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ANCD research paper

Young people's opinions

on alcohol and other drugs issues

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Executive summary

Background

Research has largely focused on young people's alcohol and drug *use*. However, the investigation of young people's *opinions and ideas* about policies, programs and control measures aimed at reducing the harms caused by alcohol and other drugs has, to date, been limited. As in all policy areas, sufficient consultation with the relevant stakeholders is an important part of the process of effective policy making. The voices of young people are thus critical in helping to develop successful responses to alcohol and other drug issues in Australia.

Aim

This research was commissioned by the Australian National Council on Drugs (ANCD) in recognition of the limited examination to date of young people's opinions about alcohol and other drugs. The aim of the study was to describe and better understand young people's ideas on alcohol and other drugs issues. A survey was designed which aimed to elicit opinions about a comprehensive and large array of policies, programs and control measures. This included prevention measures such as drug education in schools and mass media campaigns; alcohol regulation including alcohol pricing, monitoring of licensed premises, and restrictions on late night trading; law enforcement activities such as police presence and drug detection (sniffer) dogs; treatment services including withdrawal, residential rehabilitation and pharmacotherapies; and harm reduction activities such as pill-testing services and needle and syringe programs. The survey design also allowed young people to generate their own suggestions about how to respond to alcohol and drug issues in their communities.

Sample

The survey was administered via the internet and young Australians aged between 16 and 25 years were eligible to participate anonymously. The views of 2335 young people were included in the final analyses. The sample included young people from all Australian states and territories, and 62 per cent of the sample was male. Eighty-one per cent had completed Year 12, and the sample was highly experienced in terms of alcohol and other drug use. The majority of young people who completed the survey reported having consumed alcohol at least once in their lifetime (95.1%). A substantial proportion of participants also reported having consumed illicit drugs including cannabis (71.9%), ecstasy (47.7%) and hallucinogens (41.3%).

This online survey aimed to recruit a broad national sample of young people across Australia. However, there were a number of limitations. The rates of alcohol and particularly illicit drug use reported by survey participants were higher than those recorded in other population surveys. It is not clear of the extent to which alcohol and other drug internet surveys attract those young people with direct experience of substances, and hence the rates are higher; or whether other surveys are more likely to have respondents' under-report due to demand characteristics. Young people from non-English-speaking backgrounds, low socioeconomic status or diverse cultural backgrounds were not purposively sampled. Thus while the sample may include people from diverse cultural and linguistic backgrounds and of different socioeconomic status, it is more likely that the sample reflects an advantaged group of young people with easy access to the internet, who feel empowered to express their opinions in this format.

Results

Young people's views

Young Australians expressed strong support for treatment and rehabilitation, and believed that alcohol and other drug treatment should be available to people according to their needs.

Young people were also strongly supportive of harm reduction interventions, with over two-thirds of young Australians expressing support for needle and syringe programs, regulated injecting facilities and availability of pill testing.

Young Australians expressed strong opposition to alcohol regulation and restrictions on alcohol availability. Over two-thirds of young people opposed increasing the price of alcohol, reducing trading hours for pubs and clubs, reducing the number of outlets that sell alcohol, and raising the legal drinking age. Very close to two-thirds of young people also opposed the use of sniffer dogs in public places and drug testing at work or school.

Young people regarded drug law reform as an effective response to drug issues in their communities. Young Australians expressed a high level of support for the legalisation of the personal use of cannabis in particular, with two-thirds of respondents supporting this response.

When asked what would be an appropriate way to handle new and emerging psychoactive substances, the majority of young people strongly preferred a regulation approach, rather than banning them.

By placing these findings in the context of the extant effectiveness literature, the synergies and disconnects that exist between the interventions most supported by the majority of young people and those that have been demonstrated to be most effective can be noted. This is an important issue to consider and a challenge for policy makers who must balance the opinions of stakeholders with a desire for effective and evidence-informed approaches to policy.

Demographic differences and opinions

There were significant differences between females and males, between younger and older respondents, and between those who had consumed alcohol or illicit drugs and those who had not. Young Australian females expressed more conservative views than their male peers. For example, females were significantly more supportive of tough measures against drug users and dealers and restrictions on alcohol availability, whereas males were more supportive of legalisation of drugs. Those under 18 years of age were generally more conservative in their views. For example, young people under the age of 18 years were less supportive of harm reduction interventions. Young people who had not used alcohol in the previous 12 months were significantly more supportive of tough measures, law enforcement approaches, alcohol regulation, and drug education in schools. Young people who had not used drugs in their lifetime were significantly more supportive of drug education and prevention approaches, as well as punitive approaches.

Compared to young people living in metropolitan areas, young Australians who lived in rural areas expressed more conservative opinions about responses to drug and alcohol issues, indicating more support for tough measures against dealers and traffickers and less support for legalisation of drugs. Young Indigenous Australians shared similar attitudes to other young Australians; for example, both Aboriginal and non-Aboriginal respondents nominated treatment, information and prevention campaigns, and legalisation of drugs as the three most effective responses to alcohol and other drug issues.

Predictors of opinion

The role that young people's attitudes towards alcohol and drugs play as drivers of their opinions is important. Positive attitudes towards alcohol (such as believing that alcohol makes you friendly, outgoing, relaxed and is not harmful) and positive attitudes towards drugs (such as believing that drugs are fun, help people experience life to the fullest and are not dangerous) were strongly predictive of permissive opinions about alcohol and other drug policy. These attitudinal variables were on the whole more predictive of opinions than age, gender and consumption behaviour. What young people think about the risks and benefits of alcohol and drugs (that is, whether they perceive alcohol and other drugs favourably or not) is strongly linked to how they believe alcohol and other drug issues should be addressed in their communities.

Key themes

A number of recurrent themes emerged from the data. Many young people expressed a desire for more reliable or relevant drug information and education. Young people saw themselves as having agency over their own bodies, and conceptualised themselves as discerning, active agents in making choices about drug use. By having access to reliable and balanced information, participants believed that young people would be equipped to make their own informed decisions about the risks, or benefits, of using drugs. Young Australians demonstrated sophisticated understandings of models of drug law reform in their discussion of legalisation, regulation and taxation. Although many participants favoured drug law reform, others expressed a desire for harsher penalties and more active law enforcement.

Young people desire policy frameworks that give them and their peers the freedom to make their own choices (with the support of accurate information, access to services and harm reduction options), and are not generally in favour of regulatory measures that more forcibly moderate their behaviour (e.g. restricted trading hours and reduced number of outlets selling alcohol). The notion that, by having access to unbiased and 'real' information, young people would be equipped to make informed autonomous choices was a theme that emerged strongly in the qualitative data analysis. Young people perceive drug use as a personal choice, which should be confronted by government intervention only in the instances that are seen to be causing harms to others.

Conclusions

The high level of engagement with this survey by more than 2000 young Australians demonstrates that young people have opinions about how government should respond to alcohol and other drug issues, and wish to be part of that conversation.

The relationship between opinion and policy is not straightforward. Where there is strong support for a particular intervention, it is likely that the intervention will be successful because positive opinion means greater acceptability and compliance with the intervention, assuming that the intervention is based on sound research evidence. Thus, evidence-based interventions strongly supported by young people should be implemented. On the other hand, some evidence-based interventions do not have wide support. For example, the results suggest that young people do not support restrictions on alcohol availability. This does not necessarily mean that those interventions should be withdrawn; however, it implies that significant caution in the ways in which those interventions are promoted to young people is required. The results also have implications for those interventions that are not supported by young people, and do not have an adequate evidence base. The findings suggest that these interventions should be reconsidered. Finally, some existing interventions could be improved based on the survey findings here. Most obviously, drug education in schools should be informed by the opinions reported herein.

The findings of this study offer new knowledge to the alcohol and other drug field, and importantly to policy makers. The findings are a significant first step towards better understanding what young people think should be done about reducing alcohol and other drug-related harms, and as such open the door to more meaningful engagement with young people to help respond successfully to alcohol and other drug issues in Australia.

As noted by one participant:

> Just hope I never wasted my time doing this survey and that my opinion will be taken into consideration.

1. Introduction

Young people are important stakeholders in alcohol and other drug policy. Australians aged 18 to 29 years are the group most likely to have used an illicit drug in the last 12 months, and are more likely than any other age group to consume alcohol in a way that puts them at risk of harm (Australian Institute of Health and Welfare, 2011a). As such, young people often come into contact with government interventions that aim to respond to alcohol and other drug use in society, and it is young people who are frequently the focus of drug policy decisions. There are a range of initiatives aimed at better understanding the alcohol and drug *use* patterns of young people. However, the investigation of young people's *opinions and ideas* about policies, programs and control measures aimed at reducing the harms caused by alcohol and other drugs has, to date, been limited. As in all policy arenas, sufficient consultation with all relevant stakeholders is an important part of the process of effective policy making. This being the case, the voices of young people are critical in helping to develop successful responses to alcohol and other drug issues in Australia.

It is important to seek young people's participation in the policy process and to better understand their ideas and opinions about government policy, especially regarding policy responses that affect them. This principle has been gaining support internationally. For example, Article 12 of the United Nations Convention on the Rights of Child guarantees young people the right to participation (for discussion, see Bruyere, 2010). In the United Kingdom, national policy strategies explicitly state that 'young people themselves should be consulted on what is most likely to make a difference' (United Kingdom Cabinet Office, 2004, cited in Coleman & Cater, 2007, p. 307). This is true in terms of young people's engagement with alcohol and other drug policy issues, as much as any other domain. As Vander Laenen states (2011, pp. 491–492): 'Young people are not regarded as "passive", but as active agents in their social networks. They have the ability to attribute meaning and their voices are not "homogeneous".' Interventions and responses aimed at ameliorating alcohol and other drug policy problems in society impact upon young people, and it is therefore important to seek to understand young people's views. Such engagement has the potential to improve policy outcomes by ensuring policy responses are relevant and accepted by those directly affected.

The aim of this study was to describe and better understand young people's views on alcohol and other drugs issues. In doing so, it is hoped that the voices of young Australians may be included in alcohol and other drug policy deliberations. This study used an online survey to seek the opinions of Australian young people about various approaches towards alcohol and other drugs. Approaches broadly include prevention, law enforcement, regulation, treatment and harm reduction, as well as various strategies and interventions within each of these broad domains. It is hoped that, by tapping into the direct experience and opinions of young people in Australian society, we will be able to ascertain their level of support for both popular and unpopular interventions, those that are currently in widespread use in Australia, and those that have yet to be adopted.

In this report we define 'young people' as those aged between 16 and 25 years inclusively. Generally, when referring to 'youth' or 'young people', one is referring to people within this age group, or similar. For instance, the United Nations defines young people as those aged between 15 and 24 years. The Australian Government defines young people generally as between 12 and 24 years, noting that: 'While the actual age of each stage is different for each individual, youth is the period when the balance of influences on young people's behaviour shifts from the decisions and actions of their parents and guardians to their own and that of their peers' (Australian Institute of Health and Welfare, 2011b, p. 1). It is important to recognise, however, that while these particular age ranges may be commonly used, the experience of 'being young' may vary greatly between countries and regions, and that young people are not a single homogenous group, but are a diverse, heterogeneous population. In addition, the experience of 'being young' has changed over time. In relation to alcohol and drug use, and policy specifically, this age bracket captures a wide range of different individuals; from those still in high school and not legally allowed to purchase alcohol in Australia, to those who may have completed university degrees and be working full time. This age bracket also includes those aged both below and above the average age of initiation for a range of different substances (Australian Institute of Health and Welfare, 2011a).

2. Young people's alcohol and other drug use

In order to contextualise the opinions of young people, it is important to have an understanding of trends and patterns of alcohol and other drug use among young people in Australia. There are a range of surveys that give a relatively comprehensive understanding of alcohol and other drug use among this group. The most authoritative sources of information come from large, routinely collected population surveys, such as the National Drug Strategy Household Survey (NDSHS) (Australian Institute of Health and Welfare, 2011a), which is a general population survey, and the Australian Secondary Students' Alcohol and Drug Survey (ASSAD) (White & Bariola, 2012).

Results from the 2010 NDSHS demonstrate that almost 60 per cent of 12–17 year olds had never had a full serve of alcohol, but among 18–19 year olds this proportion declined to 10.2 per cent. Among 12–17 year olds, 38.4 per cent had consumed alcohol in the past 12 months, and one-third of these (33.2% of the entire age group) consumed alcohol less than weekly. Among 18–19 year olds, 86.3 per cent had consumed alcohol in the past 12 months, and 38.6 per cent consumed alcohol on a weekly basis. Among 20–29 year olds, 43.9 per cent consumed alcohol on a weekly basis. There has been little change in these figures from the 2004 NDSHS, indicating little shift in the prevalence of alcohol use among young people.

Unlike the NDSHS, which is a general population survey, the Australian Secondary Students' Alcohol and Drug Survey (ASSAD) focuses specifically on young people, surveying 12–17 year olds (White & Bariola, 2012). In the 2011 ASSAD survey, half (50.7%) of 12–17 year olds had consumed alcohol in the past year (26.0% had never consumed alcohol). One-third (29.1%) had consumed in the past month, and 17.4 per cent in the past week. There has been a decline in weekly drinking among both 12–15 year-old and 16–17 year-old respondents in the ASSAD survey since 1999.

Results from the 2010 NDSHS demonstrate that illicit drug use is most common among young people (aged below 30 years), and peaks while people are aged in their twenties. In the 2010 survey, 18.7 per cent of those aged 14–17 years had used an illicit drug in their lifetime. Among 18–19 year olds, 37.0 per cent had used an illicit drug; and among 20–29 year olds, 51.3 per cent. That is, more than half of those surveyed in 2010 aged 20–29 years reported having used an illicit drug at some point in their lifetime. Among people over the age of 30 years, rates of drug use decline.

In terms of *recent* use (defined as use during the past 12 months), the pattern among these age groups follows a similar trend, with recent use of illicit drugs the highest among the 20–29 year olds. Among 14–17 year olds, 14.5 per cent had used an illicit drug in the last 12 months, compared to 25.1 per cent of 18–19 year olds, and 27.5 per cent of 20–29 year olds. Again, recent drug use among older people is less common in Australia.

The above figures detail the use of *any* illicit drug. According to the NDSHS, the drug most commonly used by young people is cannabis (as is the case within the population more generally). In the 2010 NDSHS, 21.3 per cent of 18–19 year olds had used cannabis in the past 12 months. However, the proportion of young people using cannabis has declined dramatically since 1998, when 42.9 per cent of this age group had used cannabis in the past 12 months.

In terms of ecstasy use, there has also been a reduction in use among young people in Australia in recent years, although not as marked as the fall in cannabis use. In 2010, 6.0 per cent of 18–19 year olds reported ecstasy use in the past 12 months, a decline from 8.8 per cent in 2004. The age group with the highest ecstasy use as recorded by the NDSHS is 20–29 year olds, which has also seen a decline, from 12.0 per cent in 2004 to 9.9 per cent in 2010. Approximately one-quarter (24.2%) of 20–29 year olds surveyed in 2010 had used ecstasy at some point in their lives. In regard to other drugs, among 18–19 year olds, 4.0 per cent reported using methamphetamine, 3.2 per cent cocaine, and 5.0 per cent pharmaceuticals for non-medical use in the past 12 months.

The 2011 ASSAD survey found that 14.8 per cent of secondary students had used cannabis, 2.9 per cent had used amphetamines, and 2.7 per cent had used ecstasy. The NDSHS and the ASSAD survey show largely comparable results in terms of the popularity of different drugs among young people. Similarly to the NDSHS, the ASSAD survey has shown a decline in illicit drug use among young people. In 2011, 15.6 per cent of the sample had used any illicit drug. This has declined significantly over time, from 26.8 per cent in 2002.

As mentioned previously, young people are perhaps the most relevant target age group (or 'affected community') for many alcohol and other drug policy interventions, especially prevention programs, as use is generally initiated before turning 20 years of age. In the 2010 NDSHS, the average (mean) age of initiation into use was reported as follows: 17 years for alcohol; 18.5 years for cannabis; 19.8 years for hallucinogens; 20.9 years for methamphetamines; 21.4 years for heroin; 21.8 years for pain medication; and 22.2 years for ecstasy. Although the 12-month prevalence of drug and alcohol use among Australian young people is currently declining in some cases (as described above), it is also clear that, over time, Australians have commenced alcohol and other drug use at an increasingly younger age. Analysis of previous NDSHS data has shown that during the last half of the 20th century, the age of initiation into alcohol, cannabis and heroin fell, and in some cases quite dramatically. For instance, the mean age of initiation into alcohol for those born in 1940–44 was 18 years; for those born in 1975–79 this had fallen to 15 years. Similarly, age of initiation into cannabis use has fallen from 30 years to 16 years in the later cohort (Degenhardt, Lynskey & Hall, 2000).

Although population surveys such as the NDSHS provide the most comprehensive data on drug and alcohol use among young people, it is highly likely that these surveys underestimate the extent of drug use within this population. This is due to a number of reasons. Firstly, the NDSHS is a survey of householders, and as such underestimates drug use in the general community, as it does not sample groups that do not live in 'households', such as people experiencing homelessness or those living in institutions, where the prevalence of drug and alcohol use is likely to be higher. There may also be under-reporting, either intentionally (due to fear of detection) or by way of poor memory. Other surveys of young people have also found higher alcohol and drug use rates. For example, an online survey of 16–24 year-old Australians conducted in 2010 found higher rates of drug use than the comparable NDSHS (Hughes, Spicer, Lancaster, Matthew-Simmons & Dillon, 2010).

It is difficult to know with any great certainty how young people in Australia compare with their counterparts in other nations in regard to prevalence of alcohol and other drug use. A number of previous studies have indicated that young people in Australia exhibit higher rates of use than those in the United States (see McMorris, 2007). However, rigorous comparisons of youth populations in different countries can be difficult to undertake, as most studies that attempt to do this use pre-existing data sets, from surveys that have used different methodologies including differences in instruments, sampling, recruitment, consent procedures and interviewing methods, and response rates.

While population surveys seek to monitor young people's alcohol and other drug use patterns, there has, to date, been less focus on understanding young people's *opinions and ideas* about alcohol and other drugs and drug-related policies. It has been argued that it is important to explore the meaning of drugs in young people's lives and their attitudes towards drug issues, over and above merely examining young people's drug use behaviour (for discussion, see Duff, 2003; Lancaster & Hughes, 2013; Moore, 1990).

3. Young people's opinions – previous research

In this section we review the existing research examining young people's opinions about alcohol and drugs: opinions about alcohol and drug use; opinions about different interventions; and the research that has examined predictors of young people's opinions.

3.1 Young people's opinions about alcohol and drug use

Studies both in Australia and internationally have examined young people's perceptions of alcohol and other drugs and, in particular, their perceptions of the relative harms of different drug types. Importantly, these studies have demonstrated that young people do not regard all drugs to be equally harmful or problematic. The European School Survey Project on Alcohol and Other Drugs (ESPAD) (a large survey drawing on a sample of 10 000 European students from 36 countries) has demonstrated differences between young people's perceptions of particular illicit drugs, compared to alcohol for example (Hibell et al., 2011). In 2011, three-quarters (73%) of participants said that the regular use of cannabis, ecstasy or amphetamines posed a great risk of harm, whereas one-third thought that having one or two alcoholic drinks a day would be harmful. Young people's perception of the relative harmfulness of different illicit drugs has also been explored. A large quantitative (n=2306) and qualitative study (n=171) of 12–24 year-old Australians found that when young people were asked to think of illicit drugs, heroin and cannabis were the two most commonly mentioned. However, cannabis was perceived by young people to be a 'relatively benign' drug, in many ways similar to alcohol (Blue Moon Research & Planning, 2000). Cannabis was viewed relatively positively; a drug that 'laid-back, normal people' use. Ecstasy, LSD and speed were also positively associated with having fun, but were perceived to be more dangerous than cannabis but less dangerous than heroin or cocaine. Cocaine and heroin had the most negative associations and were associated with addiction, social problems and loss of control (the drugs that 'junkies' use).

The finding that cannabis is perceived to be a comparatively less harmful (or 'relatively benign') drug accords with other research conducted internationally. The United States National 'Monitoring the Future' Survey includes components regarding young people's attitudes to drugs, and the findings again demonstrated that cannabis was perceived to be the least risky illicit drug (although regular use was seen to be more risky than 'experimentation' by a greater proportion of the sample) (Johnston, O'Malley, Bachman & Schulenberg, 2011). Similarly, a nationwide survey (n=1000) conducted by the Drug Misuse Research Division of the Health Research Board in Ireland found that almost half of participants (43.8%) agreed that 'occasional use of cannabis is not really dangerous', whereas only 13.9 per cent of 18–29 year olds agreed that the 'occasional use of ecstasy is not really dangerous' (Bryan, Moran, Farrell & O'Brien, 2000). Age has also been shown to have an influence on young people's perception of cannabis. In the United Kingdom, Pearson and Shiner's (2002) analysis of school-based surveys there indicated that young people's attitudes regarding the perceived harmfulness of cannabis changed dramatically from the ages of 11 to 15 years. The proportion of young people who perceived cannabis as harmful halved between the ages of 11 and 15, until by the age of 16 only a minority saw cannabis as harmful. These perceptions were also found to be different from their perceptions of other drug types. In addition, the study found that the most recent cohort of young people also perceived ecstasy to be as harmful as heroin (close to 80 per cent regarded these drugs as very harmful).

Young people's perceptions of health harms specifically have also been examined. The same Health Research Board in Ireland study found that, of the study's younger participants (aged 18–29 years), two-thirds agreed with the statement that 'all illegal drugs are equally harmful to your health', while only one-quarter (26.1%) agreed that 'if you try drugs even once, you're hooked'. The 2011 Flash Eurobarometer measured young European Union citizens' (n=12 000 young people aged 15–24 years) opinions about drugs and drug-related issues and found that the vast majority of respondents (90%) said that using cocaine or ecstasy on a regular basis would pose a high risk to a person's health, whereas only 67 per cent thought that regular use of cannabis would be a high health risk (European Commission, 2011). The health risks of regular use of alcohol were perceived to be high by 57 per cent of respondents in that study.

Looking particularly at perceptions of mental health harms, an Australian study surveyed 3021 young Australians aged 15–25 years to examine young people's beliefs about the harmfulness of alcohol and cannabis for mental disorders[1] (Yap, Reavley & Jorm, 2011). After being presented with a series of vignettes, over three-quarters (75–78%) of participants reported that it was harmful for the people portrayed in the vignettes to use alcohol and cannabis for relaxation and the same proportion of participants said they would recommend that they cut down their use of these substances due to the perceived negative impact the drugs would have on their mental health.

A number of research studies have pointed towards the 'normalisation' of alcohol and other drug use among youth populations, despite the perceptions of harm identified in the studies above. It has been suggested that drug use has become increasingly 'normalised' for this generation of young people, due to the availability and acceptability of drugs and the role that drugs play within youth subcultures (Duff, 2003; Holt, 2005; Wilson, Bryant, Holt & Treloar, 2010). One United Kingdom study, which highlights this changing trend, examined the changes in young people's experience and knowledge of illicit drugs by surveying all Year 10 students in three secondary schools over a 30-year period from 1969 to 1999 (Wright & Pearl, 2000). The proportion of students who personally knew someone who used drugs increased from 15 per cent in 1969 to over half of all students in the 1990s (65% in 1994; and 58% in 1999). In 1969 only 5 per cent said they had ever been offered drugs, which increased to almost half of all students surveyed by the 1990s (45% in 1994; and 48% in 1999). Another qualitative study conducted in the United Kingdom used focus groups to explore what young people aged 16–18 years thought about illicit drugs (Wibberley, 1997). Participants were asked how they would feel if a close friend was using illicit drugs. The study found that most participants were accepting of a certain level of 'soft drug use' by their peers (especially cannabis) and perceived drug use to be a matter of individual choice. Duff's (2005) research in Australia examined the attitudes of a sample of 379 young people (mean age 22.9 years) who were surveyed in bars and nightclubs in Melbourne. The majority of participants (both drug users and abstainers) agreed that 'drug use has become a normal part of going out to nightclubs and dancing'.

1 This study also examined beliefs about tobacco, but as this is outside the scope of the current study the findings are not reported here.

How young people perceive the relative 'risks' and 'benefits' of drug use has been examined. A recent online survey of young Australians (n=2296) used the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 'Beliefs about Consequences' instrument (European Monitoring Centre for Drugs and Drug Addiction, 2004) to examine young people's attitudes to illicit drugs and how they perceived the consequences of drug use (Lancaster & Hughes, 2013). A substantial proportion of participants (45.3%) thought that they were likely to have more fun as a consequence of illicit drug use. A minority of participants reported that they thought that they would get into trouble with the police (33.6%) or become an addict (33.4%) as a result of using illicit drugs. Approximately half of participants reported that it was likely that they would have money problems (57.0%), have problems with school/work (55.1%) or get into trouble with parents (51.5%). The study found that there were, however, differences between the perceptions of young people who had used drugs and young people who had not used drugs in their lifetime. Participants who had used drugs were more likely to report the likelihood of positive outcomes as a consequence of drug use, whereas those who had not used drugs were more likely to perceive negative outcomes. Regarding alcohol specifically, the European School Survey Project on Alcohol and Other Drugs (ESPAD) asked participants about their perceptions of the personal consequences of alcohol use (Hibell et al., 2011). Alcohol was largely associated with 'having fun' (64%) and 'forgetting problems' (48%). A large proportion of participants (42%) also perceived the likelihood of negative consequences such as health harms and hangovers, and around one-third (35%) said they might 'do something they would regret' or 'feel sick'. Only one in five participants (19%) thought they would get into trouble with the police or be unable to stop drinking.

Attitudes to drugs and perceived risk among young people have been shown to be different from the opinions held by older adults. Flanagan and colleagues (2008) make the point that much of the literature around drug use and other risk behaviours has focused on a 'rational choice' assumption, that the information and attitudes young people hold will affect the decisions young people make about using or not using drugs or engaging in other risky behaviours. However, these authors suggest that this assumption leaves unexplored how young people think about rights and responsibilities associated with health and risk behaviour, and also to what extent young people think that risky choices are private/individual choices or whether these choices should be interfered with or be subject to public control. Research among college students in the United States (Spigner, Hawkins & Loren, 1993) has also shown that there may be significant differences in the way that males and females perceive alcohol and other drugs. This study found that females were significantly more likely to perceive greater risk from alcohol and other drugs, compared to their male peers.

3.2 Preferred sources of information for young people

Understanding where young people go for information and advice about alcohol and other drug issues is important for targeting effective education strategies and for understanding whether interventions are seen to be credible and relevant to young people. There is a wide range of sources of information accessible to young people, and young adults exist in a world 'awash with information' (Quintero & Bundy, 2011, p. 898). However, an issue of concern to health professionals is that some of the 'non-official' information that is freely and readily available to young people may not be accurate and therefore may potentially contribute to greater drug-related harm.

The issue of trustworthiness and credibility is important to consider in the context of how young people access information. While young people might be exposed to a particular source of information, this does not mean that this source will be the most trusted or listened to. For example, research undertaken in Australia showed that, of a sample of 2306 young people aged 15–24 years, the main sources of information about drugs were reported to be school, friends and television (with school being the primary source for 15–17 year olds) (Blue Moon Research & Planning, 2000; Clark, Scott & Cook, 2003). However, the qualitative component of the study found that young people perceived drug education to be unbalanced and were critical of it. Participants thought that media such as television and films were effective for delivering messages and imagery around illicit drug use, and information from friends or first-hand experience of drugs were found to be the most trustworthy and informative sources. However, if young people were actively seeking information about drugs (rather than passively receiving information), younger participants would seek information from parents, school and friends whereas older participants (over 20 years old) reported seeking information via the internet or doctors.

Another study by Falck and colleagues (2004) surveyed a sample of recent ecstasy users to determine which sources of information they considered to be most accurate and important. The study used respondent-driven sampling in metropolitan Ohio to recruit a sample of 304 young people aged 18–30 years who had used ecstasy in the past six months. Friends, drug treatment programs and physicians were perceived to be the most *accurate* sources of information about ecstasy. Friends were also reported to be the single most *important* source of information about ecstasy, followed by non-government websites. That friends were ranked highly both as the most accurate and most important sources of information highlights the significant role of peer networks.

The findings from older studies highlight how sources of information have changed for young people, as technology has developed rapidly over the last two decades. For example, a now-dated American study (Hickey, Brown, Chung, Kolar & et al., 1991) interviewed both adult (n=90, aged over 26 years) and adolescent (n=20, aged 20 years and below) cocaine users in Baltimore regarding sources of information about their cocaine use, how relevant this information was regarded to be, and whether it affected their attitudes towards risks associated with their cocaine use. Both adult and adolescent participants perceived books and magazines to be the most accurate sources of information, followed by television. Adolescents rated friends as the least accurate source of information.

A United Kingdom study surveyed 532 students aged 12–16 years regarding their attitudes to drugs and sources of information about drugs. Almost half of participants (47%) reported that they had learned a lot about drugs from television, followed by parents (39%), police (37%) and older friends (37%) (Hammersley, Ditton & Main, 1997). Roker and Coleman (1997) also found that, in addition to drug education programs, the majority of participants also said they received drug information from television (76.9%), books or leaflets (56.8%), newspapers and magazines (54.2%), and friends (52.1%). The findings of these studies would most likely be different today, due to widespread access to the internet and the central role of online social networking in young people's lives.

In recent years the internet has become the most important source of information for young people. There are many different websites, both official and non-official, but it has been suggested that young people are savvy consumers of information online, using evaluative techniques to access information of relevance to them and discern its trustworthiness (Gray, Klein, Noyce, Sesselberg & Cantrill, 2005; Quintero & Bundy, 2011). The recent European Commission Flash Eurobarometer 'Youth Attitudes on Drugs' survey (European Commission, 2011) found that 64 per cent of respondents said that they would use the internet to access information about drugs, while only 15 per cent said they would access other media sources (such as television, newspapers, radio or magazines) for advice. Approximately one-third of respondents still said they would seek information about drugs from a friend (37%), a parent or relative (28%), or a health professional (28%). Since 2008, the Flash Eurobarometer survey has found the internet to be the most preferred source of information for young people overall. Interestingly though, the survey also found that the internet was not the main source through which respondents usually received information about the risks of drug use. Almost half said they had been informed about the risks of drug use through a mass media campaign (46%) or a school prevention program (41%). These findings also differed depending on the age of the participant, with 15–18 year olds more likely to say they had received information through a media campaign or school prevention program. Qualitative research in the United Kingdom, which explored young people's health information-seeking behaviour, concluded that the internet is an important source of information for young people but nonetheless it is still connected to a young person's wider network of information sources (Gray et al., 2005). Importantly, it has been suggested that the internet may provide an avenue to minimise barriers that prevent young people from seeking health information through services, by providing access to anonymous, timely and non-judgmental information (Gray et al., 2005).

3.3 Young people's opinions about alcohol and other drug interventions/responses

Studies both in Australia and internationally have examined young people's opinions about alcohol and other drug interventions. However, many of these studies are small qualitative studies and the extant quantitative studies have largely examined young people's attitudes to drugs use as part of general population surveys, rather than focusing on young people's attitudes to alcohol and other drug responses and interventions explicitly. Here we review the literature that concerns young people's opinions towards alcohol and other drug policies, programs and control measures.

Young people's opinions on drug education, prevention and information

As Etter argues: 'It is important to know how the public perceives the relative importance of prevention measures and services, because this will determine their acceptability, usage and impact. In a democracy, public opinion may also influence the allocation of resources' (Etter, 2009, p. 113). However in the context of drug policy, Roker and Coleman (1997) have noted that rarely are young people's perceived needs, opinions and attitudes taken into account in discussion of drug education and prevention programs. Their study surveyed (n=2049) and also interviewed (n=58) young people aged 11–16 years in the United Kingdom, asking them what kind of drug information they had received and what they thought about it. The majority (72.9–83.5%) of young people surveyed said they had learned from various forms of drug education they had been exposed to, but qualitative interviews revealed that although they may have learned one piece of information in a particular session, the majority of drug education sessions were perceived to be unhelpful or less informative. This indicates that there may be a gap between the delivery and perceived acceptability of drug education for young people.

Young people's perceptions of the effectiveness of drug education were also explored in a study that surveyed Chicago public school students (n=719). This study sought to examine young people's perceptions of the effectiveness of two school-based drug prevention strategies (Project DARE and Captain Clean), as well as four public approaches to prevention (celebrity testimonials, billboards, television advertisements and public transport print advertising) (Lisnov, Harding, Safer & Kavanagh, 1998). School-based programs were perceived to be significantly more effective than television advertisements and celebrity testimonials, which in turn were perceived to be significantly more effective than billboards and print advertising. Captain Clean (an interactive program) was perceived to be more favourable than Project DARE in helping students talk about sensitive issues, but neither was perceived to be more effective overall than the other. The authors concluded that students may prefer prevention strategies with an interpersonal component.

One way to better understand young people's perceptions of current programs and the reasons why (or why not) they may find current approaches to be effective is to ask young people what they desire from drug education and information programs. An early study conducted in the 1970s in the United States measured young people's attitudes towards prevention programs in schools and asked students what topics they thought should be covered in prevention programs (Dembo et al., 1976). A representative sample (n=8553) of high school students was drawn from 102 public schools in New York State. Overall, participants reported that they thought church programs would deter drug use, followed by programs in the classroom or after school (although not en-masse in school assemblies), but one-quarter to one-third of all participants nonetheless thought that all of these programs would have no effect. Talks by 'ex-addicts' were also regarded as effective by the majority of participants.

Students said that they would prefer programs that talked about the effects of drugs on their mind and health, legal penalties, treatment, impact of drugs on families and how to handle 'bad' drug use experiences. Students were less interested in programs that talked about the morality of drug use. People with medical expertise or experience of drugs as users were regarded as more trustworthy sources of information about drugs than mass media. The qualitative component of the broader Australian 'Blue Moon Research' study (as discussed above, Blue Moon Research & Planning, 2000) also asked participants what they wanted from drug education. Participants said they desired drug education that was perceived to be balanced, 'real' and non-judgmental, with programs delivered by 'outsiders' (not teachers or those in positions of authority). Under these conditions, participants suggested that a school setting for the education was seen as acceptable. Internet information and television sources were also perceived to be good avenues for drug education.

Ideas about what young people desire from drug education have also been examined within specific subpopulations. For example, a United States study examined Asian–American students' perceptions of drugs and desired prevention programs (Fang, Barnes-Ceeney, Lee & Tao, 2011). Three qualitative focus groups were conducted with 31 15–18 year olds living in New York City. The participants expressed a desire for prevention programs targeted towards their own specific Asian–American community (including the need for the programs/materials to be offered in languages other than English), and suggested that parental programs be included because there was a perception that their parents needed to be educated about drugs too. School was the setting most frequently mentioned as suitable for promoting prevention and health education, along with youth centres and online social networking sites.

Another qualitative study conducted in Belgium asked 160 vulnerable young people with behavioural disorders (aged 12–21 years) what they thought about drug prevention strategies (Vander Laenen, 2011). The study found that 'group interviews highlighted divergent views on the general objective of a drug prevention policy' (Vander Laenen, 2011, p. 493). Younger people thought that abstinence was the most important message for cannabis prevention (i.e. 'do not start using drugs') whereas older participants, especially those who had used

drugs, rejected abstinence-based approaches and emphasised the importance of open communication about drug use. Participants expressed negative attitudes to existing prevention programs, especially where an 'expert' explained the harms of drug use; and these attitudes were influenced by their own experiences of prevention in institutional settings.

Research has also shown that, in the absence of school prevention and information programs that are perceived to be of relevance, young people will turn to other sources of drug information. A qualitative study in the United Kingdom explored young people's experiences of school drug education and school drug policies using semi-structured interviews with school students aged 14–15 years, living in London and south-east England (n=50) (Fletcher, Bonell & Sorhaindo, 2010). In this study, students recalled receiving little or no drug education at school and thought schools should provide better drug education programs. Without school drug education, young people said they accessed drug information through family and media but not through government sources such as helplines and websites. The teachers interviewed as part of the study (n=10) admitted that drug education was limited. Students expressed negative attitudes to other school drug prevention programs such as 'spot searches' and drug testing. Mixed attitudes were expressed in relation to drug counselling in the school setting, with some suggesting that drug counselling at school was helpful and others suggesting that it was a stigmatising experience, particularly if they were coerced into attending.

Mass media prevention campaigns are also a popular intervention used by governments for drug prevention and education. Ricciardelli and McCabe (2008) examined Australian university students' understanding and perceptions of messages conveyed in an Australian alcohol campaign, which targeted awareness of harmful drinking. Participants (n=671) were aged 18–25 years, and the majority of students identified that the campaign was communicating a negative view of excessive alcohol consumption. Over half of participants perceived the campaign to be relevant to university students (53%) and truthful and realistic (50%), however a substantial minority said that they thought the campaign would have a limited impact (26%), that students would not care (22%) or that the campaign was too simplistic (21%).

Guidelines and health promotion are also important interventions in drug prevention and education. An Australian study interviewed 60 young Victorians (aged 14–24 years) about their attitudes towards alcohol and motivations for drinking, and in particular examined young people's attitudes towards the new National Health and Medical Research Council's guidelines regarding risky drinking (Harrison, Kelly, Lindsay, Advocat & Hickey, 2011). There was a perception that the guidelines were not relevant as they were a 'one size fits all' approach and did not take into account individual factors, or the pleasurable aspects of alcohol use. The idea of an individual's ability to 'know their own limits' was also a recurrent theme among participants. The authors note that 'the dilemma of all governmental programs is that the subjects of these programs may not recognise themselves in them' (Harrison et al., 2011, p. 480).

Young people's attitudes to services and treatment provision

Few studies have examined young people's attitudes to services and treatment provision. Two studies, discussed above in the context of drug education, also explored young people's opinions about drug treatment services. The Australian 'Blue Moon Study' (Blue Moon Research & Planning, 2000) found that participants did not think treatment was relevant for themselves and their own drug use, but regarded treatment as being for people who inject drugs or 'serious users'. Counselling was the treatment intervention discussed most often and was seen to be beneficial if the individual pursued counselling rather than being coerced into it. The participants in Vander Laenen's (2011) study expressed negative attitudes about drug treatment. But despite their negative perceptions of treatment services, participants nonetheless emphasised the need to offer people 'help'. Trust, confidentiality and being at ease with staff were identified as central characteristics of what 'good help' was perceived to be.

