Home Office

Risk, protective factors and resilience to drug use: identifying resilient young people and learning from their experiences

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The views expressed in this report are those of the authors, not necessarily those of the Home Office (nor do they reflect Government policy).

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Executive summary

Introduction

This report presents the findings of a study exploring young people's resilience to drug use. There were two stages to this research. The first was multivariate analysis of the 2003 Offending, Crime and Justice Survey (OCJS)[1] data. This was carried out by the Home Office and aimed to explore risk factors associated with taking drugs and identify a sample of young people within the OCJS sample who could be considered resilient to drug use. The second stage was a qualitative study of the views and experiences of a sample of these young people, exploring the nature of their resilience to drug use. This was carried out by the Qualitative Research Unit at the National Centre for Social Research (NatCen).[2]

This research supports Home Office Aim 5, which seeks to reduce drug use among young people, in particular the most vulnerable groups. The study was commissioned by the Home Office.

Exploring risk factors and identifying resilient young people (Stage 1)

The key aims of this stage of the study were to:

- establish individual factors that are associated with predictors of drug use through secondary analysis of the OCJS data,[3] focusing in particular on factors that can be changed (e.g. family disturbance, self-esteem, attitudes) rather than those that are fixed (e.g. gender, age, ethnicity);
- assess to what extent these factors are significant for different subgroups of the population, defined by their more fixed (socio-economic) characteristics e.g. gender, age, social class and ethnic group;
- assess to what extent these factors are significant for different levels of drug use (e.g. use of any drug, use of Class A drugs); and
- identify a sampling frame of young people from the OCJS who reported these predictive factors but do not take drugs (resilience) to be used for Stage 2 of the research.

Key findings of the quantitative analysis

Exploratory logistic regression modelling with the OCJS data was carried out in order to study the factors associated with taking drugs. Logistic regression enables one to establish which variables are statistically related to a given dependent variable when all variables under examination have been taken into account. This technique determines associations between variables but does not imply a causal relationship.

The logistic regression models indicate that behavioural and attitudinal variables have a great deal to contribute to understanding risk factors for taking drugs. For the 10- to 16-year-olds the analysis shows that key factors associated with increased risk of taking any drug are:

- **serious anti-social behaviour;**

[1] Budd *et al*.,(2005)

[2] OCJS data were collected jointly by NatCen and the British Market Research Bureau (BMRB).

[3] As a precursor to this analysis a literature review was carried out to summarise studies that have explored associated factors with drug use, and the common factors arising from these studies. The detailed findings of this review have been published separately (Frisher *et al.,* 2006).

- **weak parental attitude towards bad behaviour;**
- **being in trouble at school (including truanting and exclusion);**
- **friends in trouble;**
- being unhelpful;
- **early smoking;**
- not getting free school meals; and
- minor anti-social behaviour.

And for the 17- to 24-year-olds:

- **anti-social behaviour;**
- **early smoking;**
- **being in trouble at school (including truanting and exclusion);**
- being impulsive;
- being un-sensitive; and
- **belonging to few or no groups.**

The subgroup analysis by socio-economic groups and levels of drug use clearly showed that the variables highlighted in bold above tend to also come up in the other models and there is little difference between the risk factors found by subgroup analysis or by levels of drug use.

Exploring risk, protective factors and resilience: the qualitative component (Stage 2)

This stage of the study explored young people's resilience to drug use. Respondents were young people identified by the Home Office through secondary analysis of the OCJS as being 'at risk' of using drugs but who did not report using them at the time of the survey.[4]

The aim of the research was to identify the factors young people saw as influencing their decision-making around their drug using behaviour by exploring:

- the social context in which young people are based in relation to drug use;
- young people's views and attitudes towards illicit drug use;
- young people's experiences and motivations for any illicit drug use in which they may have engaged;
- factors that young people consider to put them 'at risk' of engaging in illicit drug use;
- factors that young people consider to be contributing to their not engaging in illicit drug use; and
- the strategies used by young people to refuse drugs.

The findings presented in this report are based on face-to-face in-depth interviews with 50 young people drawn from a sampling frame provided by the Home Office based on their analysis of the 2003 OCJS. Interviews were tape-recorded and transcribed verbatim for analysis. The transcripts were analysed using 'Framework', a content analysis method developed at NatCen.

