user to cope with mental health problems.

[7] NB: The question in the Ecstasy column is because people were not aware of any mental health problems relating to the long terms usage of ecstasy, although they did not discount the possibility there might be some.

[8] The question marks in the heroin column reflect the fact that few of this sample felt sufficiently well informed about heroin to be able to state confidently whether depression was a condition relating to short term or long term usage of heroin, although they assumed this might be a side effect.

Table 5 : Drug perceptions (% agree)

	Marijuana 883	Ice 803	Speed 811	Ecstasy 880
Can make a person paranoid	93	90	91	87
Can change a user's personality over the long term	93	95	93	90
Can cause mood swings	93	93	95	94
Is addictive	86	93	91	83
Can make a person aggressive	70	91	91	81
You don't know what is in it	58	89	90	86
Can make a person depressed long term	89	89	88	85
Can increase anxiety	82	87	90	87
Can make you socially withdrawn	86	89	85	76
Can make a person depressed in the short term	80	78	83	76
Can trigger schizophrenia	83	80	81	78
Can make a person lazy and lethargic	91	57	53	55
Can help a person to relax	73	25	24	33
Is a fun drug	31	15	25	33
Can help a person cope with mental health problems	28	9	11	11
Is a good drug to share with friends	28	8	9	19

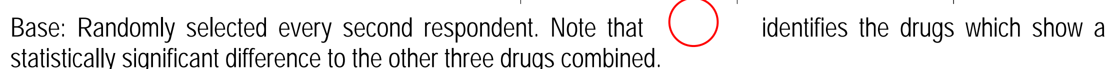

Base: Randomly selected every second respondent. Note that ◯ identifies the drugs which show a statistically significant difference to the other three drugs combined.

In order to understand changes in these perceptions over time, six of the drug perceptions statements from this survey (undertaken in 2007) were compared with the 2000 survey undertaken to assist in development of Phase 2 of National Illicit Drugs Campaign[9,10]. As illustrated in Table 6, illicit drugs are now perceived to have significantly worse effects in 2007 than in 2000. For all three drugs, marijuana, speed and ecstasy, the negative effects were perceived to be more negative in 2007, and for marijuana and speed the positive effects were perceived weaker. Ecstasy, however, was more likely to 'help a person relax' in 2007 and the other two positive effects were stable illustrating some increase in positive perceptions relative to other drugs.

[9] Clark, G., Scott, N., and Cook, S. '*Formative research with young Australians to assist in the development of the Natioanl Illicit Drugs Campaign*', Blue Moon research and Planning, June 2003.
[10] Only six statements are directly comparable.

Table 6 : Drug perceptions – 2000 survey vs 2007 survey

	MARIJUANA		SPEED		ECSTASY	
	2000 Survey 1168	2007 Survey 883	2000 Survey 1173	2007 Survey 811	2000 Survey 1168	2007 Survey 880
Is addictive	66	86	54	91	69	83
Can make a person aggressive	25	70	35	91	55	81
Can make a person lazy and lethargic	65	91	20	53	25	55
Can help a person to relax	72	73	30	24	24	33
Is a fun drug	48	31	44	25	34	33
Is a good drug to share with friends	49	28	26	9	22	19

Base: Randomly selected every second respondent. Note that  identifies the drugs which show a statistically significant difference to the other three drugs combined.

These general perceptions are discussed in more detail in the following section.

8.4 Impact of Drugs on Mental Health - Marijuana

Qualitative drug perceptions

When compared to previous research[11], marijuana is still seen as 'the gateway drug', the mainstream drug, the one that people start on. Despite this, a number of very different perceptions of it from the research seven years ago also emerged. While in the past smoking marijuana was seen as quite acceptable normal behaviour with minimal risk, concerns emerged in this research that even a small amount of marijuana could be risky.

Current perceptions of marijuana were often strongly dependent on whether people thought of marijuana in relation to 'hydroponics' or 'bush'. The hydroponic version was frequently seen as potentially quite dangerous, and more likely to lead to various mental health conditions such as paranoia, anxiety, schizophrenia, psychosis, and so on.

> *"Hydro makes you schizo."*

Long term usage, regardless of how it was grown, was strongly linked to depression, people cutting themselves off from others and from the world in general.

> *"There's no question that when people smoke a lot of pot they tend to become more*

[11] Clark, G., Scott, N., and Cook, S. *Formative research with young Australians to assist in the development of the National Illicit Drugs Campaign'*, Blue Moon research and Planning, June 2003.

introverted and less social."

Quantitative drug perceptions

Even among those who had used it in the last four weeks, respondents in the quantitative survey accepted that marijuana has many negative effects on mental health. It was primarily perceived to cause mood swings, change a user's personality, make a person paranoid, make them lazy and lethargic and depressed in the long term.

Those who had ever used marijuana were more likely than non-users to attribute both negative and positive attributes to its use. On one hand, those who had ever used the drug were more likely to perceive it as making users more lazy and lethargic and thought it is more likely to trigger schizophrenia than non-users. However, on the other hand, those familiar with the drug were also more likely to attribute positive attributes to it - it was perceived as more likely to be a fun drug, relaxing and good to share with friends.

Despite this, between 2000 and 2007 there have been significant changes in the perceptions of marijuana, in that it is now seen much more negatively, with more agreement that it is:

- more likely to be addictive, make a person aggressive, make a person lazy and lethargic; and
- less likely to be a fun drug and less likely to be a good drug to share with friends.

8.5 Impact of Drugs on Mental Health - Ecstasy

Qualitative drug perceptions

Throughout the qualitative sample, ecstasy was still largely seen as a relatively safe drug and was very popular among sections of the sample as a regularly used 'party' drug. Ecstasy was clearly not considered to be the type of drug that people become addicted to or 'get hooked on'. Rather it was perceived as a substance that is appropriate to use at a certain age and time in life.

There was limited knowledge of the possibility of any mental health problems being associated with ecstasy, particularly over the long term, with some small awareness of the possibility of depression. Despite this, many readily acknowledged short term effects after taking ecstasy, but these were related to 'hangovers' similar to those caused by alcohol.

Quantitative drug perceptions

The quantitative research found that use of ecstasy was perceived to have negative mental health effects across the sample. However, in comparison to other drugs, those who had ever used it were much less likely to agree with its negative effects. In particular, triallists were less likely to agree that ecstasy is addictive, can make a person aggressive, makes you socially withdrawn, can make a person lazy and lethargic. They were more likely to agree that ecstasy is a fun drug and is good to share with friends.

Between 2000 and 2007 there was a significant worsening in the negative perceptions of ecstasy. It was more likely to be perceived as addictive, making a person aggressive and making a person lazy and lethargic. However, the positive perceptions of ecstasy were improved or stable. Ecstasy was more likely to help a person to relax and it was stable for being a fun drug and being a good drug to share with friends.

The risk identified in both stages of research is that ecstasy is seen as mainly having positive effects. In many ways, ecstasy has adopted the 'positioning' that marijuana used to have a few years ago.

8.6 Impact of Drugs on Mental Health - Speed

Qualitative drug perceptions

Mixed attitudes to speed emerged among the qualitative sample. Some were highly positive about the focus and energy that taking speed was seen to provide, while at the same time able to comment on the negative associations they held of the drug. Attitudes towards speed seemed to depend on a number of factors, including how much an individual uses the drug, how they use it (whether they inject it or not) and the purity.

> *"You calm down, but it can make you paranoid or zonk out. In the long term it's likely to give you less energy."*

While different 'street' names for speed, such as 'base', 'goey', 'whizz' are used synonymously during discussions, the drug is consistently referred to as 'speed' regardless of geographic location and level of familiarity. The qualitative research found that, arguably, the introduction of ice has made speed seem less dangerous by comparison:

> *"Speed is a mellow drug by comparison [with Ice]. The effect is not so good but*

Speed has the legs."

Quantitative drug perceptions

Both triallists and non-triallists of speed agreed with most of its negative mental health attributes. In particular, it was seen as causing mood swings, changing users' personalities over the long term, causing paranoia, being addictive and increasing anxiety. Speed triallists were more likely than the total sample to agree that speed can increase anxiety.

Between 2000 and 2007 there were significant changes in the perceptions of speed – it is now perceived much more negatively. It is more likely to be perceived as addictive, to make a person aggressive and to make a person lazy and lethargic. It is also less likely to be perceived as helping a person relax, to be a fun drug and to be a good drug to share with friends.

8.7 Impact of Drugs on Mental Health - Ice

Qualitative drug perceptions

The qualitative research indicated that knowledge of Ice was somewhat patchy, confused, particularly in the relationship between ice, meth and speed. Ice was typically seen as very different to speed, with much stronger effects and side-effects.

Many of the qualitative sample claimed to be frightened by Ice. Both those who admitted to trying the drug, and those who have only heard about the effects, linked its use to dangerous, violent, psychotic behaviour:

> *"It made my personality change – I became really withdrawn and isolated. It made me think people were talking to me, I would see shadow warriors."*
>
> *"It produces really intense psychotic experiences – it can turn people who are not aggressive into someone who you wouldn't trust or want to be around anymore."*

Quantitative drug perceptions

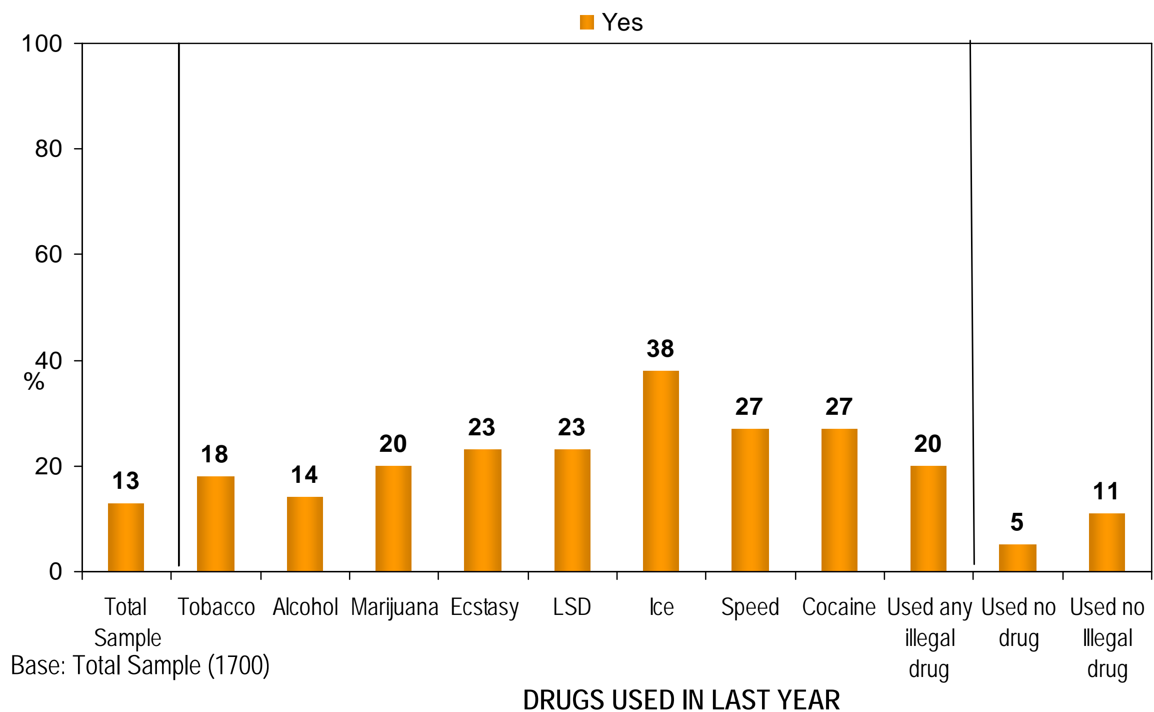
Ice was seen as very negative for mental health. It was primarily perceived to change a user's personality over the long term, cause mood swings, be addictive, cause aggression and paranoia.

