

# Section X

**X1. During the last 12 months, in general, how did you obtain your tobacco, alcohol or other drugs?**  
(Mark all that apply for each drug type)



	Tobacco	Alcohol	Other Drugs
Bought at a shop/retail outlet/ licensed premises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bought from someone else	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stole it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traded stolen goods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traded other goods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swapped drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traded sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Re-cut a previously obtained deal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Received some in payment for a job	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forged scripts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grew my own/made it myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friends or relatives offered to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did not obtain in last 12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**X2. During the last 12 months, did you have a period of a month or more when you spent a great deal of time getting, using, or getting over the effects of illicit drugs?**



- Yes
- No
- Not applicable - did not use any  
illicit drugs in the last 12 months

**X3. For each of the drugs listed below, do you personally approve or disapprove of their regular use by an adult?**

(Mark one response for each drug type below)



	Approve	Disapprove
Tobacco/cigarettes	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Pain killers/Analgesics for non-medical purposes	<input type="checkbox"/>	<input type="checkbox"/>
Tranquillisers/Sleeping pills for non-medical purposes	<input type="checkbox"/>	<input type="checkbox"/>
Steroids for non-medical purposes	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates for non-medical purposes	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana/Cannabis	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamines/ Amphetamines (Speed)	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine/Crack	<input type="checkbox"/>	<input type="checkbox"/>
Naturally Occurring Hallucinogens/ LSD/Synthetic Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>
GHB	<input type="checkbox"/>	<input type="checkbox"/>
Ketamine	<input type="checkbox"/>	<input type="checkbox"/>
Glue/Petrol/Solvents/Rush	<input type="checkbox"/>	<input type="checkbox"/>
Methadone for non-medical purposes	<input type="checkbox"/>	<input type="checkbox"/>

**X4. What is your main drug of choice (that is, your favourite or preferred drug), and what is your next drug of choice?**

(Mark only one response in each column)



	Main Choice	Next Choice
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana/Cannabis	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine/Crack	<input type="checkbox"/>	<input type="checkbox"/>
Pain killers/Analgesics	<input type="checkbox"/>	<input type="checkbox"/>
Tranquillisers/Sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamines/ Amphetamines (Speed)	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>
GHB	<input type="checkbox"/>	<input type="checkbox"/>
Ketamine	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
No main drug of choice	<input type="checkbox"/>	<input type="checkbox"/>
No next drug of choice	<input type="checkbox"/>	<input type="checkbox"/>

If you have ever used an illicit drug, please answer X5.  
 If you have never used an illicit drug, please answer X6.

## Section Y

**X5. What factors influenced your decision to first use an illicit drug (including marijuana/cannabis)?**  
 (Mark all that apply, then skip to Y1)



- Friends used/was offered by a friend (peer pressure)
- Wanted to see what it was like (curiosity)
- To feel better/to stop feeling unhappy
- To take a risk
- To do something exciting
- Family problems (e.g. parents separated, didn't get on with parents)
- Work/school/relationship problems
- Traumatic experience (e.g. sexual or physical assault, death of someone close)
- To lose weight
- Enhance experience of some event (e.g. dance party)
- Can't recall
- Don't know

Other (Please write in):

1

**X6. What factors influenced your decision never to try illicit drugs (including marijuana/cannabis)?**  
 (Mark all that apply)



- Worry about health problems (e.g. can cause cancer, affect mental health)
- Didn't want to become addicted
- Fear of being caught by police
- Fear of being convicted by a court
- Fear of going to prison
- Pressure from family or friends
- Didn't want family/friends to find out
- Didn't want employer or teachers to find out
- Didn't like to feel out of control
- Friends didn't use or stopped using
- Didn't think it would be enjoyable
- Financial reasons (e.g. too expensive to buy)
- Lack of availability (drug was too hard to get)
- Religious/moral reasons
- Just not interested
- Never had the opportunity to try illicit drugs
- Didn't want to break the law
- Don't know

Other (Please write in):

2

**Y1. In the last 12 months, did any person affected by alcohol . . . ?**

(Mark one response for each row)



- |                      | Yes                      | No                       |
|----------------------|--------------------------|--------------------------|
| Verbally abuse you   | <input type="checkbox"/> | <input type="checkbox"/> |
| Physically abuse you | <input type="checkbox"/> | <input type="checkbox"/> |
| Put you in fear      | <input type="checkbox"/> | <input type="checkbox"/> |

**Y2. In the last 12 months, did any person affected by illicit drugs . . . ?**

(Mark one response for each row)