Key findings of the qualitative component

Three aspects to being resilient were identified.

(i) Having the opportunities to access drugs and displaying other factors that could put a young person at further risk of drug use.
(ii) Deciding not to use drugs for one or more of a range of reasons.
(iii) Having the skills to put refusal strategies into practice.

[4] In this report 'drugs' or 'drug use' refers to illicit drug use (not that of alcohol or tobacco), where illicit means 'unlawful' or 'not allowed'.

1. Young people's exposure to and views about drugs

Young people fell into three groups based on the nature of the opportunities they had to use drugs and the decisions they made when faced with these opportunities.

Directly offered drugs but never used: young people who had been directly offered drugs on one or more occasions and had been in other situations where they could have accessed drugs, but had always refused them.

Directly offered drugs and had used cannabis on one/two occasions: young people who had been directly offered drugs on a number of occasions and had been in situations where they could have accessed them. They had accepted cannabis once or twice. Other than on these rare occasions, they had frequent opportunities to use drugs but decided not to.

Avoided direct offers of drugs and had never used: young people who had been in situations where they could have accessed drugs but had never been directly offered them. They had consciously taken action to avoid offers by removing themselves from certain situations that, and people who, they associated with drug use.

Underlying these decisions were young people's views about drugs and why people use them. There were four broad categories of views held within the sample (these cut across each of the three groups identified above):

- *'Cannabis use is ok but other drug use is not'*
- *'Cannabis use is ok and so is the use of Ecstasy and cocaine in certain situations, but heroin use is not'*
- *'Cannabis use is not really ok, but it is not as bad as other drug use'*
- *'All drug use is bad'*

Whilst not choosing to use drugs themselves, young people identified the following as reasons why other (young) people might: to escape from problems; to alleviate boredom; to get a 'buzz'; to feel more confident; to ease physical pain; 'to look hard'; to fit in in; peer pressure; to feed their curiosity; and to follow the example of others.

In addition to having the opportunity to use drugs, some young people reported personal circumstances, that could be considered to be putting them at further risk of using drugs. These included: coping with problematic family relationships or with substance use within the family; being in trouble at school or with the police; coping with their own mental health issues or alcohol use; and dealing with boredom.

2. Reasons young people choose not to use drugs

Underlying young people's decisions not to use was that drug use was perceived to be incompatible with their current lifestyle and what they planned or wanted for themselves in the future. Young people identified the following reasons for choosing not to use drugs.

- *The disapproval of significant people* in the young people's lives of drug use, where their disapproval could have negative consequences for the young person, such as being thrown out of the family home by parents, excluded by friends or being dropped from a sport team by the coach.
- *The fear of legal consequences*, which ranged from not wanting to break the law to fear of the impact of a possible criminal record on their life aspirations.
- *Being a parent* was not perceived to be compatible with using drugs. Those who were already parents did not have time to engage in drug use and did not want to place their child at risk. Others who wanted to become parents in the future wanted to stay healthy and be good role models for their children.

- Drug use was considered to be incompatible with achieving *career aspirations*. Young people thought, for example, it could prevent them from obtaining qualifications, or the physical fitness required for certain career paths.
- These young people made extensive use of their spare time – to follow hobbies, do part-time jobs and undertake voluntary work – that left them with *little capacity* to become involved with drugs.
- While never a reason given in isolation, *lacking the monetary means* to buy drugs contributed to some respondents' motivation not to become involved in drug use. Even if they had wanted to use drugs, they would not have had the money to do so.
- Their *own negative experience with cannabis* had made some decide not to use again. Some had been ill as a result of taking it, others had experienced no effect.
- Some young people were on medication that was incompatible with drug use, or had *health condition*s that could be aggravated by it.
- The *fear of damaging health* now and in the future was noted as another reason not to use drugs. The fears ranged from not wanting to become ill to not wanting to die. The latter view was always made with reference to Class A drugs.
- *Fear of addiction* was noted by some. While this tended to be associated with Class A drugs, it also seemed to discourage young people from experimenting with other drugs too.
- Drug use raised concerns among some young people that they would *lose control* of themselves and do something they would regret.
- Young people had *alternative sources of getting the 'buzz'* that users got from drugs. These included drinking alcohol and certain hobbies.
- Having *alternative sources of support* meant that young people did not need drugs as a way of coping with their problems. The sources of support included alcohol or tobacco, supportive relationships, and other sources of stress relief such as using a punch bag, going for a bike ride, or going to the beach to '*chill out*'.