As with marijuana, those who had used the drug previously were more likely to agree with both the negative and positive attributes of the drug. On one hand, those who have ever tried ice are more likely to consider it to be addictive and to cause anxiety. On the other hand, triallist are also more likely to agree with some of the positive attributes of ice - that it can help relaxation, it is a fun drug and is a good drug to share with friends.

8.8 Experience of the Link Between Illicit Drug Use and Mental Health

There was a very strong relationship between self-reported mental health problems and drug use in the last year. As shown in Figure 7 users of every illicit drug (and tobacco) were significantly more likely to have experienced a mental health problem in the last year than those who used no illegal drug. In particular, ice, speed and cocaine users were the most likely to have had a recent mental health problem. However, from this data, it is impossible to establish the direction of the relationship - whether illicit drug use *influenced* the mental health problem or drugs were used *because* of the mental health problem.

Figure 7 : Experienced mental health problems in last year by drugs used in last year

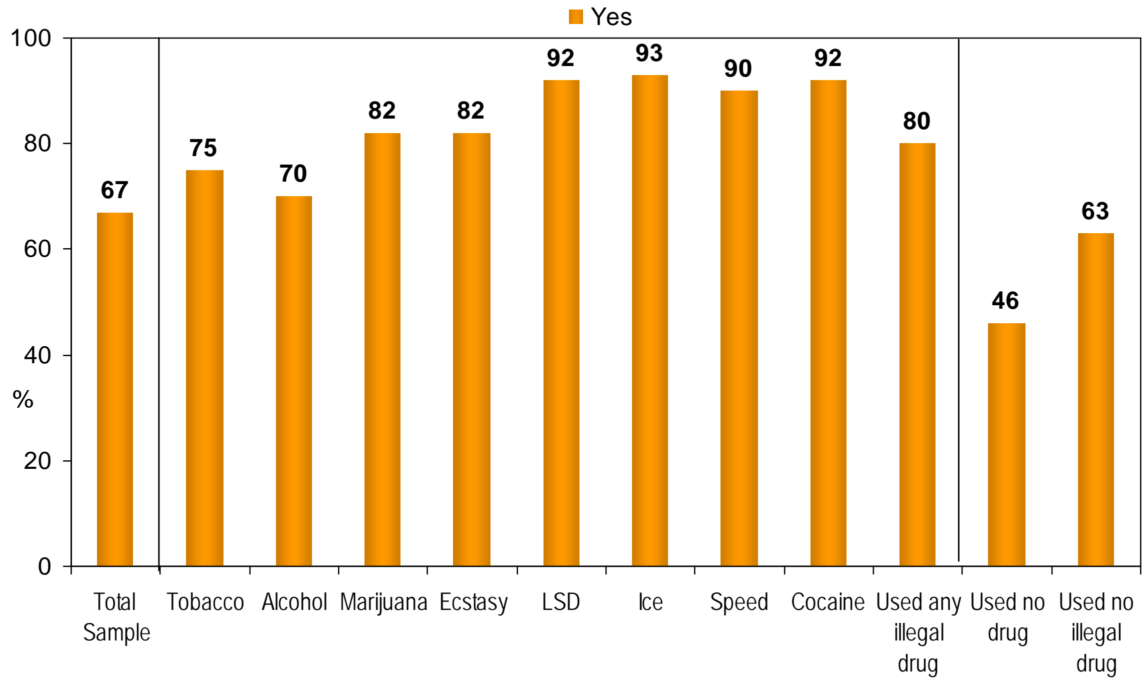


Base: Total Sample (1700)

Note: The sample sizes are quite small for the less commonly used drugs – LSD, ice and cocaine.

Across the total sample, two-thirds (67%) knew of someone with a mental health problem. However, this was significantly higher among those who had used illicit drugs in the past year (80%) than those who had not (63%). In particular, users of ice, LSD, cocaine and speed were more likely to know someone with a mental health problem (shown in Figure 8 below).

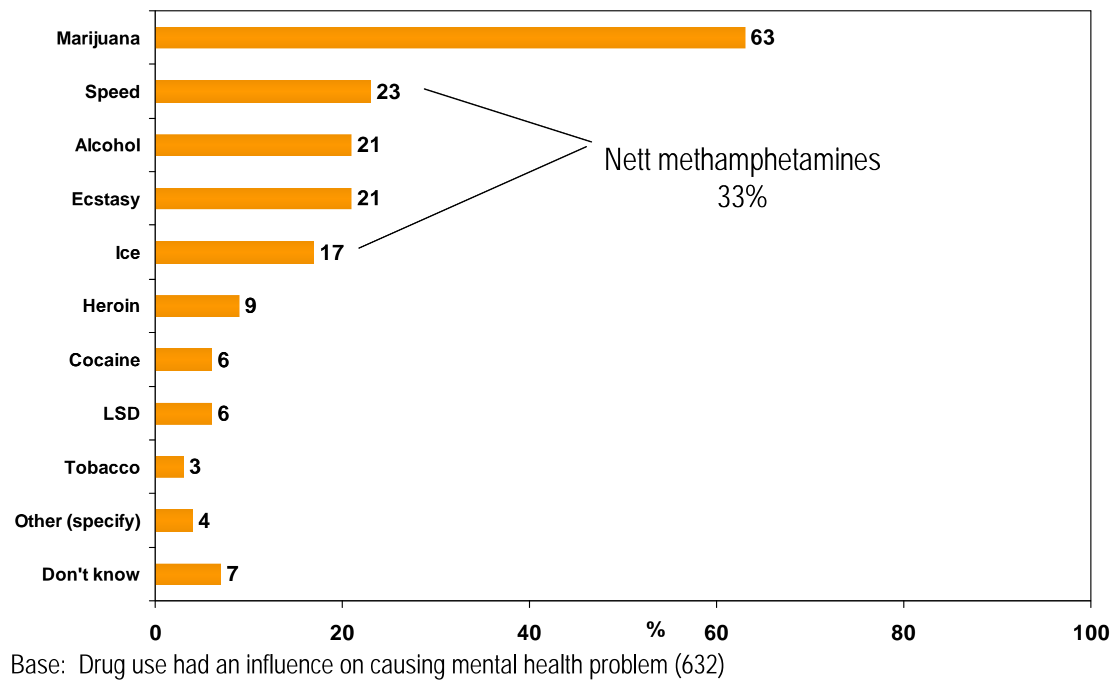
Figure 8 : Know of anyone with a mental health problem by drug used in last year



Base: Total Sample (1700)

Across the sample, drug use was perceived to have a substantial influence on mental health. Amongst those who know someone with a mental health problem, 58% believed that drug use had some influence on causing their mental health problem (34% a strong influence and 24% some influence). As detailed in Figure 9, marijuana was perceived to be the drug most likely to have influenced the mental health problems of the person they know (63%). This was followed by methamphetamines (33%).

Figure 9 : Drugs contributed to mental health problems



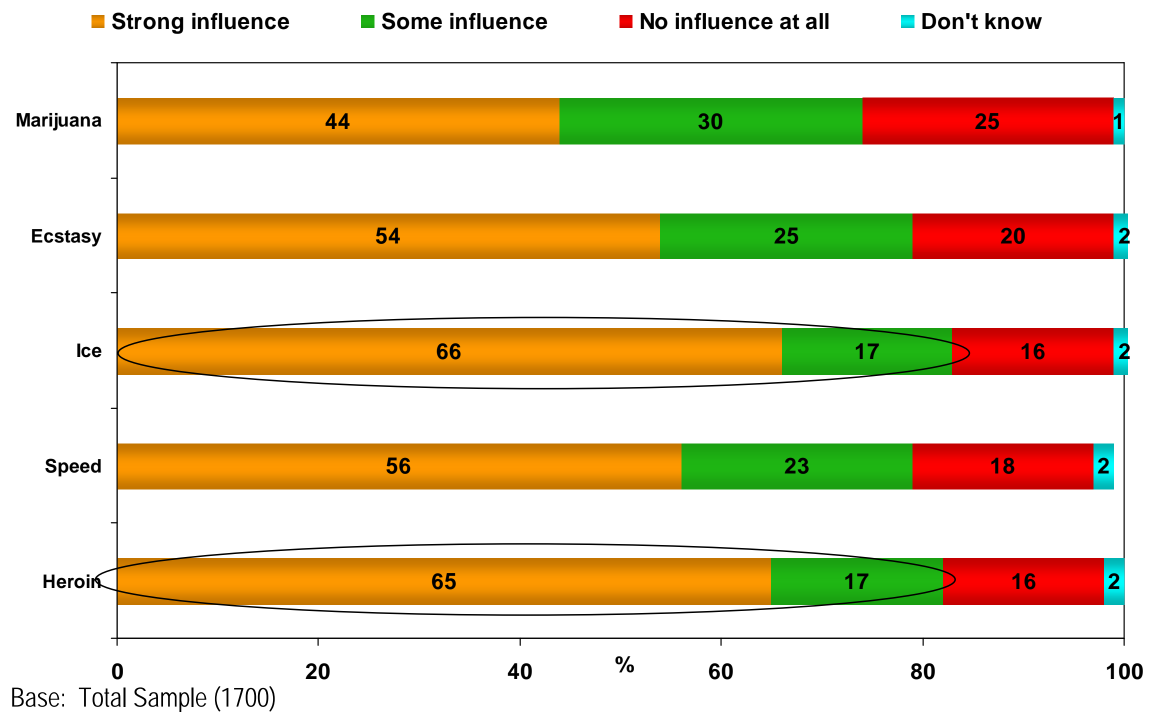
Base: Drug use had an influence on causing mental health problem (632)

8.9 Influence of Mental Health Problems on Drug Use

The quantitative research indicates that knowing someone with a drug related mental health problem made 86% more cautious about taking drugs[12]. The potential for mental health problems was perceived as having a considerable influence on the decision to accept or reject an offer of illicit drugs from a friend. As shown in Figure 10, this varies according to drug with ice and heroin having the greatest influence on acceptance or rejection on the basis of mental health issues.

[12] With the exception of LSD users for whom only 70% were more cautious about taking drugs.

Figure 10 : Influence of risk of mental health problems on decision to accept / not accept drugs



Base: Total Sample (1700)

8.10 'Side effects' vs Mental Health Problems

Across the sample, there was a distinction made between short and long-term mental health symptoms, specifically in regard to use of illicit drugs. Most felt that the short-term problems experienced after taking drugs were acceptable and manageable. They argued that 'everyone has their ups and downs' and they did not expect long-term problems to develop as a result. Short-term symptoms were perceived to be an expected and relatively accepted side-effect of drug use, the equivalent of a hangover from alcohol, which most felt were 'not that bad anyway'. All in the main qualitative sample tended to believe that long-term mental health problems would be very different than these short term side effects, although they were not exactly sure how. They assumed they would be able to tell the difference should it ever occur to them and that they would know, although many accepted that the line representing short and long-term symptoms could be somewhat grey. This could mean that they do not recognise if their perceived short term symptoms are becoming more problematic.