The attitudes towards and experiences of treatment services among specific subpopulations have also been examined. One small qualitative study (n=12) explored adolescents' own experiences and perceptions of outpatient adolescent substance abuse treatment (White, Godley & Passetti, 2004). This study found that most participants did not know what to expect from treatment and that their pre-treatment expectations did not necessarily match their experience, with some participants expecting an authoritarian environment (where treatment focused purely on an abstinence-only approach) or that treatment would be boring or a waste of time. Heim et al. (2004) explored attitudes among specific ethnic groups by examining the attitudes of young Pakistani, Indian and Chinese people aged 16–25 years living in Glasgow (n=174) towards alcohol service provision. Respondents from these minority communities reported that they thought their communities dealt with alcohol problems in the same way as the general community, although religious restrictions around alcohol consumption played a role. Most respondents said they would obtain information about alcohol from a general practitioner or medical person, friends, the internet or public information brochures. One-quarter of participants said they would involve a service provider if a friend was having problems with alcohol. Most participants were not aware of specialist services for their ethnic community. Just over half (54%) of participants expressed a preference for mainstream services, not services targeted at specific minority groups. For those who expressed a preference for specialist service, the main reasons given were regarding language barriers to access and catering to cultural differences.

Young people's attitudes to laws, regulation and supply control

Several studies have examined young people's attitudes to laws and regulations controlling the availability and supply of alcohol and other drugs, and how these regulatory frameworks in turn impact upon young people's perceptions of risk and acceptability.

Alcohol regulation

Young people's attitudes to alcohol regulatory policies such as pricing, legal drinking age and restrictions on licensed premises have been examined in several international studies, which have largely drawn on general population data. A general population study of public opinion about alcohol policy in Canada (n=11 634 (1989) and n=12 155 (1994)) examined attitudes to policies such as taxation, legal drinking age, alcohol store hours, advertising, and service of intoxicated people, as well as alcohol and drug education and prevention programs, and analysed results according to differences in age (Giesbrecht, 1999). The author found that younger participants were less supportive of most of the policies, but were more supportive of warning labels on alcoholic beverages (for example, 74.6 per cent of young people aged 15–19 years supported warning labels, compared to only 69.7 per cent of 35–54 year olds). Young people were also much less likely to support increasing the legal drinking age (12.5 per cent of 15–19 year olds, compared to 49.4 per cent of participants aged over 55 years). These Canadian findings concur with the findings of a smaller United States study which assessed adolescents' attitudes towards the introduction of warning labels on alcohol containers and advertisements (Weiss, 1997). Students aged 16–18 years (n=3065) from Moslem, Christian, Druze and Jewish high schools were surveyed, and the majority of students said they supported warning labels on alcohol containers (75.6–88.9%) and in advertisements (71.1–77.5%).

A Swedish study of public responses to community alcohol strategies in Stockholm surveyed people aged 18–65 years (n=578) and found that respondents aged less than 30 years did not support restrictions on service of alcohol to intoxicated patrons, reducing opening hours, police monitoring of service of alcohol to intoxicated patrons or being refused entry to licensed premises, compared to older respondents (Wallin & Andreasson, 2005). A Finnish study analysed population data collected as part of a community-based prevention project and found that age was related to opinions about alcohol control policies, with older participants (over the age of 35 years) being more supportive than younger participants, across all alcohol measures including restrictions on sales to intoxicated persons, warning labels, bans on advertising, minimum legal drinking age, increased pricing, and restricted hours for licensed premises (Holmila, Mustonen, Osterberg & Raitasalo, 2009).

In the Australian context, one study analysed data from the general population National Drug Strategy Household Survey to explore public opinion towards different alcohol policies (Wilkinson, Room & Livingston, 2009). Similarly to the Finnish study, the authors found that older respondents were consistently more supportive of restrictive alcohol interventions, controlling accessibility to alcohol and controlling public spaces, than younger respondents. These findings were confirmed in work by Matthew-Simmons et al. (in press), which found that younger respondents were less supportive of alcohol restrictions. A Dutch study also explored attitudes towards alcohol restrictions using a representative sample, comparing the

opinions of 16–22 year olds with the opinions of participants aged over 22 years (van der Sar, Brouwers, van de Goor & Garretsen, 2011). They found that participants aged 16–18 years and 19–22 years were significantly less supportive of restrictive alcohol policy measures than those over 22 years of age. Finally, the first study to examine attitudes towards alcohol policy in Puerto Rico was a general population telephone survey (n=514) in which participants were asked about alcohol taxation, alcohol consumption in public settings, access/provision of alcohol to minors and marketing (Harwood, Bernat, Lenk, Vazquez & Wagenaar, 2004). Regression analyses found that attitudes towards alcohol policies were associated with age. Younger participants were less likely to support bans on alcohol advertising than older participants (p =<.008), but younger participants were more likely to support punitive measures against adults who supply alcohol to minors (p= <.008).

Policy makers have also sought to respond to the potential harms associated with young people's risky drinking. Young people's attitudes to some of these interventions have been examined. For example, building on research examining why young people binge drink, a Welsh study examined young people's ideas and opinions about how policy should respond effectively to this problem (Coleman & Cater, 2007). Qualitative semi-structured interviews with 40 18–25 year olds who had experienced binge drinking were conducted, in addition to four focus groups to further explore themes from interviews. The young people surveyed did not perceive themselves to be 'binge drinkers' (despite drinking above the recommended guidelines), and thought that binge drinking was a problem for people they perceived to be stereotypical 'alcoholics'. Participants nonetheless thought that going out to get drunk was normal behaviour for young people; many believed they would grow out of this behaviour/stage of life as they got older but most also believed that under-age (under 18 years old) binge drinking was not acceptable. When asked about what should be done to reduce binge drinking, many respondents thought that nothing could be done, as binge drinking was normative and fun in their stage of life. Some strategies were proposed: participants suggested that 'shock' tactics would work if it was linked to first-hand experience of alcohol damage, but thought that abstract depictions would have less impact. Participants also suggested that the experience of seeing someone display anti-social or embarrassing behaviour would make them think about their own binge drinking. Female participants said that 'regret' about sexual experiences had an impact. Finally, some participants recommended legislative changes such as restricting service of alcohol to intoxicated patrons (although participants seemed unaware that such regulation was already in place).

The relationship between alcohol policies and young people's perceptions of alcohol-related risk has also been examined. Boluarte et al. (2011) drew on data collected as part of the 2008 Flash Eurobarometer Survey ('Young People and Drugs') to examine how policy affects adolescents' perceptions of alcohol-related risks. Only two policies were found to influence young people's risk perception: a higher blood alcohol concentration limit for drink driving increased perception of risk; and requiring warnings on alcohol advertising and bottles/containers increased perception of risk towards alcohol. Regulation limiting the purchase of alcohol to over-18 year olds did not impact significantly on young people's perceptions of alcohol-related risks. Access to information about the risks of alcohol and drug use was not found to be a significant predictor of risk perceptions, but the source from which this information came did predict risk perceptions.

Drug regulation

Perceptions of particular drug types have been examined alongside attitudes to drug law reform in several studies, largely drawing on data from population surveys. Nielsen's (2010) research suggests that there will be cohort effects regarding attitudes to drug policy given the history of drug policy development, exposure to drugs and the impact of media campaigns. The study showed that more recent cohorts have more liberal attitudes to drug policy, especially regarding cannabis legalisation, as compared to pre-Baby Boomer cohorts. In the Australian context, an older report analysed trends in public opinion towards drug policies in the 1980s and 1990s, using National Drug Strategy Household Survey data (Makkai & McAllister, 1998). Support for legalisation of cannabis was consistently higher among adolescents when compared with adults, across the decade (with just over 40 per cent of adolescents, on average, supporting cannabis legalisation between 1985 and 1995). Other analysis of public opinion data by these authors showed strongest support for cannabis legalisation among 18–24 year olds, with this age group offering 14 per cent more support for legalisation compared to the total general population sample (Makkai & McAllister, 1997). In the most recent work using the National Household Survey, Matthew-Simmons et al. (in press) have found that younger respondents were less supportive of cannabis legalisation than older respondents. Males were also more likely to support cannabis legalisation than females.

Another specific Australian youth survey of people aged 14–17 years (n=611) living in Perth, Western Australia, measured differences in perceived morality and acceptability of alcohol and cannabis use and also asked participants about the perceived legitimacy of laws restricting purchase of alcohol by age, and the illegality of cannabis (Amonini & Donovan, 2006). Over half of participants (57%) perceived cannabis use to be 'wrong under any circumstances', whereas only 17 per cent reported that alcohol use was 'wrong under any circumstances'. A substantial majority (88%) of participants approved of alcohol use under 'some or any circumstances' compared to 44 per cent for cannabis. The study also identified differences between the attitudes of males and females, with males more likely than females to perceive alcohol use as acceptable. The majority of participants (50.7–75.9%) thought laws restricting the sale of cannabis and alcohol for people their age were legitimate.[2]

In Europe, the Flash Eurobarometer measures young European Union citizens' opinions about drugs and drug-related issues, including their responses to drug policy and regulation (European Commission, 2011). In 2011, 12 000 young people aged 15–24 years were interviewed across Europe. Almost all respondents thought that heroin (96%), cocaine (94%) and ecstasy (92%) should remain illegal in Europe. However, opinions regarding the illegal status of cannabis varied across nations with only 33 per cent of young people in the Netherlands agreeing that cannabis should remain illegal, compared to 87 per cent in Romania (with the European average being 59 per cent). In examining young people's opinions about how drugs issues should be addressed in society, the survey found that young people believed that drug supply should be targeted to reduce drug problems in society, with 64 per cent saying that there should be tougher measures against drug traffickers. Prevention programs were also supported, with 49 per cent of participants saying they preferred information and prevention

2 This study also examined attitudes towards tobacco control.

campaigns, while 37 per cent said they preferred treatment responses to drug problems, and one-quarter (24%) said that reducing the underlying causes of drug problems by addressing poverty and unemployment would be a preferred strategy. Only 13 per cent perceived legalisation to be an effective approach to managing drug-related problems in society. The Flash Eurobarometer also examined young people's opinions about the regulation of new psychoactive substances. Approximately one-third (34%) of participants thought that new psychoactive substances should be banned, whereas 47 per cent thought that substances should be banned only if they were a health risk.

The opinions of people who use cannabis have also been examined. A Canadian study examined the opinions of cannabis users in Canada regarding cannabis laws and policy (Brochu, Duff, Asbridge & Erickson, 2011). The authors note that there is a gap between policy and the way those policies and laws are enforced in the community (particularly through policing practices), which may create uncertainty among cannabis users and the general public and in turn shape cannabis users' knowledge and opinions about cannabis policy. The data were drawn from in-depth qualitative interviews with 165 participants from four Canadian cities recruited via respondent-driven sampling. Participants had little awareness of cannabis laws, were 'unsure about Canadian laws', and also thought that 'Canadian laws are too harsh' and 'not enforced consistently'. Uncertainty about the laws came also from a belief among participants that there was little likelihood of being detected by law enforcement as a user. When presented with the actual legislation, participants were surprised at the 'harshness', having previously thought the laws were more permissive, and thought that cannabis use should be a personal choice not a criminal matter (and suggested cannabis should be treated in the same way as alcohol and tobacco). Participants also said that the laws were not reflective of contemporary attitudes in the community about cannabis use. Participants suggested that the attitude of police officers (and police discretion) on the street was more important than the legislation itself. Participants expressed support for the existing policy regime due to the perceived low likelihood of prosecution, and feared the impact of tax under a legalised policy.

Finally, roadside drug testing has been introduced as a drug law enforcement intervention in Australia in recent years. A qualitative study (n=20) examined young drivers' (aged 18–24 years) perceptions of random roadside drug testing in Victoria (Wilson & Wilson, 2010). Participants reported that they thought there was very little chance of being detected prior to the introduction of random roadside drug testing, but that they believed their chances of being detected had increased somewhat since the introduction of the initiative. Based on anecdotal evidence, participants nonetheless thought that there was only a small chance of being detected. Participants felt that the introduction of random roadside drug testing was not based on road safety evidence but rather based on moral opposition to drugs use per se, which the authors concluded may undermine the perceived legitimacy of the program.

3.4 Predictors of young people's opinions about alcohol and other drug interventions/responses

In addition to some of the factors highlighted in the literature above, there is a body of research that has examined the relationship between demographic characteristics and opinions about alcohol and other drugs responses. Drug use experience and peer exposure to drugs have been shown to be potentially important drivers of opinions about drugs. One Canadian study (Adlaf, Hamilton, Wu & Noh, 2009) examined young people's stigmatising attitudes towards drug addiction using a self-administered questionnaire provided to 4078 students aged 12–19 years as part of the annual Ontario Student Drug Use Survey in 2005. Over half of students (53.9%) said they would definitely or probably feel ashamed if their friends knew that someone in their family was addicted to drugs; 31.3 per cent said they would be afraid to talk to someone who is addicted to drugs; 31.2 per cent would probably or definitely not make friends with someone who is addicted to drugs; and 21.9 per cent said they'd be upset to be in the same class as someone who is addicted to drugs. However, students who had used illicit drugs were found to have significantly less stigmatising attitudes than those who had never used drugs. Students who said more than half of their friends used drugs also had less stigmatising attitudes than students with fewer drug-using friends. Whether or not friends used drugs had more influence on attitudes than the adolescent's own personal drug use. There was a decline in stigmatising attitudes across the age group, but peer drug use moderated this effect. Sex and place of residence (urban/rural) did not significantly moderate this association.

A Danish study using both quantitative (n=1936) and qualitative (n=74) methods found that young people's attitudes to the risks or pleasures of drugs correlated with their own experience of drug use (or the experience of their friends) (Jaervinen & Oestergaard, 2011). Those with experience of drug use were more likely to perceive drugs as safe or pleasurable, rather than risky, compared to young people with less exposure to drugs. Similarly, an Israeli study examined the prevalence of drug use, knowledge about drugs and attitudes towards drugs among 115 high school students (aged 14–17 years) and found that knowledge about drugs was higher among those who used illicit drugs, as were liberal attitudes towards drugs (Brook, Feigin, Sherer & Geva, 2001). Liberal attitudes towards drugs were found to increase along with increasing age. Across the whole sample, however, most participants had inadequate knowledge about illicit drugs.

Studies have also examined the impact of age, sex and ethnicity on opinions about drug law reform. A qualitative study of Swiss adolescents found that younger adolescents were against the decriminalisation of cannabis as they thought it would increase accessibility and encourage drug use among younger people, whereas older adolescents were more supportive because they thought decriminalisation would reduce street-based drug trafficking (some participants also thought that decriminalisation was already in place in Switzerland) (Menghrajani, Klaue, Dubois-Arber & Michaud, 2005). In the United States, researchers have examined the perceptions of university students regarding American drug policies. One study specifically asked about attitudes towards general drug policy, cannabis use and drug testing by surveying a convenience sample of students at a southern university (n=294) (Garland,

Bumphus & Knox, 2010). Females were found to be less tolerant to cannabis use than males (r = -.169), but there were no significant differences by sex regarding attitudes to drug policies. Participants with a history of drug use expressed more tolerant attitudes towards drug policies (r = -.194) and drug testing (r = -.429).

Differences have also been found between the attitudes of young people of different racial and ethnic backgrounds. Lambert et al. (2006) examined differences between the attitudes of white and non-white college students towards drug use and drug issues, using a convenience sample survey (n=611, median age 21 years). Overall, three-quarters of participants (77%) agreed that drugs were a pressing social issue, 45 per cent perceived drug abuse to be a character weakness, and 54 per cent thought drug users supported their drug use through acquisitive crime. However, when the attitudes of white and non-white students were compared, white students were significantly more likely to view drugs as a pressing social issue and to support punitive responses. Non-white students were more likely to view drug abuse as an illness, to support treatment as a response, and to support cannabis legalisation. Another study used a cross-sectional survey of Asian–American young people aged 15–25 years (n=87) to examine perceptions of drug problems in the Asian–American community specifically, how this community perceived characteristics of people who experience problematic drug use, their attitudes to treatment and perceptions of services (Lee, Law, Eo & Oliver, 2002). Half of the participants (53%) agreed that 'drinking is a serious problem in the Asian–American community' and 62 per cent agreed that 'drug use is a serious problem in the Asian–American community'. The majority of respondents perceived a person with drinking or drug use problems to be male, more likely to be adolescent, and of lower or middle class. The majority of respondents thought that treatment was potentially helpful for people who use drugs, and also to support their families.

Religiosity has also been found to influence attitudes towards drugs. For example, Jones and Rossiter (2009) compared responses of students aged 14–15 years at a government school (n=48) and at a religious school (n=61) regarding attitudes towards alcohol and cannabis. Differences between the responses of these two groups were detected, indicating that social support and religiosity have an impact on young people's attitudes towards drugs (see also Haddad, Shotar, Umlauf & Al-Zyoud, 2010).

Australian research on the National Drug Strategy Household Survey has examined predictors of opinions towards both alcohol and drug policies (Matthew-Simmons et al., in press). Those respondents who consume more alcohol were less supportive of alcohol control measures. Those respondents with illicit drug use experience were more supportive of measures that eased restrictions. For example, cannabis use predicted support for cannabis legalisation (Matthew-Simmons et al., in press). However, heroin use was not significantly associated with support for heroin policies. Gender was also a significant predictor of opinions, with females more supportive of alcohol control measures, harm reduction interventions and decriminalisation (but not legalisation). (These analyses were not by age.) When the entire population were examined for age effects, younger respondents (12–17 year olds) compared to older respondents (over 35 years) were less supportive of alcohol restrictions. Younger respondents were also less supportive of legalisation of cannabis (Matthew-Simmons et al., in press).

4. Efficacy and effectiveness of ways of responding to alcohol and other drugs

There is a well-known adage that what is popular does not work, and what works is not popular. As can be seen from the above review, in general young people demonstrate low support for various measures to restrict the availability of alcohol, are supportive of unbiased and balanced drug education, sceptical about mass media campaigns, unfamiliar with treatment unless they have experienced it, and have varied opinions about legalisation of currently illegal drugs. Here we consider the evidence base for the various policy options. This provides the opportunity to subsequently match young people's opinions with the evidence for efficacy and/or effectiveness. The existing literature regarding youth-focused interventions is moderately large, but the research literature concerned with evaluations of the effectiveness or efficacy of these interventions is quite small. In addition, of the evidence that exists, many studies do not find strong positive effects (see, for example, White & Pitts, 1998).

Systematic reviews and meta-analyses provide the strongest evidence regarding the overall likely effectiveness of interventions. For this reason, our review focuses on meta-analyses and other summative reviews wherever possible.

The following policies, programs and interventions are reviewed: school-based drug education; mass media campaigns; community strengthening (other community initiatives); selective prevention; guidelines and information; alcohol and other drug treatment; regulations restricting supply and availability; harm reduction; and other interventions.

4.1 School-based drug education

School-based programs to reduce alcohol, tobacco and drug use have been widespread since the 1970s. Originally concentrated on the provision of education and information alone, the variety of programs has progressed to be more focused on personal development (known as 'affective education') and social skills training. The more well-known and promoted school-based programs that use a social learning framework and contain multiple components include Life Skills Training (Botvin & Kantor, 2000), the DARE programs, Project ALERT (Ellickson, McCaffrey, Ghosh-Dastidar & Longshore, 2003) and Life Education (Australia) (2010). The common elements within such programs include alcohol and drug awareness education, social and peer resistance skills, normative feedback, and psychosocial skills. Programs vary in the extent to which they are delivered by teachers, external presenters, peers or police officers. They also vary in terms of when they are delivered (to which grade or class level), and the program length.

There have been two relevant Cochrane systematic reviews of school-based alcohol and other drug prevention interventions: one in relation to alcohol (Foxcroft & Tsertsvadze, 2011) and one in relation to illicit drugs (Faggiano et al., 2008).

Foxcroft and Tsertsvadze (2011) found 53 studies of school-based universal prevention for alcohol. Six out of 11 studies that used alcohol-specific interventions showed effectiveness relative to standard curriculum. Fourteen out of 39 studies that examined generic interventions, including such programs as life skills training, showed effectiveness regarding alcohol. Some studies demonstrated no effects. Those studies that had positive effects largely concentrated on outcome variables: drunkenness and binge drinking. The authors of the systematic review conclude, in relation to schools-based alcohol prevention programs, that 'current evidence suggests that certain generic psychosocial and developmental prevention programs can be effective' (Foxcroft & Tsertsvadze, 2011, p. 2).

The systematic review of school-based illicit drug prevention programs (Faggiano et al., 2008) located 32 studies to include in their review, the vast majority of which (n=28) hailed from the United States. They found positive effects for knowledge-based programs in increasing knowledge (although note that the relationship between increased knowledge and subsequent drug use is not clear), and positive effects for skills-based programs. However, the majority of the studies measured outcomes immediately after (n=18 studies) or at one year (n=13 studies) post-intervention. They concluded that 'skills-based programs appear to be effective in deterring early-stage drug use' (p. 1). Gandhi et al. (2007) reviewed the various lists of best practice school-based prevention programs, noting that 'we are disturbed by the frailty of evidence for some of the 'proven' programs' (p. 65).

Specific to Australia, Teesson and colleagues (2012) reviewed Australian school-based alcohol and drug prevention programs. Five of the seven programs were successful in reducing alcohol, cannabis and tobacco use, notwithstanding modest effect sizes. The programs included SHARP, Climate Schools, the Gatehouse project and Life Education (see Teesson et al., 2012, for details). More recent research with the Climate Schools program is currently examining combining the Climate Schools internet-based approach (universal prevention) with a targeted, selective program that focuses on high-risk personality traits (the program is called 'Preventure'). Both Climate Schools and Preventure have been shown to be efficacious in isolation (see Newton, Teesson, Barrett, Slade & Conrod, 2012). It is hypothesised that the combination of programs will result in better outcomes (Newton et al., 2012).

Given that the prevalence of cannabis use is high among young people, targeted efforts to prevent initiation to cannabis use in schools have been developed in Australia (e.g. 'Cannabis and Consequences'; 'Candidly Cannabis', 'Cannabis: Know the Risks'). There have been no comparative evaluations of these resources, but it has been recommended that for older students (Years 9 to 12) cannabis-specific programs are likely to be required (Bull, Arcuri & Dillon, 2009).

School-based drug education is one specific intervention delivered in school settings. Schools are also social environments, and the associated policies in schools regarding alcohol, tobacco and other drugs may have an impact on the behaviour of young people. In a review, Evans-Whipp and colleagues (2004) noted large variations in school policies. At the time of that paper (2004), there was emerging evidence that strictly enforced tobacco policies had a positive impact on tobacco use; how this may apply to alcohol and other drugs is less clear.

Across all types of school-based drug prevention, the program with the highest level of support is the Life Skills Training Program (Botvin & Kantor, 2000). A number of reviews conclude that programs that are generic psychosocial interventions are the most effective (Foxcroft & Tsertsvadze, 2011; Tobler et al., 2000). Multi-component programs that employ interactive components (rather than merely 'chalk and talk') have been shown to be most effective. Any investment in school-based prevention interventions would be best modelled on these programs. Awareness of some of the barriers and challenges to implementing evidence-based school drug education has been well documented (Cahill, 2007).

4.2 Mass media campaigns

A systematic review of the effectiveness of mass media campaigns (in this instance, termed anti-illicit drug public service announcements) by Werb et al. (2011) found seven randomised trials and four observational trials. The results indicated that public service announcements had a limited impact on the intention to use illicit drugs or on illicit drug use among the target population. Only one of the seven randomised trials showed a statistically significant positive effect. In one example of the more common negative findings, evaluation of the 'Montana Meth Project' found that the graphic advertising campaign to deter methamphetamine use among young people was ineffective (compared to an unexposed control comparison: Anderson, 2010). Importantly, two randomised controlled trials in the systematic review found evidence that public service announcements increased intention to use drugs.

Despite the ubiquity of mass media campaigns as an intervention, there remains limited research examining the relationship between mass media campaigns and actual alcohol or drug use behaviour. The United States Government Accountability Office commissioned a review of the national youth anti-drug media campaign. The evaluation found that the youth anti-drug campaign had no impact on youth drug use either during the entire period of the campaign (1998 to 2004), or between 2002 and 2004 when it focused on cannabis. The evidence was judged credible; as a result, the Government Accountability Office recommended limiting budget appropriations for such campaigns in the future (United States Government Accountability Office, 2006).

In a detailed examination of the relationship between anti-drug television advertising exposure and drug-related behaviour,[3] Terry-McElrath and colleagues (2011) found a complex set of relationships. The expected association between greater exposure to anti-drug advertisements and drug use occurred only for certain age groups, with certain drug types and with certain advertisement taglines. For example, for middle school children and cannabis use, there were no significant relationships; however, for high schools students, exposure (with a particular tagline) was associated with increased cannabis and other illicit drug use. This study demonstrates the sensitivity of mass campaigns, and the possibility of iatrogenic effects must be considered.

3 Drug-related attitudes and beliefs were also examined in this study.

4.3 Community strengthening (and other community initiatives)

Community-wide interventions, such as Strengthening Families (Spoth & Molgaard, 1999) and Communities that Care (Hawkins et al., 2008), appear to have a strong evidence base. The best evidence is for *multi-component community-wide* programs. Multi-component programs include a schools-based component built around life-skills training, a media advocacy program, parenting and family support programs, and environmental measures (for example, decreasing access to alcohol and other drugs) (Biglan, Ary, Smolkowski, Duncan & Black, 2000; Cuijpers, 2003; Perry et al., 2002). Multi-component programs appear to have the highest evidence base among universal prevention programs.

Strengthening Families and Communities that Care, both multi-component community-based programs, have been found to have significant positive effects on alcohol and other drug use (Biglan et al., 2000; Brown, Hawkins, Arthur, Briney & Fagan, 2011; Cuijpers, 2003; Perry et al., 2002). The effectiveness of multi-component prevention programs is reinforced in the review by Gates and colleagues (2006). This Cochrane review of 17 studies that targeted people under the age of 25 and with interventions delivered in a non-school setting concluded that there was some evidence to support family interventions, but as with many Cochrane reviews, a quantitative assessment of the strength of the evidence was not possible.

4.4 Selective prevention

The above interventions (school-based drug education, mass media campaigns, community strengthening) are targeted at the entire population of young people (universal prevention). It has been argued that a better use of finite resources is to target prevention activities only at those 'at risk' populations. Work by Conrod and colleagues (2006) identified the importance of understanding individual risk factors. In their work personality factors have been identified as a target for intervention. These include anti-social behaviour, impulsivity, hopelessness and anxiety-sensitivity. The selective interventions include psycho-education, motivational interventions and cognitive behaviour therapy adjusted to account for the particular personality risk factors identified above. Over a number of years multiple studies have been conducted which find significant effects on alcohol outcomes (Conrod et al., 2013; O'Leary-Barrett, Mackie, Castellanos-Ryan, Al-Khudhairy & Conrod, 2010).

4.5 Guidelines and information

A commonly supported intervention is the provision of guidelines, such as safe drinking guidelines, standard drinks labelling and so on. At the time of the Babor et al. publication (2003) there was no evidence to support the effectiveness of published drinking guidelines. This appears to continue to be the case today. A recent review from the Australian Parliamentary Library (Thomas, 2012, p. 17) concluded that alcohol warning labels may 'increase awareness of the risks associated with excess alcohol consumption' but that this awareness does not translate into behaviour change. Alcohol warning labels have not been shown to alter drinking behaviour, and are generally regarded as an ineffective intervention. For young

people, De Haan and Trageton (2001) found that adolescents received a vast amount of information regarding substance use, but this information was not related to either prevalence or attitudes. A Cochrane review of printed educational materials (not specific to alcohol/drug use) concluded that printed educational materials may have a small beneficial effect on professional practice, but there was insufficient evidence to draw conclusions about any effects on patient outcomes (Giguere et al., 2012).

4.6 Alcohol and drug treatment

Alcohol and drug treatment for young people can take many different forms. Types of treatment include motivational interviewing, drug withdrawal/detoxification, residential rehabilitation programs, cognitive behaviour therapy, relapse prevention and pharmacotherapy where appropriately indicated. The evidence base for treatment interventions with young people has largely relied on the evidence base derived from adults.

Motivational interviewing has a long history and is a brief intervention delivered either alone or in conjunction with other alcohol and other drug interventions. There have been a number of systematic reviews of motivational interviewing, with the most recent (Lundahl, Kunz, Brownell, Derrick & Burke, 2010) finding motivational interviewing to be effective when compared to no intervention, but not necessarily more effective than other treatments. More specific to young people, Macgowan and Engle (2010) concluded that motivational interviewing was a 'promising' intervention with young people (but to date lacked sufficient research trials to conclude its efficacy).

A series of Cochrane reviews outline the relative effectiveness of various detoxification/withdrawal regimes, depending on the drug (Amato, Minozzi & Davoli, 2011; Gowing, Ali & White, 2006 2009; Shoptaw, Kao, Heinzerling & Ling, 2009). One Cochrane review specific to young people withdrawing from opioids has been published (Minozzi, Amato & Davoli, 2009a). The authors could locate only two randomised trials of opioid withdrawal in young people, both concerned with buprenorphine. On that basis they were unable to draw conclusions about the efficacy of this withdrawal treatment (Minozzi et al., 2009a).

Counselling interventions largely conform to the cognitive behavioural theory (CBT) approach, as this has been shown to be both efficacious and effective. In addition, young people with complex behavioural presentations can respond well to CBT (Macgowan & Engle, 2010). A number of studies of CBT addressing problem solving, anger management, and assertiveness training demonstrate positive results with young people (for example, Hollin, 1998; Sukhodolsky & Ruchin, 2006).

Therapeutic communities (TC) and other residential rehabilitation options have been evaluated. In a Cochrane systematic review of the TC literature for substance abuse, Smith, Gates and Foxcroft (2006) concluded that, based on the seven eligible studies, 'there is little evidence that TCs offer significant benefit in comparison with other residential treatment [... but] firm conclusions cannot be drawn due to limitations of existing evidence'. These results were not specific to young people.

The community reinforcement approach (CRA) is a comprehensive treatment that aims to change the reinforcement in a person's life, across multiple domains, such that non-using behaviours receive reinforcement. Counselling, job retraining, employment, financial counselling and other interventions can all form part of a community reinforcement approach. A specific version of CRA – the Adolescent Community Reinforcement Approach (ACRA) – has been developed (Garner et al., 2009; Godley et al., 2001). A number of studies describe positive processes associated with ACRA, and it is treatment recommended by SAMHSA (United States). One study has shown that ACRA is cost-effective (Dennis et al., 2004).

There are a number of family interventions, ranging from simply engaging with family members while the young person receives care, through to formal family therapy and multi-dimensional family therapy. Reviews of the effectiveness of engagement of families could not be located. For multidimensional family therapy, the existing literature suggests positive outcomes (Liddle, 2010; Rowe, 2010).

For young people dependent on opioids, pharmacotherapy maintenance offers an opportunity to be stabilised on a legal, safe medication dose while making the necessary lifestyle changes to reduce or cease illicit drug use. Pharmacotherapy maintenance (methadone, buprenorphine) has demonstrated efficacy, effectiveness and cost-effectiveness in adult populations (Belenko, Patapis & French, 2005; Connock et al., 2007; Harris, Gospodarevskaya & Ritter, 2005). A Cochrane review sourced two relevant trials of pharmacotherapy maintenance for young people and, as a result of the small number of studies, could not draw any firm conclusions (Minozzi, Amato & Davoli, 2009b). But there is no reason to assume that pharmacotherapy maintenance is less efficacious or effective in young people than in adults.

Online interventions are now a well-established modality for delivering treatment and may have particular appeal and greater accessibility for young people. In a special issue of *Drug and Alcohol Review* (Drug and Alcohol Review, 2009), a number of articles describe the use of new technologies. White and colleagues (2010) conducted a systematic review of internet-based interventions for alcohol. While not exclusively focused on young people, White et al. found promising results across the 17 randomised controlled trials that were reviewed with reductions in various measures of alcohol consumption.

The Australian National Council on Drugs (ANCD) published a comprehensive review of the effectiveness of compulsory treatment (Pritchard, Mugavin & Swan, 2007) which concluded that there was little evidence to support compulsory treatment. Given that it involves an incursion onto an individual's civil liberties, the requirement that the treatment be beneficial is essential. There is limited research, as summarised in the 2007 ANCD research report, to support the effectiveness of compulsory treatment. Compulsory or mandatory treatment including detention without consent has become a pronounced international issue since the United Nations issued a statement calling for the closure of compulsory treatment centres (United Nations, 2012). See, for example, Csete et al. (2011) for discussion of the issues. In a Cochrane review of compulsory treatment for schizophrenia (there has been none published on drug and alcohol treatment), the authors found no evidence to support compulsory treatment (Kisely, Campbell & Preston, 2011).

Finally, a meta-analysis across multiple types of outpatient treatment for adolescent substance abuse found positive treatment effects (Tanner-Smith, Wilson & Lipsey, 2013). This meta-analysis built on an earlier one by Waldron and Turner (2008), which also found positive treatment effects. The Tanner-Smith et al. (2013) review included both randomised controlled trials and quasi-experimental studies, and summarised results across 45 studies. Most studies compared two different outpatient treatments, thus one cannot draw firm conclusions about which types of treatment for adolescents are most effective. Nonetheless the authors conclude that family therapy is the intervention with the strongest evidence of effectiveness.

4.7 Regulations restricting supply and availability

Restrictions on the manufacture, distribution and sale of alcohol products have been shown to be effective. As reviewed by Anderson and colleagues (2009), modelling work has shown that higher prices for alcohol are associated with reductions in both acute and chronic alcohol-related harms.

There is also evidence that minimum drinking age laws do have an impact on alcohol consumption (Anderson et al., 2009). An analysis of a series of case studies across the United Kingdom that were all aimed at preventing the sale of alcohol to under-age patrons found that multi-agency approaches were most successful (coordination and cooperation between licensees, local councils and enforcement bodies) (Research by Design Ltd, 2009). These were not controlled trials, but demonstrate the perceived value of multi-agency approaches to reduce under-age purchase of alcohol.

While there is technically no legal drinking age in Australia, there is a legal purchase age. Thus, raising the legal drinking age refers in Australia to raising the legal purchase age. Research examining the impact of raising the legal drinking age has shown that an older legal age is associated with reductions in car accidents, emergency department admissions and incidents of drink driving (Kypri & Langley, 2006).

Overall, the weight of evidence suggests that market measures – such as regulation, pricing strategies, licensing controls on availability – all influence alcohol consumption in a manner where greater regulation is associated with lower consumption (Anderson & Baumberg, 2006; Anderson et al., 2009; Babor et al., 2003). Specifically in relation to young people, Paschall and colleagues (2009) found that countries with greater alcohol regulation and control had lower prevalence of alcohol use among 15–17 year olds (however, some of these significant relationships disappeared when overall population consumption was taken into account, suggesting that general population alcohol consumption may override the impact of alcohol control policies for young people).

In relation to regulation for illicit substances, such as cannabis, ecstasy and heroin, there is little direct research evidence. This is partly because no country to date has legalised and regulated these substances, and hence evidence is largely drawn from hypotheses about consumption under different regulatory regimes. There are, however, a wide number of decriminalisation options that have been evaluated, including the experiences in The Netherlands

and Portugal (see Hughes & Stevens, 2012; Hughes & Wodak, 2012). There is no evidence that decriminalisation policies have resulted in significant negative impacts (such as a drug epidemic). Indeed, there have been a number of benefits recognised within decriminalisation regimes, notably the substantially reduced burden on the criminal justice system.

Regulation of emerging psychoactive substances (EPS) is a relatively recent area of research interest. These substances, variously referred to as legal highs, synthetic drugs, research chemicals, and novel psychoactives (Corazza, Demetrovics, van den Brink & Schifano, 2013) are designed to mimic the effects of prohibited drugs without actually containing controlled substances. This has resulted in significant regulatory changes, whereby as new compounds are detected, they are progressively banned. The net result is new compounds are continuously being synthesised, and law enforcement agencies are constantly one step behind in introducing regulatory controls. Dr Griffiths, head of the European Monitoring Centre on Drugs and Drug Addiction, has described the situation as one of a 'cat and mouse game' (Griffiths, 2012). Research examining the impact of banning these substances has shown some declines in use (Wilkins & Sweetsur, 2012) and some temporary displacement (Van Hout & Brennan, 2012), but on the whole researchers have concluded that regulation is largely ineffective (Ayres & Bond, 2012; Measham, 2011; Winstock, Mitcheson & Marsden, 2010; Wood, Measham & Dargan, 2012). The option to regulate EPS as foodstuffs and ensure greater quality control is emerging as a possible alternate policy response.

4.8 Harm reduction

There are a number of harm reduction interventions, not necessarily specific to young people but accessible and used by young people. Here we briefly summarise the existing efficacy and effectiveness research for needle and syringe programs, regulated injecting rooms and the provision of pill testing kits.

Needle and syringe programs (NSPs) have been proven to be highly effective and cost-effective services that reduce the transmission of blood-borne viruses, protecting both individual drug users and the community (National Centre in HIV Epidemiology and Clinical Research, 2009; Wodak & Cooney, 2006). There is a wealth of literature examining NSPs. For example, as at 2005, 344 articles were sourced, 120 of which concerned effectiveness and/or efficacy of NSPs (Ritter & Cameron, 2005). Seminal research demonstrating the efficacy of NSPs in reducing HIV seroconversion includes work by Des Jarlais et al. (1996), Kaplan and Heimer (1992), and Vlahov and Junge (1998). Given that we have now had NSPs for many years in some countries and cities, it is possible to study the incidence declines in HIV associated with harm reduction measures in new cohorts since NSPs became available (for example, Goldberg et al., 2001). MacDonald, Law, Kaldor, Hales and Dore (2003) compared 99 cities in relation to their HIV prevalence, and found that those cities with NSPs had an overall decrease of 18.6 per cent in HIV prevalence, whereas those cities without NSPs had an overall increase of 8.1 per cent (see also Raboud, Boily, Rajeswaran, O'Shaughnessy & Schechter, 2003). Not all the research on the impact of NSPs on HIV infection rates has been positive. In spite of Vancouver's NSP program, an HIV epidemic broke out among people who inject drugs approximately five years after implementation (Strathdee et al., 1997).