- |                      | Yes                      | No                       |
|----------------------|--------------------------|--------------------------|
| Verbally abuse you   | <input type="checkbox"/> | <input type="checkbox"/> |
| Physically abuse you | <input type="checkbox"/> | <input type="checkbox"/> |
| Put you in fear      | <input type="checkbox"/> | <input type="checkbox"/> |

If No to all in Y1 and Y2, Skip to Y10

**Y3. Which of the following persons affected by alcohol or illicit drugs were responsible for the incident(s) referred to above?**

(Select each of the incidents that occurred to you from the top row, and moving down the list of persons, mark all that apply)



- |   | Verbal abuse             | Physical abuse           | Put you in fear          |
|---|--------------------------|--------------------------|--------------------------|
| Spouse or partner                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Parent                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Child                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Brother or sister                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other relative                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other house/flat resident                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Current boy/girl friend                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Former spouse/partner/<br>boy/girl friend | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Work/school/university mate               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Friend                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other person known to me                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Not known to me                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**PLEASE CHECK AGAIN THAT ALL THE INCIDENTS MENTIONED IN Y1 AND Y2 HAVE THE APPROPRIATE ANSWERS IN Y3**

OFFICE USE ONLY:

1	2

**Y4. Where did the incident(s) referred to occur?**  
 (Select each of the incidents that occurred to you from the top row, and moving down the list of locations, mark all that apply)

	Verbal abuse	Physical abuse	Put you in fear
In my own home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a pub or club	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At a party	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At my workplace	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At school/university	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Public transport (e.g. train)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the street	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Somewhere else	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Y5. What was the most serious physical injury you sustained as a result of the incident(s)?**  
 (Mark one response only)

- Bruising/abrasions
- Burns, not requiring admission to hospital
- Minor lacerations (e.g. cuts/scratches)
- Lacerations requiring suturing (stitches), not requiring admission to hospital
- Fractures (broken bones) not requiring admission to hospital
- Sufficiently serious to require admission to hospital at least overnight
- Not relevant – no physical injury sustained

**Y6. Were the incidents reported to the police?**

- No – none
- Yes – some
- Yes – all  (Skip to Y8)

**Y7. Are there any reasons why you didn't report all of the incidents to the police?**  
 (Mark all that apply)

- Too trivial/unimportant
- Private matter
- Police could not do anything
- Police would not do anything
- Did not want offender punished
- Too confused/upset
- Afraid of reprisal/revenge
- Incident is not uncommon for me (e.g. it is to be expected at parties, working in pubs)
- Other

**Y8. In general, at the time(s) the alcohol or other drug-related incident(s) took place, had you also been drinking alcohol or consuming drugs other than alcohol?**

(Mark one response only)

- Yes, alcohol only
- Yes, other drugs only
- Yes, both alcohol and other drugs
- No, neither alcohol nor other drugs

**Y9. Did any of the incidents of physical abuse involve sexual abuse?**

- Yes
- No
- Not relevant (not physically abused)

ALL PLEASE ANSWER

**Y10. In the last 12 months, did you undertake the following activities while under the influence of alcohol?**

(Mark yes or no for each activity)



	Yes	No
Went to work	<input type="checkbox"/>	<input type="checkbox"/>
Went swimming	<input type="checkbox"/>	<input type="checkbox"/>
Operated a boat	<input type="checkbox"/>	<input type="checkbox"/>
Drove a motor vehicle	<input type="checkbox"/>	<input type="checkbox"/>
Operated hazardous machinery	<input type="checkbox"/>	<input type="checkbox"/>
Created a public disturbance or nuisance	<input type="checkbox"/>	<input type="checkbox"/>
Caused damage to property	<input type="checkbox"/>	<input type="checkbox"/>
Stole money, goods or property	<input type="checkbox"/>	<input type="checkbox"/>
Verbally abused someone	<input type="checkbox"/>	<input type="checkbox"/>
Physically abused someone	<input type="checkbox"/>	<input type="checkbox"/>

**Y11. In the last 12 months, did you undertake the following activities while under the influence of illicit drugs?**

(Mark yes or no for each activity)



	Yes	No
Went to work	<input type="checkbox"/>	<input type="checkbox"/>
Went swimming	<input type="checkbox"/>	<input type="checkbox"/>
Operated a boat	<input type="checkbox"/>	<input type="checkbox"/>
Drove a motor vehicle	<input type="checkbox"/>	<input type="checkbox"/>
Operated hazardous machinery	<input type="checkbox"/>	<input type="checkbox"/>
Created a public disturbance or nuisance	<input type="checkbox"/>	<input type="checkbox"/>
Caused damage to property	<input type="checkbox"/>	<input type="checkbox"/>
Stole money, goods or property	<input type="checkbox"/>	<input type="checkbox"/>
Verbally abused someone	<input type="checkbox"/>	<input type="checkbox"/>
Physically abused someone	<input type="checkbox"/>	<input type="checkbox"/>