Currently the idea that mental health problems can relate to illicit drug use is just one of a number of possible negatives for illicit drug use. Most accept that drug usage can be bad for their health, lead to a loss of control in some people, be expensive, be for 'losers', be antisocial and / or cause mental health problems. However, mental health does not spontaneously stand out as high on the list.

That said, while opinions about taking illicit drugs and the possible consequences were strongly divided across the sample, it was clear that no-one in the qualitative sample wanted to develop or suffer from mental health problems. If the link between mental health problems and illicit drug usage is able to be made successfully for groups that simply accept and manage short term effects, it is possible that the risk of mental health problems could become one of the most powerful deterrents to illicit drug taking. This is because of existing negative associations with mental health problems, namely:

- the fear that they could be permanent;
- the recognition of the 'ultimate loss of control';
- the extremely negative social perceptions;
- the idea that 'you don't realise what's happening until it's too late'; and
- the effect this would have on your family and friends.

The undesirability of mental health problems among young people aged 15-24 years was further found within the quantitative research. When asked to rank the most negative problem affecting some people's lives, mental health problems were perceived to affect a person's life much more negatively (66%) than physical health problems (14%), relationship problems (13%) or problems with study / university / school (6%).

8.11 Changing Perceptions of 'Side Effects'

From the qualitative research, four areas currently regarded as illicit drug 'side-effects' emerged as having the potential to be viewed as mental health problems. These included depression, loss of control, dependency and change in perceptions or state of mind.

Depression

Many within the qualitative sample made the link between illicit drug use and what they perceived to be bouts of depression. Some attributed the depression only to times of 'coming down' from amphetamine based drugs while others saw it as more pervasive effect from frequent use of marijuana.

> *"I think whenever you take drugs there's a down period that follows when you become a bit depressed, a bit emotional and everything becomes a bit intense."*

> *"In the past when I've smoked pot really heavily I've had severe depression – I'm trying to give it up."*

Loss of control

Loss of control was also a potentially major deterrent. While the idea of temporary loss of control can be a key motivator for people to take drugs initially, the thought of permanent loss of control was frightening for the majority.

> *"When you see people getting out of it all the time you hope you have the control to respond differently."*

> *"The issue is to make sure you slot them into your lifestyle rather than let them govern you."*

> *"Drugs change what you think is important – you don't always realise the drug is controlling you."*

Dependency

A major fear related to illicit drug usage is dependency. Many believed that as long as they only used drugs at certain times such as the weekend, they were effectively managing their drug use.

> *"The big thing is whether you're still getting anything out of it when you take it or whether you're becoming dependent on it without getting a hit."*

> *"My friend wakes up and has a cone first thing in the morning."*

> *"I have a mate with Bi Polar – marijuana is his friend, not his mates."*

Changing perceptions and states of mind

The idea that drug usage can change an individual's perceptions and state of mind was also a major concern. While these were often recognised initially by family or friends, some individuals within the qualitative sample considered these types of experiences as indicative of more serious problems for themselves.

> *"It's a way of not dealing with the problem – the trouble is they don't see their behaviour as being any different, whereas my daughter is always tired and short tempered when she's been smoking marijuana."*

> *"… I just woke up with a razor blade in my hand, and I was about to do it – the right way too. But I can't remember how I got there … couldn't remember anything before that. Just woke up and there I was … about to do it."*

9 DEVELOPING ARCHETYPES

9.1 Development of Archetypes from Qualitative Research

The participants involved in the qualitative research emerged as a highly complex and diverse group. Some had no problems, some had drug problems but not mental health problems, some had mental health problems but not drug problems, some had both drug and mental health problems. In addition there were different problems associated with different drugs, different types of mental health problem and some who were not aware they had problems (either with drugs or mental health).

We found that people generally responded to the issues in very different ways reflecting their different experiences, beliefs, needs, personalities and hopes and dreams. That said, a number of archetypal responses were able to be identified where consistent agreement on different areas existed.

In the qualitative research six possible archetypes emerge in relation to mental health problems and drug usage:

- 'Bullet-proofs';
- 'Jeopardized';
- 'Percentage Players';
- 'That's Me';
- 'Too Scarys'; and
- 'Positive Alternatives'.

Some of these were similar in characteristics as the segments identified in previous research on illicit drugs[13]. As they have been referred to throughout this section, a description of these segments has been appended (Appendix C).

[13] Clark, G., Scott, N., and Cook, S. *Formative research with young Australians to assist in the development of the National Illicit Drugs Campaign'* , Blue Moon research and Planning, June 2003.

9.2 Qualitative Archetypes

'Positive Alternatives'

'Positive Alternatives' are similar to the 'Considered Rejectors' identified in previous studies. This archetype readily accepts the idea of the link between drug usage and mental health problems, and is relatively sympathetic and understanding of those with mental health problems. This archetype has already rejected drug usage for 'positive' reasons. They believe there are 'better things in life', they feel that 'natural' highs are preferable to drug induced ones and because they have goals and ambitions they want to achieve. Any communicated link between drug usage and mental health problems would support their position.

'Too Scarys'

'Too Scarys' are similar to the 'Cocooned Rejectors' identified in previous studies. This archetype finds the whole subject emotionally very off-putting and they are uncomfortable even thinking about it. They tend to see people with mental health issues as 'nutters' and are already too frightened to take drugs. The idea that drug usage could cause mental health problems is credible for this archetype and would strongly reinforce their position by providing them with supportive evidence for their stance.

'That's Me!'

The 'That's Me!' archetype sees themselves as having the type of personality that lends itself to developing mental health problems and drug problems. Many who fall into this archetype are still willing to take drugs and are attracted to drugs but simply don't like to think about the possible negative consequences. Others are too frightened that they might develop negative side-effects. This archetype readily accepts the potential link between illicit drugs and mental health problems and would welcome support to help 'protect' themselves from themselves.

'Percentage Players'

'Percentage Players' are similar to the 'Risk Controllers' identified in previous studies. This archetype readily acknowledges that there is a risk of developing mental health problems if you use illicit drugs. However, they do not believe they have the kind of personality that makes them susceptible to mental health problems and most believe they are in control of their drug taking. They ensure that they are very familiar with the experiences they can expect in relation to any given drug, either from reading up on the drugs or via discussions with friends, from previous usage and so on. Many 'Percentage Players' will adopt measures to

minimise potential harm or negative side-effects related to taking drugs throughout the experience. That said, to some degree percentage players are frightened that despite the precautions they take their drug taking could, if they were unlucky, lead to mental health problems.

'Bullet-proofs'

'Bullet-proofs' are similar to the 'Thrill Seekers' identified in earlier illicit drug studies. They enjoy taking drugs too much to want to face up to the potential risk of mental health problems. Many have come to the belief that 'it can't happen to me', either because they are in denial or because to date they have not had any negative experiences in relation to drug taking. Clearly this archetype will be resistant to any attempts to link illicit drug usage with mental health problems and, further, may believe that such a link is contrived.

'Jeopardized'

'Jeopardized' are similar to the 'Reality Swappers' identified in earlier studies. The name relates to their negative situation in life rather than any kind of personal description. They are often aware they already have mental health issues or willing to believe they are susceptible to them. They feel their lives are somewhat out of control in any case and while some would love things to be different, others have become resigned to their desperate situation. Clearly some have highly developed problems relating to drugs but may be in denial or believe they are still in control of their drug use.

In this context, one issue is that many tend to 'shift the goal posts' of what 'in control' actually means – they can always quote other people who are worse off than they are. Certainly this archetype is willing to believe in the link between illicit drug usage and mental health problems but would need help that provides guidance as to how they can extricate themselves.

9.3 Comparing Archetypes

When comparing similarities and differences between the six archetypes between this research and the previous research undertaken for the National Drugs Campaign, a number of shared characteristics were able to be identified. Of the six archetypes those most likely to use drugs are 'Jeopardized', 'Bullet-proofs' and 'Percentage Players', with 'That's Me!' divided between users and non-users.

The different archetypes were variously driven by emotional and rational attitudes. Those

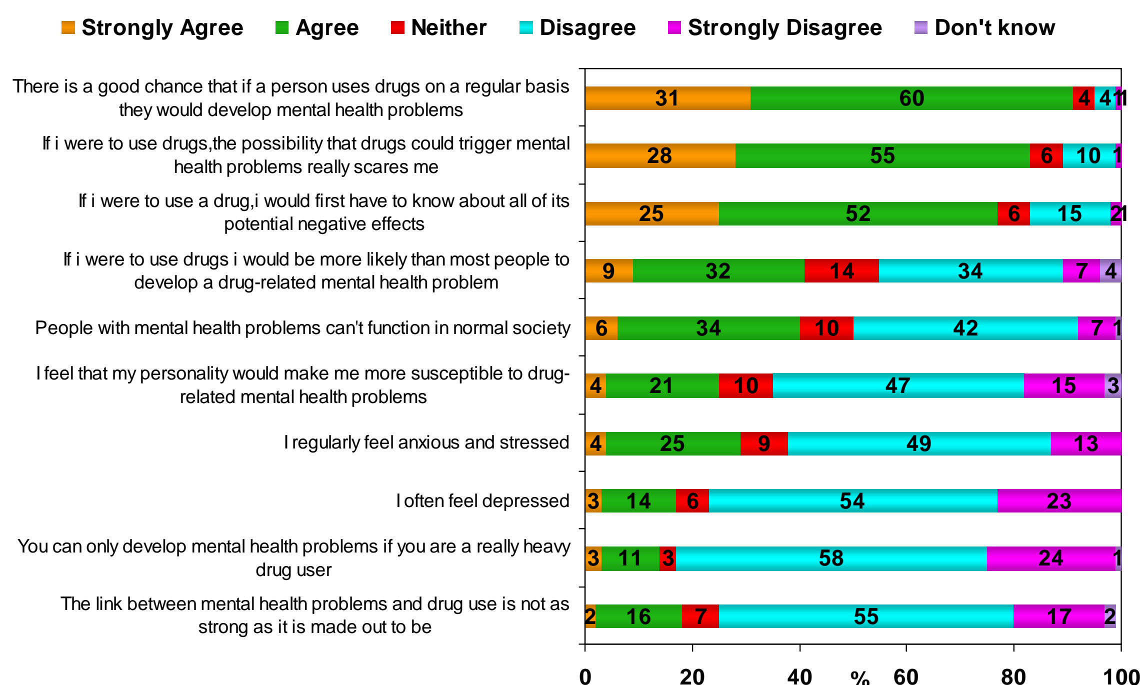
whose responses were mainly emotional included 'Too Scarys', 'That's Me!', 'Jeopardized' and 'Bullet-proofs', whereas 'Positive Alternatives' and 'Percentage Players' tended to adopt a more rational approach.

10 IDENTIFYING THE QUANTITATIVE ILLICIT DRUG / MENTAL HEALTH SEGMENTS

10.1 Development of Segments

Building on the qualitative research, the quantitative study conducted a statistically robust attitudinal segmentation of respondents. The segmentation was based on twelve attitudinal statements related to mental health and illicit drugs that were developed from the six archetypes that emerged from the qualitative research. Overall response to these statements is shown in Figure 11.