NSPs have been shown to be cost-effective. A number of studies, using a variety of methods, have shown value for money for NSPs (Holtgrave, Pinkerton, Jones, Lurie & Vlahov, 1998; Laufer, 2001; Lurie, Gorsky, Jones & Shomphe, 1998; Normand, Vlahov & Moses, 1995; Reid, 2000). However, Pollack's (2001) analysis of cost-effectiveness of NSPs for HCV prevention finds that NSPs are not cost-effective for HCV (the cost per averted HCV case is much higher than the assumed medical costs associated with treating the HCV). This is largely because his dynamic epidemiological model does not produce substantial impacts on HCV. In a comprehensive analysis of the return on investment for NSPs in Australia, researchers calculated the numbers of HIV and HCV cases averted (32 050 for HIV and 96 667 for HCV), the expenditure on the NSP program, and treatment costs avoided (National Centre in HIV Epidemiology and Clinical Research, 2009). The results indicated that, for every dollar spent on NSPs, $27 is returned in cost savings (National Centre in HIV Epidemiology and Clinical Research, 2009).

Supervised injecting facilities (SIFs) are a well-known, and at times controversial, public policy measure to reduce the harms associated with injecting drug use. SIFs are also known as 'supervised injecting sites', 'safe/safer injecting rooms', 'medically supervised injecting centres', and variations thereof. Within SIFs, attendees are provided with clean injecting equipment, in particular sterilised needles and syringes, as well as a range of other services which may include access to health care, counselling, drug treatment and social services. Drugs are not provided to users. As of 2010, there were at least 92 such facilities operating in 61 cities worldwide (Hedrich, Kerr & Dubois-Arber, 2010). In a recent overview of the literature, 133 papers and reports providing reviews, outcome studies, economic evaluations, policy analyses and descriptions of SIFs from across the globe were retrieved (de Vel-Palumbo, Matthew-Simmons, Shanahan & Ritter, 2013). Studies of SIFs have examined a wide range of outcomes. The vast majority of the outcome studies have been undertaken on the SIFs in Vancouver (16 studies) and Sydney (10 studies). Perhaps the most crucial outcomes of SIFs are related to a reduction in overdose events, as this is one of the prime reasons for their establishment. Marshall and colleagues (2011) found a 35 per cent decrease in overdose mortality in the area around the Vancouver SIF following its opening, a larger increase than the rest of the city over the same time period. Milloy et al. (2008) have also suggested that deaths were averted due to the Vancouver SIF. In Australia, Salmon and colleagues (2010) found a significant decline in the number of opioid-related ambulance call-outs around the SIF in Kings Cross, compared with the rest of New South Wales. Other outcomes investigated include changes in injecting practices, entry into drug treatment, public amenity (for instance, a reduction in publicly discarded syringes and public drug use), and decreased crime. There have been seven separate economic evaluations of SIFs in Vancouver and Sydney. These have sought to determine the financial costs and savings associated with these facilities, generally measuring the savings associated with the number of HIV/HCV infections that are avoided by their use. Each of these assessments has shown that the savings provided by SIFs outweigh the costs, making these facilities 'cost-saving'.

Pill testing is the intuitively appealing idea of providing feedback to users on the content of pills, with the goal of potentially reducing the harm from insufficient knowledge of pill content. In 2001,[4] the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)

4 This appears to have not been updated since.

completed a report on pill testing in Europe, including an inventory of pill-testing programs across the European Union; discussion of the goals of pill testing; the conditions for successful implementation; legal issues; and the various analytic procedures (testing kits and laboratory testing) (Kriener et al., 2001). As a harm reduction intervention for individual users, pill-testing facilities should be located close to users ('on site'), and provide immediate (and accurate) feedback. This can be difficult to achieve, as documented for example in the South Australian experience with pill testing at a rave (Camilleri & Caldicott, 2005) and confirmed in the United States (Murray et al., 2003). However, in Europe, on-site use of more sophisticated testing equipment (HPLC) overcomes this problem (Kriener & Schmid, 2005).[5] Since 1992, The Netherlands has had comprehensive pill-testing facilities (Spruit, 2001). Using both on-site and laboratory-based analytic procedures with a turn-around time of a few days, the system in The Netherlands appears to operate more as a potential 'warning system' leading to campaigns about particularly dangerous products, rather than an immediate harm reduction intervention for users. The Netherlands pill-testing system has enabled drug market monitoring, for example the emergence of mephedrone (Brunt, Poortman, Niesink & van den Brink, 2011). Research reports have also outlined the extensive use of the facilities, with an average of about 275 users per month presenting tablets (Brunt, Niesink & van den Brink, 2012).

The evidence for the effectiveness of pill testing is limited. The EMCDDA report (Kriener et al., 2001) notes that the numbers of users coming to a pill-testing facility are greater than other harm reduction facilities, affording greater opportunity for interventions. As a population-level warning system, Spruit (2001) cites positive findings in relation to changes in the market; that is, those products that were identified as particularly dangerous, and the subject of warning campaigns, were eliminated from the market. The Berlin and Swiss projects reported that the actual ingredients of tested pills corresponded more and more to the expected ones over time – suggesting that pill testing might have the ability to change the black market in positive ways (Kriener et al., 2001). In relation to drug user behaviour change, one positive report from the *chEck iT* project in Austria found that 50 per cent of people said the results affect their consumption; most users will wait for a result before taking the drug; and when presented with a 'bad result', two-thirds say they will not consume the drug and will warn friends (Kriener & Schmid, 2005). On the other hand, van de Wijngaart and colleagues (1999) found that most users had never had their pills tested (53%) and the majority said it had no effect on their behaviour (84%). In a survey of non-drug users (United States college students), 19 per cent reported that they might be more likely to try ecstasy if pill testing were available (Dundes, 2003). This points to a potential iatrogenic effect,[6] and concerns about pill testing have been documented (for example, Winstock, Wolff & Ramsey, 2001). Winstock and colleagues (2001, p. 1139) argued that 'it gives an artificial shine of safety to a group of diverse drugs that remain both illicit and potentially harmful'.

5 There are continuous advances in drug testing.

6 Sampling of non-users is problematic, as it does not reflect actual behaviour, and may have a strong respondent bias effect.

4.9 Other interventions

There is a range of other interventions; for example, youth mentoring, social norms programs, drug detection dogs, and drug testing in schools. A review of youth mentoring (Thomas, Lorenzetti & Spragins, 2011) concluded from four randomised controlled trials that mentoring can reduce the rate of initiation to alcohol as well as drugs. However, the studies had methodological flaws (i.e. low baseline rates of alcohol/drug use), limiting the conclusions that could be drawn.

The 'social norms' interventions (Moreira, Smith & Foxcroft, 2009) targeted at alcohol misuse assume that young people misperceive how much their peers drink. Correcting this misperception may result in reductions in alcohol consumption. A systematic review of 22 studies found that feedback to young people (whether via the internet or mail) was 'probably' effective in reducing alcohol misuse, especially for short-term outcomes (up to three months, Moreira et al., 2009).

Drug detection dogs (known as 'sniffer dogs') are used by police throughout Australia, although implementation models differ by jurisdiction. This particular intervention has attracted criticism. A review was undertaken by the New South Wales Ombudsman (2006) which concluded that 'drug detection dogs are not an effective tool for detecting persons involved in the supply of prohibited drugs, which is the primary objective' (p. iv) and that '[t]here is little or no evidence to support claims that drug detection dog operations deter drug use, reduce drug-related crime, or increase perceptions of public safety' (p. viii). Moreover, studies of regular drug users suggest that some individuals may engage in risky drug-using behaviour, such as hastily consuming drugs in their possession when sighting sniffer dogs, which is contrary to harm minimisation objectives (Dunn & Degenhardt, 2009; Hickey, McIlwraith, Bruno, Matthews & Alati, 2012). Despite these criticisms, sniffer dogs continue to be a routine part of supply reduction strategies in policing, and retain a high profile in the media.

Drug testing in schools does not routinely occur in Australia. This is consistent with the evidence base that 'indicates a strong case to be made against drug detection and screening strategies being utilised in the school setting' (Roche et al., 2008, p. ix). In their comprehensive review of the issues, Roche et al. (2008) note that drug testing is an ineffective deterrence mechanism; there are better opportunities for school-based interventions; practical problems with testing equipment reliability and cost; and legal and moral issues abound.

4.10 Summary of efficacy/effectiveness review

The table below summarises in simple terms the extent to which the variety of interventions and control measures are supported by an evidence base. It should be noted that much of the literature is not specific to young people, but is drawn from studies of adults.

Intervention	Evidence for efficacy/ effectiveness	Notes
School-based drug education	✓	Generic psychosocial interventions show best results
Mass media campaigns	×	No effect on behaviour, iatrogenic effects shown in some studies
Community strengthening	✓✓	Strong evidence base
Guidelines and health warnings	×	No evidence of effectiveness. No youth-specific research
Motivational interviewing	✓	Sound evidence base. Limited youth-specific research
Detoxification	✓	For achieving neuro-adaptation reversal, sound evidence base. Limited youth-specific research
Counselling and CBT	✓✓	Sound evidence base. Limited youth-specific research
Therapeutic communities	✓	Moderate evidence base. No youth-specific research
Community reinforcement approach	✓✓	Adolescent-specific program; strong evidence base
Family therapy	✓✓	Strong evidence base
Pharmacotherapy maintenance	✓✓	Strong evidence base. Limited youth-specific research
Online interventions	✓	Moderate evidence base. No youth-specific research
Compulsory treatment	×	No evidence for impact. No youth-specific research

Intervention	Evidence for efficacy/ effectiveness	Notes
Restrictions on alcohol distribution, sale	✓✓	Strong evidence base. No youth-specific research
Minimum age drinking laws	✓✓	Strong evidence base, youth-specific
Higher alcohol price	✓✓	Strong evidence base. No youth-specific research
Legalisation and regulation of currently illicit drugs	O	Absence of evidence
Decriminalisation of illicit drugs	✓	Moderate evidence base. No youth-specific research
Banning new psychoactive drugs as they appear	×, O	Absence of evidence; where evidence exists, no impact in long term. No youth-specific research
Needle and syringe programs	✓✓	Strong evidence base. No youth-specific research
Supervised injecting facilities	✓	Moderate evidence base. No youth-specific research
Pill testing	✓	Moderate evidence base. No youth-specific research
Youth mentoring	✓	Moderate evidence base
Social norms programs	✓	Moderate evidence base
Drug detection dogs	×	Evidence for negative impacts. No youth-specific research
Drug testing in schools	×	Evidence for no impact

✓ = evidence of efficacy/effectiveness

× = evidence of negative effects; no impact

O = absence of evidence

This review of the existing research has shown:

- variation in the extent to which young people perceive alcohol and drugs to be a significant social problem
- young people access multiple sources of information about alcohol and drugs, the most significant of which appears to be the internet
- given little experience with alcohol or drug treatment, opinions were not strongly formed
- support for unbiased and balanced drug education, and less support for mass media campaigns (which are not perceived to be effective). This is consistent with the efficacy and effectiveness research
- perception that guidelines were not necessarily relevant, also consistent with the effectiveness research
- varied opinions about the legalisation of drugs like cannabis
- lower support for increasing the legal drinking age
- little support for restrictions on service of alcohol to intoxicated patrons, reduced opening hours, and other monitoring of licensed premises. This is inconsistent with research of effectiveness.

There has not been a comprehensive national survey of young Australians' opinions and attitudes towards alcohol and other drugs and the variety of policy options, interventions and control measures. The aim of this study was to describe and better understand young people's ideas about responding to alcohol and other drugs. In doing so, it is hoped that the voices of young Australians may be included in alcohol and other drug policy processes and deliberation. As in all policy arenas, sufficient consultation with all relevant stakeholders is an important part of the process of effective policy making – the voices of young people are critical in helping to develop successful responses to alcohol and other drug issues in Australia.

5. Methods

Young Australians' ideas and opinions on alcohol and other drug issues were measured using an online survey. This section describes the development of the survey instrument; the online platform and recruitment; and statistical analysis approaches. This research was approved by the University of New South Wales Human Research Ethics Committee. Informed consent was obtained from all participants.

5.1 Survey development

As a first step, the domains to be covered in the survey were established. The domains included basic demographic information, alcohol and drug use information and attitudes/opinions towards alcohol and drug policy options.

Table 1: Survey domains

Domain	Area of enquiry; type of question
1. Attitudes to drugs and perceptions of risk	Cognitive beliefs and emotional responses about drug use Risks associated with alcohol/drug use
2. Choosing between broad policy options	Choosing between prevention, law enforcement, treatment, other measures
3. Perceptions about types of interventions	Attitudes to specific interventions: extent of support or agreement with different types of interventions
4. Sources of information about drugs	Most used sources of information
5. Alternate responses	Suggestions for alternate responses
6. Demographics	Gender, age, alcohol & drug use, education, location

It was preferred that questions were sourced from previously undertaken surveys of youth populations from Australia and overseas. This approach aimed to ensure as much as possible that the questions produced reliable and valid responses, and also allowed potential comparison between this survey and previous surveys. Sources of questions included the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) Evaluation Bank, the European School Survey Project on Alcohol and Other Drugs (EPSAD), and the National Drug Strategy Household Survey (NDSHS). In some instances it was not possible to source pre-existing questions on some of the topics that were covered in this survey. In these cases, new questions were created. The study's Reference Group reviewed a potential pool of questions, with multiple alternatives, and provided advice about the final selection of the questions. New questions were added based on the Reference Group suggestions, and some language was adapted to increase relevance and aid the understanding of young people.

Overall the survey had to be kept brief, with an under 15-minute completion time. Many questions were therefore not able to be included due to time and space. Examples of these were: detailed information about frequency of drug use; ranking of concern about alcohol and drug issues against other social issues (e.g. environment); cultural background; gender identity; and opinions towards tobacco.

The following table provides the domains and interventions covered by the survey and the source surveys used to derive the questions.

Table 2: Survey instrument domains and interventions, and source surveys used to derive the questions

Interventions	Existing question?	Source
Attitudes to drugs and perceptions of risk		
Attitudes and risks about alcohol	Yes	European School Survey Project on Alcohol and Other Drugs (ESPAD)
Attitudes and risks about drugs	Yes	European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)
Broad policy options		
Three most effective ways for public authorities to reduce drug problems?	Yes	Flash Eurobarometer (European Commission)
Broad opinions about treatment, education	Yes (some language adapted)	Health Research Board Dublin; and adapted North Dakota Community Readiness Survey
Alcohol regulation		
Regulation of sale	Yes	National Drug Strategy Household Survey (NDSHS)
Price/taxation	Yes	NDSHS
Legal drinking age	Yes	NDSHS
Regulation of advertising/sponsorship	Yes	NDSHS
More alcohol-free events/zones	Yes	NDSHS
Information/labelling	Yes	NDSHS

Interventions	Existing question?	Source
Prevention		
School-based drug education	Yes	Adapted North Dakota Community Readiness Survey
Mass media campaigns	Yes	North Dakota Community Readiness Survey
Reducing poverty/increasing employment	Yes	Flash Eurobarometer
Treatment		
Detoxification/withdrawal	Yes	NDSHS
Counselling	No	New question derived
Residential rehabilitation	No	New question derived
Seeing a doctor	No	New question derived
Opioid substitution therapy	Yes	NDSHS
Youth worker; support worker; outreach worker	No	New question derived
Compulsory treatment	No	New question derived
Harm reduction		
Needle and syringe programs	Yes	NDSHS
Safe injecting facilities	Yes	NDSHS
Regulated injecting rooms	Yes	NDSHS
Drug-free chill-out zones	No	New question derived
Laws/law enforcement		
Legalisation	Yes	NDSHS
Various decriminalisation options	No	New question derived
Drink driving	Yes	NDSHS
More police on streets	Yes	New question derived
Emerging substances	Yes	Flash Eurobarometer

Interventions	Existing question?	Source
Other responses		
Sniffer dogs	No	New question derived
Visible police presence around licensed venues	No	New question derived
Availability of pill testing	No	New question derived
ID scanners at entry to bars/nightclubs	No	New question derived
Drug testing at work or school	No	New question derived
Banning the purchase of drugs over the internet	No	New question derived
Sources of information	Yes	Flash Eurobarometer
Open-ended questions	No	New question derived

A copy of the survey instrument is included in Appendix A.

5.2 Online platform and recruitment

The survey questionnaire was constructed using the KeySurvey tool, and was hosted online for a period of three months (the recruitment phase). This commenced on 5 September 2012 and concluded on 5 December 2012.

Advertising and promotion targeted a range of different outlets across Australia, with the aim of recruiting a broad national sample of young people. Due to the nature of the survey (online), promotion efforts largely focused on websites and email lists, as opposed to offline outlets such as street press. A major focus of advertising was through Facebook, with both an ongoing paid advertisement placed, and a Facebook page about the survey created for advertising purposes (the latter was free of charge). These Facebook advertisements were supplemented with advertising on a range of other websites, forums and email lists, most of which were targeted at young people (or those who worked closely with young people, such as youth workers). Online advertising and promotion included but were not limited to listings on: university careers noticeboard websites; TAFE careers noticeboard websites; online chat forums and blogs, e.g. Bluelight; social networking sites, e.g. Twitter; government, youth-oriented, and youth drug and alcohol service websites, which were willing to publish the link on their sites such as Australian Drug Foundation Drug Info, Australian Clearinghouse for Youth Studies, Australian Youth Forum, Youth Action Policy Association, Vibewire, Youth

Central, headspace, Dovetail and local youth centres; and email explodes, e.g. through the YouthGas and ADCA Update e-lists. A media release was also circulated nationally by the National Drug and Alcohol Research Centre's media office, which generated regional and local press coverage, and radio interviews.

The target population for this survey was a national sample of young people aged 16–25 years who resided in Australia. Respondents self-selected; that is, anybody aged 16–25 years who lived in Australia was permitted to complete the survey. The proposed sample was to include a total of at least 2000 respondents nationally, broadly representative of the population distribution of each state and territory in Australia (see table below), and evenly distributed by age and sex.

Table 3: Proposed online survey sample and demographic breakdown by Australian states and territories

State or territory	Proposed survey sample (16–25 year olds) No. of respondents	ABS Estimates (16–25 year olds) Proportion %
New South Wales	640	32
Victoria	500	25
Queensland	400	20
Western Australia	220	11
South Australia	140	7
Tasmania	40	2
Australian Capital Territory	40	2
Northern Territory	20	1
Total	**2000**	**100%**

We also monitored alcohol and drug use rates throughout the three-month recruitment period. We were mindful that respondents were generally more experienced with alcohol and drug use than had been previously surveyed in the general population National Drug Strategy Household Survey (NDSHS) (see sample characteristics section for detailed analysis of the sample, and discussion of recruitment through online surveys). We therefore attempted to recruit young people who did not have past drug use experience by advertising through general youth interest websites and media, rather than heavily promoting the survey through subculture specific websites (who may have self-selected due to their interest in the drug policy content of the survey). In addition, all recruitment advertisements emphasised that

young people did not have to have tried drugs or alcohol to participate. We worked towards representativeness by ensuring that universities, youth organisations and peak bodies across multiple states and territories were contacted to promote the survey. We also partially controlled for representativeness throughout the recruitment period by adjusting Facebook advertising specifications so as to target different states, sexes and age groups where possible.

One of the first questions of the survey (after participants had read the information statement and consented to participate) asked the respondent's age, and served as a screening question. If respondents stated that they were under 16 years of age or over 25 years of age, then they were diverted away from the rest of the survey.

Respondents were permitted to leave questions blank if they wished and still complete the survey. They were also permitted to return to previously answered questions.

In addition to the online advertising, recruitment was also undertaken through the Youth Support and Advocacy Service in Melbourne, Victoria. Flyers were left in the clinic, and clients were invited to complete the survey. This phase of recruitment was undertaken to gauge the opinions of those young people currently engaged with services.

To aid in recruitment, a prize draw was also conducted (to win an iPad), with two winners drawn at random after the completion of the recruitment phase.

5.3 Statistical analysis

The final dataset was cleaned and analysed using SPSS Version 20/21. Data were analysed using descriptive statistics to describe the ideas and opinions of the Australian young people sampled. Subgroup analyses (looking for differences between subgroups of young people) used bivariate and multivariate statistics. Bivariate analyses involved chi-square tests to determine significant differences between groups.

Attitudes to drugs and alcohol scores

Two questions were used to derive individual 'attitudes to alcohol' and 'attitudes to drugs' scores, respectively drawn from European School Survey Project on Alcohol and Other Drugs (attitudes to alcohol) and the European Monitoring Centre for Drugs and Drug Addiction (attitudes to drugs) survey instruments. Scoring for both followed the method outlined by the original EMCDDA Attitudes to Drugs instrument <http://www.emcdda.europa.eu/html.cfm/index3426EN.html> where items were re-coded for directionality, then an average attitudinal score for each individual respondent was calculated. Scores can range between 1 and 5, where a score of 5.00 indicates a favourable or positive attitude, while a score of 1.00 demonstrates a negative attitude.

Alcohol and drug use categories

Alcohol use: the questionnaire asked about frequency of alcohol use among those who had used alcohol in the last 12 months, coding responses into seven alcohol frequency options (daily; 5–6 days per week; 3–4 days per week; 1–2 days per week; 2–3 days per month; about 1 day a month; less often). The daily, 5–6 days per week, 3–4 days per week and 1–2 days per week frequencies all represent at least or greater than weekly consumption. Hence we combined the first four response options into 'weekly or more alcohol consumption' category (n=901). The remaining three categories were combined into 'less than weekly alcohol consumption' (n=1207). (We also considered another option of grouping those who had consumed alcohol into daily, weekly and less than weekly consumption categories; however, the sample size for daily consumption was statistically too small to conduct analyses.)

For the analyses in this report, we categorised the whole sample of young people surveyed into three groups based on their alcohol use experience. The three groups were: those who have not consumed alcohol in the last 12 months (including those who have never consumed alcohol) (n=200); those who have consumed alcohol in the last 12 months and consume alcohol less than weekly (1207); and those who have consumed alcohol in the last 12 months and consume alcohol at least weekly (n=901).

Drug use: the questionnaire asked respondents whether they had ever used a drug, and, for those who selected one or more illicit drugs, whether they had used that drug in the last 12 months. The proportions of participants who said they had used a particular illicit drug in last 12 months, as compared to those who had used an illicit drug in their lifetime but not recently, are presented in Table 7. Our intention in categorising the sample into groups according to drug use experience was to capture the influence of experience of illicit drug use on young people's opinions about drug policy, during this formative life period. The young people surveyed in this sample are at the age that people are most likely to take up, experiment with and try different drugs. Given the age range of 16–25 years, recent use was not considered the most relevant measure of drug use experience. After discussion, it was decided that as we were interested in how drug use experience may drive opinions, lifetime use was the more relevant measure as it captured the 'experimenting youth' phenomena and the influence of those experiences (even if limited) on opinions. There is also less risk of recall error when asking young people about their lifetime drug use experience (as compared to an older general population sample). We acknowledge the disadvantage of using lifetime drug use (never/ever used) rather than recent use as our chosen categorisation – it is potentially over-inclusive of drug use experience, insofar as it includes respondents who are not currently using drugs and who may have tried a substance only once. However, if we used last 12 months' use as the grouping measure, this would have also included respondents who had used a drug only once (potentially in their lifetime given the young age of this sample). Thus all analyses categorised participants based on their illicit drug use experience into 'never used an illicit drug' (n=581) and 'ever used an illicit drug' (n=1754) to capture a range of experience and consider the influence of that experience on opinions.

Multinomial regressions – predictors of opinions

We created a more finite list of questions for more detailed analysis through multinomial logistic regression. Opinions on the following questions were selected for these analyses:

1. Increasing the price of alcohol
2. Restricting late night trading of alcohol
3. Drug education in schools helps to prevent young people from using drugs
4. Services that provide a place to stay for a long time (rehabilitation)
5. Drug sniffer dogs in public places
6. Regulation of new substances
7. Legalisation of cannabis
8. Tough measures against drug traffickers
9. Banning the purchase of drugs over the internet.

These were chosen because:

- They represent the potential full array of interventions types: law enforcement/policing; education/prevention; treatment; harm reduction and regulation (legal status and price).
- They cover both drugs and alcohol.
- They are questions where there are diverse opinions (i.e. not where the vast majority of participants expressed support).

The multinomial logistic regressions were used to assess which characteristics were most predictive of opinions. The variables that were included as predictors were: age; gender; alcohol use; illicit drug use; help-seeking; attitudes towards alcohol; and attitudes towards drugs. The sample size allowed regression models to be constructed with an adequate number of predictor variables for this study. The multinomial regressions used the backward elimination method – all variables were entered and a backward elimination method used to remove those variables that did not add significant predictive power to the regression.

Significance levels

Due to the large sample size, many comparisons (chi square) will reach statistical significance at the usual $p<0.05$ level. This is unlikely to reflect meaningful difference. In addition, due to the multiple statistical analyses, a Bonferroni correction (adjusting the p value) is required in this circumstance. We took a conservative approach, adjusting for the multiple tests, plus establishing that less than a 5 per cent difference in scores was unlikely to be meaningful. Hence the statistical significance level was determined to be $p<0.0001$. This is a highly conservative p value, but as will be seen in the results, there remain statistically significant differences between groups, even at this level. The significance level for analyses of the attitudes to drugs and attitudes to alcohol scores (Mann Whitney U test) was also set at $p<0.0001$. The significance level for the multinomial logistic regressions (of which there were nine) was set at the standard $p<0.05$ level.

5.4 Qualitative analysis

In addition to the quantitative data collected, the survey also collected qualitative responses to two open-ended questions. The first of these questions asked: 'What do you think should be done in your community about alcohol and/or drug-related problems?' The qualitative data collected in response to this question (n=1855 participants responded to the question) was analysed using qualitative thematic analysis. Broadly defined, thematic analysis is 'a method for identifying, analysing and reporting patterns (themes) within data' (Braun & Clarke, 2006, p. 79). An inductive approach to thematic analysis was taken; that is, the themes were linked to the data themselves (Braun & Clarke, 2006). After familiarisation with the data through immersion, initial codes were generated to draw out concepts. The analytic process was iterative, and themes were reviewed throughout.

The qualitative data have been used in different ways throughout the report.[7] Firstly, responses offered by participants were purposively selected from the thematically coded sample to supplement and more fulsomely understand the opinions expressed in the quantitative results. Secondly, analysis of three of the identified themes has been presented. Finally, participants' ideas and insights drawn from the thematic analysis undertaken have been used to enrich our discussion of the findings.

7 Participants' responses were spell-checked in some cases for improved readability.

6. Sample characteristics

Overall, 3326 respondents entered the survey (that is, 3326 people answered the first question: Are you male or female?).

To be included in the final results, respondents had to answer the question regarding their lifetime alcohol and other drug use, which appeared towards the end of the survey. If respondents did not answer this question, they were excluded from the final analysis.

Once missing data were excluded, 2335 completed questionnaires remained (70%), and this sample formed the basis of the analyses that follow.

6.1 Gender distribution

Of the final sample of 2335 Australian young people, 61.7 per cent were male (n=1441) and 38.3 per cent were female (n=894). Surveys of this kind usually over-represent females; however, in this case more males than females participated in the survey.

6.2 Age distribution

As can be seen in Table 4, recruitment achieved a good distribution of ages across the sampling frame. Participants aged 20 years formed the largest single age group within the sample (13.3%). A total of 25.9 per cent of respondents were aged 18 years or under. This gives us a statistically appropriate sample size to analyse the sample by comparing two age groups: under 18 years of age; and 18 years of age and over. Compared with the distribution of the general population (see Table 4, last column) there was an oversampling of 19–21 year olds, but otherwise the distributions are broadly representative of the Australian youth population (Australian Bureau of Statistics, 2012).

Table 4: Age distribution of survey participants, compared to Australian Bureau of Statistics estimates

Age	Number of respondents (n=2335)	Proportion %	ABS figures %
16	162	6.9	9.3
17	227	9.7	9.3
18	218	9.3	9.4
19	282	12.1	9.6
20	310	13.3	10.0
21	273	11.7	10.4

Age	Number of respondents (n=2335)	Proportion %	ABS figures %
22	246	10.5	10.4
23	220	9.4	10.4
24	209	9.0	10.5
25	188	8.1	10.6

6.3 Location of residence

Three-quarters of participants (75.8%) were from New South Wales, Victoria or Queensland, the three most populous states in Australia. The distribution of the sample across the states and territories is broadly representative of the population distribution of young people throughout Australia, as shown in Table 5 by comparing the sample to Australian Bureau of Statistics estimates.

The majority of respondents said they resided in a metropolitan area (67.6%), while one-quarter (24.3%) were from a regional centre, and 7.7 per cent said they lived in a rural area.

Table 5: State or territory of residence of survey participants, compared to Australian Bureau of Statistics estimates

State/territory	Number of respondents (n=2335)	Proportion %	ABS figures %
NSW	826	35.4	31.2
VIC	561	24.0	25.2
QLD	383	16.4	20.3
WA	201	8.6	10.9
SA	170	7.3	7.2
ACT	113	4.8	2.0
TAS	52	2.2	2.1
NT	23	1.0	1.2

6.4 Education and work

Overall, the sample was highly educated. The majority of participants (80.8%) said they had completed Year 12. One-quarter of the sample (26.3%, n=613) were still at school.

Many of the young people surveyed were undertaking or had completed a trade certificate or other higher educational qualification. Over one-third (39.4%, n=918) were currently undertaking a higher qualification. A further 9.8 per cent (n=227) had completed a trade/technical qualification, and 32.7 per cent (n=760) had completed a university or college qualification.

Most of the young people surveyed reported that they were currently engaged in education and/or work activities (see Table 6). One-fifth (20.4%) of participants worked full time, while 14.7 per cent said that they were engaged in part-time or casual work. One-quarter of participants studied full time (23.2%). One-third (33.7%) said they were engaged in both work and study. Only 3.2 per cent of participants said they were currently not employed and not studying.

Table 6: Current employment and study status

Work/study	Number of respondents (n=2331)	Proportion %
Both work and study	786	33.7
Full-time study	542	23.2
Full-time work	476	20.4
Part-time/casual work	343	14.7
Not employed and not studying	74	3.2
Part-time study	44	1.9
Other	40	1.7
Home duties	26	1.1

6.5 Alcohol and drug use

Our sample was very experienced in alcohol and other drug use. The majority of young people who completed the survey reported having consumed alcohol at least once in their lifetime (95.1%). A substantial proportion of participants also reported having consumed illicit drugs including cannabis (71.9%), ecstasy (47.7%) and hallucinogens (41.3%) (see Table 7). Participants were also asked to specify any other drugs that they had used in their lifetime. Responses to this question are presented in Appendix B. When asked to nominate 'other' drugs they had used in their lifetime, 11.5 per cent (n=269) of participants nominated other drugs including new and emerging substances such as 2CB, kronic and substances identified as 'research chemicals'. These substances, which are chemically different but have similar effects to other prohibited drugs, are sometimes referred to as legal highs, drug analogues, new psychoactive substances, designer drugs, herbal highs, research chemicals, or bath salts. Finally, a small number of participants (n=95, 4.1%) said they had never consumed alcohol or any other drug in their lifetime.

Compared to 16–25 year olds surveyed in the 2010 National Drug Strategy Household Survey (NDSHS) (Australian Institute of Health and Welfare, 2011a), more participants in our sample reported that they had ever used alcohol or other drugs. Previous online surveys of young Australians have also found higher rates of reported illicit drug use than in the NDSHS (e.g. Hughes et al., 2010). This may be due to the difference between recruitment methods: online surveys versus self-completed or telephone surveys. The NDSHS recruits a representative sample of the Australian population using 'drop and collect' surveys and computer-assisted telephone interviews, which in the past have excluded people who do not have a fixed telephone line, or those who are itinerant for example. Previous research has shown that the internet is a useful tool to successfully recruit young people (and young people who use drugs) because online surveys can access 'hard-to-reach' groups and facilitate convenient input by respondents (Duncan, White & Nicholson, 2003; Hughes et al., 2010; Ramo, Hall & Prochaska, 2010). It has also been suggested that participants may feel more comfortable reporting their drug use in online surveys due to the anonymity afforded online, compared to telephone or face-to-face interviews (Ramo et al., 2010). The higher rates of drug use found in this online survey (and the others cited above) attest to the possibility that this is the case.

Table 7: Lifetime and recent (last 12 month) alcohol and other drug use of survey participants (n=2335)

Drug type	Ever used %	Used in last 12 months %
Alcohol	95.1	91.4
Cannabis	71.9	58.6
Ecstasy	47.7	36.0
Methamphetamine	26.5	16.9
Cocaine	24.1	13.6
Hallucinogens	41.3	29.4
Inhalants	24.3	13.5
Heroin	2.8	1.2
Prescription drugs	32.2	22.8
Ketamine	12.8	6.5
GHB	5.6	2.2
Any other illicit drug	11.5	8.3

Of those participants who said they had consumed alcohol in the last 12 months, most said they consumed alcohol either 1–2 days per week (30.6%), or 2–3 days per month (28.6%). A very small proportion of participants (1.5%) said they consumed alcohol every day (see Table 8).

Table 8: Frequency of alcohol use, of those who had consumed alcohol in the past 12 months

Frequency	Number of respondents (n=2108)	Proportion %
Every day	31	1.5
5–6 days a week	49	2.3
3–4 days a week	177	8.4
1–2 days a week	644	30.6
2–3 days a month	602	28.6
About 1 day a month	275	13.0
Less often	330	15.7

6.6 Help-seeking among the sample

Two questions in the survey pertained to help-seeking behaviour. The first question asked whether the respondent had ever sought help relating to drug or alcohol use. The second asked whether the respondent was currently receiving help for his/her alcohol or drug use.

In our sample, 235 of the 2335 respondents had previously sought help, representing 10.1 per cent of the sample. A small group of respondents (n=33; 1.4%) said they were currently receiving help for their alcohol or drug use. The survey did not probe as to the specific nature of the past or current help-seeking, thus the responses given could cover both formal and informal help-seeking, from general health services or from specialist health services or from other services (such as school counsellors).

There was no significant difference in the rate of help-seeking among the younger respondents (under 18 years) as compared to older (18 years and older) respondents (11.5% and 10.0% respectively of the sample). There were also no significant gender differences. Approximately one in ten males and females (10.5% and 9.9% respectively) had ever sought help for their alcohol or drug use.

Unsurprisingly, those who had sought help were significantly more likely to have ever used illicit drugs (methamphetamine, ecstasy, cannabis, etc). However, there were no significant differences in alcohol consumption when comparing those who had ever sought help with those who had not (97.4 per cent of help-seekers had consumed alcohol in their lifetime, compared to 94.8 per cent who had never sought help).

6.7 Indigenous respondents

The survey was piloted with a small number of Indigenous young people, and following their feedback we proceeded with including Indigenous Australians within the sample of respondents. In total, 50 Aboriginal and Torres Strait Islander young people participated in the survey, representing 2.2 per cent of the total sample (see Table 9).

Table 9: Demographics of Aboriginal and Torres Strait Islander survey participants (n=50)

	Indigenous respondents %
Sex	
Male	42.0
Female	58.0
Age	
16	16.0
17	16.0
18	4.0
19	10.0
20	8.0
21	14.0
22	12.0
23	8.0
24	6.0
25	6.0
Place of residence	
Rural	20.0
Regional	28.0
Metropolitan	52.0
State/territory	
NSW	18.0
VIC	18.0
QLD	26.0
WA	4.0
SA	16.0
ACT	2.0
TAS	8.0
NT	8.0

Over half of Indigenous respondents had completed Year 12 (60.0%) and 34.0 per cent were still at school. One-third (34.0%) reported that they were currently undertaking a trade certificate or higher educational qualification. A further 12.0 per cent of Indigenous respondents said they had completed a trade/technical qualification, and 30.0 per cent had completed a university or college qualification. The majority of Indigenous participants were engaged in work and/or study, with 36.0 per cent engaged in work and study, 32.0 per cent working full time and 14.0 per cent studying full time. Only 2.0 per cent said they were neither currently employed nor studying.

As shown in Table 10, the majority of Indigenous participants reported experience of alcohol and other drug use in their lifetime. Almost all said they had consumed alcohol (96.0%), and two-thirds had used cannabis in their lifetime (62.0%). A substantial minority had also tried other illicit drugs including ecstasy (38.0%), prescription drugs (34.0%) and hallucinogens (30.0%). A small proportion (2.0%) of Indigenous respondents said they had never used alcohol or any illicit drug.

Table 10: Lifetime and recent (last 12 month) alcohol and other drug use of Aboriginal and Torres Strait Islander survey participants (n=50)

Drug type	Ever used %	Used in last 12 months %
Alcohol	96.0	90.0
Cannabis	62.0	40.0
Ecstasy	38.0	28.0
Methamphetamine	24.0	18.0
Cocaine	26.0	18.0
Hallucinogens	30.0	16.0
Inhalants	20.0	12.0
Heroin	4.0	0.0
Prescription drugs	34.0	24.0
Ketamine	12.0	4.0
GHB	6.0	2.0
Any other illicit drug	12.0	12.0

Comparing the reported alcohol and other drug use of the full sample (Table 7) with the Indigenous sample (Table 10), one can note that there are not substantial differences between Aboriginal and Torres Strait Islander survey participants and non-Indigenous participants. The Indigenous sample had lower lifetime cannabis use rates (62.0% compared to 71.9%), lower lifetime ecstasy use rates (38.0% compared to 47.7%), and lower lifetime hallucinogen use rates (30.0% compared to 41.3%).

It is important to note that, given the small sample sizes, these data cannot be used for epidemiological comparisons of alcohol and other drug use rates.