Young people usually cited several of these reasons as having shaped their decision not to use rather than a single one. It was evident from the way in which they discussed the factors that they were very much interlinked.

3. Experiences of and strategies used for refusing drugs

There were three types of refusal strategies reported.

Actively saying 'no'

These included simply saying 'no', offering explanations, and when faced with persistent offers, using a more confrontational refusal strategy.

Avoiding drug-related situations or offers

Where young people wanted to completely avoid potential offers of drugs, they sought to pre-empt and avoid situations where they thought drugs would be used – this involved both people and locations that they associated with drug use. They *'walked away'* from situations before a direct offer was made, or ignored offers.

Faking acceptance

Although not a strategy ever used by respondents, they suggested that they could pretend to accept an offer of drugs. They could accept a drug but did not have to use it.

There were a number of factors related to the context in which offers were made that impacted on how easy or difficult young people found it to make a refusal and, in some cases, the type of strategy they chose to use. These key factors were:

Who made the offers: whether offers came from friends or strangers impacted on some young people's experiences of refusing drugs.

Friends who made it easier to refuse respected a young person's decision not to use and did not try to coerce or convince them into accepting. However, it was more difficult to refuse friends who were more persistent in their offers or were *'high'*. In these situations young people needed to be more forceful in the refusal strategies they used. Another factor that made refusing friends difficult was the potential for there to be negative consequences such as being excluded from a group.

Refusing offers of drugs made by strangers rather than friends was regarded as easier by some and more difficult by others. It could be easier in that they did not care what a stranger thought of them, and also they were less trustful of what was being offered by them. On the other hand, refusing strangers could be more difficult because they were viewed as much more likely to become verbally or physically aggressive.

Who the young person was with when offers were made: irrespective of the source of an offer, having been with friends who do not use drugs or those who do impacted on how easy or difficult young people found it to refuse.

Being with friends who did not use made refusing easier because they offered respondents an alternative place to go or activity to do, they discouraged respondents from using when they had been tempted, and they provided support when offers were *'particularly persistent'*. Being with friends who were using when offered tended to make refusing more difficult because young people felt *'compelled to try and join in'*.

There were some *underlying factors* that affected refusal, for some making it easier and for others harder to refuse. These included: how happy the young person felt to be the odd one out when all their friends were using drugs; whether they had a reputation as a tobacco smoker or alcohol drinker; whether they had built up a reputation as someone who does not use drugs; their age; whether they were under the influence of alcohol when the drugs were offered; and what type of drug was being offered.

Discussion: facilitating resilience

The results of Stage 1, the multivariate modelling of risk factors, while limited by the range of variables available for analysis, suggest two different areas where policy could have an impact: early interventions with truants and interventions focused on strengthening parenting skills. It is, however, important to point out that not all interventions work and that in developing them it would be important to learn from interventions that are proven to have an effect on preventing drug use. These interventions need not necessarily be drug specific interventions and could take a more interdisciplinary form aimed at improving the general environment of children by strengthening and developing more protective factors around them and supporting their parents and families.

The findings from Stage 2 of the research show that young people's resilience is facilitated by a range of factors, some of which are related to their character and some to the context in which they are based. There appear to be three processes running concurrently for young people when they are resilient: they operationalise a schema in which they view drug use as harmful to themselves and therefore a behaviour in which they do not want to engage (*schema theory*), alongside which they have developed a set of resilience-focused goals (*self-regulation theory).* They then draw on a strong sense of self-efficacy so that they are able to put this decision not to use into practice (*self-efficacy theory*). Based on these findings, a number of policy implications are suggested to encourage, promote and facilitate young people's resilience.

To develop and maintain an effective resilience to drugs schema: a strategy of providing accurate and credible information, using relevant appropriate language could help provide

young people with the facts necessary to begin developing a resilience to drug use collection of beliefs and attitudes. The experiences of young people included in this study could be used to inform future advertising campaigns and awareness-raising resources such as FRANK. The case studies presented in the report, motivations for not using drugs and the range of strategies suggested for refusing them could all be used in this context and in school drugs education.