Figure 11 : Attitudes towards the link between illicit drugs and mental health



Base: Total Sample (1700)

Firstly, principle components analysis (a type of factor analysis) was conducted on the responses to these statements which grouped highly correlated statements together under five themes. Secondly, cluster analysis was conducted on the outputs of the factor analysis, which grouped respondents together in segments. Clusters were formed from people who were similar to each other and different to those outside the cluster. A number of solutions were examined, ranging from a three cluster to a ten cluster solution. The six cluster solution appeared both statistically efficient and practical.

Factor analysis

There are five underlying factors in attitudes towards illicit drugs and mental health.

Table 7: Factors in attitudes towards illicit drugs and mental health

FACTORS	ATTITUDINAL STATEMENTS
Factor 1 Susceptibility	• I feel that my personality would make me more susceptible to drug-related mental health problems • If I were to use drugs I would be more likely than most people to develop a drug-related mental health problem
Factor 2 Anti-drugs / scared of link	• If I were to use a drug, I would first have to know about all of its potential negative effects • I'm not interested in drugs • If I were to use drugs, the possibility that drugs could trigger mental health problems really scares me
Factor 3 Instability	• I'm not really in control of my life • I regularly feel depressed • I regularly feel anxious and stressed
Factor 4 Unsympathetic	• People with mental health problems can't function in normal society • You can only develop mental health problems if you are a really heavy drug user
Factor 5 Sceptical of link	• The link between mental health problems and drug use is not as strong as it is made out to be • There is a good chance that if a person uses drugs on a regular basis they would develop mental health problems

The Segments

Using these factors, six segments of young people aged 15-24 years were identified. The segments were named as follows:

- 'Positive Alternatives';
- 'Too Scarys';
- 'Intolerant Deniers';
- 'Sceptics';

- 'Bullet Proofs'; and
- 'Jeopardized'.

Table 8 illustrates how strongly each segment scored on each factor by showing the degree a cluster is above or below the factor mean. For example, the 'Jeopardised' segment felt that they are very susceptible to the illicit drug use and mental health link, they are pro-drugs but accept the link and are quite unstable as signified by higher agreement to statements about anxiety and depression.

Table 8: Factor by segment

		Positive Alternatives	Too Scarys	Intolerant Deniers	Sceptics	Bullet Proofs	Jeopardized
Sample Size		**567**	**284**	**239**	**236**	**227**	**144**
FACTORS	1 Susceptible	-	++++	-	-	- - -	++++
	2 Anti-drugs / scared of link	++	+++	++	-	- - -	- - - - -
	3 Instability	- -	+++	+++++	-	-	+++
	4 Unsympathetic of MI	+	- -	+++	0	- -	0
	5 Sceptical of link	- -	-	0	+++++	- -	- -

This table shows the degree a cluster is above or below the factor mean

Although based purely on attitudes, these segments were very good predictors of drug usage levels and of mental health problems. As detailed below in the next three charts, the attitudinal segmentation provides good behavioural discrimination between segments. There is a clear pattern of:

- drug trial, with 'Jeopardized' followed by 'Bullet Proofs' the most likely to have trialled illicit drugs (Figure 12);
- last four week drug use, with 'Jeopardized', 'Bullet Proofs' and 'Sceptics', the most likely to have recently used illicit drugs (Figure 13) and also to have used them more frequently, particularly the 'Jeopardized' (see Appendix D for details of use of individual drugs by segment); and
- mental health problems, which were most likely to have been experienced by 'Too Scarys', 'Intolerant Deniers' and 'Jeopardized' (Figure 14). These three segments were also the most at risk of accepting drugs if offered by a friend, in particular the 'Jeopardized' segment.

Figure 12: Ever used illicit drugs

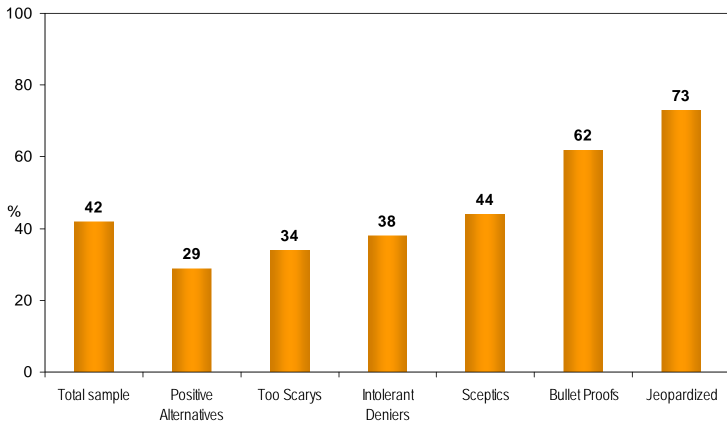
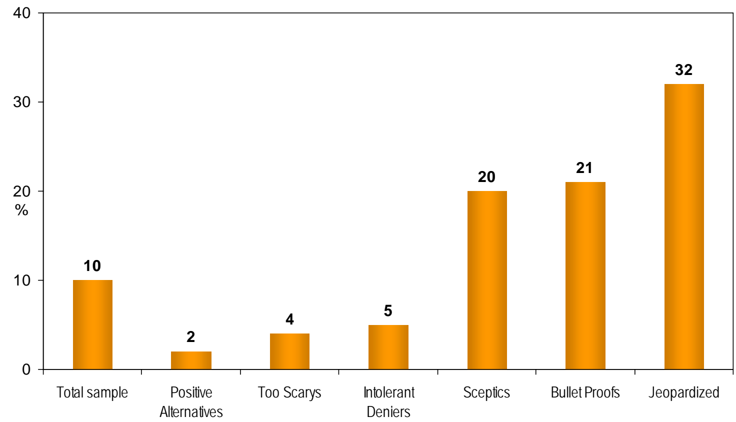
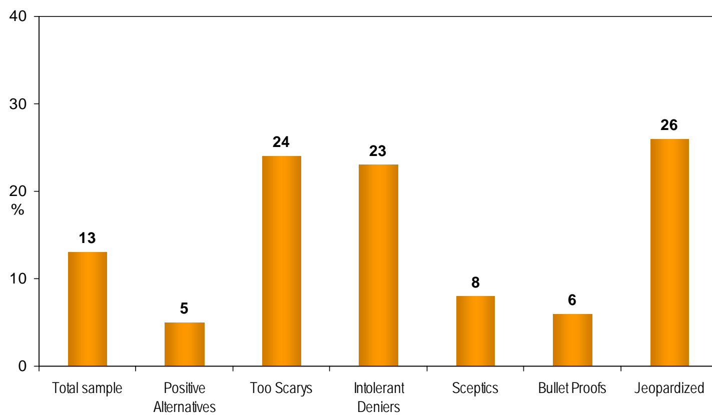


Figure 13: Used illicit drugs in the last 4 weeks



Base: Total Sample (1700)

Figure 14: Experienced mental health problems in last year



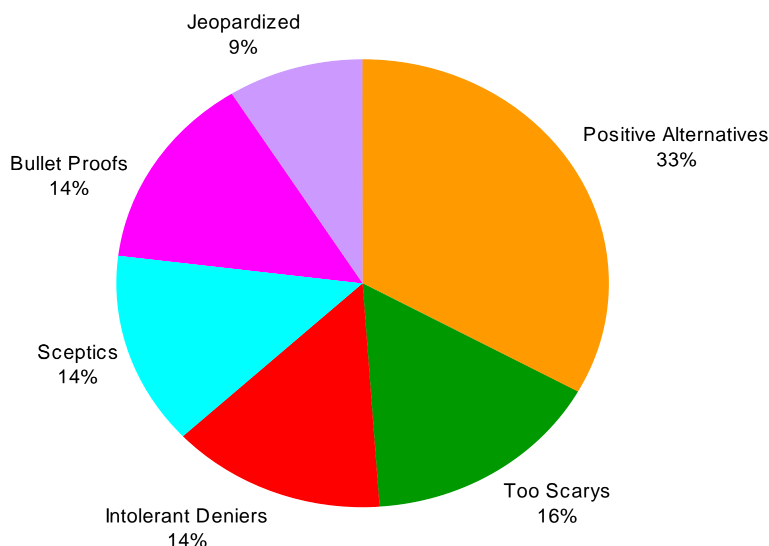
10.2 Comparison of Qualitative and Quantitative Segmentation

While not identical to the qualitative segmentation, the quantitative results bore a relatively strong relationship to the archetypes originally hypothesised. The 'Positive Alternatives' segment remained the same. A new segment, 'Intolerant Deniers', emerged in the quantitative research. This segment was not readily identified in the qualitative research as this segment's key difference is that its members are unsympathetic to those with mental health problems, an attitude that is unlikely to be uncovered in a qualitative focus group of peers. Three of the original qualitative segments were split to form the quantitative segments on the basis of three key attitudes - interest in drugs, acceptance of link between drug use and mental health problems and personal susceptibility of a drug-related mental health problem.

10.3 Size of Segments

The following figure (Figure 16) illustrates the size of each of the segments among the total sample of 15-24 years olds.

Figure 16: Size of segments



10.4 Description of Segments

'Positive Alternatives' – 33%

Attitudinally, this segment is not interested in drugs. They accept the link between drugs and mental health problems, are frightened of it but do not feel personally susceptible even if they were to take drugs. They are less accepting of those with mental health problems than other groups.

This segment has the lowest drug use, with only 29% having ever used illicit drugs and few mental health problems (5%). Although they have little exposure to mental health problems amongst people they know, risk of mental health problems is a strong deterrent to using illicit drugs.

'Too Scarys' – 16%

Attitudinally, this segment is quite unstable relative to other segments with many agreeing to feeling anxious, stressed and depressed. They feel that if they used drugs they would be

personally susceptible to mental health problems. However, they are anti-drugs and scared of the link between drugs and mental health problems. They do not stigmatise people with mental health problems.

This segment has low drug use, only 34% have ever used illicit drugs and are more likely to have mental health problems (24%) than others. They have considerable exposure to people with mental health problems, are very aware of the link and the risk of mental health problems is a very strong influence on their decision not to use drugs.

'Intolerant Deniers' – 14%

Attitudinally, while this segment appears the most unstable with many feeling that life is out of control, depressed and anxious, they are very unsympathetic to those with mental health problems. They are not interested in drugs. They are scared of the link between drug use and mental health problems but consider it only applicable to heavy drug users and thus they do not feel personally susceptible.

They have low drug use with 38% ever having used illicit drugs. While they are much more likely to have mental health problems (23%), they have a minimal understanding of mental health problems as well as the link to drug use.

'Sceptics' – 14%

Attitudinally, this segment is the only one sceptical of the link between drug use and mental health problems. They do not feel personally susceptible and are not scared of the link. They are mentally stable and somewhat interested in drugs.

This segment has a male skew. They have average drug trial but above average use of drugs in the last four weeks (particularly marijuana), and are at risk of accepting drugs if offered by a friend. They are less likely to have mental health problems (8%) and have very low exposure to, and understanding of, mental health problems.