7. Results: Young people's opinions

In this section we describe the opinions of the sample as a whole (n=2335), across the range of alcohol and drug policy domains and interventions examined. In addition to the quantitative questions, the online survey also gave participants the opportunity to respond freely to open-ended questions. In particular, participants were asked: 'What do you think should be done in your community about alcohol and/or drug-related problems?' Below, we draw on the qualitative insights offered by participants to supplement and more fulsomely understand the opinions expressed in the quantitative results.

7.1 Opinions about alcohol and drug use

Participants were asked about their perceptions of the likelihood of a range of consequences if they were to use alcohol. The results are provided in Table 11. Overall, participants held a positive view of alcohol and its likely effects. A substantial majority of participants said it was likely that alcohol would help them 'feel more friendly and outgoing' (82.6%), 'feel relaxed' (78.9%), 'feel happy' (74.1%) or 'have a lot of fun' (72.3%). Some short-term negative consequences were also perceived as likely; for example, getting a hangover (51.1%) and feeling sick (40.8%). There was heterogeneity of opinion within the sample in relation to some consequences; for example, 39.2 per cent of the sample thought that it was likely that alcohol would 'harm my health', while 35.9 per cent perceived health harms as being unlikely. Similarly, 35.1 per cent said it was likely they would 'do something I would regret', while 36.8 per cent of respondents perceived this as unlikely. Only a small proportion of the sample responded 'Don't know' to the likelihood of each of the consequences.

Table 11: How likely is it that each of the following consequences would happen to you personally, if you were to use alcohol?

	Likely %	Neither likely or unlikely %	Unlikely %	Don't know %
Feel relaxed (n=2326)	78.9	8.1	10.7	2.2
Get into trouble with the police (n=2311)	11.0	11.0	76.6	1.4
Harm my health (n=2325)	39.2	23.4	35.9	1.5
Feel happy (n=2328)	74.1	16.6	7.4	1.9
Forget my problems (n=2327)	46.8	23.2	27.8	2.2
Not be able to stop drinking (n=2320)	14.2	13.4	70.4	2.0
Get a hangover (n=2323)	51.1	18.1	28.9	1.9
Feel more friendly and outgoing (n=2322)	82.6	9.4	5.7	2.2

	Likely %	Neither likely or unlikely %	Unlikely %	Don't know %
Do something I would regret (n=2321)	35.1	26.4	36.8	1.7
Have a lot of fun (n=2322)	72.3	19.4	6.2	2.1
Feel sick (n=2321)	40.8	28.1	29.5	1.6

We derived a summary attitudinal score for each respondent[8] (see Table 12). When the summary scores were compared, we found no significant difference between the attitudes of males and females. There was also no significant difference when comparing the attitudes of participants under 18 years of age, with those 18 years of age and older.

There was however a significant difference in attitudes when we compared the responses of different groups according to their frequency of alcohol use. Those who had not consumed alcohol in the last 12 months (including those who had never used alcohol) had a more negative attitude towards alcohol, compared to those who used alcohol less than weekly and those who consumed alcohol at least weekly in the last 12 months.

Table 12: Computed attitudes towards alcohol score
(higher number = more favourable or positive attitude)

Males	3.49
Females	3.55
No alcohol last 12 months	2.85
Used alcohol at less than weekly	3.53*
Used alcohol at least weekly	3.61*
Under 18 years of age	3.49
18 years of age or over	3.52

* $p<0.0001$

8 Following the principles of the scoring method used by the EMCDDA 'Attitudes to Drug Use' instrument, <http://www.emcdda.europa.eu/html.cfm/index3426EN.html>, we computed an overall attitudinal score for each individual. A score of 5.00 indicates a favourable or positive attitude, while a score of 1.00 demonstrates a negative attitude.

Participants were also asked about their attitudes to drugs. As shown in Table 13, overall the sample had positive attitudes towards drug use. The majority of participants agreed that 'using drugs can be a pleasant activity' (73.9%), that 'many things are much more risky than trying drugs' (66.9%), and that 'using drugs is fun' (54.5%). Almost three-quarters (71.5%) of participants disagreed with the statement that 'drug use is one of the biggest evils in Australia'. It is interesting to note that 84.0 per cent of participants agreed that 'schools should teach about the real hazards of taking drugs'. A slightly larger number of participants responded with 'Don't know' to some of the statements made about drug use, compared to the responses to the attitudes to alcohol questions above.

Table 13: Here are some statements that people have made about drug use. Tick the answer that is closest to your opinion

	Agree %	Neither %	Disagree %	Don't know %
Using drugs can be a pleasant activity (n=2328)	73.9	7.5	12.5	6.1
A young person should never try drugs (n=2317)	20.5	32.3	46.4	0.7
There are few things more dangerous than experimenting with drugs (n=2318)	36.8	14.5	47.8	1.0
Using drugs is fun (n=2320)	54.5	22.0	17.3	6.2
Many things are much more risky than trying drugs (n=2317)	66.9	17.2	15.6	0.3
Everyone who tries drugs eventually regrets it (n=2319)	11.6	13.4	71.2	3.8
The laws about illegal drugs should be made stronger (n=2320)	18.2	9.4	70.2	2.2
Drug use is one of the biggest evils in Australia (n=2318)	16.6	9.9	71.5	2.0
Drugs help people to experience life to the fullest (n=2323)	26.9	31.3	40.6	1.2
Schools should teach about the real hazards of taking drugs (n=2322)	84.0	11.6	3.8	0.6
The police should not be annoying young people who are trying drugs (n=2317)	36.7	23.8	38.1	1.5
To experiment with drugs is to give away control of your life (n=2324)	15.8	11.4	70.6	2.2

Again, to further examine the sample's attitudes towards drugs and drug use, we derived a summary attitudinal score[9] (see Table 14). When we compared the scores of males and females, we found that male participants had significantly more positive and favourable attitudes towards drugs. Similarly, participants who had ever used an illicit drug in their lifetime also had more positive attitudes towards drugs, compared to those who had never used an illicit drug. There was no significant difference between the attitudes of participants under 18 years of age, compared with those aged 18 years and older.

Table 14: Computed attitudes towards drugs score
(higher number = more favourable or positive attitude)

Males	3.75*
Females	3.07
Never used illicit drug	2.55
Used illicit drug	3.73*
Under 18 years of age	3.41
18 years of age or over	3.53

*p<0.0001

9 Following a scoring method used by the EMCDDA 'Attitudes to Drug Use' instrument <http://www.emcdda.europa.eu/html.cfm/index3426EN.html>, we computed an overall attitudinal score for each individual. A score of 5.00 indicates a favourable or positive attitude, while a score of 1.00 demonstrates a negative attitude.

7.2 Interventions: three most effective

Participants were asked a series of questions to examine what they thought the government and their community could do to reduce or prevent problems relating to drug and alcohol use. As such, participants were asked for their opinions about approaches to prevention, law enforcement, regulation, treatment and harm reduction, as well as various specific strategies and interventions within each of these broad domains. Participants were told that, in asking these questions, the researchers do not assume that all drug and alcohol use necessarily results in problems.

Participants were firstly asked to nominate what they regarded as the three most effective ways for public authorities to reduce drug and alcohol problems. The question aimed to ascertain how young people perceived the relative effectiveness of a range of interventions, including supply reduction, harm reduction, treatment and prevention domains, by asking them to prioritise their choices. Two-thirds (66.6%) of participants nominated treatment and rehabilitation of drugs users as an effective response to drug and alcohol problems, while half nominated information and prevention campaigns (55.3%) and making illegal drugs legal (49.3%). Notably, almost half (46.9%) of the young people surveyed nominated reduction of poverty and unemployment as an effective response, which would suggest that a substantial proportion of this sample of young people recognise the importance of socioeconomic drivers of drug use:

> People don't turn to alcohol and drugs for no reason. I believe abuse of these substances is the result of social circumstances – improving these could help.
>
> Unfortunately it does seem that problematic drug use amongst young Australians is correlated with wider systemic disadvantage – Australia needs to have a look at the underlying causes (e.g. marginalisation, poverty, unemployment, emotional problems, etc) in order to effectively respond to problematic drug use.
>
> Alcohol and drugs do not cause violence. Poverty, boredom, a lack of education, and stupid people do.

The difference in ranking between support for tough measures against drug traffickers (nominated by 29.1 per cent of the sample) as compared to tough measures against drug users per se (9.9%) suggests that the young people surveyed draw a distinction between what they regard as appropriate measures for users and dealers respectively when thinking about law enforcement and criminal justice responses to drug issues:

> Less penalties for people using drugs recreationally and for personal use. Not everyone is a dealer.
>
> Drug dealers should be dealt with harshly ... yet users should be treated as a medical problem.
>
> Treat the dealers harder, not the users.

Table 15: What are the three most effective ways for public authorities to reduce drug and alcohol problems?

Whole sample; and comparing males and females

	Persons (n=2335) %	Males (n=1441) %	Females (n=894) %
Information and prevention campaigns	55.3	54.1	57.3
Treatment and rehabilitation of drug users	66.6	65.0	69.1
Tough measures against drug dealers and traffickers	29.1	19.5	44.5*
Making illegal drugs legal	49.3	63.4	26.5*
Reduction of poverty/unemployment	46.9	45.5	49.0
Tough measures against drug users	9.9	5.1	17.6*
More leisure opportunities	24.1	24.3	23.7
Don't know	3.1	3.8	2.0

*p<0.0001

There were a number of differences when we compared the responses of male and female participants. A significantly greater proportion of female participants supported tough measures against drug dealers and traffickers (44.5%, compared to 19.5% of males) as well as tough measures against drug users (17.6%, compared to 5.1% of males). Male participants were significantly more likely to nominate legalisation – two-thirds (63.4%) of male participants supported making illegal drugs legal, compared with only 26.5 per cent of females (a separate analysis of specific legalisation questions is dealt with below). The top three interventions nominated by females were treatment and rehabilitation (69.1%), information and prevention campaigns (57.3%), and reduction of poverty and unemployment (49.0%). Male participants also nominated treatment and rehabilitation as their top intervention (65.0%), followed by making illegal drugs legal (63.4%) and information and prevention campaigns (54.1%).

7.3 Interventions (general)

Participants were asked to what extent they agreed or disagreed with a series of statements about approaches to drug policy. As shown in Table 16, participants were not in favour of abstinence-based treatment, with 60.5 per cent disagreeing with the statement that 'treatment should only be given to drug users who intend to give up drugs for good'. Rather, 89.8 per cent agreed that 'treatment should be available to all drug users, according to their needs'. Two participants described their views on treatment in this way:

> A move away from persecuting users. Treatment of those with substance abuse problems as people with a medical problem, rather than as criminals.

> providing a holistic treatment approach to drug users. Often the drug use is a side effect of other psychological and social issues, and this needs addressing as well as the health effects and the addiction itself. In my experiences, many of these people struggle to look after themselves. Treatment needs to include skills training so that they can be employed at the end of treatment.

Although two-thirds of participants (63.3%) agreed that 'drug education in schools provides helpful information to young people about drugs and alcohol', only one-third (36.6%) thought that 'drug education in schools helps to prevent young people from using drugs and alcohol'. This finding suggests that, although participants are in favour of drug education in principle, they may question its effectiveness. This disconnect was explained in the following way by some participants:

> provide a balanced education for school students as to the benefits, negatives and side effects of drugs and alcohol (as opposed to the fairly one-sided 'drugs are bad' approach typically found in drug education classes today), so that the taboos and stigmas surrounding drug use can be removed for current and future generations of young people (potential drug users) so that the REAL issues surrounding drug use can be addressed.

> Need education, I think this is the key, and by education I mean accurate information that is not skewed towards scare tactics to prevent young people from taking drugs, this simply does not work.

Table 16: To what extent would you agree or disagree with the following statements?

	Agree %	Neither %	Disagree %	Don't know %
Treatment should only be given to drug users who intend to give up drugs for good (n=2323)	21.3	16.6	60.5	1.6
Public awareness/mass media campaigns are a good way to change attitudes about alcohol and other drug use (n=2320)	60.7	18.2	19.6	1.5
Drug education in schools provides helpful information to young people about drugs and alcohol (n=2321)	63.3	11.7	23.8	1.1
It is possible to reduce drug and alcohol problems through prevention (n=2320)	60.5	16.7	19.7	3.1
Treatment should be available to all drug users, according to their needs (n=2321)	89.8	6.6	2.8	0.9
Drug education in schools helps to prevent young people from using drugs and alcohol (n=2326)	36.6	23.7	37.9	1.8

Of the six statements, responses to five were significantly different when we compared the responses of males and females (Table 17: the only question to not show statistically significant differences concerned treatment being available to all according to need).

Female respondents were more likely to support public education campaigns (68.5% compared to 55.9%). Females were also more likely to agree that drug education in schools is both helpful (72.4% compared to 57.7%) and effective (46.0% compared to 30.8%); and that it is possible to reduce drug and alcohol problems through prevention (73.7% compared to 52.2%).

Table 17: To what extent would you agree or disagree with the following statements?
Comparing males and females

	Males (n=1441) %				Females (n=894) %			
	Agree	Neither	Disagree	Don't know	Agree	Neither	Disagree	Don't know
Treatment should only be given to drug users who intend to give up drugs for good*	23.5	18.2	56.9	1.5	17.7	13.9	66.5	1.9
Public awareness/mass media campaigns are a good way to change attitudes about alcohol and other drug use*	55.9	19.0	23.1	2.0	68.5	16.9	14.0	0.7
Drug education in schools provides helpful information to young people about drugs and alcohol*	57.7	12.4	28.5	1.4	72.4	10.5	16.2	0.9
It is possible to reduce drug and alcohol problems through prevention*	52.2	18.4	26.1	3.3	73.7	14.0	9.3	2.9
Treatment should be available to all drug users, according to their needs	88.6	7.7	2.8	0.9	91.6	4.9	2.7	0.8
Drug education in schools helps to prevent young people from using drugs and alcohol*	30.8	23.5	44.2	1.5	46.0	23.9	27.9	2.2

* $p<0.0001$

7.4 Alcohol interventions

Participants were asked whether they supported or opposed a range of specific interventions to reduce the problems associated with excessive alcohol use. As shown in Table 18, the top three most supported interventions were more severe drink driving penalties (76.6%), stricter enforcement of laws against serving drunk patrons (62.2%), and requiring information on national drinking guidelines on all alcohol containers (58.2%).

The least supported interventions were raising the legal drinking age (15.1%), increasing the price of alcohol (16.9%), reducing trading hours for pubs and clubs (18.4%), and reducing the number of outlets that sell alcohol (19.6%) (indeed, over half of participants opposed each of these measures). Only a small proportion of the sample responded with 'Don't know' when asked for their opinion about each of the interventions. When given the opportunity to respond freely, some participants expressed strong negative views about some of these interventions:

> Putting a tax on alcohol isn't going to go towards education or the health care system. That's just going to piss people off.

> RAISING PRICE OF ALCOHOL DOES NOT WORK — alcopops tax is the reason cider and beer is so popular these days.

We later consider whether there are certain individual characteristics associated with these views. For example, do those young people who consume alcohol more frequently have different opinions to those young people who are infrequent drinkers or abstainers? However, from the results presented here regarding the attitudes of the sample overall, we can discern that this sample of young people are supportive of measures which provide them with facts and information (e.g. guidelines), or which curb the behaviour of 'others' who may be causing trouble (e.g. stricter enforcement of laws and stricter penalties) but they desire personal freedom to make their own choices, and are not generally in favour of regulatory measures (e.g. restricted trading hours and outlets):

> The general and safe consumption of alcohol by minors should not be seen as such a terrible problem as long as it is done in a safe environment with adequate supervision. As a teenager myself, I am constantly frowned upon for having 3 or 4 drinks at events, and teenagers are stereotyped because of the minor groups that do cause trouble and lose control of their behaviour.

> In my community, where violence in the clubs is regular, the prevention methods used such as lockouts and drink limits fail to keep patrons and local citizens safe. Allowing for more small-scale venues and ending lockouts would mean less concentration of people in the handful of major nightclubs and less chance of violence on the street because people will not 'pre-load' before going out nor will they be out on the streets while intoxicated early in the morning not ready to go home.

> Alcohol is a complicated issue, it dulls the mind and many people become violent and irrational when drunk. If you tighten laws concerning sale, treatment of drunks, the drinking age, etc. you aren't really treating the core of the problem, you're simply making it a little harder for people to drink and get drunk, but they will find a way, because that's what people do.

Table 18: To reduce the problems associated with excessive alcohol use, to what extent would you support or oppose...

	Support %	Neither %	Oppose %	Don't know %
Increasing the price of alcohol (n=2326)	16.9	11.8	70.5	0.8
Reducing the number of outlets that sell alcohol (n=2319)	19.6	14.3	65.6	0.6
Reducing trading hours for all pubs and clubs (n=2315)	18.4	12.1	68.7	0.8
Serving only low alcohol drinks at sporting events or venues (n=2321)	39.8	13.7	45.7	0.8
Increasing the number of alcohol-free public events (n=2322)	46.3	20.9	32.1	0.7
Raising the legal drinking age (n=2317)	15.1	10.2	73.9	0.7
Stricter enforcement of the law against serving customers who are drunk (n=2321)	62.2	14.9	22.2	0.7
More severe legal penalties for drink driving (n=2323)	76.6	13.5	9.1	0.9
Restricting late night trading of alcohol (n=2319)	29.1	18.1	51.7	1.1
Strict monitoring of late night licensed premises (n=2315)	50.4	20.0	28.5	1.1
Limiting advertising for alcohol on TV until 9:30pm (n=2318)	55.5	23.1	20.3	1.1
Banning alcohol sponsorship of sporting events (n=2320)	38.7	22.5	37.7	1.1
Requiring information on national drinking guidelines on all alcohol containers (n=2317)	58.2	24.0	16.4	1.3
Increasing the size of standard drink labels on drink containers (n=2314)	54.4	29.5	14.2	1.9
Increasing the tax on alcohol products to pay for health, education, and the cost of treating alcohol-related problems (n=2321)	37.0	17.8	43.9	1.4

When we compared the responses of male and female participants, we found that a smaller proportion of female respondents expressed opposition to each of the alcohol measures, as compared to males (in each case in Table 19, the percentage of female respondents selecting 'Oppose' is lower). With the exception of two measures, the differences between the responses of males and females were statistically significant, with females demonstrating higher support for all alcohol interventions.

Table 19: To reduce the problems associated with excessive alcohol use, to what extent would you support or oppose...

Comparing males and females

	Males (n=1437) %				Females (n=889) %			
	Support	Neither	Oppose	Don't know	Support	Neither	Oppose	Don't know
Increasing the price of alcohol	15.1	10.6	73.6	0.8	19.8	13.8	65.5	0.9
Reducing the number of outlets that sell alcohol*	16.1	13.0	70.4	0.5	25.3	16.4	57.7	0.7
Reducing trading hours for all pubs and clubs*	14.0	10.1	75.0	1.0	25.4	15.4	58.7	0.4
Serving only low alcohol drinks at sporting events or venues*	30.2	14.3	54.6	0.9	55.2	12.8	31.4	0.7
Increasing the number of alcohol-free public events*	38.2	22.8	38.1	0.8	59.3	17.9	22.4	0.4
Raising the legal drinking age	12.9	9.7	76.6	0.8	18.7	11.0	69.6	0.7
Stricter enforcement of the law against serving customers who are drunk*	55.5	16.5	27.4	0.6	73.0	12.4	13.8	0.9
More severe legal penalties for drink driving*	71.7	16.5	11.0	0.8	84.5	8.7	6.0	0.9
Restricting late night trading of alcohol*	22.2	18.5	58.6	0.7	40.2	17.5	40.6	1.7
Strict monitoring of late night licensed premises*	43.1	21.4	34.9	0.7	62.2	17.8	18.3	1.7

	Males (n=1437) %				Females (n=889) %			
	Support	Neither	Oppose	Don't know	Support	Neither	Oppose	Don't know
Limiting advertising for alcohol on TV until 9:30pm*	50.1	24.2	24.7	1.1	64.3	21.3	13.3	1.0
Banning alcohol sponsorship of sporting events*	32.2	22.0	44.8	1.0	49.2	23.2	26.4	1.2
Requiring information on national drinking guidelines on all alcohol containers*	52.1	25.1	21.6	1.2	68.0	22.3	8.2	1.5
Increasing the size of standard drink labels on drink containers*	50.5	31.4	16.4	1.7	60.6	26.4	10.7	2.2
Increasing the tax on alcohol products to pay for health, education, and the cost of treating alcohol-related problems*	34.6	16.4	47.6	1.4	40.7	19.9	37.9	1.5

* p<0.0001

7.5 Law enforcement, regulation, treatment and harm reduction

Participants were asked to what extent they supported various specific programs and interventions within treatment, harm reduction, law enforcement and regulatory domains.

As shown in Table 20, there were high levels of support for all forms of treatment and harm reduction interventions with over half of the sample supporting each of these services. There was, however, less support for compulsory treatment (53.7%) compared to other treatment modalities. Young people also expressed lower levels of support for methadone-type pharmacotherapy, with a substantial minority (19.4%) opposing this treatment modality. These different levels of support for various treatment modalities are also reflected in the general population survey data. For example, in the 2010 NDSHS general population survey 69.3 per cent supported methadone maintenance programs, while three-quarters of the general population supported naltrexone (75.5%) and rapid detoxification (77.9%). Support for methadone maintenance programs in the general population has been significantly rising statistically over the last decade (Australian Institute of Health and Welfare, 2011a).

As shown in Table 20, a substantial majority of participants expressed support for the availability of pill testing (82.5%), which again demonstrates a desire for factual information (in this case, knowledge of the contents of pills) such that young people can make informed personal choices:

> First and foremost: Make pill testing kits free or cheap through subsidy, and available everywhere, to everyone. I feel that a LACK of this information does not discourage drug use; merely allows more people to DIE.

> Drug test facilities, specifically pill testing facilities/kits, must be made available. They do not identify the strength, but the chemicals that make the pill. A percentage of the public will take ecstasy. If pills are tested, people are less likely to take ketamine for instance and end up in hospital.

> I would really like to see a government-funded gc/ms pill testing facility opened in major cities in Australia. There are too many dangerous pills in Australia and it would decrease the amount of overdoses if people were aware of different dangerous pills in their city/area.

In terms of law enforcement and regulation interventions, participants expressed strong opposition to the use of sniffer dogs, with two-thirds of the sample (64.3%) opposing this measure. One participant expressed opposition in this way:

> I think there needs to be less of a focus on criminalising young people who take drugs. I don't think sniffer dogs in public places are a good idea. A young girl died in my city a few years ago because she was worried about them, so took all her drugs and overdosed, which I think is likely to happen again if sniffer dogs keep being used.

That said, over half of participants supported visible police presence around licensed venues (59.1%) and more police on the streets (53.5%). Thus, a distinction was made by participants between the use of sniffer dogs and more general police presence:

> Less sniffer dogs (invasion of privacy) but more police presence in problem areas (for prevention of drug/alcohol-related crime rather than having people charged for petty possession and no other crime).

Table 20: To what extent would you support or oppose...

	Support %	Neither %	Oppose %	Don't know %
Treatment services				
A service that provides a place to stay for a short time (n=2323)	81.5	11.8	5.3	1.4
A service that provides a place to stay for a long time (rehabilitation) (n=2316)	88.6	8.2	2.2	1.0
Seeing a doctor (n=2298)	88.0	9.1	2.3	0.6
Counselling (n=2318)	89.0	7.7	2.6	0.7
A service that provides withdrawal (detoxification) from alcohol and/or drugs (n=2312)	91.3	6.2	1.4	1.1
Meeting a youth worker in places where young people hang out (n=2322)	71.1	19.3	7.5	2.1
Compulsory education and/or treatment (n=2310)	53.7	22.8	21.4	2.0
Medications that mimic the effects of illegal drugs (e.g. methadone/dexamphetamine (n=2319)	54.8	21.7	19.4	4.2
Harm reduction services				
Needle and syringe programs (where people can access clean syringes) (n=2326)	76.0	10.7	10.9	2.1
Regulated injecting rooms (where people are able to inject drugs in a safe place) (n=2321)	67.7	13.2	16.8	2.4
Availability of pill testing (where people can have the contents of their pills tested) (n=2324)	82.5	8.9	7.1	1.5
Drug-free chill-out zones (n=2320)	65.6	25.0	6.6	2.8

	Support %	Neither %	Oppose %	Don't know %
Law enforcement and regulation				
Drug sniffer dogs in public places (n=2325)	24.5	10.8	64.3	0.5
Visible police presence around licensed venues such as bars and nightclubs (n=2330)	59.1	15.8	24.3	0.7
More police on the streets (n=2313)	53.5	23.7	22.0	0.8
ID scanners at the entry to bars and nightclubs (n=2321)	49.2	20.2	29.4	1.2
Drug testing at work or at school (n=2323)	21.7	12.9	64.6	0.8
Banning the purchase of drugs over the internet (n=2326)	30.3	23.6	42.4	3.6

When we compared the responses of male and female participants, we found significant differences in levels of support across most interventions (with the exception of some treatment services including seeing a doctor, detoxification services and methadone-type pharmacotherapy). As shown in Table 21, females were generally more supportive of treatment services and law enforcement responses, but less supportive than males of harm reduction interventions.

Table 21: To what extent would you support or oppose...

Comparing males and females

	Males (n=1441) %				Females (n=894) %			
	Support	Neither	Oppose	Don't know	Support	Neither	Oppose	Don't know
Treatment services								
A service that provides a place to stay for a short time*	79.0	14.0	5.6	1.4	85.6	8.2	4.8	1.4
A service that provides a place to stay for a long time (rehabilitation)*	85.9	10.4	2.7	1.0	92.8	4.6	1.5	1.1
Seeing a doctor	86.9	10.0	2.6	0.5	89.8	7.6	1.9	0.7
Counselling*	85.7	10.3	3.3	0.7	94.3	3.5	1.6	0.7
A service that provides withdrawal (detoxification) from alcohol and/or drugs	89.7	7.6	1.7	1.0	93.8	4.0	0.9	1.4
Meeting a youth worker in places where young people hang out*	65.3	23.3	8.7	2.6	80.3	12.8	5.6	1.2
Compulsory education and/or treatment*	44.9	26.6	26.8	1.7	68.0	16.8	12.7	2.6
Medications that mimic the effects of illegal drugs (e.g. methadone/dexamphetamine)	56.2	22.3	18.1	3.5	52.5	20.7	21.4	5.3

	Males (n=1441) %				Females (n=894) %			
	Support	Neither	Oppose	Don't know	Support	Neither	Oppose	Don't know
Harm reduction services								
Needle and syringe programs (where people can access clean syringes)*	81.6	9.0	8.1	1.4	67.8	13.5	15.5	3.1
Regulated injecting rooms (where people are able to inject drugs in a safe place)*	73.8	11.8	12.8	1.6	57.7	15.4	23.2	3.6
Availability of pill testing (where people can have the contents of their pills tested)*	85.7	6.6	6.7	1.0	77.3	12.6	7.8	2.4
Drug-free chill-out zones*	61.8	28.1	7.3	2.7	71.8	20.0	5.3	2.9
Law enforcement and regulation								
Drug sniffer dogs in public places*	14.1	7.7	78.0	0.2	41.2	15.6	42.2	0.9
Visible police presence around licensed venues such as bars and nightclubs*	52.5	17.2	29.7	0.6	69.8	13.7	15.6	0.9
More police on the streets*	46.3	26.8	26.1	0.8	65.2	18.7	15.3	0.8
ID scanners at the entry to bars and nightclubs*	42.4	22.0	34.5	1.1	60.1	17.3	21.2	1.5
Drug testing at work or at school*	14.5	10.3	74.4	0.8	33.4	17.1	48.9	0.7
Banning the purchase of drugs over the internet*	16.2	24.1	56.4	3.3	53.0	22.9	20.1	4.0

* $p<0.0001$

7.6 New and emerging substances

One highly topical area is what should be done about new and emerging substances. These substances, which are chemically different but have similar effects to other prohibited drugs, are sometimes referred to as legal highs, drug analogues, new psychoactive substances, designer drugs, herbal highs, research chemicals, or bath salts. Many participants in the sample were experienced with these types of substances. When asked to nominate 'other' drugs they had used in their lifetime, 11.5 per cent (n=269) of participants nominated other drugs including new and emerging substances such as 2CB, kronic and substances identified as 'research chemicals' (the full list of responses is shown in Appendix B).

Terms such as 'legal high' used to describe these new and emerging substances can be misleading in the Australian context. At present, the approach of Australian governments (federal, state and territory) is to introduce legislation to declare these substances illicit by extending the list of prohibited substances and by establishing 'group entry' offences that cover current and all future substances that mimic the effects of already prohibited substances. However, approaches to the regulation of these substances vary across nations, including criminal prohibition but also policies to control substances under consumer protection regulation (where the safety of the product must be demonstrated) or medicines regulation (see Winstock & Wilkins, 2011).

When asked what they thought would be an appropriate way to handle new and emerging substances, the majority of young people in our sample appeared to strongly prefer a regulation approach, where these substances are treated like other legal drugs (alcohol, tobacco and medicines). As can be seen in Table 22, 51.3 per cent support a regulation approach; and 31.7 per cent support a ban only if the substance poses a health risk. Only a very small number (6.3%) supports banning them under any circumstance. These views are not in line with the current Australian approach to new and emerging substances. The participants also contextualised their views about the regulation of new substances, within the context of the availability and relative harms of other drugs:

> Furthermore, if you legalise certain substances, then their consumption becomes much safer as they are more pure and people can be more sure of what they contain. This will also contribute to lowering the amount of new substances that are flooding the market from online vendors that aim at mimicking other drugs.

While the vast majority supported some form of regulation (Table 22), there were alternate views:

> There should be a complete ban on synthetic cannabinoids instead of the current ban we have now that only bans some, creating a new market with even more obscure chemicals.

Table 22: What would be an appropriate way to handle new substances that imitate the effects of illegal drugs and that are sold as legal substances (e.g. kronic)?

Whole sample; and comparing males and females

	Persons (n=2326) %	Males (n=1437) %	Females (n=889) %
Regulate them like alcohol, tobacco and medicines	51.3	52.2	49.7
Ban them only if they pose a risk to health	31.7	30.9	33.1
Ban them under any circumstances	6.3	5.2	8.1
Do nothing	3.9	5.2	1.7*
Other	2.8	3.5	1.6
Don't know	4.0	2.9	5.8*

* $p<0.0001$

As can also be seen in Table 22, the only statistically significant differences between male and female respondents were between the small proportions of respondents who said 'Do nothing' or 'Don't know' in response to this question.

7.7 Legal status of drugs

Respondents were asked for their opinion about the legal status of five different illicit drugs. In each case, they were given five options: personal use should be legalised; personal use should be decriminalised; the law should be left as is; penalties for personal use should be increased; and don't know. As shown in Table 23, there was heterogeneity in the responses of participants, which varied according to drug type. That is, participants did not regard one option as being appropriate across all drugs. This finding suggests nuanced views towards the legal status of different drugs, and what young people regard as appropriate responses.

There was a high level of support for the legalisation of the personal use of cannabis, with two-thirds (62.6%) of respondents supporting this response. This level of support is higher than that of the general population. The 2010 NDSHS found that 24.8 per cent of the general population supported the legalisation of cannabis (Australian Institute of Health and Welfare, 2011a). Young people expressed specific understandings of the meaning and effects of legalisation:

> In relation to cannabis, I am in support of legalisation as while it does increase the number of people who now have access, it also means that it is out in the light of day and can be regulated, taxed accordingly and allow centres to be set up to deal with the health risks.

> Legalise, tax and regulate currently illegal drugs. Most of the problems associated with illicit drugs could be eliminated or greatly reduced if the opportunity to monitor and regulate the market and consumption patterns were available.

> Legalise cannabis for 18+, but strictly tax it. Regulate and control it like alcohol and tobacco. Maintain laws on alcohol and other drugs.

One-third (31.7%) of respondents also supported the legalisation of the personal use of ecstasy, which was the second highest level of support behind cannabis. There was much lower support expressed for the legalisation of heroin (10.0%), methamphetamine (9.6%) or cocaine (13.0%). Indeed, approximately one-quarter to one-third of the respondents thought that penalties should be increased for these drugs (29.2%, 30.2% and 22.2% respectively). The distinctions made between drugs, and views on why legalisation would be favoured for some but not others, were expressed by some participants:

> Rid of all dirty drugs, i.e. meth, heroin, ecstasy, coke, crack, they're the ones that get the better of most people. Not to say that weed doesn't, or shrooms and other natural products don't, I just witness on a day-to-day basis people who are totally ruined from methamphetamine and other stimulant drugs. Natural products such as weed, mushrooms, salvia, anything containing psilocybin that have psychedelically induced effects on the user, I believe can be legalised.

> I think that in regards to recreational substances like ecstasy and cannabis there should be an element of decriminalisation and regulation. Especially something like ecstasy where there could theoretically be any number of chemicals involved in the manufacture it would be much safer for the community as a whole if there was government regulation. At the very least they should be decriminalised and the police resources used to target hard drugs like heroin or meth.

That said a substantial minority of approximately one-quarter of participants nonetheless thought the personal use of heroin (22.8%), methamphetamine (23.2%), ecstasy (28.9%) and cocaine (29.8%) should be decriminalised. As one participant suggested:

> All drugs should immediately move into a decriminalisation stage before being assessed for real health problems and becoming fully legalised.

Table 23: For the following drugs, which statement is closest to your opinion?

	Personal use should be legalised %	Personal use should be decriminalised %	The law should be left as is %	Penalties for personal use should be increased %	Don't know %
Cannabis (n=2329)	62.6	18.8	8.0	8.5	2.1
Heroin (n=2327)	10.0	22.8	32.7	29.2	5.3
Methamphetamine (n=2318)	9.6	23.2	31.4	30.2	5.6
Ecstasy (n=2329)	31.7	28.9	16.2	19.6	3.6
Cocaine (n=2322)	13.0	29.8	29.9	22.2	5.1

There were significant differences between male and female respondents on this question, with females generally less supportive of legalisation options. For example, 40.6 per cent of female young people supported legalisation of cannabis, compared to 76.3 per cent of young males. This pattern remained consistent across all drug types, with one of the most pronounced differences being in relation to ecstasy, where almost half (43.4%) of males supported legalisation compared to only 12.9 per cent of females.

A substantial minority of females supported increased penalties across all drug types. For example, 42.0 per cent of females supported increased penalties for methamphetamine, compared to 22.9 per cent of males.

Table 24: For the following drugs, which statement is closest to your opinion?
Comparing males and females

	Males (n=1441) %					Females (n=894) %				
	Legalise	Decriminalise	As is	Penalty should increase	Don't know	Legalise	Decriminalise	As is	Penalty should increase	Don't know
Cannabis*	76.3	15.4	3.5	3.8	0.9	40.6	24.2	15.2	15.9	4.0
Heroin *	13.2	28.4	32.5	21.5	4.3	4.7	13.6	33.1	41.6	7.0
Methamphetamine*	12.7	28.4	31.4	22.9	4.6	4.6	14.9	31.3	42.0	7.2
Ecstasy*	43.4	31.3	12.4	10.4	2.4	12.9	24.8	22.4	34.4	5.5
Cocaine*	17.2	36.2	29.3	13.2	4.0	6.2	19.5	30.9	36.6	6.9

* $p<0.0001$

7.8 Sources of information

When asked where they would turn for information and advice about alcohol and other drugs, the top three sources of information nominated by participants were the internet (88.4%), a friend (62.9%) and a doctor, nurse or other health professional (45.2%). It is noteworthy that parents and relatives were not nominated in the top three choices, with only 18.0 per cent of participants selecting this option. Moreover, only a small proportion of participants nominated the mass media (8.3%) or telephone helplines (6.3%) as important sources of information. Perhaps unsurprisingly, only 2.2 per cent nominated the police as a preferred source of information or advice. Participants expressed a desire for accessible, relevant and non-judgemental sources of information:

> Using people with real experiences that young people can relate to and therefore actually listen to their advice instead of elderly teachers with no first-hand drug or alcohol experience. The information should be factual, not all negative and judgey because then kids just feel like it's a lecture from their parents.

> Information about the negative effects should be widely accessible and shown throughout mass media. There should be a known safe house or counsellor in the area in which people can go to get information or help.

Provide support and anonymity for drug users seeking help, so there is no fear in going to police or medical professionals for information, advice, or help.

The main reason there are so many health and social problems due to drug and alcohol is lack of easy access to information which makes it harder for young people to make informed decisions, and the fact it's a criminal offence which makes people (especially young people) much more likely to not seek help or advice.

When we compared the choices of males and females, there were some significant differences. More males than females said they would turn to a friend or the internet for information or advice. Males were also less likely to say they would seek advice from a social worker or from the mass media.

Table 25: If you wanted information or advice about alcohol and drug use, which three sources would you turn to?

Whole sample; and comparing males and females

	Persons (n=2335) %	Males (n=1441) %	Females (n=894) %
A friend	62.9	65.9*	57.9
Parents/relatives	18.0	16.8	19.9
Brother/sister	12.4	12.5	12.3
Someone at school or at work	16.7	17.3	15.7
Doctor, nurse or another health professional	45.2	47.5	41.5
Social/youth worker	10.8	8.0	15.3*
Drug counsellor/centre	22.4	21.2	24.2
The police	2.2	2.0	2.6
A telephone helpline	6.3	5.1	8.1
The internet	88.4	90.6*	84.8
Mass media	8.3	5.6	12.6*
Don't know	6.0	6.9	4.5

* $p<0.0001$

7.9 Other suggestions

The survey instrument was extremely comprehensive and included a vast number of policies, programs and control measures across both alcohol and illicit drugs. Many of these are already implemented in Australia; some are not. In the open-ended questions, respondents were asked whether there were other things that could be done to respond to alcohol and other drug problems in their community. Perhaps unsurprisingly there were few novel ideas that emerged, given the comprehensiveness of the survey content, with most participants offering more fulsome explanations of their support or opposition to interventions mentioned in the quantitative component of the survey. Nonetheless a few notable suggestions were made. A number of participants commented about provision of transport options, for example:

> Increased public transport to avoid instances of drunk driving.
>
> Make public transport, trains in particular 24 hours a day 7 days a week.
>
> Decreased taxi rates.