To develop and maintain appropriate approach goals: appropriate agencies, including schools, could help young people develop realistic and achievable goals, for example in terms of what career they would like to pursue in the future. Particular challenges may be faced where young people are based in a social context characterised by high levels of unemployment and social deprivation.

To develop and maintain strong self-efficacy: the skills required to be able to maintain a decision not to use drugs in practice, including general social skills such as assertiveness, appear to be used by young people in a wide range of contexts. This would suggest that these skills could be developed and promoted in a variety of settings including both drug education and citizenship school-based classes.

Programmes that promote discussion and tolerance of diversity within peer groups that are based on a 'normative' approach to education should be encouraged.[5] These programmes could facilitate resilience by creating an environment where young people feel confident in expressing their personal choice about whether or not to use drugs and in which peer pressure to use would be minimised.

The three areas complement each other and therefore it would appear that for resilience to drug use to be developed and maintained, all three issues need to be addressed. For example, a young person can receive accurate, credible and accessible information in order to develop a resilience to drugs schema. However, without the accompanying goals and life-skills necessary to develop a strong sense of self-efficacy, these schema may be redundant.

The factors young people have identified as facilitating them to remain resilient (as summarised in Table S.1) may be useful in the development of a tool for social workers, schools and other agencies that work with young people to assess a young person's vulnerability to using drugs.

[5] For example, the Blueprint programme currently being piloted with a sample of Year 7 and Year 8 pupils in England.

Table S.1: Summary of factors young people identified as facilitating or impeding resilience to drug use[6]

Other people's motivations to use	Contextual risk factors	Factors making it easier/more difficult to refuse offers	Motivations not to use
Following example of others	In trouble with the police/school	Reputation as 'resilient' to drug use	Other people's disapproval
To fit in	Alcohol use	Type of drug offered	Fear of effect on health
Peer pressure	Boredom	Reputation as a smoker or drinker	Fear of addiction
Alleviate boredom	Familial substance use	Age	Alternative sources of support/coping mechanisms
The buzz	Mental health issues	'Happy to be the odd one out'	Current health conditions
Curiosity about effects	Problematic family relationships	Being drunk	Fear of losing control
Escape problems		Offered by friends or strangers	Career aspirations
Ease physical pain			Role as a parent
'To look hard'			Availability of time
To feel more confident			Financial cost
			Personal experiences with drugs

[6] These are not presented in any particular order and are explored in depth in Chapters 4 through to 7 In this report.

1 Introduction

This report presents the findings of a study exploring young people's resilience to drug use. There were two stages to this research. The first was a multivariate analysis of the 2003 Offending, Crime and Justice Survey (OCJS)[7] data. This was carried out by the Home Office and aimed to explore factors associated with taking drugs and identify a sample of young people within the OCJS sample who could be considered resilient to drug use (the findings are reported in Chapter 2). The second stage was a qualitative study of the views and experiences of a sample of these young people, exploring the nature of their resilience to drug use. This was carried out by the Qualitative Research Unit at the National Centre for Social Research (NatCen).[8] (The findings are reported in Chapters 4 through to 7.)

Background

The Government's Drugs Strategy has the overarching aim of 'reducing the harm that drugs cause to society, including communities, individuals and their families'.[9] There are four key Drugs Strategy targets: young people; treatment of problem drug users; supply of drugs; and, drug-related crime. Under the young people's target the Government has set the objective, between 1998 and 2008, to:

> *have reduced the use of Class A drugs and the frequent use of any illicit drugs by all young people [under the age of 25] and, in particular, by the most vulnerable groups by 2008.*
>
> (Updated Drug Strategy 2002, Home Office 2002: 21)

In support of this, and the Every Child Matters: Change for Children programme to improve the lives of children and young people, addressing the Be Healthy outcome, one of five included within the Children Act 2004, a cross-Government approach to the development of services to prevent drug harm has been adopted. The approach includes:

> *Ensuring provision is built around the needs of vulnerable children and young people; more focus on prevention and early intervention with those most at risk…*
>
> *Targeted interventions within children and young peoples' services for those most at risk from drugs.*
>
> (Every Child Matters: Change for Children, Young People and Drugs, HM Government 2005: 2 (&7))

The current study focuses on the views and experiences of young people who have been offered drugs and may be considered 'at risk' of using them, but who choose not to do so. In doing so it discusses some of both the risk and protective factors that may influence young people's decisions about using drugs, and the nature of resilience among a sample of young people. It is concerned with building the knowledge base upon which drug prevention programmes are developed.