'Bullet Proofs' – 14%

Attitudinally, this segment is very interested in drugs, regardless of any negative effects. They do not feel at all personally susceptible to the mental health effects of drugs and while they accept there is a link, they are not scared of it. Their mental health is stable and they appear supportive of those with mental health problems

This segment skews towards males and 21-24 year olds. They are the 2nd most likely to have each drug with 62% ever having used illicit drugs and less likely to have mental health problems (6%) than other segments. However, they are very familiar with mental health problems and drug related mental health problems but they just do not think it will happen to them.

'Jeopardized' – 9%

Attitudinally, this segment is the most interested in drugs, regardless of effects. They are quite unstable, feeling anxious and depressed, and feel very susceptible to mental health effects of drugs. They accept there is a link between drug use and mental health problems but they are not scared of it.

This segment skews towards males and 21-24 year olds. They are the most likely to have used every drug ever, with 73% ever having used illicit drugs, and in the last 4 weeks and the most frequently. They are also the most likely to have mental health problems (26%). They have a very good awareness of mental health problems in general as well as those they see as drug-related. This segment accepts the link, know they are personally susceptible but they ignore it.

11 NESB AND INDIGENOUS YOUTH

The responses of youth from non-English speaking backgrounds (NESB) and Indigenous youth largely reflected those of mainstream Australians. These audiences also typically linked illicit drugs and mental health problems, often without prompting. There was a sense that the more long-term the drug usage, the greater the potential for more serious mental health problems to develop. For those with NESB backgrounds in particular 'mental health' was something of a taboo area.

Overall, we found similar responses to those of mainstream Australians in relation to attitudes towards and perceptions of specific drugs, especially Ice, and potential advertising approaches.

There were, however, some important differences among the NESB audience. Many were clearly frightened at the thought that their parents might find out about them taking drugs. Also they tended to think of more extreme scenarios in relation to mental health, such as suicide, dangerous and 'crazy people', mental institutions and so on. Some linked mental health issues with discrimination and cultural issues, although many admitted that there was not a great deal of discussion of these areas within their respective communities. The drug scene seemed to be more contained within a specific cultural community. This appeared to be particularly true for the Chinese community.

Among the Indigenous audience there was a belief that 'white fella's drugs', such as Speed, Ecstasy and Heroin, were different to 'black fella's drugs' such as alcohol and 'Cones'. Within the Indigenous community there appeared to be greater openness about discussing mental health issues. Indigenous Australians claimed they could openly talk with friends, family and mental health workers about the issues and believed there were a number of support options readily available to them if they were to develop mental health problems. Overall mental health was considered a big issue for Indigenous Australians due to racism, poverty, poor health and their history.

12 CONCLUSIONS

12.1 Link Between Mental Health and Illicit Drugs

Both stages of research found that the link between illicit drug use and mental health problems is strong and credible and has strengthened since the illicit drugs research in 2000[14]. Further, as suggested in the qualitative research, the subsequent quantitative survey found that there was a strong relationship between self-reported mental health problems and recent illicit drug use.

Communication of the risk of mental health problems is likely to be a very strong deterrent to using illicit drugs amongst young people.

12.2 The Campaign

Overall, the campaign could focus on one or both of the following:

1. prevention by educating young people about the potential negative mental health consequences of using illicit drugs, using credible evidence-based information; and

2. help-seeking by promoting services that provide counselling and treatment for current drug users with mental health problems.

It is important to bear in mind during campaign development that there will be a very fine line between raising awareness of drug-related mental health problems and the risk of further stigmatisation of those with non-drug related mental health problems.

[14] Clark, G., Scott, N., and Cook, S. '*Formative research with young Australians to assist in the development of the National Drugs Campaign*', Blue Moon Research and Planning, June 2003

APPENDICES

A RESEARCH INSTRUMENTS

QUALITATIVE RESEARCH DISCUSSION GUIDE

1. Introduce research

The initial focus will differ according to whether the group has been recruited primarily in relation to drugs or to mental health issues

2. Drugs – focus upon illicit drugs

- write down first thoughts and feelings associated with drugs in general
- overall attitudes towards drugs (good and bad)
- for non-users:
  - why don't they take drugs
  - if they are lapsed users, why did they stop
- for users, why do they take drugs
  - do they see different drugs differently, if so:
  - what specific associations do they have with specific drugs (image profiles)
- what are the short term and long term effects of different drugs (good and bad aspects)
- do they feel differently about drugs now from when they first took them.

Explore in detail if there are any spontaneous associations between drug use and mental health problems / illness

3. Mental health problems

Get them to write down their first thoughts, feelings and associations.

- when they think about mental health issues, what images come to mind
- what are mental health problems, what are the symptoms, what are the effects (on the individual, on others around them)
- do they see different levels of severity with regard to mental health problems

- what causes mental health problems
- do they see a difference between mental health problems and mental illness – if so, what is it
- do they know of anyone who has had mental health problems
- if they do (or they self-identify):
  - what was the situation
  - what do they think caused the problems
  - what happened, were the problems addressed, if so how
  - could the problems have been avoided or minimised, if so how
- do you think people would know if they had a mental health problem – if so how would they know
- imagine someone you know had what you thought was a mental health problem. What can people do if they think they have mental health problems
  - where can people go to talk about them
  - what could you do to help someone
  - what treatment options or services are available
- what would you do if you believed you had a mental health problem

If there is a spontaneous link made between mental health problems and drugs then explore in detail

4. Mental Health problems and drugs:

- do they think there can sometimes be a link between drug use and mental health problems
- if so:
  - under what circumstances
  - in relation to which drugs (any drugs, or specific drugs)
  - is this affected by long term use, heavy use
  - are some people more susceptible than others
- do they know of people who have had mental health problems as a consequence of drug taking – if so, explore in detail (situation, outcome, etc)

5. **Explain there is to be a campaign linking mental health problems with drug taking:**

- how do they feel about this idea
- do they see any issues in developing such a campaign
- what kinds of things would they focus upon if they were developing such a campaign

6. **Play the video of ads and explore responses in detail:**

- which (if any) of the approaches are most appropriate (in relation to the possible link between mental health and illicit drug issues) in terms of:
  - tone
  - style
  - content
  - credibility
  - impact
- specifically focus briefly upon the earlier illicit drugs advertising and identify:
  - the credibility of the backstreet lab
  - whether 'speed' is still a current term (and if not, what terminology is more 'current')
  - does 'speed' encompass all types of amphetamine (eg crystal meth, ice etc) – if not, is there a word that does so (or does it better)
- overall, what guidelines emerge for the development of ideas for a mental health and illicit drugs campaign in the future

QUANTITATIVE QUESTIONANIRE

ILLICIT DRUGS & MENTAL HEALTH QUESTIONNAIRE

INTRODUCTION AND SCREENING

Good morning/afternoon/evening. I am _____________ calling from I-view, the market research company on behalf of the Australian Government Department of Health and Ageing. Today we are conducting a major national survey of attitudes regarding some of the issues facing young people today.

S1 Are any of the people who live in your household aged 15 to 24 years?

Yes...1 CONTINUE
No ....2 CLOSE

IF NO, THANK AND CLOSE. IF YES, CONTINUE

PN- ASK SUPERVISOR MONITOR AFTER S1

I would like to speak to the person aged 15 to 24 who is next to have a birthday. Is that person home at the moment?

If Yes ask:

Would they be aged

between 15-17

or 18 to 24?

If qualifying respondent/person on the phone is aged 15-17 confirm you are speaking with/or ask for a parent/guardian of the 15-17 year old and ask for permission to do the survey…

If 15-17 in HH-

Am I currently speaking with the parent/guardian of the 15-17 year old?

[IF speaking to a 15-17 year old say: May I please speak to your parent or guardian?]

Explanation: This survey covers a range of sensitive issues which will provide the Government with information to develop future health campaigns targeted at young people. If they do not wish to answer any question that is OK.

(ONLY IF ABSOLUTELY NECESSARY TO PARENTS: I can reveal that the study is to help develop a campaign linked to illicit drugs and mental health. You can contact the project manager Craig Smith at the Department of Health on 02 92633548 or 1800 250 015 during business hours if you would like to verify the survey)

1. Permission given, name provided (RECORD PARENTS NAME)
2. Permission given, name NOT provided (CONTINUE)
3. Parental permission refused (GO TO TERMINATION SCRIPT 2)

IF NO, ASK: COULD I JUST GET THE FIRST NAME AND AGE OF THE PERSON AGED 15-24 WITH NEXT BIRTHDAY? 1. PERSON 1: FIRST NAME: 2. AGE__________ RECORD DETAILS AND MAKE UP TO THREE CALLBACKS TO SPEAK TO THAT PERSON. FOR RESPONDENTS AGED 15 TO 17, OBTAIN PARENTAL PERMISSION BEFORE PROCEEDING WITH THE INTERVIEW WHEN THE QUALIFYING RESPONDENT IS ON THE LINE, CONTINUE.

Good morning/afternoon/evening. I am _____________ calling on behalf of the Australian Government Department of Health and Ageing from I-View, the market research company. Today we are conducting a major national survey of attitudes regarding some of the issues facing young people today.

The interview will take around twenty minutes, and the answers you give will be completely confidential. If there are any questions you don't want to answer just tell me and I'll skip over them. Your answers will only be looked at together with the response of hundreds of other people we are talking to. Would you be willing to help us?

S2 RECORD LOCATION

CHECK QUOTAS.

S3 RECORD GENDER

CHECK QUOTAS.

Male 1

Female 2

S4 How old are you?

Response	Code	Instruction
Under 15	1	CLOSE
15 years	2	CONTINUE
16 years	3	
17 years	4	
18 years	5	
19 years	6	
20 years	7	
21 years	8	
22 years	9	
23 years	10	
24 years	11	
Over 24 years	12	CLOSE

CHECK QUOTAS.

GENERAL LIFE ATTITUDINAL STATEMENTS FOR DRUG SEGMENTATION

[NOTE: A REFUSAL CODE WOULD BE INCLUDED FOR ALL QUESTIONS]

Q1 I'm going to read out some things that people have said about their attitudes to life generally. For each one, please tell me whether you personally strongly agree , agree, neither agree nor disagree, disagree, or strongly disagree with each of these statements.

READ OUT AND ROTATE STATEMENTS.

		Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Don't know
a)	I don't really have any problems in life	5	4	3	2	1	6
b)	I like new and exciting experiences, even if I have to break the rules	5	4	3	2	1	6
c)	I don't care about what people think	5	4	3	2	1	6
d)	I like my life	5	4	3	2	1	6
e)	I worry about what my friends think of me	5	4	3	2	1	6
f)	I like the world the way it is	5	4	3	2	1	6
g)	I'm not really in control of my life	5	4	3	2	1	6
h)	You have to live for today, rather than worry about the future	5	4	3	2	1	6

BACKGROUND TO DRUGS

ASK ALL

Q2 And now some questions on drugs. What percentage of people your age do you think have tried (DRUG) at least once?