## Section Z

**Z1. In the last 3 months, how many days of work, school, TAFE or university did you miss because of your personal use of alcohol?**

(Please write your best estimate in whole days (e.g. 0, 1, 2, 10, etc.) in the boxes provided)

Number of days:

Not applicable (don't work or study)  (Skip to Z4)

**Z2. In the last 3 months, how many days of work, school, TAFE or university did you miss because of your personal use of drugs other than alcohol?**

(Please write your best estimate in whole days (e.g. 0, 1, 2, 10, etc.) in the boxes provided)

Number of days:

**Z3. In the last 3 months, how many days of work, school, TAFE or university did you miss because of any illness or injury?**

(Please write your best estimate in whole days (e.g. 0, 1, 2, 10, etc.) in the boxes provided)

Number of days:

ALL PLEASE ANSWER

**Z4. Have you ever participated in an alcohol or other drug treatment program to help you reduce or to quit your consumption?**

(Mark one response for each type of program)

	<b>Yes, in the <u>last</u> <u>12</u> <u>months</u></b>	<b>Yes, but <u>not</u> in the <u>last 12</u> <u>months</u></b>	<b><u>No</u></b>
Smoking (e.g. Quit)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol (e.g. Alcoholics Anonymous)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Detoxification Centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methadone Maintenance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription Drugs (e.g. GP supervised)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Counselling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Therapeutic community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Naltrexone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Z5. Which of the following procedures have you undergone and when?**

(Mark one response for each type of program)

	<b>Yes, in the <u>last 12</u> <u>months</u></b>	<b>Yes, more <u>than 12</u> <u>months ago</u></b>	<b><u>Not</u> had the procedure</b>
Tattoo(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear piercing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Body piercing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If no procedure has been done, then Skip to Z7a

**Z6. Had you been drinking alcohol or using other drugs when any of these procedures were undertaken?**

Yes  No

**FEMALES ONLY (MALES SKIP TO SECTION YY)**

**Z7a. At any stage in the last 12 months were you . . . ?**  
(Mark all that apply)

Pregnant and breastfeeding at the same time    
 Pregnant only  (Continue)   
 Breastfeeding only

Neither pregnant nor breastfeeding at any time in past 12 months  (Skip to Section YY)

**Z7b. For how much of the last 12 months were you . . . ?**  
(Please indicate in either weeks or months)

	Weeks	or	Months
Pregnant and breastfeeding at the same time	<input type="text"/>		<input type="text"/>
Pregnant only	<input type="text"/>		<input type="text"/>
Breastfeeding only	<input type="text"/>		<input type="text"/>

**Z8. Are you currently . . . ?**

Pregnant and breastfeeding    
 Pregnant only    
 Breastfeeding only    
 Neither pregnant nor breastfeeding

**Z9. At any time in the last 12 months when you were pregnant or breastfeeding, did you use any of the following . . . ?**

(Select each that applies to you during the last 12 months from the top row, and moving down the list of substances, mark all that apply)

	When Pregnant only	When Breastfeeding only	When pregnant and breastfeeding
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana/Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain killers/Analgesics for non-medical purposes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tranquillisers/Sleeping pills for non-medical purposes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steroids for non-medical purposes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates for non-medical purposes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inhalants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methadone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamines/Amphetamines (Speed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy/Designer Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injected illegal drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Z10. In the last 12 months when you were pregnant, in general, did you drink more, less or the same amount of alcohol compared to when you were neither pregnant nor breastfeeding?**  
(Mark one response only)

More    
 Less    
 Same amount    
 Don't drink alcohol    
 Not applicable, was not pregnant in the last 12 months

**Z11. In the last 12 months when you were breastfeeding, in general, did you drink more, less or the same amount of alcohol compared to when you were neither pregnant nor breastfeeding?**  
(Mark one response only)

More    
 Less    
 Same amount    
 Don't drink alcohol    
 Not applicable, was not breastfeeding in the last 12 months

**Z12. In the last 12 months when you were pregnant or breastfeeding did anyone advise you not to smoke?**

Yes    
 No    
 Not applicable, don't smoke  (Skip to Section YY)

**Z13. Who advised you not to smoke?**  
(Mark all that apply)

Spouse or partner    
 Parents    
 Brother or sister    
 Doctor or Specialist    
 Nurse or Midwife    
 Pharmacist    
 Other