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[7] Budd *et al.* (2005).

[8] OCJS data were collected jointly by NatCen and the British Market Research Bureau (BMRB).

[9] Home Office (2002: 6).

Risk, protective factors and resilience

It has been suggested that rather than just focus on prevention and treatment of drug use, there should also be a focus on preventing the risk factors and enhancing the protective factors, increasing young people's resilience capability, helping with strategies for refusal and hence supporting young people's resilience. The risk factor approach is one that has already been shown to be successful in other areas such as preventing heart and lung disease. The approach works by targeting the risk factors and therefore by reducing the chances of developing the disease (Hawkins *et al.*, 1992).

Although a key advantage of the risk factor approach is linking explanation and prevention in a form which is easy to understand and communicate, it is not without problems. Whilst some risk factors are causes others may be merely markers or correlated with causes, (Farrington, 2000). It is also important to establish processes or pathways that intervene between risk factors and outcomes.

Most initiation of drug use occurs at a young age, and therefore interventions need to be provided at an early age. The vast majority of literature concentrates on young people because it is likely that it is the risk factors at this age that are most informative in predicting and hence preventing drug use. It should be borne in mind that at different stages of a young person's development some factors will be more salient than others (Hawkins *et al*., 1992).

There has been a large amount of research exploring the factors that may 'predict' drug use and no definitive list has been agreed. However, authors agree that there is not just one factor which predisposes an individual to drug use. Rather it is a multiplicity of factors that act together for that one individual and contribute to his/her decision to use drugs. This is not to say that the same combination of factors will result in a different individual deciding to use drugs. Therefore, it is important to establish that the search for predictive factors is not a search for the causes of drug use, but rather the factors that may make a person more likely to use drugs.

Risk factors

The literature tends to term each factor associated with predicting drug use as a 'risk factor'. Risk factors have been defined as those that 'occur before drug abuse and are associated statistically with an increased probability of drug abuse' (Hawkins *et al*., 1992:65). Clayton (1992) defines a risk factor as "an individual attribute, individual characteristic, situational condition, or environmental context that increases the probability of drug use or abuse or a transition in level of involvement in drugs" (Clayton, 1992:15). These risk factors are not just associated with drug use, but are often the same as, or similar to, those that are risk factors for other adolescent problem behaviours (Hawkins *et al.*, 1992).

There is also evidence that the number of risk factors that a person has been exposed to is a predictor of drug use, regardless of what the particular risk factors are. The more risk factors there are, the greater the likelihood of drug use (Newcomb *et al*., 1986). Therefore, any predictive models of drug use should consider using the number of risk factors as a predictor.

A recent literature review commissioned by the Home Office (Frisher *et al*., 2006) has identified associations between a diverse group of risk factors for drug use. These factors include parental discipline, family cohesion, parental monitoring, peer drug use, drug availability, genetic profile, self-esteem, hedonistic attitudes, reasons for drug use and the ratio of risk to protective factors. There is less consistent evidence linking drug use to mental health, parental substance use, Attention Deficit Hyperactivity Disorder/stimulant therapy, religious involvement, sport, health educator-led interventions, school performance, early onset of drug use and socio-economic status.

The Surgeon General in 1999 noted that as in the context of youth violence, risk factors have differential predictive values throughout adolescence. Some factors may occur at birth (or before) while others occur at varying times throughout adolescence. Some factors may

persist for long periods whilst others are transitory. Frisher *et al.* (2006) noted that different factors are associated with the initiation and continuation of drug use, although this distinction is not always clear in the literature. Risk factors are not discrete entities and their complex interactions are difficult to conceptualise, let alone analyse.