READ OUT IN ORDER. RECORD A NUMBER BETWEEN 0 AND 100 FOR EACH DRUG. DK/REFUSED ALLOWED

Drug	
Tobacco	
Alcohol	
Marijuana	
Ecstasy	
Ice	
Speed	
Heroin	

Q3 **I'm going to read out four ways that drugs have affected some people's lives. I'd like you to rank them in order of how negative each is to a person's life. Which one of the following is the most negative? And the 2nd? And the 3rd? And the 4th? READ OUT ALL PROBLEMS THEN RANK ONE AND PROMPT FOR REASONS NOT YET MENTIONED. EACH OF 1-4 TO BE SELECTED SEQUENTIALLY ONCE EACH ACROSS 4 PROBLEMS IF DON'T KNOW / REFUSED CODE 9 ANSWERED SKIP REMAINING PROBLEMS.**

PN – Rotate the statements.

	RANK				**DON'T** KNOW/Refused
Mental health problems	1	2	3	4	9
Physical health problems	1	2	3	4	9
Relationship problems	1	2	3	4	9
Problems with study/uni/school	1	2	3	4	9

PERCEPTIONS OF SPECIFIC DRUGS

Q4 Now I'm going to read out a number of statements about two different drugs. It doesn't matter whether you've ever tried each drug or not, it's just your impressions I'm after.

ROTATE DRUGS MENTIONED WITHIN EACH ROTATION. ASK EACH RESPONDENT ABOUT TWO DRUGS READ OUT AND ROTATE STATEMENTS.

DRUGS – Marijuana, Ice, Speed, Ecstasy

ROTATION A: Marijuana, Ice

ROTATION B: Marijuana, Ecstasy

ROTATION C: Speed, Marijuana

ROTATION D: Ecstasy, Ice

ROTATION E: Speed, Ice

ROTATION F: Ecstasy, Speed

PN- Only agree / disagree and refused / DK.

Firstly, thinking about (FIRST DRUG). Do you personally agree or disagree (Accept DK/ Refused) that (FIRST DRUG)……

(STATEMENTS)

a) Is a fun drug..1
b) Can help a person to relax..2
c) Can make a person lazy and lethargic...3
d) Is a good drug to share with friends...4
e) Is addictive...5
f) Can make a person aggressive 6
g) You don't know what is in [DRUG]...7
h) Can make a person paranoid...8
i) Can make a person depressed in the short term....................................9
j) Can make a person depressed long term...10
k) Can change a user's personality over the long term..............................11
l) Can help a person cope with mental health problems...........................12
m) Can increase anxiety 13
n) Can make you socially withdrawn..14
o) Can trigger schizophrenia..15
p) Can cause mood swings..16

And now some questions about (SECOND DRUG)…..[STATEMENTS IN SAME ORDER AS FIRST DRUG]

DRUG USAGE

IF NECESSARY: Just a reminder that your responses are completely confidential and are used for research purposes only. If there are any questions you don't want to answer, just let me know and I'll skip over them.

Q5 Now, which, if any, of the following drugs have you personally ever used?

READ OUT. DO NOT ROTATE. IF NONE, GO TO Q10

Q6 Which have you used in the last year?

READ OUT DRUGS EVER USED. DO NOT ROTATE. IF NONE, GO TO Q10

Q7 And which have you used in the last four weeks?

READ OUT DRUGS USED IN LAST YEAR. IF NONE, GO TO Q10

Q8 How many times have you used (DRUG) in the last four weeks?

READ OUT DRUGS USED IN LAST 4 WEEKS. FOR TOBACCO, RECORD VERBATIM. FOR OTHERS WRITE IN THE NUMBER OF TIMES IN THE LAST FOUR WEEKS.

	Q5 Ever used	Q6 last year	Q7 last 4 wks	Q8 # times in last 4 wks
a. Tobacco	1	1	1	______________
b. Alcohol	2	2	2	☐☐
c. Marijuana	3	3	3	☐☐
d. Ecstasy	4	4	4	☐☐
e. LSD	5	5	5	xx DO NOT ASK
f. Ice	6	6	6	☐☐
g. Speed	7	7	7	☐☐
h. Cocaine	8	8	8	xx DO NOT ASK
i. Heroin	9	9	9	xx DO NOT ASK
j. Any other illegal drug	10	10	10	

None of the above.................................... 11........................11........................11

IF ICE USED IN THE LAST FOUR WEEKS AT Q8, ASK:

Q9 How do you usually use ice? SR

Smoke it....................................... 1
Sniff/snort it.................................. 2
Inject it 3
Eat it / take orally 4
Other (specify) 5
Don't know.................................... 6

IF NOT USED ANY ILLEGAL DRUG IN THE LAST YEAR [NOT Q6c-j], ASK:

Q10a Have you been offered any illegal drug in the last 12 months?

Yes... 1
No ....2 GO TO Q11
Don't know.................................... .....3 GO TO Q11

IF USED OR BEEN OFFERED ANY ILLEGAL DRUG. ASK Q10B FOR EACH OF THE FOLLOWING DRUGS, NOT USED IN LAST 12 MONTHS AT Q6

Q10b Have you been offered (DRUG) in the last twelve months?

	Yes	No	Don't Know
Marijuana	1	2	3
Ecstasy	1	2	3
Ice	1	2	3
Speed	1	2	3

ASK ALL

Q11 If a friend offered you (DRUG) in a situation where they were using it, would you...

READ OUT AND ROTATE DRUGS. READ OUT RESPONSE CODES.

Definitely say yes, and take it

Probably say yes

Probably say no

Definitely say no

	Definitely Yes	Probably Yes	Probably No	Definitely No	Don't know
Marijuana	1	2	3	4	5
Ecstasy	1	2	3	4	5
Ice	1	2	3	4	5
Speed	1	2	3	4	5
Heroin	1	2	3	4	5

ASK ALL

Q12 What influence, if any, would the risk of mental health problems from using [DRUG] have on your decision to [CODE AT Q11]? Would you say a strong influence, some influence or no influence at all? SR

	Strong influence	Some influence	No influence at all	Don't know
Marijuana	1	2	3	4
Ecstasy	1	2	3	4
Ice	1	2	3	4
Speed	1	2	3	4
Heroin	1	2	3	4

DRUG ATTITUDINAL STATEMENTS FOR DRUG SEGMENTATION

ASK ALL

Q13 Now I'd like to find out what you think about drugs and drug use generally. I'm going to read out a number of things that people have said about drugs. For each one, please tell me whether you personally strongly agree, neither agree nor disagree, disagree, or strongly disagree with each of these statements.

(IF ASKED SAY: ALL DRUGS – INCLUDING ILLEGAL DRUGS)

READ OUT AND ROTATE STATEMENTS.

	Strongly Agree	Agree	Neither A nor D	Disagree	Strongly Disagree	Don't know
a) Most of my friends have experimented with illegal drugs	5	4	3	2	1	6
b) Drugs are only a problem if you let them be..	5	4	3	2	1	6
c) Some drugs are OK, but others are a problem..	5	4	3	2	1	6
d) Drugs are not a problem for me......	5	4	3	2	1	6
e) I would recognise if I had a problem with drugs before it became too much	5	4	3	2	1	6
f) I can control my use of drugs..........	5	4	3	2	1	6
g) I'm not interested in drugs..............	5	4	3	2	1	6

DRUG DANGER / ENJOYMENT

Q14 This time I'd like to know how dangerous you think different drugs are. I'm going to read out a list of drugs. For each one, please tell me if you think it is dangerous to use this drug or not. Firstly, do you consider it dangerous or not dangerous to use…

READ OUT AND ROTATE DRUGS.
IF THOUGHT DANGEROUS, SAY:

And would you say it's quite dangerous or very dangerous.

IF NOT THOUGHT DANGEROUS, SAY:

And would you say it's not very dangerous or not at all dangerous.

	Not at all Dangerous	Not very Dangerous	Neither	Quite Dangerous	Very Dangerous	Don't know
Tobacco	1	2	3	4	5	6
Alcohol	1	2	3	4	5	6
Marijuana	1	2	3	4	5	6
Ecstasy	1	2	3	4	5	6
Ice	1	2	3	4	5	6
Speed	1	2	3	4	5	6
Heroin	1	2	3	4	5	6

ILLICIT DRUGS AND MENTAL HEALTH

PN-Q15 Deleted Q16 moved to before Q22
ASK ALL
And now some questions on a different topic. I'm going to ask you a few questions about mental health problems that can affect teenagers and young adults. Remember, if there are any questions you would prefer not to answer, we can skip them.

Q16 MOVED BEFORE Q22

Q17 Have you experienced any mental health problems in the past year?

Yes....................1
No....................2
Don't know....................3

IF EXPERIENCED ANY MENTAL HEALTH PROBLEMS IN THE LAST YEAR, ASK:

Q18 Which mental health problem or problems have you experienced in the last year? DO NOT READ OUT MR

Anxiety....................1
Schizophrenia....................2
"Schizo"....................3
Bi-polar (manic depression)....................4
Depression....................5
Mood swings....................6

Psychosis 7
Paranoia 8
Hallucinations 9
Social withdrawal / shy / introverted............................ 10
Phobias 11
Obsessive compulsive disorder 12
Manic / mania 13
Delusions 14
Eating disorders... 15
Drug or alcohol disorders.. 16
Stress 17
Lethargy 18
Insomnia / sleeplessness.. 19
Lack of concentration.. 20
Restlessness / fidgety... 21
ADHD / ADD 22
Other (specify) 97
Don't know 98

IF EXPERIENCED ANY MENTAL HEALTH PROBLEMS IN THE LAST YEAR, ASK:

Q19 Have you ever sought help for this/these problem/s?

Yes...1
No 2
Don't know 3

IF EVER SOUGHT HELP, ASK:

Q20 Where or who did you seek help from? DO NOT READ M/R

Parents 1
Friends..2
Teacher...3
Doctor / GP 4
Counsellor...5
Psychologist..6
Psychiatrist 7
Drug and alcohol treatment centre..8
Telephone counselling service...9
Web-sites...10
Partner 11
Other (specify) 97
Don't know 98

IF NOT HAD PROBLEM OR NOT SOUGHT HELP (Q17=2,3 OR Q19=2,3) ASK:

Q21 Imagine that you did have a mental health problem in the future. Who do you think that you would contact or talk to about it? MR

Parents 1

Friends..2
Teacher..3
Doctor / GP..4
Counsellor...5
Psychologist...6
Psychiatrist...7
Drug and alcohol treatment centre..8
Telephone counseling service...9
Web-sites..10
Partner..11
Other (specify)..97
Don't know...98
No-one...99

ASK ALL

Now still thinking about mental health problems which can affect teenagers and young adults

Q16 Which serious mental health problem comes to mind first? What other serious mental health problems can you think of? DO NOT READ

First mention (SR)		Other mentions (MR)
Anxiety	1	1
Schizophrenia	2	2
"Schizo"	3	3
Bi-polar (manic depression)	4	4
Depression	5	5
Mood swings	6	6
Psychosis	7	7
Paranoia	8	8
Hallucinations	9	9
Social withdrawal / shy / introverted	10	10
Phobias	11	11
Obsessive compulsive disorder	12	12
Manic / mania	13	13
Delusions	14	14
Eating disorders	15	15
Drug or alcohol disorders	16	16
Stress	17	17
Lethargy	18	18
Insomnia / sleeplessness	19	19
Lack of concentration	20	20
Restlessness / fidgety	21	21
ADHD / ADD	22	22
Other (specify)	97	97
Don't know	98	98

ASK ALL

Q22 Do you know of anyone who has had mental health problems?