Others noted possible further control strategies, placing limits on individuals, such as:

> Alcohol should be sold in limited amounts to families, so we should have a system that monitors alcohol buying, so allowing a set amount of alcohol per week bought only by one family member.
>
> You should only be able to buy a max of 2 drinks at a time. This stops people excessively shouting each other drinks especially when they have had too much.

There were also creative suggestions, such as using mass media to promote penalties, and having the alcohol industry sponsor treatment centres:

> Show penalties faced by those who break law on news.
>
> Stop blaming those who drink and blame those who make money from it. Put the responsibility with those who make the stuff – they should also fund the rehab centres, e.g. XXXX or Bundaberg Rum rehab clinic.

The survey did not include specific questions concerned with naloxone availability (a drug which reverses the effects of heroin and is used to manage overdose) and heroin prescription. These were noted by at least two participants:

> Drug treatment centres like Switzerland has, doctors giving heroin to addicts and weaning them off the drug.
>
> Naloxone easily available in high-density clusters of users.

The role of experienced users was noted, as a possible influential strategy:

> We should be able to take drugs under the supervision of trained instructors. If we can drive after driving lessons with a trained instructor, we should be able to take drugs under the supervision of trained instructors.
>
> Drug users should be taught to not influence youths as well in order to efficiently prevent drug uses.

Community guidelines were mentioned:

> regulation in public venues should be encouraged/ recommended guidelines for sporting clubs, town halls etc – this provides an example for regional communities. Especially if the event targets under 18s like a concert, formal or deb ball, introduce wristbands and serve low alcoholic drinks. An additional hire cost could also be applied for high alcoholic drinks.

In relation to alcohol, some of the other ideas included encouraging moderate drinking at a younger age (mention was made of the 'France' model). And in contrast, the suggestion to make alcohol illegal, as noted by these participants:

> make a very low alcohol drink (1.5% or less) available to be purchased by 16–17 year olds in low quantities, and with restrictions on how much that person could get each month. To ease the people who would be drinking anyways into it instead of bingeing as soon as they get 18 like is often done now days.

> Alcohol should be made illegal.

> LOWER the drinking age so people are used to alcohol. It works in Europe and it works with soft drinks!

Distinguishing the legal age for drinking from the legal age for driving was also mentioned, for example:

> Raise the Learners/Provisional licence ages!

The availability of free water at licensed venues was also raised:

> It should be compulsory for all licensed venues to give patrons free tap water in a cup if they ask.

And there were other suggestions:

> Replace all politicians with smarter people.

8. Associations between opinion, age and alcohol and drug use

We hypothesised that both age and experience with alcohol and drugs were likely to be important drivers of opinion. Previous research has shown, for example, that those people who have consumed more alcohol and other drugs are likely to hold more liberal attitudes towards drug policies (e.g. Garland et al., 2010).

In addition, we know from past research that age is a predictor of opinions, with younger people generally holding more liberal attitudes than older people across the whole population (e.g. Makkai & McAllister, 1997, 1998; Nielsen, 2010). Here we have the opportunity to carefully examine age differences across a sample of 16–25 year-old young people. We treated 18 years of age as the cut-off for our analyses, grouping participants into two groups: those aged under 18 years, and those aged 18 years and older.

The extant literature also suggests that prior alcohol and other drug use experience may influence young people's ideas about drug issues (e.g. Adlaf et al., 2009; Brook et al., 2001). Therefore, in regard to alcohol and drug use experience, we compared subgroups in the sample using two variables. For alcohol use, the sample was divided into three groups to compare the responses of those who have not consumed alcohol in the last 12 months (including those who have never consumed alcohol), with those who consume alcohol less than weekly, and those who consume alcohol at least weekly. We also compared the responses of participants who reported that they had used an illicit drug in their lifetime, with the responses of those who have never used an illicit drug (the rationale for these groupings is provided in the Methods section). We explore the extent to which positive attitudes towards alcohol and other drugs are associated with opinion in the multinomial logistic regressions. Here we focus on alcohol and drug use per se.

8.1 Interventions: three most effective, compared by age and alcohol and other drug use

There were statistically significant differences between the responses of older and younger participants, when asked to consider the three most effective ways for public authorities to reduce drug and alcohol problems (Table 26). Younger participants were more supportive of 'tough measures', with 38.0 per cent of those under 18 years of age supporting tough measures against dealers and 17.7 per cent supporting tough measures against drug users (compared to 27.3% and 8.3% of older participants, respectively). Respondents under 18 years of age were also significantly less likely to nominate reduction of poverty and unemployment as an effective approach (38.3%, compared to 48.6% of older participants).

Similarly, as shown in Table 26, participants who had never used an illicit drug were also more supportive of tough measures against drug dealers (55.9%) and drug users (26.7%). The reverse was also true – only 4.3 per cent of those who had used an illicit drug rated tough measures against users as an effective approach. There were also significant differences between these two groups regarding support for legalisation (which we discuss in greater detail below).

Table 26: What are the three most effective ways for public authorities to reduce drug and alcohol problems?

Comparing under-18 year olds with those aged 18 and over; and those who have never used an illicit drug and those who have used an illicit drug in their lifetime

	Under 18 (n=389) %	18 and over (n=1946) %	Never used illicit drug (n=581) %	Used an illicit drug (n=1754) %
Information and prevention campaigns	50.4	56.3	56.3	55.0
Treatment and rehabilitation of drug users	63.0	67.3	65.1	67.1
Tough measures against drug dealers and traffickers	38.0	27.3*	55.9	20.2*
Making illegal drugs legal	41.6	50.8	18.9	59.4*
Reduction of poverty/ unemployment	38.3	48.6*	46.1	47.1
Tough measures against drug users	17.7	8.3*	26.7	4.3*
More leisure opportunities	24.4	24.0	19.8	25.5
Don't know	4.6	2.8	1.7	3.6

* $p<0.0001$

There were significant differences between those who had not used alcohol in the last 12 months, compared to those who used alcohol more frequently (Table 27). Those who had not used alcohol in the last 12 months were more supportive of tough measures against dealers (46.0%) and users (24.0%), compared to those who consumed alcohol less than weekly (32.6% and 12.1% respectively), with the least support for tough measures offered by those who consumed alcohol at least weekly (21.2% and 4.1% respectively). Participants who consumed alcohol at least weekly were also more in favour of making illegal drugs legal (over half, 55.0%, compared to 32.0% of non-drinkers).

Table 27: What are the three most effective ways for public authorities to reduce drug and alcohol problems?

Comparing those who have not consumed alcohol in the last 12 months, with those who consume alcohol less than weekly and those who consume alcohol at least weekly

	No alcohol last 12 months (n=200) %	Alcohol less than weekly (n=1207) %	Alcohol at least weekly (n=901) %
Information and prevention campaigns	59.5	54.1	55.8
Treatment and rehabilitation of drug users	61.5	65.7	69.1
Tough measures against drug dealers and traffickers*	46.0	32.6	21.2
Making illegal drugs legal*	32.0	47.3	55.0
Reduction of poverty/ unemployment	41.5	46.4	49.2
Tough measures against drug users*	24.0	12.1	4.1
More leisure opportunities	19.5	23.9	25.6
Don't know	2.0	2.9	3.6

* $p<0.0001$

8.2 Opinions about interventions (general), compared by age and alcohol and other drug use

Only one significant difference between younger and older respondents emerged when comparing responses to a range of attitudinal statements about approaches to drug policy (Table 28). Those under 18 years of age were more likely to agree that treatment should be given only to drug users who intend to give up drugs for good (29.2%, compared to 19.7% of participants over 18 years of age).

Table 28: To what extent would you agree or disagree with the following statements?
Comparing under-18 year olds with those aged 18 and over

	Under 18 (n=387) %				18 and over (n=1938) %			
	Agree	Neither	Disagree	Don't know	Agree	Neither	Disagree	Don't know
Treatment should only be given to drug users who intend to give up drugs for good*	29.2	13.4	54.8	2.6	19.7	17.2	61.7	1.4
Public awareness/mass media campaigns are a good way to change attitudes about alcohol and other drug use	62.1	16.1	19.2	2.6	60.5	18.6	19.7	1.2
Drug education in schools provides helpful information to young people about drugs and alcohol	62.9	12.4	23.7	1.0	63.4	11.5	23.8	1.2
It is possible to reduce drug and alcohol problems through prevention	58.4	18.6	19.6	3.4	60.9	16.3	19.7	3.1
Treatment should be available to all drug users, according to their needs	86.3	8.5	3.6	1.6	90.4	6.3	2.6	0.9
Drug education in schools helps to prevent young people from using drugs and alcohol	35.1	21.1	40.7	3.1	36.9	24.2	37.4	1.5

* $p<0.0001$

When comparing the responses of participants based on their alcohol consumption, we found only one significant difference (see Table 29). Half of participants (51.0%) who had not consumed alcohol in the last 12 months agreed that drug education in schools helps to prevent young people from using drugs and alcohol, compared to 37.2 per cent of participants who consumed alcohol less than weekly, and 32.6 per cent of participants who consumed alcohol at least weekly.

Table 29: To what extent would you agree or disagree with the following statements?

Comparing those who have not consumed alcohol in the last 12 months, with those who consume alcohol less than weekly and those who consume alcohol at least weekly

	No alcohol last 12 months (n=200) %				Alcohol less than weekly (n=1207) %				Alcohol at least weekly (n=901) %			
	Agree	Neither	Disagree	Don't know	Agree	Neither	Disagree	Don't know	Agree	Neither	Disagree	Don't know
Treatment should only be given to drug users who intend to give up drugs for good	24.5	15.5	57.5	2.5	22.3	15.6	60.4	1.7	19.2	18.1	61.3	1.4
Public awareness/ mass media campaigns are a good way to change attitudes about alcohol and other drug use	68.3	11.6	18.6	1.5	62.4	17.4	19.0	1.2	57.0	20.9	20.5	1.7
Drug education in schools provides helpful information to young people about drugs and alcohol	71.5	8.5	19.0	1.0	63.3	13.4	22.0	1.3	61.2	10.1	27.4	1.2

	No alcohol last 12 months (n=200) %				Alcohol less than weekly (n=1207) %				Alcohol at least weekly (n=901) %			
	Agree	Neither	Disagree	Don't know	Agree	Neither	Disagree	Don't know	Agree	Neither	Disagree	Don't know
It is possible to reduce drug and alcohol problems through prevention	69.3	12.6	14.1	4.0	60.9	17.5	18.7	2.9	58.0	16.7	22.0	3.4
Treatment should be available to all drug users, according to their needs	87.5	6.5	3.5	2.5	89.4	7.5	2.4	0.7	90.8	5.6	3.0	0.6
Drug education in schools helps to prevent young people from using drugs and alcohol*	51.0	18.5	28.0	2.5	37.2	23.8	37.2	1.8	32.6	24.7	41.0	1.7

* $p<0.0001$

In contrast to the age and alcohol use analysis above, the analysis comparing those respondents who had used an illicit drug with those who had never used an illicit drug demonstrated significant differences on a number of statements. Notably, those who had never used illicit drugs were more likely to support mass media campaigns (70.6%), drug education in schools (76.5%), prevention (76.5%), and also perceived drug education in schools to be effective (55.4%). Interestingly, the proportion of 'Don't know' responses was not dissimilar between these two groups.

Table 30: To what extent would you agree or disagree with the following statements?

Comparing those who have never used an illicit drug and those who have used an illicit drug in their lifetime

	Never used illicit drug (n=580) %				Used an illicit drug (n=1743) %			
	Agree	Neither	Disagree	Don't know	Agree	Neither	Disagree	Don't know
Treatment should only be given to drug users who intend to give up drugs for good	24.0	15.0	59.0	2.1	20.4	17.1	61.0	1.5
Public awareness/mass media campaigns are a good way to change attitudes about alcohol and other drug use*	70.6	14.2	14.2	1.0	57.5	19.5	21.4	1.6
Drug education in schools provides helpful information to young people about drugs and alcohol*	76.5	10.4	11.8	1.4	59.0	12.1	27.8	1.1
It is possible to reduce drug and alcohol problems through prevention*	76.5	12.4	7.9	3.1	55.1	18.2	23.5	3.1
Treatment should be available to all drug users, according to their needs	86.5	8.6	3.5	1.4	90.8	6.0	2.5	0.7
Drug education in schools helps to prevent young people from using drugs and alcohol*	55.4	21.2	20.5	2.9	30.3	24.5	43.7	1.4

* $p<0.0001$

8.3 Opinions about alcohol policies, compared by age and alcohol use

As restrictions on alcohol purchasing affects under-18 year olds and those aged over 18 years differently, we compared the attitudes of older and younger respondents across a range of alcohol interventions and policies (Table 31). Although there were few substantial differences between the responses of the two groups, the variation in impact of particular policies on older and young people is reflected in some the responses. For example, there were significant differences in levels of opposition for reduced trading hours between older and younger respondents, with 70.7 per cent of older respondents opposing reduced trading hours for pubs and clubs (compared to 58.8% of those under 18 years of age).

Table 31: To reduce the problems associated with excessive alcohol use, to what extent would you support or oppose...

Comparing under-18 year olds with those aged 18 and over

	Under 18 (n=388) %				18 and over (n=1938) %			
	Support	Neither	Oppose	Don't know	Support	Neither	Oppose	Don't know
Increasing the price of alcohol	18.0	13.4	67.3	1.3	16.6	11.5	71.2	0.7
Reducing the number of outlets that sell alcohol	22.8	11.7	65.0	0.5	19.0	14.8	65.6	0.6
Reducing trading hours for all pubs and clubs*	25.1	14.8	58.8	1.3	17.0	11.6	70.7	0.7
Serving only low alcohol drinks at sporting events or venues*	50.9	10.6	37.7	0.8	37.6	14.3	47.3	0.8
Increasing the number of alcohol-free public events	48.3	19.5	31.4	0.8	45.9	21.2	32.2	0.7
Raising the legal drinking age	12.9	9.3	76.0	1.8	15.6	10.4	73.5	0.5
Stricter enforcement of the law against serving customers who are drunk	60.1	16.3	22.0	1.6	62.6	14.6	22.2	0.5
More severe legal penalties for drink driving	80.5	10.6	7.5	1.3	75.8	14.0	9.4	0.8

	Under 18 (n=388) %				18 and over (n=1938) %			
	Support	Neither	Oppose	Don't know	Support	Neither	Oppose	Don't know
Restricting late night trading of alcohol	34.6	19.1	44.2	2.1	28.0	17.9	53.2	0.9
Strict monitoring of late night licensed premises	49.4	19.9	27.9	2.8	50.6	20.0	28.6	0.7
Limiting advertising for alcohol on TV until 9:30pm	55.1	22.6	20.5	1.8	55.6	23.2	20.3	0.9
Banning alcohol sponsorship of sporting events	37.8	19.8	40.6	1.8	38.9	23.0	37.1	1.0
Requiring information on national drinking guidelines on all alcohol containers	57.0	21.8	18.4	2.8	58.4	24.4	16.2	1.0
Increasing the size of standard drink labels on drink container*	53.6	24.1	16.8	5.4	54.5	30.6	13.7	1.2
Increasing the tax on alcohol products to pay for health, education, and the cost of treating alcohol-related problems	35.0	19.9	42.0	3.1	37.4	17.3	44.2	1.1

* $p<0.0001$

We also compared the responses of participants who said they had not consumed alcohol in the last 12 months, with the responses of those who had consumed alcohol less than weekly and those who had consumed alcohol at least weekly in the last year (Table 32). More significant differences were evident when we compared these three groups, than when we compared responses by age. We found significant differences ($p<0.0001$) between the three groups across all alcohol-related policies and interventions (see Table 32). A larger proportion of respondents who consumed alcohol at least weekly expressed opposition to each regulatory measure, whereas a larger proportion of those who had not consumed alcohol in the last 12 months were more supportive of each measure.

Table 32: To reduce the problems associated with excessive alcohol use, to what extent would you support or oppose...

Comparing those who have not consumed alcohol in the last 12 months, with those who consume alcohol less than weekly and those who consume alcohol at least weekly

	No alcohol last 12 months (n=198) %				Alcohol less than weekly (n=1205) %				Alcohol at least weekly (n=898) %			
	Support	Neither	Oppose	Don't know	Support	Neither	Oppose	Don't know	Support	Neither	Oppose	Don't know
Increasing the price of alcohol*	41.9	20.7	34.3	3.0	18.8	13.4	67.1	0.7	9.0	8.1	82.4	0.4
Reducing the number of outlets that sell alcohol*	50.3	18.3	28.9	2.5	21.5	16.2	61.8	0.5	10.4	11.0	78.4	0.2
Reducing trading hours for all pubs and clubs*	43.7	26.6	27.1	2.5	21.0	13.1	65.1	0.8	9.3	7.7	82.7	0.3
Serving only low alcohol drinks at sporting events or venues*	70.1	12.2	16.2	1.5	44.4	15.5	39.4	0.7	27.0	12.0	60.1	0.9
Increasing the number of alcohol-free public events*	71.2	15.2	11.6	2.0	49.5	22.0	28.0	0.5	37.1	20.8	41.4	0.7
Raising the legal drinking age*	37.4	17.2	42.4	3.0	15.0	12.4	71.8	0.7	10.3	6.0	83.5	0.2
Stricter enforcement of the law against serving customers who are drunk*	76.3	13.1	8.1	2.5	66.1	15.3	17.8	0.7	53.7	15.1	31.0	0.2
More severe legal penalties for drink driving*	84.8	9.1	4.0	2.0	79.9	11.6	7.7	0.8	70.7	16.9	11.7	0.7

	No alcohol last 12 months (n=198) %				Alcohol less than weekly (n=1205) %				Alcohol at least weekly (n=898) %			
	Support	Neither	Oppose	Don't know	Support	Neither	Oppose	Don't know	Support	Neither	Oppose	Don't know
Restricting late night trading of alcohol*	59.9	16.8	19.8	3.6	33.4	21.1	44.4	1.1	17.1	14.3	68.1	0.6
Strict monitoring of late night licensed premises*	67.5	17.3	12.7	2.5	54.0	21.1	23.6	1.3	42.8	19.1	37.5	0.6
Limiting advertising for alcohol on TV until 9:30pm*	67.2	18.2	12.6	2.0	57.6	22.8	18.5	1.1	50.5	24.9	23.7	0.9
Banning alcohol sponsorship of sporting events*	58.9	19.3	17.8	4.1	40.3	23.0	35.6	1.1	32.5	22.8	44.2	0.6
Requiring information on national drinking guidelines on all alcohol containers*	72.8	15.4	8.2	3.6	60.9	22.5	15.3	1.3	51.7	28.2	19.4	0.7
Increasing the size of standard drink labels on drink container*	57.4	23.6	12.8	6.2	57.1	28.6	12.2	2.0	50.2	32.3	16.7	0.9
Increasing the tax on alcohol products to pay for health, education, and the cost of treating alcohol-related problems*	60.1	18.2	17.2	4.5	41.0	20.0	37.8	1.2	26.8	14.9	57.3	1.0

* p<0.0001

8.4 Opinions about law enforcement, regulation, treatment and harm reduction services, compared by age and alcohol and other drug use

We compared expressed levels of support for a range of law enforcement, regulatory, treatment and harm reduction policy measures (Table 33). Older participants were more supportive of harm reduction measures such as needle and syringe programs (79.8% compared to 58.9%) and supervised injecting facilities (71.3% compared to 49.6%). Older participants were also more supportive of all treatment interventions, expressing significantly more support for doctors, counselling and detoxification services. Younger participants were more supportive of sniffer dogs in public places (31.2% compared to 23.1% of participants over 18 years of age).

Also shown in Table 33, participants who had ever used an illicit drug in their lifetime were significantly more supportive of harm reduction measures including needle and syringe programs (82.6%), supervised injecting facilities (73.6%), and availability of pill testing (86.8%), as well as drug treatments with medications that mimic the effects of drugs (i.e. methadone) (58.6%). By way of contrast, participants with no experience of illicit drug use were significantly more supportive of all law enforcement and regulation interventions, as well as compulsory drug treatment.

Comparisons between those who have not consumed alcohol in the last 12 months, those who consume alcohol less than weekly and those who consume alcohol at least weekly are shown in Table 34. Participants who consumed alcohol at least weekly were more supportive of needle and syringe programs (83.9%), supervised injecting facilities (76.3%) and availability of pill testing (86.2%). Those who had not consumed alcohol in the last 12 months were significantly more supportive of sniffer dogs (52.0%), visible police presence around licensed venues (68.8%) and more police on the streets (60.3%). Despite the statistically significant differences, while there were very low levels of support for sniffer dogs among participants who drank at least weekly (13.0%), half of this group nonetheless supported visible police presence (51.9%) and more police on the streets (48.0%).

Table 33: To what extent would you support or oppose...

Comparing under-18 year olds with those aged 18 and over; and those who have never used an illicit drug with those who have used an illicit drug in their lifetime

	Under 18 (n=389) %				18 and over (n=1937) %			
	Support	Neither	Oppose	Don't know	Support	Neither	Oppose	Don't know
Treatment services								
A service that provides a place to stay for a short time	81.4	11.9	3.9	2.8	81.5	11.8	5.6	1.1
A service that provides a place to stay for a long time (rehabilitation)	88.3	6.5	2.6	2.6	88.6	8.5	2.2	0.7
Seeing a doctor	**83.6**	**10.6**	**3.6**	**2.1**	**88.9**	**8.8**	**2.1**	**0.3**
Counselling	**84.0**	**10.3**	**3.6**	**2.1**	**89.9**	**7.2**	**2.4**	**0.4**
A service that provides withdrawal (detoxification) from alcohol and/or drugs	**85.3**	**9.2**	**2.6**	**2.9**	**92.4**	**5.6**	**1.1**	**0.8**
Meeting a youth worker in places where young people hang out	67.0	19.3	10.1	3.6	71.9	19.3	7.0	1.8
Compulsory education and/or treatment	51.6	24.1	21.0	3.4	54.2	22.6	21.5	1.8
Medications that mimic the effects of illegal drugs (e.g. methadone)	48.1	21.2	23.8	7.0	56.1	21.8	18.5	3.6

Bolded $p<0.0001$

	Under 18 (n=389) %				18 and over (n=1937) %			
	Support	Neither	Oppose	Don't know	Support	Neither	Oppose	Don't know
Harm reduction services								
Needle and syringe programs	**58.9**	**16.5**	**20.6**	**4.1**	**79.8**	**9.6**	**9.0**	**1.7**
Regulated injecting rooms	**49.6**	**15.2**	**30.8**	**4.4**	**71.3**	**12.8**	**13.9**	**2.0**
Availability of pill testing	77.7	10.9	9.3	2.1	83.4	8.5	6.7	1.4
Drug-free chill-out zones	67.7	22.7	6.2	3.4	65.2	25.5	6.6	2.7
Law enforcement and regulation								
Drug sniffer dogs in public places	**31.2**	**11.1**	**56.4**	**1.3**	**23.1**	**10.7**	**65.9**	**0.3**
Visible police presence around licensed venues such as bars and nightclubs	55.5	16.2	27.5	0.8	59.8	15.8	23.7	0.7
More police on the streets	50.1	23.4	24.9	1.6	54.1	23.8	21.4	0.7
ID scanners at the entry to bars and nightclubs	44.5	20.8	32.6	2.1	50.1	20.1	28.7	1.1
Drug testing at work or at school	25.8	13.4	60.3	0.5	20.9	12.8	65.5	0.8
Banning the purchase of drugs over the internet	36.7	17.1	42.6	3.6	29.0	25.0	42.4	3.6

Bolded $p<0.0001$

	Never used illicit drug (n=580) %				Used an illicit drug (n=1746) %			
	Support	Neither	Oppose	Don't know	Support	Neither	Oppose	Don't know
Treatment services								
A service that provides a place to stay for a short time	77.4	12.9	7.4	2.2	82.8	11.4	4.6	1.1
A service that provides a place to stay for a long time (rehabilitation)	86.8	8.2	3.3	1.7	89.1	8.2	1.9	0.8
Seeing a doctor	**91.5**	**6.3**	**1.0**	**1.2**	**86.8**	**10.0**	**2.8**	**0.3**
Counselling	92.5	4.3	1.9	1.2	87.8	8.8	2.9	0.5
A service that provides withdrawal (detoxification) from alcohol and/or drugs	90.6	6.2	1.7	1.4	91.5	6.2	1.3	1.0
Meeting a youth worker in places where young people hang out	**79.1**	**14.0**	**5.2**	**1.7**	**68.4**	**21.0**	**8.3**	**2.2**
Compulsory education and/or treatment	**70.2**	**17.3**	**9.9**	**2.6**	**48.2**	**24.7**	**25.3**	**1.8**
Medications that mimic the effects of illegal drugs (e.g. methadone)	43.3	24.2	25.8	6.7	58.6	20.9	17.2	3.3

Bolded $p<0.0001$

	Never used illicit drug (n=580) %				Used an illicit drug (n=1746) %			
	Support	Neither	Oppose	Don't know	Support	Neither	Oppose	Don't know
Harm reduction services								
Needle and syringe programs	57.4	15.5	21.7	5.3	82.6	9.1	7.3	1.0
Regulated injecting rooms	49.8	16.5	29.3	4.3	73.6	12.1	12.6	1.7
Availability of pill testing	69.7	16.2	10.9	3.3	86.8	6.4	5.8	1.0
Drug-free chill-out zones	76.6	14.7	5.9	2.8	62.0	28.4	6.8	2.8
Law enforcement and regulation								
Drug sniffer dogs in public places	58.5	14.3	25.6	1.5	13.1	9.6	77.2	0.1
Visible police presence around licensed venues such as bars and nightclubs	77.8	10.7	10.0	1.5	52.9	17.6	29.1	0.5
More police on the streets	72.1	16.3	10.4	1.2	47.3	26.2	25.9	0.7
ID scanners at the entry to bars and nightclubs	64.8	18.1	15.5	1.6	43.9	20.9	34.0	1.1
Drug testing at work or at school	46.6	18.1	34.0	1.2	13.5	11.1	74.8	0.6
Banning the purchase of drugs over the internet	63.6	17.2	15.5	3.6	19.2	25.8	51.4	3.6

Bolded $p<0.0001$

Table 34: To what extent would you support or oppose...

Comparing those who have not consumed alcohol in the last 12 months, with those who consume alcohol less than weekly and those who consume alcohol at least weekly

	No alcohol last 12 months (n=199) %				Alcohol less than weekly (n=1204) %				Alcohol at least weekly (n=898) %			
	Support	Neither	Oppose	Don't know	Support	Neither	Oppose	Don't know	Support	Neither	Oppose	Don't know
Treatment services												
A service that provides a place to stay for a short time	74.7	14.1	7.6	3.5	81.7	11.8	5.1	1.5	82.7	11.2	5.4	0.8
A service that provides a place to stay for a long time (rehab)	83.2	10.2	3.1	3.6	88.5	8.2	2.6	0.8	89.8	7.6	1.7	0.9
Seeing a doctor	87.3	8.6	2.5	1.5	88.4	9.4	1.8	0.5	87.8	8.7	3.1	0.5
Counselling	87.4	6.5	4.5	1.5	89.7	7.8	1.8	0.7	88.4	7.7	3.4	0.6
A service that provides withdrawal (detoxification) from alcohol and/or drugs	87.9	7.1	3.0	2.0	91.0	6.4	1.5	1.1	92.3	5.8	0.9	1.0
Meeting a youth worker in places where young people hang out	75.9	14.6	7.5	2.0	70.8	19.8	7.2	2.2	70.7	19.3	8.0	2.0
Compulsory education and/or treatment*	61.7	18.4	16.3	3.6	56.2	22.4	19.5	1.9	48.1	24.6	25.4	1.9
Medications that mimic the effects of illegal drugs (e.g. methadone)*	39.3	25.0	28.6	7.1	51.2	21.5	22.4	5.0	62.5	21.9	13.1	2.6

	No alcohol last 12 months (n=199) %				Alcohol less than weekly (n=1204) %				Alcohol at least weekly (n=898) %			
	Support	Neither	Oppose	Don't know	Support	Neither	Oppose	Don't know	Support	Neither	Oppose	Don't know
Harm reduction services												
Needle and syringe programs*	54.3	16.1	21.6	8.0	74.1	12.2	11.8	1.9	83.9	7.5	7.7	1.0
Regulated injecting rooms*	49.2	16.6	29.1	5.0	64.1	14.2	19.0	2.7	76.3	10.9	11.4	1.3
Availability of pill testing*	73.2	14.6	9.1	3.0	80.9	9.0	8.2	1.9	86.2	7.7	5.3	0.8
Drug-free chill-out zones*	77.3	14.1	4.5	4.0	67.4	23.5	6.2	2.9	61.0	29.5	7.0	2.5
Law enforcement and regulation												
Drug sniffer dogs in public places*	52.0	12.1	34.3	1.5	28.8	12.1	58.4	0.6	13.0	8.9	78.0	0.1
Visible police presence around licensed venues such as bars and nightclubs*	68.8	13.1	16.6	1.5	63.1	15.1	21.0	0.7	51.9	17.7	29.8	0.6
More police on the streets*	60.3	19.6	17.6	2.5	56.6	22.3	20.5	0.7	48.0	26.5	24.8	0.7
ID scanners at the entry to bars and nightclubs*	58.6	20.7	17.7	3.0	53.1	19.1	26.6	1.2	41.6	21.9	35.5	1.0
Drug testing at work or at school*	46.2	15.2	37.1	1.5	23.5	14.5	61.0	1.1	14.5	10.3	75.0	0.2
Banning the purchase of drugs over the internet*	57.1	14.6	24.7	3.5	32.9	21.3	42.3	3.6	21.6	29.0	45.6	3.8

* $p<0.0001$

8.5 Opinions about new and emerging substances, compared by age and alcohol and other drug use

Participants were asked: 'What would be an appropriate way to handle new substances that imitate the effects of illegal drugs and that are sold as legal substances (e.g. kronic)?' Here we compare the responses of younger and older participants, as well as the responses of those who consume alcohol at least weekly and those who consume alcohol less frequently, and those who have ever used an illicit drug in their lifetime with those who have never used an illicit drug.

There were significant differences between the responses of participants under 18 years of age, and those aged 18 years and older ($p<0.0001$) (see Table 35). A larger proportion of older participants thought that new substances should be regulated like alcohol, tobacco and medicines (53.0%, compared to 42.3% of younger participants).

The responses of participants who had not consumed alcohol in the last 12 months, were also significantly different when compared with those who consume alcohol less than weekly and those who consume alcohol at least weekly ($p<0.0001$). Participants who consume alcohol at least weekly were more supportive of regulating new substances (56.9%, compared to 39.6% of participants who had not consumed alcohol recently).

The responses of participants who had ever used an illicit drug in their lifetime were also significantly different compared to the responses of those who had never used an illicit drug ($p<0.0001$). Over half (54.9%) of participants with experience of drug use thought that new substances should be regulated, compared to 40.1 per cent of participants who had never used an illicit drug. A substantial minority (13.1%) of participants with no drug use experience thought that new substances should be banned (compared to 4.1 per cent of participants who had used drugs in their lifetime).

Table 35: What would be an appropriate way to handle new substances that imitate the effects of illegal drugs and that are sold as legal substances (e.g. kronic)?

Comparing under-18 year olds with those aged 18 and over; those who have not consumed alcohol in the last 12 months, with those who consume alcohol less than weekly and those who consume alcohol at least weekly; and those who have never used an illicit drug with those who have used an illicit drug in their lifetime

	Under 18 (n=388) %	18 and over (n=1938) %	No alcohol last 12 months (n=199) %	Alcohol less than weekly (n=1204) %	Alcohol at least weekly (n=898) %	Never used illicit drug (n=578) %	Used an illicit drug (n=1748) %
Regulate them like alcohol, tobacco and medicines	42.3	53.0*	39.6	48.8	56.9*	40.1	54.9*
Ban them only if they pose a risk to health	34.3	31.2	31.0	34.2	29.0	35.6	30.4
Ban them under any circumstances	9.3	5.7	16.2*	6.6	3.6	13.1	4.1*
Do nothing	5.2	3.6	4.1	3.4	4.5	2.2	4.4
Other	2.3	2.9	3.0	3.0	2.3	1.7	3.1
Don't know	6.7	3.5	6.1	4.0	3.8	7.1	3.0*

* $p<0.0001$

8.6 Opinions about the legal status of cannabis, compared by age and drug use

Here we examine differences of opinion within the sample about the legal status of cannabis specifically. We chose to examine differences of opinion about the legal status of cannabis, rather than other drugs, as cannabis is the illicit drug most often discussed in the context of decriminalisation and legalisation policy debate both in Australia and internationally. When opinions were compared by age, we found significant differences between participants aged under 18 years, and those aged 18 years and older ($p<0.0001$). Two-thirds (63.8%) of older participants stated that the personal use of cannabis should be legalised, compared to 56.7 per cent of younger participants. A substantial minority of younger participants (14.7%) thought that penalties for personal use should be increased (compared to 7.2% of participants aged 18 years and older).

Table 36: For the following drugs, which statement is closest to your opinion?

Comparing under-18 year olds with those aged 18 and over

	Under 18 (n=388) %					18 and over (n=1941) %				
	Legalise	Decriminalise	As is	Penalty should increase	Don't know	Legalise	Decriminalise	As is	Penalty should increase	Don't know
Cannabis*	56.7	17.8	8.0	14.7	2.8	63.8	19.0	8.0	7.2	2.0

* $p<0.0001$

We also found significant differences when comparing the opinions of those who have experience of drug use and those who have never used drugs ($p<0.0001$). Three-quarters (74.6%) of participants who had used a drug in their lifetime supported the legalisation of the personal use of cannabis, compared to one-quarter (26.6%) of participants who had never used drugs. Participants who had never used an illicit drug were heterogeneous in their responses, with one-quarter (26.6%) supporting legalisation of the personal use of cannabis, one-quarter supporting the decriminalisation of personal use (23.3%), and one-quarter (25.9%) suggesting that penalties for personal use should be increased.

Table 37: For the following drugs, which statement is closest to your opinion?

Comparing those who have never used an illicit drug with those who have used an illicit drug in their lifetime

	Never used illicit drug (n=579) %					Used an illicit drug (n=1750) %				
	Legalise	Decriminalise	As is	Penalty should increase	Don't know	Legalise	Decriminalise	As is	Penalty should increase	Don't know
Cannabis*	26.6	23.3	17.8	25.9	6.4	74.6	17.3	4.7	2.7	0.7

* $p<0.0001$

8.7 Sources of information, compared by age and alcohol and other drug use

We sought to examine whether groups of young people sought information about alcohol and drugs from different sources, depending on their age and experience with alcohol and drug use.

A larger proportion of older participants said they would seek information from the internet or from a friend or health professional, whereas a larger proportion of younger participants said they would seek information from parents or someone at school or work (Table 38). However, despite these proportional differences, the rank ordering of the internet and friends as the two top sources of information is true for both age groups.

There were some significant differences when we compared those who consume alcohol at least weekly and those who consume alcohol less frequently. A larger proportion of participants who consumed alcohol at least weekly said they would seek information from a friend.

Similarly, a larger proportion of participants with experience of drug use said that they would seek information from a friend or the internet. A larger proportion of participants who had never used drugs said that they would seek information from parents (25.3% compared to 15.6% of those with drug use experience) and the mass media (12.6% compared to 6.9% of those with drug use experience).

Table 38: If you wanted information or advice about alcohol and drug use, which three sources would you turn to?

Comparing under-18 year olds with those aged 18 and over; those who have not consumed alcohol in the last 12 months, with those who consume alcohol less than weekly and those who consume alcohol at least weekly; and those who have never used an illicit drug and those who have used an illicit drug in their lifetime

	Under 18 (n=389) %	18 and over (n=1946) %	No alcohol last 12 months (n=200) %	Alcohol less than weekly (n=1207) %	Alcohol at least weekly (n=901) %	Never used illicit drug (n=581) %	Used illicit drug (n=1754) %
A friend	55.0	64.4*	42.0	60.7	70.4*	45.1	68.8*
Parents/relatives	26.7*	16.2	27.0	17.6	16.8	25.3*	15.6
Brother/sister	13.9	12.1	6.0	11.5	15.1	9.8	13.3
Someone at school or at work	28.0*	14.4	19.0	16.7	16.4	17.4	16.5
Doctor, nurse or another health professional	37.0	46.9*	45.0	46.6	43.4	51.3	43.2
Social/youth worker	17.2*	9.5	18.0*	11.9	7.9	14.3	9.6
Drug counsellor/centre	21.3	22.6	30.5	23.1	19.3	25.3	21.4
The police	3.9	1.9	6.5*	2.3	1.2	5.0*	1.3
A telephone helpline	7.2	6.1	8.0	6.0	6.1	7.9	5.7
The internet	77.9	90.4*	76.5*	89.1	89.9	80.7	90.9*
Mass media	7.7	8.4	11.0	8.0	8.2	12.6*	6.9
Don't know	4.1	6.4	9.0	6.4	5.0	5.3	6.2

* $p<0.0001$

9. Predictors of opinion: including age, alcohol and other drug use, help-seeking and risk perception

Statistical techniques that assess the extent to which certain demographic or alcohol/drug use variables predict opinions over and above other variables are reported here. Multinomial logistic regressions were used, whereby all variables of interest in predicting opinions (age, gender, alcohol use, illicit drug use, help-seeking, attitudes towards alcohol, and attitudes towards drugs) were entered into the equations, and then a backward elimination method used to remove those variables that did not add significant predictive power to the regression.[10]

Predictors were analysed for support for the following (n=9):

1. Increasing the price of alcohol
2. Restricting late night trading of alcohol
3. Drug education in schools helps to prevent young people from using drugs
4. Services that provide a place to stay for a long time (rehabilitation)
5. Drug sniffer dogs in public places
6. Regulation of new substances
7. Legalisation of cannabis
8. Tough measures against drug traffickers
9. Banning the purchase of drugs over the internet.

The rationale for this choice of questions is given in the Methods section. To recap, these nine questions represent a range of opinions across multiple policy domains. We wish to assess the extent to which certain variables drive opinions in these areas and the extent of differences in the drivers across policy domains.

Each regression is reported individually, followed by a summary analysis of the findings across all the regression models.

10 Stepwise multinomial logistic regressions were also performed as a cross-check. The results did not differ if the stepwise entry versus the backward elimination method was used.