Yes..1
No...2

Don't know 3

IF KNOWS SOMEONE WITH MENTAL HEALTH PROBLEM, ASK:

Q23 How much influence would you say that drug use had on causing their mental health problems? Would you say drug use had a strong influence, some influence or no influence at all? SR

Strong influence 1
Some influence 2
No influence at all 3
Don't know (DON'T READ) 4

IF DRUGS INFLUENCED MENTAL HEALTH PROBLEM (CODE 1 OR 2), ASK:

Q24 What drug or drugs do you think contributed to their mental health problems? DO NOT READ MR

Marijuana 1
Ecstasy 2
LSD 3
Ice 4
Speed 5
Cocaine 6
Heroin 7
Alcohol 8
Other (specify) 9
Don't know 10

IF KNOW SOMEONE WITH DRUG-RELATED MENTAL HEALTH PROBLEMS [Q22=1,2], ASK:

Q25 Has knowing someone with a drug-related mental health problem made you more cautious about using drugs?

Yes 1
No 2
Don't know 3

ASK ALL

Q26a For each of the following drugs, how likely or unlikely do you think that its regular use would lead to serious mental health problems? First of all, do you think regular use of [1st DRUG) is very likely, likely , neither likely nor unlikely, unlikely or very unlikely to lead to serious mental health problems? And what about [2nd DRUG]?

ROTATE READ OUT EACH DRUG

	Very likely	Likely	Neither	Unlikely	Very unlikely	Don't know
Marijuana	1	2	3	4	5	6
Ecstasy	1	2	3	4	5	6
Ice	1	2	3	4	5	6
Speed	1	2	3	4	5	6
Heroin	1	2	3	4	5	6

FOR EACH DRUG SAID VERY LIKELY OR LIKELY TO CAUSE MENTAL HEALTH PROBLEMS (Q26a=1 or 2), ASK:

Q26b What mental health problems do you think [1ST DRUG VERY LIKELY/LIKELY AT Q26A] would cause? Any other problems? MR DO NOT READ REPEAT FOR ALL DRUGS VERY LIKELY/LIKELY AT Q26A

Marijuana Heroin	Ecstasy	Ice	Speed
Anxiety	1	1	etc.
Schizophrenia	2	2	
"Schizo"	3	3	
Bi-polar (manic depression)	4	4	
Depression	5	5	
Mood swings	6	6	
Psychosis	7	7	
Paranoia	8	8	
Hallucinations	9	9	
Social withdrawal / shy / introverted	10	10	
Phobias	11	11	
Obsessive compulsive disorder	12	12	
Manic / mania	13	13	
Delusions	14	14	
Eating disorders	15	15	
Drug or alcohol disorders	16	16	
Stress	17	17	
Lethargy	18	18	
Insomnia / sleeplessness	19	19	
Lack of concentration	20	20	
Restlessness / fidgety	21	21	
ADHD / ADD	22	22	
Other (specify)	97	97	
Don't know9	8	98	

IF MENTIONED MORE THAN ONE PROBLEM AT Q26B ACROSS ALL DRUGS ASK:

Q26c Of all the mental health problems related to drug use that you just mentioned, which one do you think is the most serious? SR IF NECESSARY, PROMPT WITH PROBLEMS MENTIONED AT Q26B

IF MENTIONED MORE THAN TWO PROBLEMS AT Q26B ACROSS ALL DRUGS AND NOT DON'T KNOW AT Q26C ASK:

And which do you think is the 2nd most serious mental health problem? SR IF NECESSARY, PROMPT WITH PROBLEMS MENTIONED AT Q26B

	First	Second
Anxiety	1	1
Schizophrenia	2	2
"Schizo"	3	3
Bi-polar (manic depression)	4	4
Depression	5	5
Mood swings	6	6
Psychosis	7	7
Paranoia	8	8

Hallucinations	9	9
Social withdrawal / shy / introverted	10	10
Phobias	11	11
Obsessive compulsive disorder	12	12
Manic / mania	13	13
Delusions	14	14
Eating disorders	15	15
Drug or alcohol disorders	16	16
Stress	17	17
Lethargy	18	18
Insomnia / sleeplessness	19	19
Lack of concentration	20	20
Restlessness / fidgety	21	21
ADHD / ADD	22	22
Other (specify)	97	97
Don't know	98	98

MENTAL HEALTH/ILLICIT DRUGS STATEMENTS FOR SEGMENTATION

[Note that at least three statements will also be used from the straight drugs attitudinal battery – highlighted in purple]

ASK ALL

Q27 Now I'm going to read out a number of things that people have said about drugs and mental health. Whether you use drugs or not, for each one, please tell me whether you personally strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree with each of these statements.

READ OUT AND RANDOMISE STATEMENTS.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't know
There is a good chance that if a person uses drugs on a regular basis they would develop mental health problems	5	4	3	2	1	6
If I were to use drugs I would be more likely than most people to develop a drug-related mental health problem	5	4	3	2	1	6
The link between mental health problems and drug use is not as strong as it is made out to be.	5	4	3	2	1	6
I regularly feel anxious and stressed	5	4	3	2	1	6
I feel that my personality would make me more susceptible to drug-related mental health problems	5	4	3	2	1	6
If I were to use a drug, I would first have to know about all of its potential negative effects	5	4	3	2	1	6
If I were to use drugs, the possibility that drugs could trigger mental health problems really scares me.	5	4	3	2	1	6
You can only develop mental health problems if you are a really heavy drug user	5	4	3	2	1	6
People with mental health problems can't function in normal society	5	4	3	2	1	6
I often feel depressed	5	4	3	2	1	6

DEMOGRAPHICS

ASK ALL

D1 To make sure we have spoken with a good range of people, I'd like to ask you a final few questions.

Are you currently doing paid work of any kind, even if it's only a temporary or casual position? (INCLUDES SELF-EMPLOYED OR OWN BUSINESS).

Yes...1
No 2
Don't Know / Can't Say 3
Refused 4

IF AGED 15 TO 19 YEARS CONTINUE ELSE GO TO D3

D2 Are you still attending school or have you left school?

Still attending 1
Left School...2 (GO TO D3)
Refused ....3 (GO TO D3)

If AGED 15-19 AND STILL ATTENDING SCHOOL, ASK:

D2a What year of secondary school are you currently attending?

Year 7 or below..1
Year 8 2
Year 9 3
Year 10 4
Year 11 5
Year 12 6
(Refused) 7

(NOW GO TO D5)

IF AGED 20-24, OR 15-19 AND LEFT SCHOOL, ASK:

D3 What is the highest level of formal education you have <u>completed</u>? (PN- qualification should not be here?)

Primary School 1
Year 10 or below..2
Year 11 3
Year 12 4
Trade / apprenticeship qualification 5
Other TAFE/ Technical 6
Certificate or Diploma 7
Degree 8
Post Graduate...9
Other (SPECIFY) 10
Don't Know 11
Refused 12

IF AGED 20-24, OR 15-19 AND LEFT SCHOOL, ASK:

D4 Which one of the following best describes your main activity at the moment? Are you mainly doing… (READ OUT)

Paid full-time work ....1 (DISPLAY ONLY IF D1=1)
Paid part-time or casual work ....2 (DISPLAY ONLY IF D1=1)
Studying or training....................3
Looking for work 4
Doing unpaid voluntary work....................5
Retired 6
Home duties, or 7
Something else (SPECIFY) 8
Don't Know / Can't Say....................9
Refused 10

ASK ALL

D7 Are you from an Aboriginal or Torres Strait Islander background?

Yes....................1
No 2
Don't know....................3
Refused 4

ASK ALL

D5 Is a language other than English regularly spoken in your household?

Yes....................1
No ....2 (GO TO D8)
Refused ....3 (GO TO D8)

IF LANGUAGE OTHER THAN ENGLISH SPOKEN AT HOME, ASK:

D6 What language other than English is regularly spoken at home?

Arabic....................1
Cantonese 2
Mandarin....................3
Greek....................4
Italian 5
Vietnamese....................6
Spanish....................7
Turkish....................8
Serbian 9
Croatian 10
Macedonian 11
Other (SPECIFY)....................97
Don't Know / Can't Say....................98
Refused 99

ASK ALL

D8 What are your current household living arrangements.? For example, do you live at home with your parents, are you sharing with friends, or something else? (SINGLE RESPONSE) (PROBE TO CLARIFY)

I live with my parents or guardians 1
I live with my parents or guardians and other family members 2
I share with other adults I'm not related to 3
I live alone.. 4
I live with my spouse or partner 5
I live with my spouse or partner and our child or children 6
I'm a sole parent or guardian living with my child or children... 7
I live with my sole parent or guardian 8
Other (SPECIFY) 9
Refused 10

That's the end of the survey.
In case my supervisor needs to contact you to check that I actually conducted this interview, could I please ask for your first name?

____

Can I just check the phone number I called:^E30

As a market Research company, we comply with the requirements of the Privacy Act. Would you like me to read out our full Privacy Statement?
IF NECESSARY - In accordance with the Privacy Act, once information processing has been completed, please be assured that your name and contact details will be removed from your responses to this survey. After that time we will no longer be able to identify the responses provided by you. However, for the period that your name and contact details remain with your survey responses, which will be approximately 2 to 4 weeks, you will be able to contact us to request that some or all of your information be deleted.

Just in case you missed it, my name is _______ and this survey was conducted on behalf of the Australian Government Department of Health and Ageing.

ONLY IF NECESSARY:
If you have any queries about this survey, or would like any further information, you can ring the Department of Health and Ageing on (02) 9263 3548 or 1800 250 015 during business hours. Thank you for your cooperation.

TERMINATION SCRIPT 1

Thanks anyway, but for this survey we need to speak to people aged between 15 and 24 years of age.

TERMINATION SCRIPT 2

Thanks anyway, but to interview young people aged 17 years or under, we need to first get parental permission.

B RECRUITMENT SCREENERS

1. SCREENER ONE - Teens and young adults – no issues or only drug issues (GPs 1,2, 10, 15, 16, 17)

We are conducting research that looks into issues affecting teens and young adults.

1. Psychographic segments

To begin with can we find out a little bit about yourself. Which of the following applies to you?

	YES	NO
1. I like new and exciting experiences........................		
2. I am interested in drugs		
3. Drugs could easily become a problem for me........		
4. I like the world the way it is		
5. I'm not really in control of my life............................		

To qualify as 'thrill seekers' they must answer "YES" to question one and two and four.

To qualify as 'reality swappers' they must answer "YES" to question two, question three and question five. They should also answer "NO" to question four.

2. Have you done any of the following in the last three months:

	YES		NO
Smoked a cigarette			
Drunk alcohol			
Used drugs (such as marijuana, ecstasy, that kind of thing)			

If they say NO to 'Used drugs' consider for the NON groups.

If they say YES to 'Used drugs' ask Q3.

3. Have you taken any of the following drugs (remind them the information is confidential and read list)

	YES		NO
Marijuana			
Ecstasy			
Speed....................			
LSD			
Cocaine.................			
Ice			

GBH			
Heroin; and			
Ketamine...............			
Other			

4. For the drug you've mentioned how often do you take it?

I take ____________ regularly

I take ____________ occasionally

I have only ever taken ____________ rarely

For ecstasy or speed 'regular' should be at least once a month

For marijuana 'regular' should be at least once a week

2. SCREENER TWO - Teens and young adults – focusing upon mental health issues (GPs 5, 6, 13)

We are conducting research that looks into issues affecting teens and young adults.