9.1 Increasing the price of alcohol

The regression-assessing characteristics associated with support for increasing the price of alcohol (where the reference category was 'Oppose increase in price') resulted in a number of significant predictor variables. These were age, attitudes to alcohol, attitudes to drugs, alcohol use and drug use, all of which significantly differentiated between respondents who supported price increases and those who did not. Support for increasing the price of alcohol was associated with a less positive attitude to drugs and a less positive attitude to alcohol. This is in the expected direction – those who perceive negative aspects to alcohol (OR=0.33) or drugs (OR=0.73) are more supportive of price increases for alcohol. Additionally age predicts support for increases in price – with older respondents more supportive of price increases (OR=1.13). Those who had never used an illicit drug were twice as likely to support price increases compared to those who had used an illicit drug (OR=1.99). And unsurprisingly, relative to more frequent drinkers, those respondents who were abstainers were four times more likely to support increases in alcohol price (OR=4.25). This finding is consistent with the Chi Square analyses, demonstrating a strong relationship between opinions about alcohol price and consumption (see Table 32).

Table 39: To reduce the problems associated with excessive alcohol use, to what extent would you support... Increasing the price of alcohol

		B	Sig.	Odds ratio (95% CI)
Support (n=252)	Intercept	1.758	.006	
	Age	.127	.000	1.135 (1.072 to 1.202)
	Attitude to drugs	-.311	.004	.733 (.591 to .908)
	Never used any illicit drug (compared to used an illicit drug)	.693	.002	1.999 (1.301 to 3.072)
	Attitude to alcohol	-1.100	.000	.333 (.254 to .437)
	No alcohol last 12 months (compared to alcohol at least weekly)	1.447	.000	4.252 (2.262 to 7.993)
	Alcohol less than weekly (compared to alcohol at least weekly)	.718	.000	2.051 (1.462 to 2.878)

		B	Sig.	Odds ratio (95% CI)
Neither support nor oppose (n=203)	Intercept	.031	.965	
	Age	.047	.121	1.048 (.988 to 1.111)
	Attitude to drugs	-.172	.148	.842 (.667 to 1/063)
	Never used any illicit drug (compared to used an illicit drug)	.251	.300	1.285 (.800 to 2.064)
	Attitude to alcohol	-.588	.000	.555 (.415 to .744)
	No alcohol last 12 months (compared to alcohol at least weekly)	1.572	.000	4.816 (2.455 to 9.449)
	Alcohol less than weekly (compared to alcohol at least weekly)	.728	.000	2.070 (1.462 to 2.932)

Reference category: Oppose n=1216

n=1671; overall model significance χ^2=239.37, p<0.0001

9.2 Restricting late night trading of alcohol

Support for restricting late night trading of alcohol (relative to opposition) was predicted by four variables: age; attitudes towards drugs; attitudes towards alcohol; and alcohol consumption (Table 40). The largest odds ratio was for alcohol consumption – abstainers (relative to more frequent drinkers) were 3.6 times more likely to support these restrictions (consistent with the Chi Square results reported earlier). Older respondents were more supportive of restrictions (OR=1.05), and unsurprisingly on the attitudinal predictors, those who had more positive attitudes to alcohol and to drugs were less likely to support restrictions on late night trading (OR of 0.44 and 0.35 respectively).

Table 40: To reduce the problems associated with excessive alcohol use, to what extent would you support... Restricting late night trading of alcohol

		B	Sig	Odds ratio (95% CI)
Support (n=437)	Intercept	4.931	.000	
	Age	.050	.047	1.051 (1.001 to 1.104)
	Attitude to drugs	-1.0498	.000	.350 (.294 to .418)
	Attitude to alcohol	-.823	.000	.439 (.343 to .562)
	No alcohol last 12 months (compared to alcohol at least weekly)	1.287	.000	3.620 (1.986 to 6.600)
	Alcohol less than weekly (compared to alcohol at least weekly)	.798	.000	2.220 (1.691 to 2.914)
Neither support nor oppose (n=293)	Intercept	2.554	.000	
	Age	-.011	.675	.989 (.938 to 1.042)
	Attitude to drugs	-.612	.000	.542 (.446 to .659)
	Attitude to alcohol	-.515	.000	.597 (.457 to .780)
	No alcohol last 12 months (compared to alcohol at least weekly)	.33	.406	1.396 (.636 to 3.068)
	Alcohol less than weekly (compared to alcohol at least weekly)	.728	.000	2.071 (1.554 to 2.760)

Reference category: Oppose n=934

n=1664; overall model significance χ^2=355.40, p<0.0001

9.3 Drug education in schools helps to prevent young people from using drugs

Less than half of the full sample (36%) supported the statement that 'Drug education in schools helps to prevent young people from using drugs' – an almost equivalent percentage disagreed (38%). It is therefore of interest to examine what predicts agreement with the statement (the reference category was 'Disagree'). After all variables were entered then the non-significant (non-predictive) variables removed, two variables were associated with support for drug education in schools: these were age, and attitude towards drugs. As shown in Table 41, a higher age was predictive of greater support for school-based drug education (OR=1.073). A positive attitude towards illicit drugs was predictive of decreased support for school-based drug education (OR=0.212). No other variables predicted agreement with school-based drug education being helpful in preventing young people from using drugs. While the Chi Square analysis showed gender differences (see Table 17; males had a lower percentage agreement than females), this association was not significant in this (statistically more powerful) multinomial regression.

Table 41: To what extent would you agree or disagree with the following statements? Drug education in schools helps to prevent young people from using drugs and alcohol

		B	Sig.	Odds ratio (95% CI)
Agree (n=596)	Intercept	4.999	.000	
	Age	.070	.003	1.073 (1.023 to 1.125)
	Attitude to drugs	-1.557	.000	.211 (0.172 to 0.258)
Neither agree nor disagree (n=410)	Intercept	2.622	.000	
	Age	.045	.072	1.046 (0.996 to 1.098)
	Attitude to drugs	-.908	.000	.403 (0.326 to 0.499)

Reference category: Disagree n=653

n=1659; overall model significance χ^2=315.79, p<0.0001

9.4 Services that provide a place to stay for a long time (rehabilitation)

Unlike the school drug education question, support for services that provide a place to stay in the long term was a prevailing view. Across the whole sample, 89 per cent supported services that provide a place to stay 'for a long time'. In terms of which variables were associated with support, after all variables were entered then the non-significant (non-predictive) variables removed, two variables significantly differentiated between respondents who supported long-term rehabilitation and those who did not: gender; and attitude towards drugs. Being male was associated with lower support for long-term rehabilitation (OR=0.35), as found in the Chi Square analysis (Table 21). A positive attitude to drugs predicted support for long-term rehabilitation (OR=2.05). Neither alcohol nor drug use per se predicted support on this question (consistent with the non-significant Chi Square analyses, Tables 33 and 34).

Table 42: To what extent would you support or oppose services such as... A service that provides a place to stay for a long time (rehabilitation)

		B	Sig.	Odds ratio (95% CI)
Support (n=1491)	Intercept	1.937	.002	
	Attitude to drugs	.717	.000	2.049 (1.381 to 3.041)
	Male (compared to female)	-1.046	.011	.351 (0.158 to 0.784)
Neither support nor oppose (n=136)	Intercept	-.167	.817	
	Attitude to drugs	.435	.059	1.538 (0.984 to 2.425)
	Male (compared to female)	-.067	.885	.942 (0.376 to 2.322)

Reference category: Oppose n=39

n=1666; overall model significance χ^2=30.78, p<0.0001

9.5 Drug sniffer dogs in public places

In the analysis of opinions about sniffer dogs, the following variables were associated with support for sniffer dogs: gender; attitudes towards drugs; attitudes towards alcohol; and alcohol consumption. Table 43 provides the results of the regression. As can be seen, those who have a more positive attitude towards drugs have decreased support for sniffer dogs (OR less than 1.0). The reverse pattern is true for attitudes towards alcohol – those who have positive attitudes towards alcohol are twice as likely (OR=2.0) to support use of sniffer dogs. Being male predicted lower support for sniffer dogs (OR=0.7). Finally, those who had not consumed alcohol in the last 12 months (relative to those who consumed alcohol frequently) were substantially more likely to support the presence of sniffer dogs (OR=4.12).

Table 43: Thinking about other responses to alcohol and/or drug use, to what extent would you support... Drug sniffer dogs in public places

		B	Sig.	Odds ratio (95% CI)
Support (n=326)	Intercept	6.620	.000	
	Attitude to drugs	-2.731	.000	.066 (0.48 to 0.88)
	Attitude to alcohol	.692	.000	1.997 (1.403 to 2.841)
	Male (compared to female)	-.363	.047	.696 (0.487 to .995)
	No alcohol last 12 months (compared to at least weekly alcohol)	1.434	.000	4.197 (1.956 to 9.009)
	Alcohol less than weekly (compared to at least weekly alcohol)	.591	.001	1.806 (1.255 to 2.599).

		B	Sig.	Odds ratio (95% CI)
Neither support nor oppose (n=168)	Intercept	2.725	.000	
	Attitude to drugs	-1.479	.000	.228 (.169 to .307)
	Attitude to alcohol	.222	.218	1.249 (.877 to 1.779)
	Male (compared to female)	-.648	.001	.523 (.362 to .756)
	No alcohol last 12 months (compared to at least weekly alcohol)	.204	.674	1.226 (.474 to 3.173)
	Alcohol less than weekly (compared to at least weekly alcohol)	.437	.017	1.549 (1.081 to 2.219)

Reference category: Oppose n=1181

n=1675; overall model significance χ^2=817.76, p<0.0001

9.6 Regulation of new substances

Predictors of opinions towards regulation of new substances used 'Ban them under any circumstance' as the reference category. In the regression analysis, the following variables significantly differentiated between respondents who supported a legalised and regulated model for emerging psychoactive substances (EPS): attitudes towards alcohol; attitudes towards drugs; and gender. Those with more positive attitudes to drugs were at least five times more likely to support a full legalisation model (OR=5.12). Those with a more positive attitude to alcohol were twice as likely to support regulation (OR=2.10). Being male predicted lower support for regulation (OR=0.58). These patterns were replicated for those who supported the statement 'Ban them only if they pose a health risk'; that is, positive attitudes to drugs (OR=2.95) and positive attitudes towards alcohol (OR=1.85) were associated with greater support for a health-related ban compared to banning them under any circumstances. Preferences for the other options (Do nothing; Other) followed a similar pattern to that above. For example, those with a positive attitude towards drugs were 13 times more likely to support doing nothing than a complete ban (OR=13.48).

Table 44: What would be an appropriate way to handle new substances that imitate the effects of illegal drugs and that are sold as legal substances (e.g. kronic)? Please pick one

		B	Sig.	Odds ratio (95% CI)
Regulate them like alcohol, tobacco and medicines (n=892)	Intercept	-5.203	.000	
	Attitude to drugs	1.633	.000	5.118 (3.793 to 6.905)
	Attitude to alcohol	.745	.000	2.106 (1.451 to 3.056)
	Male (compared to female)	-.542	.040	.582 (.347 to .976)
Ban if only pose health risk (n=522)	Intercept	-3.507	.000	
	Attitude to drugs	1.082	.000	2.951 (2.202 to 3.953)
	Attitude to alcohol	.616	.001	1.852 (1.279 to 2.682)
	Male (compared to female)	-.276	.296	.759 (.452 to 1.273)
Do nothing (n=69)	Intercept	-12.494	.000	
	Attitude to drugs	2.601	.000	13.480 (7.132 to 25.477)
	Attitude to alcohol	.779	.007	2.180 (1.232 to 3.857)
	Male (compared to female)	.536	.270	1.710 (.659 to 4.433)
Other (n=48)	Intercept	-10.215	.000	
	Attitude to drugs	2.164	.000	8.702 (4.573 to 16.560)
	Attitude to alcohol	.687	.035	1.988 (1.051 to 3.763)
	Male (compared to female)	-.152	.740	.859 (.351 to 2.105)

Reference category: Ban them under any circumstances (n=97)

n=1628; overall model significance χ^2=247.77, p<0.0001

9.7 Legalisation of cannabis

Predictors of cannabis legalisation were gender and attitudes towards drugs (not any of the other entered variables). The reference category for this analysis was 'The law should be left as is'. Unsurprisingly and as shown in Table 45, the largest predictor for legalisation of cannabis (relative to the law being left as is) was a positive attitude towards drugs, with an odds ratio of 21.76. The other significant predictor, gender, showed that being male predicted support for legalisation (OR=2.24). This result is in line with the earlier Chi Square analyses (see Table 24). A positive attitude towards drugs also significantly predicted support for decriminalisation options (relative to the law being left as is), with an odds ratio of 3.43.

Table 45: For the following drugs, which statement is closest to your opinion? Cannabis

		B	Sig.	Odds ratio (95% CI)
Personal use should be legalised (n=1142)	Intercept	-8.305	.000	
	Attitude to drugs	3.080	.000	21.760 (14.567 to 32.506)
	Male (compared to female)	.808	.002	2.243 (1.362 to 3.692)
Personal use should be decriminalised (illegal but with non-criminal penalties, e.g. a fine) (n=305)	Intercept	-2.754	.000	
	Attitude to drugs	1.234	.000	3.435 (2.420 to 4.874)
	Male (compared to female)	.425	.094	1.530 (.930 to 2.515)
Penalties for personal use should be increased (n=108)	Intercept	3.150	.000	
	Attitude to drugs	-1.401	.000	.246 (.153 to .396)
	Male (compared to female)	.128	.689	1.137 (.607 to 2.126)

Reference category: Law left as is, n=110

n=1665; overall model significance χ^2=933.29, p<0.0001

9.8 Tough measures against drug dealers and traffickers

In the regression predicting support for tough measures against drug dealers and traffickers, a binary logistic regression was used, with the score of 0 reflecting that the respondent did not select 'Tough measures' in his/her top three. Therefore the odds ratios represent the likelihood than an individual will select 'Tough measures'. Three variables were associated with choosing 'Tough measures' in the top three responses: attitudes to drugs; gender; and help-seeking. This was the only regression equation where help-seeking significantly predicted opinion. While the overall model was significant (χ^2=454.60, p<0.0001), the help-seeking variable did not reach statistical significance in the parameter estimation. However, the direction of the results suggests that those who had sought help were less likely to support tough measures against drug dealers and traffickers (OR=0.675). In terms of the variables that significantly differentiated between respondents who chose 'Tough measures', being male was associated with lower support for tough measures (OR=0.71). Likewise, positive attitudes towards drugs were associated with lower support for tough measures (OR=0.20).

Table 46: What are the three most effective ways for public authorities to reduce drug problems... Tough measures against drug dealers and traffickers

		B	Sig.	Odds ratio (95% CI)
Selected in top three (n=1268)	Intercept	4.490	.000	
	Attitude to drugs	-1.594	.000	.203 (.167 to .247)
	Male (compared to female)	-.345	.016	.708 (.535 to .937)
	Sought help (compared to never sought help)	-.393	.075	.675 (.438 to 1.040)

Reference category: Tough measures against dealers/traffickers not selected in top three (n=418)

n=1686; overall model significance χ^2=454.60, p<0.0001

9.9 Banning the purchase of drugs over the internet

Support for banning the sale of drugs over the internet (relative to opposition) was predicted by five variables: age; gender; attitudes towards drugs; attitudes towards alcohol; and alcohol consumption. Those who supported a ban on internet purchasing were less likely to have positive attitudes towards drugs (OR=0.03), were less likely to be male (OR=0.33) and to drink in the less than weekly category (OR=0.66). They were also more likely to have positive attitudes toward alcohol (OR=1.46). Age was not a significant predictor of support, but was a significant predictor of the neutral position (relative to oppose) (OR=1.06), in the direction of older respondents more likely to hold a neutral position relative to opposing.

Table 47: Thinking about other responses to alcohol and/or drug use, to what extent would you support... Banning the purchase of drugs over the internet

		B	Sig.	Odds ratio (95% CI)
Support (n=434)	Intercept	10.296	.000	
	Age	.052	.109	1.054 (.988 to 1.123)
	Attitude to drugs	-3.340	.000	.035 (.025 to .050)
	Attitude to alcohol	.377	.033	1.457 (1.031 to 2.060)
	Male (compared to female)	-1.108	.000	.330 (.232 to .469)
	No alcohol last 12 months (compared to at least weekly alcohol)	.121	.772	1.129 (.496 to 2.568)
	Alcohol less than weekly (compared to at least weekly alcohol)	-.410	.021	.664 (.468 to .940)

		B	Sig.	Odds ratio (95% CI)
Neither support nor oppose (n=421)	Intercept	6.321	.000	
	Age	.058	.025	1.059 (1.007 to 1.114)
	Attitude to drugs	-1.788	.000	.167 (.124 to .225)
	Attitude to alcohol	.024	.858	1.024 (.790 to 1.327)
	Male (compared to female)	-.501	.001	.606 (.448 to .820)
	No alcohol last 12 months (compared to at least weekly alcohol)	-.849	.035	.428 (.194 to .943)
	Alcohol less than weekly (compared to at least weekly alcohol)	-.458	.001	.632 (.484 to .826)

Reference category: Oppose n=775

n=1630; overall model significance χ^2=954.39, p<0.0001

9.10 Summary across analysis

From this research, young people's attitudes towards alcohol and drugs appear to be the strongest drivers of their opinions about interventions and control measures. Positive attitudes towards alcohol (such as believing that alcohol makes you friendly, outgoing, relaxed and is not harmful) and positive attitudes towards drugs (such as believing that drugs are fun, help people experience life to the fullest and are not dangerous) are strongly predictive of permissive opinions about alcohol and other drug policy, including support for full regulation of new and emerging substances, legalisation of cannabis, and long-term rehabilitation. Positive attitudes also predicted less support for drug education in schools, increasing the price of alcohol, tough measures against drug dealers and traffickers, banning the sale of drugs over the internet and restrictions on late night trading.

Actual consumption of alcohol or illicit drugs did not appear to significantly distinguish respondent opinions. In five of the eight regressions, these variables were not significant. The exceptions were opinions towards alcohol pricing (both alcohol and drug consumption), banning the sale of drugs over the internet (alcohol consumption), support for sniffer dogs (alcohol consumption), and restricting late night trading (alcohol consumption). It is possible that actual consumption behaviour is highly correlated with attitudes towards substances. However, examination of the degree of association between these variables revealed modest correlations. Alcohol consumption was correlated with attitudes to alcohol at 0.181 (Spearman rho); illicit drug consumption was correlated with attitudes to drugs at 0.499 (Spearman rho). The strength of the relationship appears stronger for illicit drugs than for alcohol. Nonetheless, these degrees of association are not of such a size that it can account for the findings. That is, the predictive power of positive attitudes to alcohol and drugs is not accounted for by their association with alcohol or drug use.

The regression results also suggest some differences between alcohol and drug attitudes. For example, opinions about sniffer dogs distinguished attitudes to drugs from attitudes to alcohol: those who have a positive attitude to drugs do not support sniffer dogs; those who have a positive attitude toward alcohol do support sniffer dogs. This appears to signal an important difference in young people regarding opinions about alcohol versus opinions about drugs, and suggests aspecificity associated with attitudes that differentiate positive attitudes towards alcohol from positive attitudes towards drugs.

In only four of the nine regression equations, age was predictive of opinions. This suggests that age may not be a particularly salient variable in distinguishing young people's opinions. In the regressions where age was significantly predictive, it was in the direction of older respondents being more supportive of control measures. Older respondents were more supportive of alcohol price increases, late night trading restrictions and drug education in schools. Otherwise there was little that distinguished older from younger respondents in their opinions.

Gender may be an important variable to take into consideration when assessing opinions. In six of the nine regression equations, gender was significantly associated with opinions. These were in the expected direction: females were more supportive of long-term rehabilitation options, tough measures against dealers, sniffer dogs and banning sales of drugs on the internet. And females were less supportive of legalisation of cannabis and legalisation of emerging psychoactive substances. It is worth noting that gender was not predictive of the alcohol control measures. Previous opinions research has shown that females are generally more conservative and support greater regulatory control over drugs.

The help-seeking variable was not significantly associated with opinions in any of the regression equations, suggesting that this variable does not distinguish opinions.

10. Opinions of Indigenous respondents

In the following sections we examine more closely the opinions of particular subpopulations within the sample by looking at their responses to two questions which consider overarching opinions about approaches to drug policy, and then by examining responses to the same list of 'key' questions used in predictors of opinion analyses above.

Firstly, the responses of Aboriginal and Torres Strait Islander participants are compared with the opinions of the rest of the sample of young people. As shown in Table 48, Indigenous participants nominated the same interventions as the rest of the sample in their top three most effective ways to reduce drug and alcohol problems. Indigenous participants said that treatment (70.0%), information and prevention campaigns (56.0%) and making illegal drugs legal (40.0%) were the three most effective responses.

Table 48: What are the three most effective ways for public authorities to reduce drug and alcohol problems?

Comparing responses of Aboriginal and Torres Strait Islander participants with the rest of the sample

	Aboriginal and Torres Strait Islander (n=50) %	Rest of sample (n=2275) %
Information and prevention campaigns	56.0	55.3
Treatment and rehabilitation of drug users	70.0	66.6
Tough measures against drug dealers and traffickers	38.0	28.9
Making illegal drugs legal	40.0	49.5
Reduction of poverty/unemployment	36.0	47.1
Tough measures against drug users	14.0	9.8
More leisure opportunities	30.0	24.0
Don't know	4.0	3.1

* $p<0.0001$

There were also no significant differences between the opinions of Indigenous respondents and the rest of the sample, when responses to the attitudinal statements presented in Table 49 are compared. Although the differences did not reach statistical significance, a greater proportion of Aboriginal and Torres Strait Islander participants agreed with all the statements. Notably, close to all Indigenous respondents (94.0%) agreed that treatment should be available to all drug users, according to their needs. One Indigenous participant suggested that treatment should be accessible in this way:

> Free help and support services for drug information, counselling, rehabilitation and helping to reconnect 'lost' youth that have had their lives slowly torn apart by drugs or alcohol. It should be available to teenagers/young adults who are financially insecure, without a doctor or other health professional's referral or recommendations. NO parental notification/consent should be compulsory for youth that seek drug/alcohol help.

There was also strong support for drug education among Indigenous participants (52.0%). This support for drug education in schools was expressed in the open-ended responses by several Indigenous participants:

> I think substance abuse should be spoken about in high schools around the country to prepare young adults for the type of troubles that are involved in taking drugs and alcohol as an adult as most young people start these habits in high school.

> Better educational programs in schools about strong drugs and their social impacts on individuals and families.

> More education in the local schools, and more health promotion in the local communities.

> Run free drug/alcohol information sessions, make it COMPULSORY for schools to have to learn about drug/alcohol use or have someone within the community (e.g. nurse, police officer, etc) who can provide some time out of their job.

> We need more education on how easy it is to fall into a habitual using of drugs and alcohol. Enforce that it is very easy to get addicted to alcohol and other drugs and to really rally and support that marijuana is a 'gateway' drug. I haven't learnt anything useful about drugs at school and I'm almost clueless to the effects it can have on people's lives.

Table 49: To what extent would you agree or disagree with the following statements?
Comparing responses of Aboriginal and Torres Strait Islander participants with the rest of the sample

	Aboriginal and Torres Strait Islander (n=50) %				Rest of sample (n=2266) %			
	Agree	Neither	Disagree	Don't know	Agree	Neither	Disagree	Don't know
Treatment should only be given to drug users who intend to give up drugs for good	36.0	16.0	44.0	4.0	21.0	16.6	60.9	1.6
Public awareness/mass media campaigns are a good way to change attitudes about alcohol and other drug use	62.0	22.0	14.0	2.0	60.8	18.1	19.7	1.5
Drug education in schools provides helpful information to young people about drugs and alcohol	79.6	4.1	14.3	2.0	63.1	11.8	24.0	1.2
It is possible to reduce drug and alcohol problems through prevention	64.0	18.0	16.0	2.0	60.4	16.7	19.7	3.2
Treatment should be available to all drug users, according to their needs	94.0	4.0	0.0	2.0	89.6	6.7	2.8	0.8
Drug education in schools helps to prevent young people from using drugs and alcohol	52.0	20.0	26.0	2.0	36.3	23.7	38.2	1.8

* $p<0.0001$

In addition to the overarching opinions about approaches to drug policy outlined above, we also examined the opinions of Aboriginal and Torres Strait Islander participants across the nine questions of interest. Again, although differences did not reach statistical significance, a larger proportion of Indigenous respondents expressed support for restricting late night trading of alcohol (38.8% compared to 28.9% of the rest of the sample). Like the rest of the sample, the desire for alcohol regulation that provides room for personal choice was evident in the open-ended responses, as expressed by these Indigenous participants:

> I think the government needs to lay off on the taxing of alcohol and tobacco, these are not a problem as it is personal choice, it is a free world. I think the laws for drink driving and public nuisance need to be increased and enforced and more time and resources need to be put in to the control of illegal substances.

> Alcohol is taxed enough and enough is being done. If anything the price should be lower because people are still drinking the same and are looking for drugs as a cheaper alternative to drinking, i.e. $30 pill or a 2-3 hundred night out drinking for an even lesser feeling.

Table 50: Key questions, comparing responses of Aboriginal and Torres Strait Islander participants with the rest of the sample

	Aboriginal and Torres Strait Islander (n=50) %				Rest of sample (n=2266) %			
	Support	Neither	Oppose	Don't know	Support	Neither	Oppose	Don't know
Increasing the price of alcohol	16.3	24.5	57.1	2.0	16.9	11.5	70.9	0.8
Restricting late night trading of alcohol	38.8	26.5	32.7	2.0	28.9	17.9	52.1	1.1
A service that provides a place to stay for a long time (rehabilitation)	87.8	10.2	0.0	2.0	88.6	8.1	2.3	1.0
Drug sniffer dogs in public places	26.0	10.0	60.0	4.0	24.4	10.8	64.4	0.4
Banning the purchase of drugs over the internet	42.0	26.0	26.0	6.0	30.0	23.6	42.8	3.6

* $p<0.0001$

There was a higher level of support for banning new and emerging substances among Indigenous participants, with a substantial minority of 14.6 per cent supporting this measure, compared to only 6.2 per cent of the rest of the sample. One Indigenous participant suggested it was the role of authorities to remove unsafe substances:

> More involvement from authorities to ensure unsafe drugs are taken off the street or at least the community is made more aware.

Table 51: Key questions: What would be an appropriate way to handle new substances that imitate the effects of illegal drugs and that are sold as legal substances (e.g. kronic)?

Comparing responses of Aboriginal and Torres Strait Islander participants with the rest of the sample

	Aboriginal and Torres Strait Islander (n=48) %	Rest of sample (n=2271) %
Regulate them like alcohol, tobacco and medicines	39.6	51.4
Ban them only if they pose a risk to health	37.5	31.7
Ban them under any circumstances	14.6	6.2
Do nothing	2.1	3.9
Other	2.1	2.8
Don't know	4.2	4.0

* $p<0.0001$

Support for the legalisation of cannabis was similar for both Indigenous and non-Indigenous participants (58.0% compared to 62.8%, respectively – see Table 52).

Table 52: Key questions: For the following drugs, which statement is closest to your opinion?
Comparing responses of Aboriginal and Torres Strait Islander participants with the rest of the sample

	Aboriginal and Torres Strait Islander (n=50) %					Rest of sample (n=2272) %				
	Legalise	Decriminalise	As is	Penalty should increase	Don't know	Legalise	Decriminalise	As is	Penalty should increase	Don't know
Cannabis	58.0	20.0	10.0	12.0	0.0	62.8	18.8	7.9	8.4	2.2

* $p<0.0001$

The complexity of responding to alcohol and other drug issues in their communities was recognised by Indigenous participants. As one participant insightfully noted:

> It seems to be quite a complicated problem; one that won't be fixed overnight. If anything, I think research is the first step. Understanding why, how and who will find unique solutions to complex problems.

11. Opinions compared by place of residence: rural, regional, metropolitan areas

We compared the responses of participants who lived in rural, regional and metropolitan areas (as self-nominated by the participants). As shown in the tables below, there is a consistent pattern of responses when the three groups are compared. Generally, rural participants expressed more 'conservative' opinions about responses to drug and alcohol issues, compared to metropolitan participants. Participants from regional areas tended to sit between the other two groups. For example, as shown in Table 53, almost half (45.6%) of rural participants regarded tough measures against dealers and traffickers to be an effective response, compared to 31.6 per cent of regional participants and 26.2 per cent of metropolitan participants. By way of contrast, 52.1 per cent of metropolitan participants favoured making illegal drugs legal, compared to 46.6 per cent of regional participants and only 35.0 per cent of rural participants.

The impact of location and how the experience of living in different parts of Australia influenced perceptions was evident in the responses of participants to the open-ended questions. For example, the role of police in managing drug use in small communities or the need for more entertainment options in rural communities was discussed in this way by some rural participants:

> I think that within my community we have a drug use problem. I think that police should make it harder to obtain and be more harsh on the usage of cannabis. Many students at my school are smoking cannabis at least every day and even coming to school under the influence of drugs. It makes me think where they get it from and how police don't know about it as I live in a small town. I 100% agree that it is affecting their education and something should be done about it. I believe that the police know about it.

> Police should act as an intervention system rather than a punishment mechanism. Rather than arresting, detaining and charging someone under the influence of drugs they should sit down and spend 5 minutes of their time to say 'Look, we don't mind what you do but this, this and this is likely to happen as a result of what you are doing'. This would make them much more approachable and make drug users respect them rather than hate them.

> I live in a rural community so education and more entertainment options could help reduce the levels of drug use and binge drinking. The problem is, it's like an integral cultural thing and here drug use seems to be primarily within low socioeconomic groups.

> My local community needs more places and youth-friendly events to prevent alcohol use due to boredom.

> Being 16 and in a small town, there is nothing to do on weekends but drink. If we had more things to do drinking wouldn't be as big of a problem.

Table 53: What are the three most effective ways for public authorities to reduce drug and alcohol problems?

Comparing responses of rural, regional and metropolitan participants

	Rural (n=180) %	Regional (n=567) %	Metropolitan (n=1579) %
Information and prevention campaigns	57.2	53.6	55.7
Treatment and rehabilitation of drug users	55.6	66.5	68.1
Tough measures against drug dealers and traffickers*	45.6	31.6	26.2
Making illegal drugs legal*	35.0	46.6	52.1
Reduction of poverty/unemployment	37.2	46.4	48.3
Tough measures against drug users*	22.8	11.1	8.0
More leisure opportunities	28.3	25.9	23.0
Don't know	3.3	3.5	2.9

*$p<0.0001$

Although there were no statistically significant differences between the responses of rural, regional and metropolitan participants regarding the statements as shown in Table 54, the pattern across the groups (as described above) remained similar across most measures.

Table 54: To what extent would you agree or disagree with the following statements?
Comparing responses of rural, regional and metropolitan participants

	Rural (n=180) %				Regional (n=567) %				Metropolitan (n=1579) %			
	Agree	Neither	Disagree	Don't know	Agree	Neither	Disagree	Don't know	Agree	Neither	Disagree	Don't know
Treatment should only be given to drug users who intend to give up drugs for good	22.5	18.5	55.6	3.4	24.6	18.4	55.5	1.4	20.0	15.5	63.0	1.5
Public awareness/ mass media campaigns are a good way to change attitudes about alcohol and other drug use	65.7	14.0	17.4	2.8	61.2	18.3	18.7	1.8	60.0	18.5	20.2	1.2
Drug education in schools provides helpful information to young people about drugs and alcohol	69.3	13.4	15.6	1.7	63.8	11.2	23.3	1.8	62.4	11.6	25.0	1.0
It is possible to reduce drug and alcohol problems through prevention	61.1	16.1	18.3	4.4	63.0	16.9	16.2	3.9	59.5	16.7	21.1	2.7
Treatment should be available to all drug users, according to their needs	88.9	5.6	2.2	3.3	88.3	7.3	3.5	0.9	90.3	6.6	2.5	0.6

	Rural (n=180) %				Regional (n=567) %				Metropolitan (n=1579) %			
	Agree	Neither	Disagree	Don't know	Agree	Neither	Disagree	Don't know	Agree	Neither	Disagree	Don't know
Drug education in schools helps to prevent young people from using drugs and alcohol	46.7	20.0	31.7	1.7	37.1	24.5	36.7	1.8	35.2	23.9	39.1	1.8

*p<0.0001

The pattern continued when the responses across several key interventions of interest are compared. Rural participants were significantly more likely to support punitive measures such as banning the purchase of drugs over the internet (48.0%, compared to 35.3% of regional and 26.5% of metropolitan participants respectively). Rural participants were also significantly more likely to support restricting late night trading of alcohol, and drug sniffer dogs in public places (see Table 55). As some participants from a rural area said:

> I believe more police need to be out on the streets, with drug sniffer dogs in random places to smell the drugs. There should be more severe penalties for drunk drivers and there should be more severe penalties for drug users. But there should also be more people that help those affected by drugs to remove it from their life.

> I feel that Walgett and the surrounding areas (so they can't just drive up to Lightning Ridge) should be made dry communities and although I would not be able to drink in the future, I feel that the possible improvements to the towns would be immeasurable. I also feel that if Walgett were to be a dry community, there would need to be strict punishment imposed upon those drinking/using drugs (heavy fines then jail time).

> I live in the NT in Arnhem Land and I think the problem drinkers register that is run from your driver's licence is a great program – it eliminates problem drinkers from purchasing too much grog. As a Queenslander of origin, I would like to see other states follow.

Table 55: Key questions, comparing responses of rural, regional and metropolitan participants

	Rural (n=180) %				Regional (n=566) %				Metropolitan (n=1569) %			
	Support	Neither	Oppose	Don't know	Support	Neither	Oppose	Don't know	Support	Neither	Oppose	Don't know
Increasing the price of alcohol	24.4	12.2	61.7	1.7	18.0	12.0	69.4	0.5	15.6	11.7	71.9	0.8
Restricting late night trading of alcohol*	41.7	18.9	35.6	3.9	32.0	22.4	44.5	1.1	26.5	16.5	56.2	0.8
A service that provides a place to stay for a long time (rehabilitation)	85.4	9.6	1.7	3.4	88.3	8.3	2.3	1.1	89.0	8.0	2.3	0.8
Drug sniffer dogs in public places*	46.1	7.8	43.9	2.2	29.4	11.9	58.2	0.5	20.2	10.7	68.9	0.3
Banning the purchase of drugs over the internet*	48.0	17.3	30.2	4.5	35.3	22.8	40.3	1.6	26.5	24.6	44.7	4.1

* $p<0.0001$

Metropolitan participants were significantly more likely to support the regulation of new and emerging substances, with over half (53.4%) of this group supporting regulation, compared to 47.3 per cent of regional participants and 45.3 per cent of rural participants. A significantly greater proportion of rural participants thought that new substances should be banned under any circumstances (16.2%, compared to 7.3% of regional participants and only 4.8% of metropolitan participants).

Table 56: Key questions: What would be an appropriate way to handle new substances that imitate the effects of illegal drugs and that are sold as legal substances (e.g. kronic)?

Comparing responses of rural, regional and metropolitan participants

	Rural (n=180) %	Regional (n=567) %	Metropolitan (n=1579) %
Regulate them like alcohol, tobacco and medicines*	45.3	47.3	53.4
Ban them only if they pose a risk to health	25.1	34.0	31.6
Ban them under any circumstances*	16.2	7.3	4.8
Do nothing	1.7	4.6	3.9
Other	3.4	3.0	2.7
Don't know*	8.4	3.9	3.6

* p<0.0001

Again the pattern continued when participants' responses regarding the legal status of cannabis are compared. Metropolitan participants were significantly more supportive of legalisation, with 65.7 per cent supporting legalisation compared to 59.5 per cent of regional participants and 46.1 per cent of rural participants. One-quarter (25.0%) of rural participants thought that penalties should increase, compared to only 10.4 per cent of regional participant and 5.8 per cent of participants from metropolitan areas (see Table 57).

Table 57: Key questions: For the following drugs, which statement is closest to your opinion?

Comparing responses of rural, regional and metropolitan participants

	Rural (n=180) %					Regional (n=567) %					Metropolitan (n=1579) %				
	Legalise	Decriminalise	As is	Penalty increase	Don't know	Legalise	Decriminalise	As is	Penalty increase	Don't know	Legalise	Decriminalise	As is	Penalty increase	Don't know
Cannabis*	46.1	14.4	11.7	25.0	2.8	59.5	17.3	9.9	10.4	2.8	65.7	19.8	6.9	5.8	1.8

* p<0.0001

12. Opinions of those who have never used drugs or alcohol

As a small proportion of the sample (n=95, 4.1%) said they had never used either alcohol or any other drug, we compared the opinions of this group with the rest of the sample who were more experienced with alcohol and other drugs. Overall, as shown in the tables below, participants who had not used alcohol or other drugs in their lifetime were more conservative in their opinions and more supportive of punitive approaches to drug policy as compared to the rest of the sample. For example, a larger proportion of participants who had never used alcohol or other drugs supported tough measures against dealers, as well as tough measures against drug users (see Table 58). In the open-ended question, many participants who had not used alcohol or other drugs expressed a desire for stronger police presence and more punitive responses:

> [There] should be more severe consequences for illegal drug use and under-age drinking. Many teenagers heavily use marijuana and drink at parties every weekend and I do not understand how they are not being caught.

> Police should concentrate on under-age parties to ensure no one under age is drinking/doing drugs on the property.

> The penalties should be severely increased because alcoholics and drug users aren't bothered by a little fine or a 6-month licence suspension for drink driving – enforce significant jail time and community service as a penalty.

> There needs to be greater enforcement, the users need to feel the constant pressure of police and therefore be made to feel guilty about their using.

> A bunch of guys tried to sell us cannabis at McDonalds. Right next to the police station. Their presence needs to be felt more, not their power.

While half (50.6%) of participants with drug use experience regarded legalisation as an effective response, only 18.9 per cent of participants with no experience of drug use thought legalisation was an effective approach to reducing drug problems.

Table 58: What are the three most effective ways for public authorities to reduce drug and alcohol problems?

Comparing responses of those who have never used alcohol or other drugs with the rest of the sample

	Never used alcohol or drugs (n=95) %	Rest of sample (n=2240) %
Information and prevention campaigns	65.3	54.9
Treatment and rehabilitation of drug users	64.2	66.7
Tough measures against drug dealers and traffickers*	54.7	28.0
Making illegal drugs legal*	18.9	50.6
Reduction of poverty/unemployment	34.7	47.4
Tough measures against drug users*	28.4	9.1
More leisure opportunities	16.8	24.4
Don't know	2.1	3.2

* $p<0.0001$

When comparing responses to attitudinal statements about drug policy responses, only one significant difference emerged between the two groups. Participants who had never used alcohol or other drugs were more likely to agree that drug education prevents young people from using drugs and alcohol (58.9%) compared to 35.6 per cent of the rest of the survey participants (see Table 59). As one participant said:

> Education is key – kids need to be aware of the risks before any potential use. We also need a more rational and research-grounded debate (need to counter simplistic arguments that arise in the public discourse, many which can have the opposite effect in which they intend).

Participants who had never used alcohol or other drugs also expressed the desire for reliable drug information to help young people make their own choices:

> To fix the problems, people need objective, researched information about various effects that drugs and alcohol can do, and what consequences they can have, short and long term. Allow people to make up their own minds, with the proper research to back them up.

> Greater honesty is needed in drug education, especially in regards to side-effects and statistics.

Notably, the groups were not significantly different in their responses to the question regarding treatment being given to drug users who intend to give up drugs for good (Table 59).

Table 59: To what extent would you agree or disagree with the following statements?
Comparing responses of those who have never used alcohol or other drugs with the rest of the sample

	Never used alcohol or drugs (n=95) %				Rest of sample (n=2228) %			
	Agree	Neither	Disagree	Don't know	Agree	Neither	Disagree	Don't know
Treatment should only be given to drug users who intend to give up drugs for good	21.1	20.0	55.8	3.2	21.3	16.4	60.7	1.6
Public awareness/mass media campaigns are a good way to change attitudes about alcohol and other drug use	73.4	10.6	13.8	2.1	60.2	18.5	19.9	1.4
Drug education in schools provides helpful information to young people about drugs and alcohol	81.1	6.3	10.5	2.1	62.6	11.9	24.3	1.2
It is possible to reduce drug and alcohol problems through prevention	74.7	11.6	7.4	6.3	59.9	16.9	20.2	3.0
Treatment should be available to all drug users, according to their needs	86.3	6.3	4.2	3.2	89.9	6.6	2.7	0.8
Drug education in schools helps to prevent young people from using drugs and alcohol*	58.9	13.7	22.1	5.3	35.6	24.1	38.6	1.7

* $p<0.0001$

In addition to the overarching opinions outlined above, we also compared opinions across some key questions of interest. There were significant differences between those with no alcohol or drug use experience and the rest of the sample across all the interventions, as presented in Table 60. Notably, 51.6 per cent of those who had never consumed alcohol or other drugs supported increasing the price of alcohol, compared to only 15.4 per cent of the rest of the sample. Several participants expressed opinions about the regulation of alcohol in answer to the open-ended question:

> Alcohol should be sold in limited amounts to families, so we should have a system that monitors alcohol buying, so allowing a set amount of alcohol per week bought only by one family member.

> I do believe the minimum drinking age should be increased to 20. I'm not idealistic enough to think it'll get people to have their first drink at 20, but it'll have kids starting at 16/17, and they'll be safer and more aware of dangers in clubs when out drinking. I also think it's a silly correlation between a full licence and legal drinking age.

> I think restricting sales of alcohol and increasing laws regarding the legality of drugs isn't going to solve anything. If people want to drink and do drugs, then they are going to regardless of the legality/price/difficulty in [acquiring] it.

Participants who had not used drugs were also more supportive of measures such as sniffer dogs (63.2%, compared to 22.8% of the rest of the sample) and banning the purchase of drugs over the internet (73.4%, compared to 28.5% of the rest of the sample):

> Have drug sniffing dogs at big events and regulations on alcohol sold at big sporting events, random drug and alcohol testing in high schools and on the streets. The issue of drugs and alcohol has gotten out of hand and innocent people are usually the victims of intoxicated offenders.

Table 60: Key questions, comparing responses of those who have never used alcohol or other drugs with the rest of the sample

	Never used alcohol or drugs (n=95) %				Rest of sample (n=2228) %			
	Support	Neither	Oppose	Don't know	Support	Neither	Oppose	Don't know
Increasing the price of alcohol*	51.6	11.6	32.6	4.2	15.4	11.8	72.1	0.7
Restricting late night trading of alcohol*	69.5	11.6	15.8	3.2	27.4	18.4	53.2	1.0
A service that provides a place to stay for a long time (rehabilitation)*	79.3	10.9	4.3	5.4	88.9	8.0	2.2	0.9
Drug sniffer dogs in public places*	63.2	14.7	20.0	2.1	22.8	10.6	66.2	0.4
Banning the purchase of drugs over the internet*	73.4	8.5	14.9	3.2	28.5	24.3	43.6	3.6

* $p<0.0001$

Those with no drug use experience were significantly more likely to support banning new substances (15.1%, compared to 6.0% of the rest of the sample – Table 61). Nonetheless, it is notable that a substantial one-third (35.5%) of participants who had never used drugs supported regulating new substances.

Table 61: Key questions: What would be an appropriate way to handle new substances that imitate the effects of illegal drugs and that are sold as legal substances (e.g. kronic)?

Comparing responses of those who have never used alcohol or other drugs with the rest of the sample

	Never used alcohol or drugs (n=95) %	Rest of sample (n=2228) %
Regulate them like alcohol, tobacco and medicines*	35.5	51.9
Ban them only if they pose a risk to health	35.5	31.6
Ban them under any circumstances*	15.1	6.0
Do nothing	3.2	3.9
Other	3.2	2.8
Don't know	7.5	3.9

* $p<0.0001$

There was less support for cannabis legalisation among participants who had not used alcohol or other drugs, with only one in five of this group (22.1%) supporting legalisation compared to two-thirds (64.4%) of the rest of the sample. Support for legalisation was expressed in this way by some participants who had not used drugs or alcohol:

> Legalise all alcohol and drugs to put use out in the open. Drug and alcohol use is an exercise of liberty.

> Looking at what happened to alcohol-related problems during the American Prohibition era (i.e. an increase in alcohol consumption, alcohol-related violence and the rise of organised crime) and countries that legalised marijuana, such as the Netherlands, it seems the best way to solve drug-related problems would be to legalise certain 'soft' drugs and bring them under government control.

> Make all drugs legal, regulating the sale of drugs will minimise black market dealings and also create a pure product for users. By also making a high tax on drugs the government would be able to use this tax money to get out of debt or be used for public schooling systems.

> Illicit drugs can be managed much better by being legalised and regulated. Combined with good education and rehabilitation programs this could do wonders for the community.

This suggests that the assumption that all abstainers are not supportive of legalisation is misplaced.

One-third (36.8%) of participants who had not used drugs in their lifetime thought that penalties for cannabis possession should increase, compared to 7.3 per cent of the rest of the sample (see Table 62).

Table 62: Key questions: For the following drugs, which statement is closest to your opinion?
Comparing responses of those who have never used alcohol or other drugs with the rest of the sample

	Never used alcohol or drugs (n=95) %					Rest of sample (n=2228) %				
	Legalise	Decriminalise	As is	Penalty should increase	Don't know	Legalise	Decriminalise	As is	Penalty should increase	Don't know
Cannabis*	22.1	18.9	14.7	36.8	7.4	64.4	18.8	7.7	7.3	1.9

* $p<0.0001$

13. Qualitative data analysis

So as to better understand young people's perceptions and ideas about responding to alcohol and other drug issues, the online survey also asked open-ended questions where participants could respond freely. In response to the question 'What do you think should be done in your community about alcohol and/or drug related problems?' we received a substantial number of responses – 1855. The majority of these responses were detailed (two or three sentences in length), rather than single-word answers, which suggests that participants were highly engaged with the survey question and eager to share their opinions. As shown in Figure 1, we used the online tool Wordle <http://www.wordle.net/> to generate a word cloud to visually represent the full range of responses collected (first removing the words 'drug', 'drugs' and 'alcohol'). The Wordle tool gives greater size and prominence to words and terms used more frequently by participants. As this 'visual snapshot' shows, participants offered responses across a range of alcohol- and other drug-related topics and domains.

Further immersion in the data revealed several frequently mentioned issues. These included: desire for reliable drug information; support for drug law reform; punitive responses and perceptions of law enforcement; access to and provision of services; young people's experiences of alcohol and other drug use (including harms, perceptions of risks and benefits, and issues associated with different drug types); the settings where alcohol and other drugs are used (e.g. licensed venues, house parties); the culture of alcohol and other drug use in Australian society and among young people specifically; how drug use is talked about (or stigmatised); and how young people conceptualised the problem of drugs in their communities (including the broader social and policy context of drug issues, and the locations, populations and particular drugs that they associated with 'problems').

Although the vast majority of participants offered thoughts and ideas about alcohol and other drug issues in their communities (with many discussing what they perceived to be effective or ineffective interventions), some participants nonetheless said that they did not perceive alcohol or drugs to be a concern in their community:

> There doesn't seem to be any real drug problems.
>
> There is no problem with drugs/alcohol in my community.
>
> Who cares? Stop beating it up like it's the biggest problem our country faces.

Additionally, a small number of participants responded by saying that they did not know the answer to the question, or what could be done to ameliorate current approaches:

> I don't know, it's a huge issue that has many variables and contributors.
>
> I don't know. It is very difficult and complex.

Using qualitative thematic analysis, we analysed the participants' responses. Through an iterative process, a number of themes were identified. In this section we examine three of the most dominant themes which dealt with specific responses to alcohol and other drug issues: desire for reliable alcohol and drug information; support for drug law reform; and punitive responses and perceptions of law enforcement.

Figure 1: Participants' responses (n=1855) to the question: 'What do you think should be done in your community about alcohol- and/or drug-related problems?' (presented as a word cloud)

13.1 Desire for reliable drug information

Many participants expressed a desire for more reliable or relevant drug information and education. The shortfalls of current drug education programs were frequently noted. A significant number of participants identified the need for 'more' and 'better' education. Indeed, of the participants who mentioned drug education, not one thought that current approaches were sufficiently good or effective. Current approaches to drug education were perceived by many participants to be ineffective and biased:

> Education needs to be presented in a better way than the lectures and presentations that I received at school.

> Provide 'real' information and possible outcomes and scenarios. The current drug education is rubbish and almost a lie.

> Frankly I think accurate information should be given to everyone. In high school we learnt about the dangers of illegal drugs. How one-sided can you get? They didn't mention any benefits of illegal drugs, they didn't mention any problems with legal drugs; they simply stuck to the mantra that any drug the government has deemed illegal is evil. There's a reason America is finally turning away from abstinence-based sex education — it simply doesn't work.

Moreover, some participants suggested that the negative framing of drug education placed limits around the way drug issues could be discussed and therefore contributed to the stigmatisation of young people who use drugs:

> Provide a balanced education for school students ... so that the taboos and stigmas surrounding drug use can be removed for current and future generations of young people (potential drug users) so that the REAL issues surrounding drug use can be addressed.

> It is important to inform people of the dangers of drug use, but it is also important to make them feel like even if they do use drugs, they won't necessarily be stigmatised or excluded from the community or made to feel like there is 'no way back'.

The reality that many of their peers did use drugs was also evident in the way participants talked about the perceived limitations of current drug education. Beyond drug education as prevention, many participants thought that drug education should include harm reduction information to make drug use safer for those who choose to use:

> It should be recognised that teenagers will experiment and so the teachers should provide information about what to experience and how to create a safer experience.

> Prevention is very important, but all people should be made to feel that there are viable options in terms of harm minimisation.

> It's also important to show why people choose to take drugs and how to do so in a safe way if they so choose.

> Don't try to stop people from doing drugs – this is futile and stupid. Instead give people the REAL information about these drugs, give them a safe place to do them and the amount of harm people take from these drugs will drop.

> More education in schools from people of the same age-group providing real information – not just scare tactics. The reality is many young people will try alcohol and drugs – it's about informing youth how to do so safely and what the possible consequences could be.

> Educating kids early and explicitly about drugs and their effects, beyond 'drugs are bad, don't do them'. Practical education, e.g. what you should do if a friend overdoses.

> I believe that schools should teach students how to safely take drugs rather then tell them to not do drugs at all.

In particular, many participants said they wanted access to drug education that provided balanced and unbiased information about drugs, and especially the short- and long-term effects on their bodies:

> Better education – a lot of people think they know what they are putting in their bodies and getting themselves into but they don't. I am a science student and think that if more people knew exactly what they were putting in their body they would make better decisions – not necessarily not doing drugs but just being smart about it.

> A lot more understanding about real effects – i.e. don't just show the terrible effects; show the good effects, the minor bad effects and the really bad.

> Better education about what drugs do to the human body and instead of not just saying to avoid them.

> People need to be educated about what drugs really do instead of always showing the worst-case scenario.

Thus, a strong connection was made by many participants between access to better drug information and autonomous decision making. Participants conceptualised themselves as having agency over their own bodies, and having access to information was regarded as an essential part of making choices for themselves:

> Showing the effects, whether positive or negative, of alcohol and drugs on the human body. There are many people who will make their own choices regardless of others' opinions, so the best thing that can be done is to let them know what they're doing or taking.

> Education! Drugs are dangerous, but so is driving, yet you need lessons to learn to drive. I think if you educate somebody on the FACTS, then they as a person [adult] can make the choice whether he/she experiments with drugs at least knowing what to expect. Drug use is dangerous, and yes deadly, but can also be used safely with decreased risks.

> These issues are problematic yes, but at the end of the day it's a very fascist mentality to tell people what they can and cannot put into their own bodies. Sure there may be health risks, so educate. Educate our population and give them the assets they need on an intellectual level to make informed choices. Don't make choices for them, we don't have a nation of 4-year-old children. We have conscious, thinking adults.

> To fix the problems, people need objective, researched information about various effects that drugs and alcohol can do, and what consequences they can have, short and long term. Allow people to make up their own minds, with the proper research to back them up.

Although the majority of respondents spoke of the need for factually accurate and balanced information, a minority mentioned the role that 'scare tactics' can play:

> Promotions on what drugs do to the body should be more prominent and the more gruesome and detailed the better, because it could just scare teenagers out of doing those drugs and save some lives.

> Have people meet/shown an ex drug addict and alcoholic or a current drug addict and alcoholic whether in person or image to show them a bigger picture and understanding to what may happen to them if they continue to have an addiction/problem.

> Really advertise the damaging health effects, life stories of people who have had their world shatter around them due to the drugs they are consuming. Quick 30-second ads, showing how a person's life can turn from being wonderful, to being nothing but a drug seeker and user.

However, it should be noted that the use of scare tactics was not the prevailing view:

> Schools and governments should stop using fear tactics and spreading misinformation regarding drugs and alcohol.

Young people conceptualised themselves as discerning, active agents in making choices about drug use. By having access to reliable and balanced information, participants believed that young people would be equipped to make their own informed decisions about the risks, or benefits, of using drugs. In this way drug education was not regarded as helpful if it simply told young people what to do; rather, participants expressed desire for information which could be used as an 'input' into their own autonomous decision-making processes.

13.2 Support for drug law reform

Opinions about legalisation and decriminalisation of currently illegal drugs were extensively offered in answer to the open-ended question. Indeed, the vast majority of answers to the open-ended questions contained requests for the legalisation and regulation of drugs. Many participants were explicit about what they meant by the term 'legalisation', and most who mentioned legalisation were supportive of it and regarded drug law reform as an effective response to drug issues in their communities. Discussion of legalisation was often connected specifically to notions of regulation and taxation, and placed within a broader harm minimisation approach to drug policy:

> Legalisation and taxation of illicit substances combined with harm-reduction policies.

> Legalise, tax and regulate currently illegal drugs. Most of the problems associated with illicit drugs could be eliminated or greatly reduced if the opportunity to monitor and regulate the market and consumption patterns were available.

> Legalise, tax and regulate currently illicit drugs. Use the tax revenue to fund voluntary treatment programs, health services, and awareness campaigns like we currently have for alcohol and tobacco.

> Currently illegal drugs should be regulated and marketed by a strict government body, with the tax generated going to public works, drug treatment and environmental infrastructure.

Connected to the notions of regulation and taxation, there was also a clear understanding from many participants that drug legalisation may be a way of responding to drug trafficking and organised crime. It was suggested that regulation would take the control away from drug dealers and give more power to government authorities:

> Take the money out of criminal hands by making them legal, putting a tax on them and selling them through pharmacies. Use the revenue produced through them to then make treatment facilities for addicts available.

> I believe legalising and regulating natural drugs such as cannabis would be a good source of tax income for the government and take a lot of money away from criminal drug dealers which would limit their ability to buy and sell harder class A drugs.

> Current policies are only profiting organised crime. The exact same lessons were learnt in the US during prohibition of alcohol, it didn't work and it is time for a change of approach.

Some participants noted that legalisation may increase rates of drug use in the community, but weighed up the advantages and disadvantages of this. As one participant reasoned:

> In relation to cannabis, I am in support of legalisation as while it does increase the number of people who now have access, it also means that it is out in the light of day and can be regulated, taxed accordingly and allow centres to be set up to deal with the health risks.

In this context, some participants also suggested that legalisation and regulation of substances would make drug use less risky as it would control the supply, so the contents and purity of substances would be known:

> Legalising drugs allows the government to more closely monitor who drugs are sold to, what kind of drugs are sold (i.e. how strong, what additives they contain) and the quantity of drugs sold.

> Drugs should be produced legally under strict laws, so the contents are known to the taker. It is impossible to stop drug taking but making sure what is in the drug will make it a lot safer.

> All drugs should immediately move into a decriminalisation stage before being assessed for real health problems and becoming fully legalised ... [I]f many drugs were legalised then the government could regulate their production much like many pharmaceuticals, ensuring they aren't laced with other substances like petrol or flour.

> I think that ecstasy should be a government-regulated drug. It isn't the MDMA you hear about killing people but other drugs being passed off as MDMA or what a pill is cut with. By regulating this and selling similarly to alcohol it would ensure safer consumption and less problems.

However, not all drugs were regarded as equally amenable to law reform. A distinction was made by some participants between cannabis and ecstasy (which were regarded as less harmful), and other drugs:

> Decriminalise 'soft' drugs while continue with the current procedures relating to 'hard' drugs.

> The use of cannabis should be legalised primarily. Harmful drugs aka heroin and meth should be kept the way that is; however, MDMA, mushrooms, LSD should all be decriminalised.

> Legalise cannabis for 18+, but strictly tax it. Regulate and control it like alcohol and tobacco. Maintain laws on alcohol and other drugs.

> I think that in regard to recreational substances like ecstasy and cannabis there should be an element of decriminalisation and regulation ... At the very least they should be decriminalised and the police resources used to target hard drugs like heroin or meth.

> Legalise the 'softer' 'party' drugs, regulate and tax. Use the drug and alcohol taxes to campaign against the more dangerous side to drug using and to build more hospitals with more drug and alcohol facilities.

> Legislation should be made in response to the evidence of potential harm from a particular drug, not the perceived harm of the uninformed. Alcohol and methamphetamine are by far the most harmful drugs in my opinion. Cannabis and ecstasy have less potential for harm, so should not be treated in the same manner by the authorities and the community.

Young people also drew a connection between the prohibition of drugs and the stigmatisation and marginalisation of the people who use them. Some participants suggested that drug law reform and ceasing to treat drug use as a criminal issue could have a positive effect on the way that people who use drugs were viewed in society:

> People who are outcast and judged as a result of drug addiction would be less impacted upon by social judging if drugs were decriminalised and accepted as OK, and therefore they may feel better about getting help, and the degree to which they do drugs to 'get away from their problems' may be reduced as they don't feel like shit all the time.

> I think drugs should be decriminalised, but not necessarily legalised. The threat of gaol doesn't stop people from using drugs, it only discourages them from seeking help.

> The only problem is teenagers who are getting criminal records for being in possession of a small quantity of drugs, and having that stay with them for the rest of their life. The majority of teenagers will outgrow drug use, and do not need that held against them.

> The stigma of usage should be broken down. This is [done] through legalisation.

> Legalise and regulate many drugs, particularly drugs such as cannabis ... allows for less stigma, easier access to correct information and treatment.

For other participants, support for drug law reform was not simply about responding pragmatically to perceived drug problems. Rather, the notion of personal freedom was central to their thinking:

> Decriminalisation of all drug users is essential. Why are people being punished when there is no victim? If someone is taking a drug, and isn't hurting anyone else, what is the big deal?

> Drugs should be legalised so individuals are given the freedom and responsibility to live their lives.

> Prohibition and lack of personal liberty represent the biggest problem with substance abuse. Prohibition takes a public health issue and makes it a legal one. ... Legalisation and regulation should be the first actions taken.

> I believe in personal liberty and think people should have the right to put whatever they like into their body as long as it is not having a negative effect on others.

As such, for most participants who were supportive of drug law reform, their support of decriminalisation and legalisation of drugs was not merely about increasing accessibility to drugs or promoting drug use. For many participants legalisation was regarded as a pragmatic policy response, with particular benefits, understood in a broader interconnected framework of policy priorities. For others, drug law reform was seen to be important because of how young people perceived the discursive and lived effects of prohibition. Prohibition placed limits on personal freedom and entrenched the stigmatisation of people who use drugs. Thus, drug law reform was conceptualised in a sophisticated way by participants, both as a pragmatic policy response but also as important in terms of the way drug issues are framed within public discourse.

13.3 Punitive responses and perceptions of law enforcement

The role of law enforcement and punitive responses to alcohol and other drug issues was identified as a theme within the sample. Although drug law reform was favoured by many participants (as discussed above), many other participants also expressed a desire for harsher penalties and more active law enforcement. These responses were perceived by some to be effective deterrents:

> I think there should be more police present to try and deter drug dealings and the use of illegal drugs.

> Harsher penalties: no one sees it as much of a big deal because they easily get away with it, and young people such as many of my friends don't look to the long term.

It is also important to note that it was not only illicit drugs that were the focus of participants' responses within this domain. The perceived need to respond firmly to alcohol-related issues also featured heavily:

> harsher penalties for drink driving and alcohol-fuelled violence.

> stricter penalties on drink driving, more booze buses around quiet suburbs and more on weeknights such as Tuesday and Thursday.

> The problem is alcohol-related violence and destruction, therefore an increased presence of police in suburban areas as intoxicated persons are on the way home could alleviate some of these problems.

> More police presence in streets around clubs, a warning system of alcohol abuse that leads to bigger and greater fines.

> More patrolling police on the streets of the city where popular bars and nightlife areas are, e.g. Kings Cross, to help reduce violence.

> Heavier penalties for alcohol-fuelled violence, all-night public transport with present security and penalties for parents or under-age drinkers.

> There should be stronger/harsher penalties put on people that drink under-age, drink driving should also be monitored more, especially that of P platers.

Among opinions expressed on this issue, there were a small number of participants who suggested that punitive responses should be delivered through welfare and income support services, not only through law enforcement and criminal justice mechanisms:

> Drug testing for welfare. And welfare recipients should only be able to buy food not alcohol and smokes and have vouchers instead of cash.

> Get rid of the junkies, they cause more problems then anything and are useless 'dole' bludgers who need to get a job. The government might not understand but their payments to these people fixes their addiction. It needs to be stopped.

> Stop paying welfare cheques so everyone has to find a job – except for the single parents.

> Centrelink support should be changed so that the money they get does not go towards alcohol and drugs, possibly by using food and petrol vouchers. Creating a Centrelink card that works like a bank card so they can control what the money is spent on.

Although punitive responses such as increased police presence or harsher penalties were supported by some participants, some also suggested that these responses needed to be balanced with other prevention and treatment approaches. For example, some participants suggested that greater help and support should be offered to people who use drugs in conjunction with tough measures:

> I believe more police need to be out on the streets, with drug sniffer dogs in random places to smell the drugs. There should be more severe penalties for drunk drivers and there should be more severe penalties for drug users. But there should also be more people that help those affected by drugs to remove it from their life.

> I think that stronger penalties should apply to those who are reckless when under the influence, driving drunk or on drugs ... Drug rehabilitation centres should be accessible to all drug users, as everyone deserves help, it should be available to all.

> Have help available for people who need it and encourage acceptance of that help – stronger penalties for those who knowingly and recklessly use alcohol and/or drugs to the extent that it affects others in the community.

Differences emerged in the way participants discussed what, or who, should be the focus of law enforcement activities. For example, some participants regarded alcohol as the problem, while others thought the focus should be on illicit drugs. A clear distinction was made by some participants between punishing drug traffickers and drug users, and between what were perceived to be more serious and minor offences:

> The manufacturers and traffickers of illicit drugs should be more harshly punished than their 'customers'.

> Stricter enforcement for multiple offenders, less serious punishment for minor infringements.

> Harsher penalties for dealers.

> Lower penalties for personal use and possession of drugs; less police dispatched to catch personal users (such as police at train stations with sniffer dogs). Higher penalties for drug dealers and traffickers; more police dispatched to catch the traffickers/dealers.

> Less focus upon targeting those that are at the very bottom of the illegal drug 'chain', such as people attending festivals, and more focus upon targeting those manufacturing and supplying drugs.

> treat the dealers harder, not the users.

> More attention needs to be paid to the gang activity that occurs due to the illegality of widely used substances. Substance use or the other extreme of substance abuse can not be stopped merely though police activity and awareness, but gang-related criminal activity just might.

Further distinctions were made by some participants between using harsh penalties to deter drug use per se, and preventing harm. For these participants, the purpose of punitive responses was not to prevent drug use altogether, but rather to curb what they perceived to be anti-social or harmful behaviour of others:

> Leave alone drug users that aren't doing any other illegal activities or harm to anyone else. Enforce the law on people under the influence of drugs that are an actual threat to the community, e.g. violence, theft etc.
>
> Stricter penalties on people who have been reported as conducting drug-related violence in public areas or venues such as clubs and pubs.
>
> Have police actually do something about the large groups of visibly overly intoxicated people that go out with intention to cause harm.
>
> tougher penalties for those users who choose to cause trouble within the community, especially repeat offenders.

The desire for tough responses to curb the harmful behaviour of others was particularly mentioned in conjunction with driving under the influence of alcohol and other drugs:

> Instances where drug/alcohol use can harm people other than themselves should be heavily fined, e.g. drink driving, but personal use should not be prosecuted as heavily as it is today.
>
> in my opinion, drink/drug driving is the biggest issue. If people want to damage their own health by using to extremes, that's their own choice and I don't think anyone has the right to tell them how they should enjoy their night out. However the moment they sit behind a wheel they are a danger to others around them. How is killing someone with your car a lesser offence than killing someone with a gun? You have taken away a life and are a danger to the community.
>
> Harsher penalties for those causing harm while under the influence of alcohol and drugs (such as DUI).

Opinions about the role of the police were a point of division within the sample. Some participants believed that police were an effective response, and that there should be more police presence to respond to alcohol and other drug issues in the community:

> more police to help stop these things from happening.
>
> More police in the city to catch people earlier, better public transport at all hours (with police on them).
>
> Police should have increased resources and power to search premises possibly containing drugs. If people do not have drugs on the premises, they have nothing to fear.
>
> I think police officers should monitor all streets, pubs and parks for alcohol and drugs. I also think that officers on duty would help catch illegal acts.

> I think having police dogs walking around neighbourhoods catching people in drug possession is an ideal method of addressing the drug-related problem directly. Drug abuse should not be acceptable in society. And I believe this method would strike awareness into youths of the community while gain the communities' trust and faith in the police.

However, others regarded current policing practices as problematic:

> Remove guns from police and scale back both their powers and numerousness.
>
> Stronger police presence as long as they are focusing on problem persons instead of just filling their notebook so it looks like they've done something, e.g. booking non-nuisance people.
>
> The swamps of police and dogs makes me feel sick, it's an invasion of our privacy and the way we want to live our lives.
>
> Instead of combating issues such as this with more-so forceful methods, in my opinion the NSW Police force and agencies alike should recognise that instead of it being an issue of law breaking it's more an issue of self-harm.
>
> Better police presence driving around town, but not being assholes and feeling like they need to make some sort of show of force and go about arresting and taking unnecessary measures. Please leave the rest of us be and just be alert for troublemakers!

As such, although desire for strict enforcement and punitive responses to alcohol and other drug issues was identified as a theme within participants' responses, the opinions expressed by participants on these issues were in many ways divergent. In expressing support for more police presence, greater enforcement of current laws and harsher penalties, many participants made a distinction between control of drugs per se, and responding to the harmful behaviour of 'other' people who used them. While some participants regarded harsh penalties as a deterrent to prevent drug use, other participants regarded punitive responses as necessary only where alcohol and other drugs adversely affected others.

14. Discussion

The aim of this study was to describe and better understand young people's ideas about responding to alcohol and other drugs issues, so that the voices of young Australians may be included in drug policy processes and deliberation. The findings of this study offer new knowledge to the alcohol and other drug field, and importantly to policy makers, as this is the first time a comprehensive national survey of young Australians' opinions and attitudes towards a variety of alcohol and drug policies, programs and control measures has been undertaken. The findings are therefore a significant first step towards better understanding what young people think about drug policy in Australia, and as such open the door to more meaningful engagement with young people to help respond successfully to alcohol and other drug issues in Australia.

The findings of this study demonstrate that young Australians are strongly supportive of a range of alcohol and other drug interventions. If we take just those interventions where more than two-thirds of respondents indicated support, we can see that young Australians expressed strong support for treatment and rehabilitation, and believed that treatment should be available to people according to their needs. More specifically, the majority of young Australians expressed support for particular treatment and rehabilitation services to be available, including services that provide a place to stay for a short time or a long time, doctors, counselling, youth workers and detoxification services. Young people were also strongly supportive of harm reduction interventions, with over two-thirds of young Australians expressing support for needle and syringe programs, regulated injecting facilities and availability of pill testing. The majority of young people also expressed strong support for more severe penalties for drink driving (which was the only alcohol-specific policy to elicit a high level of support from young people).

Young Australians expressed strong opposition to a small number of interventions, primarily related to alcohol regulation and restricted availability. Over two-thirds of young people opposed increasing the price of alcohol, reducing trading hours for all pubs and clubs, reducing the number of outlets that sell alcohol, and raising the legal drinking age. These findings are consistent with previous studies, internationally and domestically, which demonstrate low support for alcohol control measures (Giesbrecht, 1999; Matthew-Simmons et al., in press; Wallin & Andreasson, 2005; Wilkinson et al., 2009). Very close to two-thirds of young people also opposed the use of sniffer dogs in public places and drug testing at work or school. By placing these findings in the context of the extant effectiveness literature, we can examine some synergies and disconnects which exist between the interventions most supported by the majority of young people and those that have been demonstrated to be most effective. This is an important issue to consider and a challenge for policy makers who must balance the opinions of stakeholders (as young people are), with a desire for effective and evidence-informed approaches to policy.

The support expressed by young Australians for a range of treatment interventions accords with the effectiveness literature, which has shown detoxification, counselling and therapeutic communities to be effective interventions. Young people's support for treatment according to need (as opposed to compulsory treatment) is also in line with the literature, which offers little evidence to support the efficacy of compulsory treatment.

The support expressed by young Australians for harm reduction interventions including needle and syringe programs and supervised injecting facilities also accords with the evidence base, which has demonstrated these approaches to be effective. Of particular interest is the strong support expressed by young people for pill-testing facilities, which is an intervention currently not available in Australia. Pill testing may be conceptualised primarily as a harm reduction measure, but can also operate as a research tool: monitoring changes in drug markets. At a population level, pill testing can lead to campaigns to warn users (via the internet, bulletins, etc) about particularly dangerous products. For medical emergencies, pill-testing information can be used to improve overdose management. In relation to individual-level harm reduction, pill testing at raves (on site) can provide a venue for the provision of general harm reduction information, improving users' factual knowledge about substances and risks associated with use. Finally, and perhaps most obviously, pill testing can result in the user choosing not to consume a tablet perceived as harmful or containing substances that were not expected or desired. Young people's high level of support for this intervention suggests that it should be strongly considered as a harm reduction approach in the Australian context.

Young people's opposition to the use of sniffer dogs in public places and drug testing in schools also accords with the extant literature. Both of these interventions have been shown to be ineffective deterrent mechanisms, with strong civil liberty arguments made against them. Young people's opposition to sniffer dogs is of particular pertinence because Australian studies have shown that there is a risk that individuals may engage in risky drug-using behaviour, such as hastily consuming drugs in their possession when sighting sniffer dogs, which is contrary to harm minimisation objectives (Dunn & Degenhardt, 2009; Hickey et al., 2012). Sniffer dogs are also often used in settings where young people spend time (such as at music festivals, outdoor events and in high-density entertainment precincts). Therefore, the continued use of this intervention is likely to impact disproportionately on younger people.

The opposition expressed by young people to interventions aimed at managing alcohol-related harms does not accord with the effectiveness literature. Restrictions on alcohol availability and sales, higher alcohol prices and raising the minimum drinking age have been shown to impact on alcohol consumption and reduce alcohol-related harms. This finding demonstrates a disconnect between the opinions of young people and what have been shown to be effective responses. This finding suggests that, despite the effectiveness of these alcohol interventions, they may not resonate with young people as acceptable responses – an issue which requires careful consideration as to how best to balance the opinions and experiences of young people with the evidence base to ensure responses are both effective and acceptable to the community most directly affected by these interventions. Further education and information communicating the reasons for these policy approaches may be warranted to increase the likelihood of acceptability among this target population.

When asked where they would turn for information and advice about alcohol and other drugs, the majority of young people nominated the internet or a friend as sources of information. The preference for the internet as a source of information was even more pronounced for males, older participants and those who have used illicit drugs or consume alcohol regularly. This finding accords with the extant literature in suggesting that the internet has become central to young people's lives (and is perhaps preferred due to the easy accessibility and anonymity afforded), and that peer networks remain important.

Importantly, the findings demonstrate that young Australians are not a homogeneous group and that different individual characteristics influence their views about how drug and alcohol issues should be managed. In the simple measures of association (Chi Square) we found significant differences between females and males; between younger and older respondents; and between those who had consumed alcohol or illicit drugs and those who had not. Young Australian females expressed generally more conservative views than their male peers. These findings reflect previous research which has shown that males and females have different attitudes towards drugs and drug issues (e.g. Spigner et al., 1993). Females were significantly more supportive of tough measures against drug users and dealers, restrictions on alcohol availability, law enforcement responses and treatment. By way of comparison, males were more supportive of legalisation of all drugs and of most harm reduction interventions.

Younger Australians were generally more conservative in their views. For example, young people under the age of 18 years were significantly more supportive of tough measures against users and dealers and sniffer dogs, and less supportive of harm reduction interventions. Those aged 18 years and over were more supportive of drug legalisation, regulation of new and emerging substances, harm reduction interventions, and were more likely to agree that reduction of poverty and unemployment was of key importance to reduce alcohol- and drug-related harms. The finding that age influences opinions about drug law reform accords with previous research, which has shown that older adolescents are more supportive of decriminalisation (Menghrajani et al., 2005) and that perceptions of drugs may change with increasing age (Pearson & Shiner, 2002).

In terms of alcohol consumption, young people who had not used alcohol in the previous 12 months were significantly more supportive of tough measures, law enforcement approaches, alcohol regulation, drug testing and drug education in schools. There were also significant differences between young people who had not consumed alcohol in the last 12 months, those who consumed alcohol less than weekly, and weekly drinkers across all alcohol regulation measures. Those who consumed alcohol at least weekly consistently expressed stronger opposition across all control measures. Young people who had not used drugs in their lifetime were more supportive of punitive approaches such as tough measures, compulsory treatment and law enforcement interventions, and were significantly more strongly supportive of drug education and prevention approaches. Young people who had experienced drug use at some point in their lifetime were significantly more supportive of cannabis legalisation and harm reduction measures (a finding which accords with previous studies, e.g. Garland et al., 2010).

In summary then, younger, female non-consumers of alcohol or illicit drugs appeared to form a particular cluster of conservative views, supportive of tougher measures, greater regulatory control and law enforcement response. However, the logistic regression analyses suggest that these measures of simple association may not reveal the full story. Indeed, in the regression equations, both age and gender were less predictive than other variables – and notably, less predictive than the young person's overall attitude towards alcohol or drugs, irrespective of their experience of the use of these substances. The findings of this study demonstrate that attitudinal variables may be the strongest predictor of young people's opinions about alcohol and other drug policy. What young people think about the risks and benefits of alcohol and drugs (that is, whether they perceive alcohol and other drugs favourably or not) is strongly linked to how they believe alcohol and other drug issues should be addressed in their communities. The multinomial logistic regression analyses demonstrate that these underlying attitudes about how young people perceive drugs may more strongly influence their opinions about interventions (that is, how drug issues should be managed), even more so than their own alcohol and drug use experience. It is important to note that much of the literature that has explored young people's attitudes towards alcohol and drug policy interventions has not engaged with this concept. This finding again highlights the need to better understand not only young people's alcohol or drug use behaviour, but rather also the meaning of alcohol and drugs in young people's lives (for discussion, see Duff, 2003; Lancaster & Hughes, 2013; Moore, 1990). Moreover, it is possible that young people's attitudes towards alcohol and drugs, and therefore their opinions about how alcohol and other drug issues should be managed, will change over time and will vary between cohorts of young people. This should be further explored in future research.