1. Psychographic segments

To begin with can we find out a little bit about yourself. Which of the following applies to you?

	YES	NO
1. I like new and exciting experiences		
2. I am interested in drugs		
3. Drugs could easily become a problem for me.........		
4. I like the world the way it is		
5. I'm not really in control of my life		

To qualify as 'thrill seekers' they must answer "YES" to question one and two and four.

To qualify as 'reality swappers' they must answer "YES" to question two, question three and question five. They should also answer "NO" to question four.

2. Do any of the following statements relate to you?

	YES		NO
1. Sometimes I get really nervous and find it hard to calm down.................			
2. Sometimes I feel like I am hopeless at everything..................................			
3. Sometimes I get very depressed and it's very hard to feel positive about anything..			
4. Sometimes my moods swing a lot – I might be really happy one moment and then really depressed the next...			
5. I find that I worry an awful lot about things – even little things................			

Must answer yes to at least one of either three, four or five

SCREENER THREE – Older adults – Drug issues (GPs 18,19)

We are conducting research that looks into issues affecting people in society today

1. Have you done any of the following in the last three months:

	YES		NO
Smoked a cigarette			
Drunk alcohol			
Used drugs (such as marijuana, ecstasy, that kind of thing)			

If they say NO to 'Used drugs' consider for the 'NON' groups.

If they say YES to 'Used drugs' ask Q3.

2. Have you taken any of the following drugs (remind them the information is confidential and read list)

	YES		NO
Marijuana			
Ecstasy			
Speed...................			
LSD			
Cocaine................			
Ice			
GBH			
Heroin; and			
Ketamine..............			
Other			

For the drug you've mentioned how often do you take it?

I take ____________ regularly

I take ____________ occasionally

I have only ever taken ____________ rarely

For ecstasy or speed 'regular' should be at least once a month

For marijuana 'regular' should be at least once a week

3. SCREENER FOUR – Older adults who have mental health and drug issues (GPs 9,21)

We are conducting research that looks into issues affecting teens and young adults.

1. Do any of the following statements relate to you?

	YES		NO
1. Sometimes I get really nervous and find it hard to calm down................			
2. Sometimes I feel like I am hopeless at everything..................................			
3. Sometimes I get very depressed and it's very hard to feel positive about anything..			
5. Sometimes my moods swing a lot – I might be really happy one moment and then really depressed the next...			
6. I find that I worry an awful lot about things – even little things................			

Must answer yes to at least one of either three, four or five

2. What are the biggest issues facing young people today **DO NOT PROMPT.**

3. Have you ever used any of the following drugs (remind them that information is confidential and read list)

	YES		NO
Marijuana			
Ecstasy			
Speed...................			
LSD			
Cocaine			
Ice			
GBH			
Heroin; and			
Ketamine..............			

Other			

4. For the drug you've mentioned how often do you take it?

I take ____________ regularly

I take ____________ occasionally

I have only ever taken ____________ rarely

For ecstasy or speed 'regular' should be at least once a month

For marijuana 'regular' should be at least once a week

5. SCREENER FIVE – Parents (3, 4, 7, 8, 11, 12 14, 20)

We are conducting research that looks into issues affecting teens and young adults.

1. Have any of your children had problems in any of the following areas?

	YES		NO
Alcohol*			
Drugs (such as marijuana, ecstasy, 'hard' drugs, other illegal drugs)			
Mental health (such as depression, severe anxiety, severe mood swings, etc)			

* If alcohol only, go to Q3.

2. If they say YES to drugs, do they still have these problems?

Yes ☐ Try to get a mix

No ☐

What kinds of drugs were involved (Try to get a mix)

---

3. If NO to question one (or only alcohol problems) then ask the following…

Have you or any of your immediate family ever had problems with drugs or mental health issues?

Yes ☐

No ☐

If they answer NO, then recruit for the general population groups

C ILLICIT DRUG SEGMENTS (2000)

Considered Rejectors

(16% of 15-24 year olds): believe 'drugs are bad', and don't have reasons to take drugs. This group appears to experience more protective factors against problem behaviours in their lives than any of the other segments. They are confident and have a positive view of life. Their peers feel much the same ay about life and drugs as they do, and so they have little exposure to drug-taking situations. They account for less than 1% of the last four weeks of consumption of any illegal drug covered in the research. They are light to moderate users of alcohol, may be light smokers, and whilst some have tried marijuana, most haven't tried other drugs and do not intend to. There is a slight skew toward females.

Cocooned Rejectors

(13% of 15-24 year olds): are frightened by drugs, and believe drugs just make your problems worse. They don't feel they are in control of their life and are not particularly happy or secure. They do not see themselves as having the same options as their friends and do not like new and exciting experiences. They are light and moderate users of alcohol and tobacco. Many have tried marijuana and a few have tried other drugs, however, most no longer use these drugs. They account for 3% of marijuana and 2% of the Ecstasy consumed in the last four weeks. One in five people in this segment are from a non-English speaking background.

Ambivalent Neutrals

(16% of 15-24 year olds): are not interested in drugs and don't have reason to take drugs. They recognise that drugs are a problem. Their peers are drug users, and so they are exposed to drug use situations. However, they are moderate users of alcohol, tobacco and marijuana. A few have tried other drugs, but most don't use them any more. This group accounts for 2% of the marijuana, 3% of the Ecstasy and 5% of the speed consumed in the last four weeks. Demographically they are the most distinctive segment tending to be female, older (21-24) and studying at a tertiary level.

Risk Controllers

(20% of 15-24 year olds): are a big frightened of drugs, and believe some drugs are OK but others are a problem. To the extent that they are exposed to drugs, they are happy to use them, believing that they are in control of the situation and will not let it get out of hand. They are moderate users of alcohol and tobacco, and light users of marijuana (more than half have tried marijuana, and one in

ten have used it in the last four weeks). They account for 20% of the last four weeks consumption of speed. Some have tried other drugs, but don't use them often. Demographically they are very close to the population profile, with a slight skew toward females.

Thrill Seekers

(20% of 15-24 year olds): are the most likely people to be looking for additional excitement, and strongly feel they are in control of their lives. They are happy, secure and self-motivated. They live for today and don't worry about the future. They don't believe drugs are bad, are interested in them and see them as fun. They like new and exciting experiences and are most likely to be male, working and from an English-speaking background. Both their interest in drugs and their sensation seeking behaviour are identified risk factors for drug use. They are heavy users of all drugs, particularly ecstasy, but no heroin. They account for more than 40% of the last four weeks' consumption of marijuana, ecstasy and speed, 30% of LSD and more than 20% of cocaine.

Reality Swappers

(16% of 15-24 year olds): are interested in drugs, and believe they have good reasons to take drugs. They are unhappy and insecure, and have a less positive attitude to drugs. This group appears to experience more risk factors for problem behaviours than any of the other segments. They do not feel in control of their lives. They don't' like their life, and believe the future doesn't hold good things for them. They are the heaviest users of all drugs, particularly heroin. Their incidence of trial of most drugs is lower than for the Thrill Seekers, but they tend to use them more heavily. This group has the highest level of trial of heroin. They account for half of the marijuana and ecstasy consumed in the last four weeks, two thirds of the LSD, a third of the speed, four fifths of the cocaine and almost all of the heroin. They tend to be male and living alone or with a peer group.

D USE OF INDIVIDUAL DRUGS BY SEGMENT

	Weighted Sample	Positive Alternatives	Too scarys	Intolerant Deniers	Sceptics	Bullet Proofs	Jeopardized
Sample	*1700*	*567*	*284*	*239*	*236*	*227*	*144*
DRUGS EVER USED (%)							
Tobacco	55	44	53	49	58	73	79
Alcohol	89	87	91	86	88	94	97
Marijuana	40	28	33	36	43	60	71
Ecstasy	16	7	11	11	18	26	43
LSD	4	1	1	2	6	9	16
Ice	4	1	1	2	5	7	21
Speed	12	5	7	7	13	23	37
Cocaine	6	2	1	3	7	12	24
Heroin	1	0	0	0	2	1	5
Any other illegal drug	3	1	0	1	5	6	9
Nett any illegal drug	42	29	34	38	44	62	73
DRUGS USED LAST YEAR (%)							
Tobacco	39	28	38	33	43	52	66
Alcohol	86	83	86	81	86	92	94
Marijuana	19	7	12	13	29	31	50
Ecstasy	10	3	5	5	13	16	31
LSD	2	0	0	2	4	3	8
Ice	2	0	0	1	1	2	11
Speed	6	1	3	4	9	11	20
Cocaine	3	1	0	1	4	5	14
Heroin	0	0	0	0	0	0	1
Any other illegal drug	1	0	0	0	1	3	3
Nett any illegal drug	22	10	15	14	31	37	55
DRUGS USED LAST 4 WEEKS (%)							
Tobacco	26	18	23	21	29	32	52
Alcohol	66	61	66	56	67	76	81
Marijuana	7	2	3	3	14	13	24
Ecstasy	3	1	2	1	4	7	10
LSD	0	0	0	0	0	0	4
Ice	1	0	0	0	0	1	6
Speed	2	0	1	1	2	3	9
Cocaine	1	0	0	0	2	2	7
Heroin	0	0	0	0	0	0	1
Any other illegal drug	0	0	0	0	0	0	1
Nett any illegal drug	10	2	4	5	17	19	30
DRUGS USED MORE THAN WEEKLY IN LAST 4 WEEKS (%)							
Alcohol	25	20	22	16	24	38	44
Marijuana	3	0	1	1	5	7	11
Ecstasy	0	0	0	1	0	1	2
Ice	0	0	0	0	0	0	2
Speed	0	0	0	0	0	1	1

E USING THIS RESEARCH

It is important that clients should be aware of the limitations of survey research.

Qualitative Research

Qualitative research deals with relatively small numbers of respondents and attempts to explore in–depth motivations, attitudes and feelings. This places a considerable interpretative burden on the researcher. For example, often what respondents do not say is as important as what they do. Similarly, body language and tone of voice can be important contributors to understanding respondents' deeper feelings.

Client should therefore recognise:

- that despite the efforts made in recruitment, respondents may not always be totally representative of the target audience concerned
- that findings are interpretative in nature, based on the experience and expertise of the researchers concerned

Quantitative Research

Even though quantitative research typically deals with larger numbers of respondents, users of survey results should be conscious of the limitations of all sample survey techniques.

Sampling techniques, the level of refusals, and problems with non-contacts all impact on the statistical reliability that can be attached to results.

Similarly quantitative research is often limited in the number of variables it covers, with important variables beyond the scope of the survey.

Hence the results of sample surveys are usually best treated as a means of looking at the relative merits of different approaches as opposed to absolute measures of expected outcomes.

The Role of Researcher and Client

Blue Moon believes that the researchers' task is not only to present the findings of the research but also to utilise our experience and expertise to interpret these findings for clients and to make our recommendations (based on that interpretation and our knowledge of the market) as to what we believe to be the optimum actions to be taken in the circumstances: indeed this is what we believe clients seek when they hire our services. Such interpretations and recommendations are presented in good faith, but we make no claim to be infallible.

Clients should, therefore, review the findings and recommendations in the light of their own experience and knowledge of the market and base their actions accordingly.