The findings of this study reveal a number of important insights about how young people think about and experience alcohol and other drug issues in their communities, and how they perceive current approaches to addressing alcohol- and other drug-related harms. Overall, the findings of this study have shown that young people are supportive of measures that provide them with facts and information (e.g. 'unbiased' drug education or drinking guidelines), or that curb the behaviour of 'others' who may be causing trouble (e.g. stricter penalties for drink driving or stricter enforcement against people who serve intoxicated customers). As such, young people desire policy frameworks that give them and their peers the freedom to make their own choices (with the support of accurate information, access to services and harm reduction options), and are not generally in favour of regulatory measures that more forcibly moderate their behaviour (e.g. restricted trading hours and reduced numbers of outlets selling alcohol). The notion that, by having access to unbiased and 'real' information, young people would be equipped to make informed autonomous choices was a theme that emerged strongly in the qualitative data analysis. Similarly, support for drug law reform (decriminalisation and legalisation) was also framed by many participants as an issue of personal choice (as demonstrated in the qualitative analysis). In the context of the overall findings, these comments reach beyond the boundaries of drug education and information

campaigns or drug law reform per se, and speak to the broader principles which young people hope will underpin responses to drug issues. Young people perceive drug use as a personal choice, which should be confronted by government intervention only in the instances that are seen to be causing harms to others in the community:

> Taking drugs is a personal choice and should not be up to the government to decide if the choices are legal. If they are a danger to the public then they should be arrested and charged with the crime.
>
> I believe it is entirely up to the individual if they decide to use a drug and society should only intervene if they are negatively affecting the community.
>
> what a person does with their own body should be their choice and not punishable, as long as it does not physically harm anyone else.

It is in the context of young people's 'values of autonomy' that support for policy interventions that curb the behaviour of others can be understood. This is reflected in support for treatment interventions (that is, rehabilitation, detoxification and therapeutic options available, according to individual need, for people whose drug use has become problematic in the eyes of the individual or the community), as well as support for stricter penalties for drink driving or, as shown particularly in the qualitative data, harsher penalties for drug traffickers or 'problematic' drug users. It could be argued that distinctions made between 'us' (as young people who may choose to consume alcohol and other drugs in an informed and responsible manner) and 'others' (whose alcohol and other drug use needs to be addressed through policy) underpin many of the opinions expressed in the findings of this study, in terms of which interventions were supported and which were opposed:

> Not all drug users should be treated the same. In my community, there are some people that pose little threat to themselves or anyone else and are educated about drugs that are doing drugs. Why stop them?
>
> Less focus on the people that don't have problems (e.g. party goers). More focus on those with chronic drug/alcohol problems, rehabilitating these people, helping them get their lives set up and enter the workforce. More facilities for these people.
>
> Not 'solutions' that disadvantage those of us who do not have drug and alcohol problems such as raising prices etc.

The findings of this study point to the larger discursive framework of how alcohol and other drugs are constructed and represented as 'problems' in society, and how drug issues are talked about. Consideration of these broader issues of how alcohol and other drugs are talked about and framed in public discussion, and especially in policy deliberation, is essential. It is perhaps unsurprising that young people expressed strong support for some interventions that are not available (or not widely available) in Australia including pill testing and supervised injecting facilities, or when given the opportunity to comment freely, that so many young people discussed drug law reform options or the desire for different ('more' and 'better') drug

information. These findings speak to the way young people imagine different approaches to drug policy than the interventions currently on offer, and highlight one of the central reasons that their voices should be included in drug policy processes: young people can offer a fresh and creative perspective on issues that have become embedded and intractable policy problems. The high level of engagement with this survey by more than 2000 young Australians demonstrates that young people have opinions about how government should respond to alcohol and other drug issues in their community, and wish to be a part of that conversation. Moreover, young people have ideas about how the issue of drugs in society should be thought about:

> I think that drugs should be looked at in a different way by the government, not just black and white, good and bad.
>
> Treat it as a health and social issue. Not as an issue of simple criminality. Authorities need to recognise that drug culture is imbedded in popular and Australian culture.
>
> Policy should be based on evidence not ideology.

Many young people in Australia today experiment with and consume alcohol and other drugs, and as Duff argues (2005, p. 163), 'whether or not one accepts that this shift is tantamount to the normalisation of young people's drug use, it is clear that young people themselves have very different attitudes to drug use to those who purport to make policy on their behalf'. The findings of this study attest to this, and demonstrate that young people have nuanced views about a range of alcohol and other drug interventions, and want their opinions to be heard.

15. Limitations

It is hoped that this survey is a first step towards regular engagement with young Australians regarding their ideas about responding to alcohol and other drugs. As such, it is important to highlight limitations to this study so as to improve future surveys in this domain.

The internet as a method for surveying people has become common, but there remain some important questions about this survey method. We do not know if people who respond to internet-based surveys are systematically different from those who do not (i.e. the extent of population representativeness). For young people, the internet is highly accessible and therefore may indeed be the most efficient and representative survey method for this sub-population. The rates of alcohol and particularly illicit drug use reported by survey participants was higher than that recorded in face-to-face or self-complete population surveys, such as the National Drug Strategy Household Surveys or the Australian Secondary School Students surveys. It is not clear the extent to which alcohol and other drug internet surveys attract those young people with direct experience of substances, and hence the rates are higher, or whether other surveys are more likely to have respondents' under-report due to demand characteristics. It is plausible that both these aspects are true – that is, that household survey respondents under-report, and internet survey respondents are self-selected with bias towards higher responses on variables of interest for the survey itself (in our case, alcohol and other drug use). Further research examining systematic bias in self-reported alcohol and other drug use across multiple surveys methods is required. Overall, however, the advantages of an internet-based survey in terms of efficiency and anonymity outweigh the potential disadvantages of securing a highly alcohol- and other drug-experienced group of young people. Moreover, as a proportion of participants reported that they had never used alcohol and other drugs, we were still able to analyse differences in attitudes between those with and without experience of alcohol and other drug use.

The choice of survey questions was guided by previous opinion surveys. However, some domains did not have existing questions, and new questions were derived. The overall reliability and validity of the full questionnaire could not be tested. Future administrations of the survey could consider assessing reliability (through multiple administrations) and validity (through a comparison set of alternate questions). Despite the absence of reliability and validity testing per se, the careful selection of questions should mitigate against any systemic measurement issues.

The age range for this survey was 16–25 years of age. Young people under 16 years of age were not included. The National Health and Medical Research Council ethical guidelines regarding human research involving minors note that parental consent is generally required to interview young people under the age of 16 years. While there are some exceptions, such as the 'mature minor' notion, we were unable to apply this exception to the sample, due to its diversity. Future surveys should consider ways to include under-16 year olds, and obtain parental consent, which is likely to require recruitment through institutions such as schools, and would involve a substantially greater budget than that allocated to this study.

Keeping the survey instrument to less than 15 minutes completion time was imperative, and contributed to the excellent sample size and representativeness. However, the limitation associated with this is that there were a number of questions that were not asked. Most importantly, the survey did not include details about the respondents' cultural background or socioeconomic status. This survey aimed to recruit a broad, national sample of young people across Australia. While this sample (through the online recruitment methods used) may include people from diverse cultural and linguistic backgrounds and of different socio-economic status, it is more likely that the sample reflects an advantaged group of young people with easy access to the internet, who feel empowered to express their opinions in this format. This survey did not include questions regarding cultural background or household income, so we are unable to determine to what extent the sample is broadly representative along these measures, nor explore whether or not these subpopulations of young people have different opinions to others within the sample. Given the budget and time restraints associated with this current study, these limitations could not easily be resolved. However, it is vitally important that future surveys are resourced to facilitate recruitment of other subpopulations of young people, such as those with non-English-speaking backgrounds, disabilities and low socioeconomic status. This would require a more targeted approach for culturally diverse and disadvantaged groups. This recommendation is not simply reflective of principles of access and equity, but also because little research has examined what these subpopulations of young people think about alcohol and other drug issues. Culture and personal experience are likely to shape attitudes. Therefore ensuring full participation, and capturing more detailed demographic data, like cultural background or socioeconomic status, is essential to capturing the experiences of and including the voices of diverse populations of young people in policy processes. Additionally, future surveys could be resourced to provide translations in multiple languages, could be distributed utilising networks of young people from culturally and linguistically diverse backgrounds, provide low-literacy options, and have a high disability accessibility rating.

In order to keep the survey length to a minimum, the questions regarding help-seeking were intentionally brief. In discussion with the Reference Group, it was clear that if a comprehensive list of treatment, youth and support services were listed to ascertain where exactly the respondent had sought help, the list would be unmanageably long for the purposes of this online survey. It was decided that the nature of the service from which help was sought was not essential. As such, however, the very general help-seeking questions that were used were not specific enough, and open to broad interpretation by participants. The analyses were unable to distinguish between young people who had been engaged in drug or alcohol treatment, as opposed to young people who may have sought advice from a school counsellor, for example. The specificity of this question requires consideration for the administration of future surveys. In addition, the placement of the question could be reconsidered, because a few respondents noted that the help-seeking question implied that their drug and alcohol use was necessarily problematic (*I didn't like this question 'Are you currently receiving help because of your drug or alcohol use?' because it assumes my drug and alcohol use is causing problems in my life*).

Another area that was curtailed due to endeavours to keep the survey brief was further questions about alcohol and other drug use, including patterns of consumption, harmful consumption and negative consequences associated with use. The questions covered only basic consumption patterns: frequency of use (ever used, last 12 months, and daily, weekly and so on). Quantity consumed or the settings where alcohol and other drugs were consumed were not surveyed. The purpose of the survey was to ask about opinions and attitudes, hence detailed information about quantity and frequency of consumption was regarded as less important to this particular survey (the focus of the survey was not to describe the consumption patterns of young people). Future administration of the survey will need to consider whether it is worthwhile collecting more detailed consumption data in order to further assess the relationship between consumption patterns and opinions about policy. The results found here would suggest that this is perhaps less important than understanding how young people feel about alcohol and other drugs, and better understanding the role and meaning of drugs in young people's lives (the attitudinal questions were significantly more predictive than the consumption questions). The survey also did not include tobacco. There is existing research regarding attitudes towards tobacco control measures (for example, see Amonini & Donovan, 2006; Crawford, Balch, Mermelstein & Tobacco Control Writing Group, 2002; Koh et al., 2011; Moodie, MacKintosh & Hammond (2010); Schofield, 1997; Unger et al., 1999; White, Tan, Wakefield & Hill, 2003). The inclusion of tobacco in future surveys should be reviewed, but again the balance between survey length and comprehensiveness is critical.

The survey was designed as a quantitative instrument to collate opinions of young people towards various alcohol and other drug policies, interventions and control measures. Two open-ended questions were included, but it was not anticipated that these questions would necessarily yield substantial new data. This turned out to be an incorrect assumption, and more than half of the respondents gave extensive responses to the open-ended questions. This meant that substantial qualitative data were obtained. Analytic methods had to be curtailed due to time constraints and the large qualitative sample size. However, future surveys should include open-ended questions again, and ensure that sufficient time is available to conduct a full analysis of the qualitative data. In addition, the field provided in the online survey should be long enough to accommodate detailed answers (in this case, the field was limited to a specific number of characters and some young people had more to say). Techniques such as discourse analysis could be applied to the qualitative data to yield interesting insights.

There are many further statistical analyses that could be completed with the existing data. These include analyses of jurisdictional differences in the sample; analysis of those respondents who were neither employed nor studying and whether their attitudes differed significantly from others. Further research on the opinions of Aboriginal and Torres Strait Islander young people is required, as this survey did not explicitly include specific Aboriginal and Torres Strait Islander-related alcohol and other drug interventions.

16. Implications and conclusions

The relationship between opinion and policy is not straightforward. Where there is strong support for a particular intervention, it is likely that the intervention will be successful because positive opinion means greater acceptability and compliance with the intervention, assuming that the intervention is based on sound research evidence. In this way, strongly supported evidence-based interventions should be implemented. One example from this study is pill testing – young people clearly support this intervention. It is a good harm-reduction measure that could be readily implemented in Australia. On the other hand, some evidence-based interventions do not have wide support. For example, the survey results suggest that young people do not support restrictions on alcohol price and availability. This does not necessarily mean that those interventions should be withdrawn; however, it implies that significant caution in the ways in which those interventions are promoted to young people is required. Some engagement in marketing of interventions, with better information about what works, is reasonable. There is however a cautionary tale – young people are astute (as found here) and want factual, unbiased information. A simple campaign outlining the relationship between alcohol price and consumption is likely to be unsuccessful precisely because the research evidence is not necessarily complete. Higher alcohol prices are associated with lower consumption at a population level. However, we do not know if this applies to young people specifically, and research has suggested that price will impact differentially, depending on consumption patterns, purchase patterns, income, how price rises are achieved (e.g. through taxation or minimum pricing), co-consumption of drugs and alcohol, and so on (Carragher & Chalmers, 2011). This example merely highlights that strategies that aim to change opinions need careful consideration.

The results of this survey also have implications for those interventions that are not supported by young people, nor have an adequate evidence base. The findings suggest that these interventions should be reconsidered. One example is sniffer dogs – young people do not support this intervention and there is not an evidence base. This suggests reconsideration of this measure, particularly as young people are frequently subject to this measure, given their high presence at music events and entertainment precincts. The findings of this study offer insight into how policing strategies in this domain could be altered. Although young people expressed strong opposition to sniffer dogs, there were also high levels of support for different policing strategies, such as visible police presence around licensed venues and more police on the streets. This suggests that, by altering policing approaches, young people may be more accepting and supportive of the role of police in the community in responding to alcohol- and other drug-related issues.

Some existing interventions could be improved based on the survey findings in this report. Most obviously, drug education in schools should be substantially informed by the opinions reported herein and modified to be consistent with the views of young people. As Roker and Coleman (1997) have noted, rarely are young people's perceived needs, opinions and attitudes taken into account in discussion of drug education and prevention programs. Improving drug education based on the opinions expressed in this survey would require a substantially more balanced approach, such as explicit inclusion of the benefits of alcohol and drug use and harm reduction information, and ensuring factually correct information is

provided at all times. The central role of the internet for young people seeking information and advice about drug issues is also a pertinent finding, and endeavours should be focused on further developing innovative and engaging online information resources, treatment and brief interventions for young people in this domain.

It is important to seek young people's participation in the policy process and to better understand their ideas and opinions about government policy, especially regarding policy responses that affect them. Young people are important stakeholders in alcohol and other drug policy, and are often the focus of public discussion about 'the problem' of drugs in society. To date, alcohol and other drug research involving young people has primarily focused on understanding the alcohol and drug *use* patterns of young people. Less energy has been spent trying to explore and understand young people's *opinions and ideas* about policies and programs aimed at reducing the harms caused by alcohol and other drugs. This study has aimed to address this gap in knowledge, and thus provides a starting point for policy makers to more fulsomely include the voices of young people in alcohol and other drug policy deliberation in the future.

The young people surveyed in this study were actively engaged, and eager to share their ideas and opinions. More than this, participants expressed a strong desire for the voices of young people to continue to be heard on these issues, and for action to be taken:

> I think that there needs to be more done to engage young people in the policy discussions around drugs (including alcohol). So often the only engagement with young people is the negative stereotypes we see on the media, politicians. Young people's use of drugs is not specific to young people but is a population-wide issue – that said, young people should always be consulted in the development of policies that target issues that affect them.
>
> consult Youth Advisory Committees and schools for ideas about what they think. Increase youth participation in the solution and outcome.
>
> Just hope I never wasted my time doing this survey and that my opinion will be taken into consideration.

The findings of this study demonstrate that young people are indeed 'active agents' (Vander Laenen, 2011, pp. 491–492), with nuanced understandings of the meaning of alcohol and other drug issues in their communities. It is hoped that the opinions expressed herein by young Australians will be used by policy makers to inform drug policy for the better. By including the voices of young people in alcohol and other drug policy, there exists an opportunity for policy to be valuably informed by those it affects, and in so doing, to implement successful interventions that are seen to be of relevance and value.

17. References

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Appendix A: Survey instrument

By clicking 'I accept', having read the information provided above, you have decided to participate.

Please pick one of the answers below.

- ○ I accept
- ○ No thanks

Are you male or female?

Please pick one of the answers below.

- ○ Male
- ○ Female

What is your current age?

Please pick one of the answers below.

- ○ Under 16
- ○ 16
- ○ 17
- ○ 18
- ○ 19
- ○ 20
- ○ 21
- ○ 22
- ○ 23
- ○ 24
- ○ 25
- ○ Over 25

Here are some statements that people have made about drug use. Tick the answer that is closest to your opinion.

Please mark the corresponding circle - only one per line.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
Using drugs can be a pleasant activity	○	○	○	○	○	○
A young person should never try drugs	○	○	○	○	○	○
There are few things more dangerous than experimenting with drugs	○	○	○	○	○	○
Using drugs is fun	○	○	○	○	○	○
Many things are much more risky than trying drugs	○	○	○	○	○	○
Everyone who tries drugs eventually regrets it	○	○	○	○	○	○
The laws about illegal drugs should be made stronger	○	○	○	○	○	○
Drug use is one of the biggest evils in Australia	○	○	○	○	○	○
Drugs help people to experience life to the fullest	○	○	○	○	○	○
Schools should teach about the real hazards of taking drugs	○	○	○	○	○	○
The police should not be annoying young people who are trying drugs	○	○	○	○	○	○
To experiment with drugs is to give away control of your life	○	○	○	○	○	○

How likely is it that each of the following would happen to you personally, if you were to use alcohol?

Please mark the corresponding circle - only one per line.

	Very likely	Likely	Neither likely nor unlikely	Unlikely	Very unlikely	Don't know
Feel relaxed	○	○	○	○	○	○
Get into trouble with the police	○	○	○	○	○	○
Harm my health	○	○	○	○	○	○
Feel happy	○	○	○	○	○	○
Forget my problems	○	○	○	○	○	○
Not be able to stop drinking	○	○	○	○	○	○
Get a hangover	○	○	○	○	○	○
Feel more friendly and outgoing	○	○	○	○	○	○
Do something I would regret	○	○	○	○	○	○
Have a lot of fun	○	○	○	○	○	○
Feel sick	○	○	○	○	○	○

The following questions relate to what the government and/or community could do to reduce or prevent problems relating to drug and alcohol use.

In asking these questions, we do not assume that all drug and/or alcohol use neccesarily results in problems.

Please click Next to continue.

What are the three most effective ways for public authorities to reduce drug and alcohol problems? Please choose up to 3.

Please check all that apply.

- ☐ Information and prevention campaigns
- ☐ Treatment and rehabilitation of drug users
- ☐ Tough measures against drug dealers and traffickers
- ☐ Making illegal drugs legal
- ☐ Reduction of poverty/unemployment
- ☐ Tough measures against drug users
- ☐ More leisure opportunities
- ☐ Don't know

For the following drugs, which statement is closest to your opinion?

Please mark the corresponding circle - only one per line.

	A	B	C	D	E
Cannabis	○	○	○	○	○
Heroin	○	○	○	○	○
Meth/amphetamine	○	○	○	○	○
Ecstasy	○	○	○	○	○
Cocaine	○	○	○	○	○

Legend for rank grid table: For the following drugs, which statement is closest to your opinion?

Columns:

A - Personal use should be legalised

B - Personal use should be decriminalised (illegal but with non-criminal penalties, e.g. a fine)

C - The law should be left as is

D - Penalties for personal use should be increased

E - Don't know

To what extent would you agree or disagree with the following statements?

Please mark the corresponding circle - only one per line.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
Treatment should only be given to drug users who intend to give up drugs for good	○	○	○	○	○	○
Public awareness/mass media campaigns are a good way to change attitudes about alcohol and other drug use	○	○	○	○	○	○
Drug education in schools provides helpful information to young people about drugs and alcohol	○	○	○	○	○	○
It is possible to reduce drug and alcohol problems through prevention	○	○	○	○	○	○
Treatment should be available to all drug users, according to their needs	○	○	○	○	○	○
Drug education in schools helps to prevent young people from using drugs and alcohol	○	○	○	○	○	○

To what extent would you support or oppose services such as...

Please mark the corresponding circle - only one per line.

	Strongly support	Support	Neither support nor oppose	Oppose	Strongly oppose	Don't know
Needle and syringe programs (where people can access clean syringes)	○	○	○	○	○	○
Regulated injecting rooms (where people are able to inject drugs in a safe place)	○	○	○	○	○	○
Medications that mimic the effects of illegal drugs (e.g. methadone/dexamphetamine)	○	○	○	○	○	○
A service that provides a place to stay for a short time	○	○	○	○	○	○
A service that provides a place to stay for a long time (rehabilitation)	○	○	○	○	○	○
Meeting a youth worker in places where young people hang out	○	○	○	○	○	○
Counselling	○	○	○	○	○	○
Seeing a doctor	○	○	○	○	○	○
A service that provides withdrawal (detoxification) from alcohol and/or drugs	○	○	○	○	○	○
Compulsory education and/or treatment	○	○	○	○	○	○

Thinking about other responses to alcohol and/or drug use, to what extent would you support or oppose...

Please mark the corresponding circle - only one per line.

	Strongly support	Support	Neither support nor oppose	Oppose	Strongly oppose	Don't know
Drug sniffer dogs in public places	○	○	○	○	○	○
Visible police presence around licensed venues such as bars and nightclubs	○	○	○	○	○	○
More police on the streets	○	○	○	○	○	○
Availability of pill testing (where people can have the contents of their pills tested)	○	○	○	○	○	○
Drug-free chill out zones	○	○	○	○	○	○
ID scanners at the entry to bars and nightclubs	○	○	○	○	○	○
Drug testing at work or at school	○	○	○	○	○	○
Banning the purchase of drugs over the internet	○	○	○	○	○	○

What would be an appropriate way to handle new substances that imitate the effects of illegal drugs and that are sold as legal substances (e.g. kronic)? Please pick one.

Please pick one of the answers below.

- ○ Regulate them like alcohol, tobacco and medicines
- ○ Ban them only if they pose a risk to health
- ○ Ban them under any circumstances
- ○ Do nothing
- ○ Other
- ○ Don't know

To reduce the probems associated with excessive alcohol use, to what extent would you support or oppose...

Please mark the corresponding circle - only one per line.

	Strongly support	Support	Neither support nor oppose	Oppose	Strongly oppose	Don't know
Increasing the price of alcohol	○	○	○	○	○	○
Reducing the number of outlets that sell alcohol	○	○	○	○	○	○
Reducing trading hours for all pubs and clubs	○	○	○	○	○	○
Serving only low alcohol drinks at sporting events or venues	○	○	○	○	○	○
Increasing the number of alcohol-free public events	○	○	○	○	○	○
Raising the legal drinking age	○	○	○	○	○	○
Stricter enforcement of the law against serving customers who are drunk	○	○	○	○	○	○
More severe legal penalties for drink driving	○	○	○	○	○	○

To reduce the probems associated with excessive alcohol use, to what extent would you support or oppose...

Please mark the corresponding circle - only one per line.

	Strongly support	Support	Neither support nor oppose	Oppose	Strongly oppose	Don't know
Restricting late night trading of alcohol	○	○	○	○	○	○
Strict monitoring of late night licensed premises	○	○	○	○	○	○
Limiting advertising for alcohol on TV until 9:30pm	○	○	○	○	○	○
Banning alcohol sponsorship of sporting events	○	○	○	○	○	○
Requiring information on national drinking guidelines on all alcohol containers	○	○	○	○	○	○
Increasing the size of standard drink labels on drink containers	○	○	○	○	○	○
Increasing the tax on alcohol products to pay for health, education, and the cost of treating alcohol related problems	○	○	○	○	○	○

If you wanted information or advice about alcohol and drug use, which 3 sources would you turn to? Please choose 3.

Please check all that apply.

- ☐ A friend
- ☐ Parents/relatives
- ☐ Brother/sister
- ☐ Someone at school or at work
- ☐ A doctor, a nurse or another health professional
- ☐ A social/youth worker
- ☐ A drug counsellor/centre
- ☐ The police
- ☐ A telephone helpline
- ☐ The internet
- ☐ Mass media
- ☐ Don't know

What do you think should be done in your community about alcohol and/or drug related problems?

Please write your answer in the space below.

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What area do you live in?

Please pick one of the answers below.

- ○ Rural
- ○ Regional
- ○ Metropolitan

What state/territory do you live in?

Please pick one of the answers below.

- ❍ New South Wales
- ❍ Victoria
- ❍ Queensland
- ❍ Western Australia
- ❍ South Australia
- ❍ Australian Capital Territory
- ❍ Tasmania
- ❍ Northern Territory

What is the highest level of primary or secondary school you have completed?

Please pick one of the answers below.

- ❍ Did not go to school
- ❍ Year 8 or below
- ❍ Year 9
- ❍ Year 10
- ❍ Year 11
- ❍ Year 12

Are you still at school?

Please pick one of the answers below.

- ❍ Yes
- ❍ No

Have you completed a trade certificate or other educational qualification?

Please pick one of the answers below.

- ❍ No
- ❍ No, currently undertaking one
- ❍ Yes, trade/technical
- ❍ Yes, university/college

How are you currently employed?

Please pick one of the answers below.

- ❍ Not employed and not studying
- ❍ Full time work
- ❍ Part time/casual work
- ❍ Full time study
- ❍ Part time study
- ❍ Both work and study
- ❍ Home duties
- ❍ Other

Are you Aboriginal or Torres Strait Islander?

Please pick one of the answers below.

- ❍ No
- ❍ Yes, Aboriginal
- ❍ Yes, Torres Strait Islander
- ❍ Yes, both Aboriginal and Torres Strait Islander

Have you ever used...(check all that apply)

Please check all that apply and/or add your own variant.

- ☐ Alcohol
- ☐ Cannabis
- ☐ Ecstasy
- ☐ Meth/amphetamine
- ☐ Cocaine
- ☐ Hallucinogens (e.g. Magic mushrooms/LSD)
- ☐ Inhalants (e.g. Nitrous oxide)
- ☐ Heroin
- ☐ Prescription drugs/pain killers (non-medical use)
- ☐ Ketamine
- ☐ GHB
- ☐ I have never used alcohol or other drugs

Other (please specify)

.....

Given your responses to the previous question, have you used these drugs in the past 12 months?

Please mark the corresponding circle - only one per line.

	Yes	No
Alcohol	○	○
Cannabis	○	○
Ecstasy	○	○
Meth/amphetamine	○	○
Cocaine	○	○
Hallucinogens (e.g. Magic mushrooms/LSD)	○	○
Inhalants (e.g. Nitrous oxide)	○	○
Heroin	○	○
Prescription drugs/pain killers (non-medical use)	○	○
Ketamine	○	○
GHB	○	○
	○	○

Given your responses to the previous questions, in the past 12 months, how often did you use alcohol?

Please mark the corresponding circle - only one per line.

	Every day	5 to 6 days a week	3 to 4 days a week	1 to 2 days a week	2 to 3 days a month	About 1 day a month	Less often
Alcohol	○	○	○	○	○	○	○

Given your responses to the previous questions, in the past 12 months, how often did you use...

Please mark the corresponding circle - only one per line.

	Every day	Once a week or more	About once a month	Every few months	Once or twice a year
Cannabis	○	○	○	○	○
Ecstasy	○	○	○	○	○
Meth/amphetamine	○	○	○	○	○
Cocaine	○	○	○	○	○
Hallucinogens (e.g.Magic mushrooms/LSD)	○	○	○	○	○
Inhalants (e.g. Nitrous oxide)	○	○	○	○	○
Heroin	○	○	○	○	○
Prescription drugs/pain killers (non-medical use)	○	○	○	○	○
Ketamine	○	○	○	○	○
GHB	○	○	○	○	○
	○	○	○	○	○

Have you ever sought help from someone relating to drug or alcohol use?

Please pick one of the answers below.

○ Yes

○ No

Are you currently receiving help because of your drug or alcohol use?

Please pick one of the answers below.

○ Yes

○ No

Is there anything else that you would like to say about this survey, or about what should be done about drugs and alcohol?

Please write your answer in the space below.

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You have reached the end of the survey. Thank you for your time!

If you would like to enter the draw to win 1 of 2 iPads, please leave your email address or phone number on the next page (to maintain confidentiality, this information will be separated from your responses to the survey and will not be given out to others)

If you provide your email address, we will also send you a summary of the survey results when the project is completed.

If you would like further information or assistance:
There are a range of services and information lines listed on the Australian Drug Foundation Website:
http://www.druginfo.adf.org.au/contact-numbers/hel p-and-support

ADIS is a telephone service providing information, referral, crisis counselling and advice about illegal drugs such as heroin, ice and cannabis, and legal drugs such as alcohol.
Phone: 1800 422 599.

Or if you feel you are experiencing a crisis and need help, call lifeline
Phone: 13 11 14

If you would like to know more information about your legal rights when it comes to alcohol and drug use, please visit lawstuff:
http://www.lawstuff.org.au

Would you like to enter the prize draw to win 1 of 2 iPads? If so, please select "Yes" below.

Please pick one of the answers below.

- ○ Yes
- ○ No

Appendix B: Other drugs used by participants in their lifetime

In addition to alcohol and ten specific illicit drug types, respondents were asked to nominate whether they had ever used any other drug in their lifetime. This is a list of drug types used by those who said they had consumed 'any other drug' in their lifetime (n=269, 11.5% of the total sample), as described in their own words.

Other drug nominated (verbatim)
'Research Chemicals', namely Psychedelics
'synthetic' drugs
2-CB
2-cb, 2-ci, MDA
2-cb, 25i-nBome
2-cb, methylon, mephedron,
25C-NBOMe
25I-NOMBe
2c-b, 25i-NBOMe
2C-B, 2C-E
2c-b, DMT
2C-B, MDA, Mephedrone, Methylone
2c-b, salvia
2C-P, 2C-C, 2C-E, DOC, TMA-6, Methylone, 6-APB, 4-ACO-DMT, N-N-DMT, DXM, AMT, 25I-Nbome, Mescaline, Butylone, Alpha-PVP, 4-FA
2c-x analogues
2c(x), DXM, BZP
2CB
2CB and other rubbish people try to pass off as other substances
2cb ingested accidentally in an 'ecstasy tablet', almost certainly many other undesirable substances consumed accidentally in pills purported to be ecstasy

Other drug nominated (verbatim)
2cb, 2ce, 2ci, 25i-nbome, 25c-nbome, MDA, salvia, DMT, 5-meo-dmt and more that I forget
2cb, 2ce, mdpv, I have taken 'ecstasy' where I don't know the active drug
2cb, MDA, MDEA, 2ci, other research chems, opium, lsa, dmt
2cb, MXE
2cb. 25i-nbome, dmt, jwh-073
2Cb/e
2cbi, 2cp
2ce, 2cp, 2cb, 2ci, 2ctc21, 4-aco-dmt, 4-ho-met, 4-ho-dipt, dpt, dmt, 5meo-dmt, mdpv, amt, 4fa, 2fa, 2fma, methylone, butylone, jwh73, jwh250, jwh018
4-methylmethcathinone, 4-methylaminorex, methoxetamine, various hallucinogenic research chemicals
6-APB, salvia
A microwave
a vast range of relaxation and dream inducing herbs / medicinal drugs
Acid
also legal synthetic drugs
Amanatia Muscaria, Brugmansia, DXM, caffeine, nicotine and a range of other entheogens
amel nirtate
Amyl nitrate
Amyl Nitrite
Analogues of currently illegal drugs (overall, not recommended)
artificial cannabinoids, clenbuterol
Based DMT, Salvia, legal herbals, have likely consumed smack / coke / meth / GHB or K based pills =/
bath salts

Other drug nominated (verbatim)
bath salts, 2cb, mda, bk-mdma, dmt, ether
benzodiazepines, synthetic hallucinogens, nootropics
Black powder (Sativa?) Hallucinogen
BZP/TMFPP in New Zealand
Caffeine
caffeine, nicotine
caffeine, nicotine, meditation, breathwork, astral travel
Caffieine
Chocolate
Cigarettes
Clenbuterol
Crack Cocaine
Creatine
Dexamphetamine
Dexampthetamine
Dextromethorphan
Dextromethorphan and 2-CB
Dextromethorphan, Methylphenidate, Nicotine, Diazepam
Dimenhydrinate, 2CB, MXE, DXM, Piperazine, MDMA
Dimethyltryptamine
DiMethylTryptamine (DMT)
Dissociatives (DXM)
DMT
DMT (dimethyltryptamine)
DMT, 2cb
DMT, DXM, Opium, Amphetamine

Other drug nominated (verbatim)
DMT, Kronic, MDA, 2-CT
DMT, Meow, 2cB
DMT, Mescalin, Opium, salvia, LSA, 5-MEO-DMT, assorted entheogens
Doesn't matter
Drug – A substance that has a physiological effect when ingested or otherwise introduced into the body .....everything is drugs
Drugs sold as ecstasy that hasn't been I.e dxm, PMA, 2-CB. Not by choice
DXM
DXM and Legal 'Weed"
dxm xanax Clonidine Temazapam codeine
Dxm, 'legal' highs, tobacco
DXM, 4-Methylaminorex, Research chemicals (2C-b, 2C-i, 2C-t7), Psychadelic Amphetamines (DOB, DOM, DOi)
Dxm, codeine OTC
DXM, Kronic, LSA, DMAA
dxm, synthetic cannabis
entheogens in spiritual context: san pedro cactus, kambo
Goey aka derivative of speed. Related to cocaine
hallucinogens (DMT, Mescaline)
hallucinogens should be under the name of psychedelics, that more so correctly describes them
happy high herbs legal products
heaps of others
herbal extacy, herbal speed, etc
I didn't want to tick Meth, but I've done speed
I have a dexamphetamine prescription for my ADHD
I have a prescription for methylphenidate because I have ADHD

Other drug nominated (verbatim)
I have never had any problems with any of these drugs. I use drugs infrequently for both recreational and personal reasons. I almost never drink alcohol as I consider it to be the most damaging of most generally popular drugs.
I've used a fair few minor things and unusual things, never regularly apart from I was a smoker for a while
In dud pills, when I have not done the proper research (i.e. been responsible), I have had DXM and a variety of other unknown substances.
jenkem
jj
Junger Fever (legal weed in Aus) made me feel weird, not good. Will never try those 'legal' alternatives. Only things I KNOW what is in them.
K
Kava
kava, kratom, betel nut, ritalin, modafinil and many others
Kava, TOBACCO, Caffeine
Khatt, Lions Main
kronic
Kronic
Kronic and other synthetic forms of cannabis
Kronic and tobacco
Kronic, BZP etc
Kronic, K2
Laced Cannabis with Speed
large quantities of caffeine
Legal alternatives (K2, Spice, Kronic)
legal herbal drugs
legal party pills, (diablo)
legal substances from the happy herb shop e.g. cherry pop

Other drug nominated (verbatim)
Legalise It
LEGALIZE IT
lol in your dreams, acab yoooo!
lots more
LSD, DXM, Salvia, Northern Lights, party pills
LXD (super speed), 2CB, MDA, Crystal MDMA, MDEA, PCP, DXM (Dodgey pill hospitalised me), PMA (Dodgey pill hospitalised me)
Make LSD legal and I will. It's safer than driving, alcohol, swimming, completing online surveys, etc.
many
Many analogues of the above mentioned drugs
Marijuana
maybe GHB by accident, MDA
mcat, mda, mpa, dmx, rohypnol, mephedrone
MDA
MDA, 2CB
mdma
MDMA
mdma, f1
MDMA, MDA, Kronic, DMT, 2C-B, Magic Mushrooms, LSD, 2C-I, Mescaline, Salvia, Meth, Cocaine
MDMA, MDA, SPEED
MDPV, CHANGA, SYNTHETIC CANNABIS
mdpv, dxm
mdpv, mephedrone
MDPV, MXE
Medical tablets such as panodol

Other drug nominated (verbatim)
Meez
Meow meow
Mephadrone
Mephadrone, amyl nitrate
Mephedrone
mephedrone (meow-meow)
Mephedrone while living in London England 2010
Mephedrone, BZP , Methylone
Mephedrone, DMT, 2CB
Mephedrone, JWH018, BZP
Mephedrone, methylone, mdvp, dimethacaine, salvia, 2ce, 2ci, 5-meo-dmt
mephedrone, salvia
Mescaline
mescaline, ether, amyl nitrate, Dimethyltryptamine
methadrone
methadrone, ritalin
Methaqualone
methedrone
methylphenidate
most
mushrooms
mxe
MXE, 2cb
my body's weight in tobacco
Nicotine
nicotine, caffeine

Other drug nominated (verbatim)
Nicotine, caffeine
Non-illegal drugs, not for recreational usage - but not within guidelines either
Nootropics (smart pills)
Nutmeg, nicotine (patches, gum, cigarettes and cigars - all for recreational purposes)
Opium
Opium in Asia
Opium, 4-methylaminorex, 4-methylmethcathinone, dimethyltryptamine, DXM, 2-Cx
Oxycontin
Panadol
Pills containing both MDMA/MDA and amphetamines
PMA (sold as ecstasy)
PMMA and bunk pills. have seen myself and friends in bad states from these. you NEED to make pill testing kits easier to get would save a lot of lives!
pre workout supplements with 1-DMAA (regular badass over here!)
prescription drugs I did not like to strong cannabis was great
Pseudoephedrine
research chemicals
Research chemicals
Research chemicals - e.g. mephedrone, 4-mec, 5-apb, 6-apb, 2c-i
Research chemicals (2-CI, nBIOME)
research chemicals, salvia, dmt, plant based entheogens
Research chemicals
Ritalin
Salvia
salvia divinorum... and uh... not so smart experiment with datura (<-- that's what happens when kids don't have access to proper drugs :-)
several legal highs (e.g. party pills and herbal incense)

Other drug nominated (verbatim)
Some legal highs such as Kroniic previously mentioned
speed
Speed
Steroids
Synthetic Cannabinoids (Both store bought and black market), Nicotine, Caffeine
Synthetic Cannabinoids i.e.kronic / northern lights
synthetic cannabinoids, numerous research chemicals in 'ecstasy' pills
Synthetic cannabis
Synthetic Cannabis
Synthetic coke, speed, Ketamine, weed
Synthetic Ketamine, Khronic
Synthetic weed, non legal called k2
synthetics
The drugs I have used are irreverent to my views.
this box is not large enough for the list.
tobacco
Tobacco
tobacco count?
Tobacco, caffeine, MDA, amyl nitrate
Tobacco, Nutmeg, Catnip, Spinach, Orange, A good sandwich. The definition for 'drug' is fairly broad, you should try to narrow it down a little.
Tobacco, Stimulants of a non phenylethylamine backbone
Too many to list
valium
Various benzodiazepines, dextromethorphan, diphenhydramine
Various RC's such as 2-CB and it's derivatives

Other drug nominated (verbatim)
various RCs
various research chemicals, mainly phenylethylamines
whatever was going
Whipper
Yzho