Protective factors

In attempting to predict drug use, protective factors need to be considered in addition to risk factors. A protective factor is defined by Clayton (1992) as "an individual attribute, individual characteristic, situational condition, or environmental context that inhibits, reduces, or buffers the probability of drug use or abuse or a transition in level of involvement in drugs".

Protective factors are often seen as the converse of risk factors. For example, good parenting would be a protective factor, bad parenting a risk factor; siblings taking drugs would be a risk factor, siblings not taking drugs would be a protective factor. However, the nature of protective factors is often more complex. Simply possessing protective factors does not mean an individual will choose not to take drugs, but the protective factors may play a part in mediating or moderating the effects of risk factors. Protective factors can be seen as enhancing the resiliency of an individual for coping with risk factors in their lives and protect them from drug use (Hawkins *et al*., 1992). Protective factors may also be seen to work by reducing the effect of somebody having a large number of risk factors. There is also limited evidence which suggests that there is a linear relationship between the number of protective factors and not using drugs, as has been seen with the number of risk factors and drug use (Swadi, 1999).

Resilience

In this report, resilience is understood as the behaviours that young people exhibit in making their decisions not to use drugs and putting this into practice, despite having been exposed to drugs and other risk factors A distinction needs to be made between being capable of resilience and being resilient. Being capable of resisting drug use depends on the circumstances of the particular young person: how the risk and protective factors interact at different stages in their life course. Resilience is the act of being resilient, therefore, putting the capability into action. Resilience is not a permanent feature or characteristic of a person; people may go through stages in which it fluctuates and they are more or less capable of being resilient (Jessor and Jessor, 1978).

Research aims

In its broadest terms, the current research aims to identify what may be considered the risk and protective factors associated with young people's drug use, and to explore in depth the nature of resilience among those who are considered to be 'at risk' but decide not to use. To achieve this aim there were two stages of research carried out, the findings of which are presented in this report.

The aims of Stage 1 were to:

- establish individual factors that are associated with drug use through secondary analysis of the OCJS data[10], focusing in particular on factors that can be changed (e.g. family disturbance, self-esteem, attitudes) rather than those that are fixed (e.g. gender, age, ethnicity);
- assess to what extent these factors are significant for different subgroups of the population, defined by their more fixed (socio-economic) characteristics e.g. gender, age, social class, ethnic group;
- assess to what extent these factors are significant for users of different levels of drug use (e.g. use of any drug, use of Class A drugs); and

[10] As mentioned above a literature review was carried out as a precursor to this analysis to summarise studies that have explored predictive factors of drug use, and the common factors arising from these studies (Frisher *et al*., 2006).

- identify a sampling frame of young people from the OCJS who reported these associated factors but do not take drugs (resilience) to be used for Stage 2 of the research.

Stage 2 explored the factors young people identified as influencing their decision-making around their drug using behaviour. Its aims were to:

- explore the social context in which young people are based in relation to drug use;
- explore young people's views and attitudes towards illicit drug use;
- explore young people's experiences and motivations for any drug use in which they may have engaged;
- identify and explore factors that young people consider to put them 'at risk' of engaging in drug use;
- identify and explore factors that young people consider to be contributing to their not engaging in drug use; and
- identify the strategies used by young people to refuse drugs.

Structure of the report

Chapter 2 discusses the methods used in Stage 1 of the research, and presents the outcomes of the logistic regression models carried out on the 2003 OCJS data. Chapter 3 discusses the design and methods used in Stage 2 of the research. Chapters 4 through to 7 present the findings of the qualitative work (Stage 2). Chapter 4 explores the opportunities young people have had to use drugs and the decisions they have made when faced with these opportunities. It also presents young people's perceptions about the reasons why other people might choose to use drugs, and features of respondents' lives that may be considered as putting them at 'risk'. Chapter 5 explores the factors young people identified as having influenced their decision not to use drugs. The following chapter, Chapter 6, looks at the strategies used by young people to refuse offers of drugs and the factors that made it easier or more difficult to make these refusals. Chapter 7 presents five case studies that illustrate the nature of resilience among a selection of the young people. The final chapter reflects on the main findings of the research, identifying factors that facilitate resilience and the implications for policy.

2 Exploring the factors associated with drug use (Stage 1)

This chapter presents the findings of Stage 1 of the research. The section used the 2003 Offending, Crime and Justice Survey (OCJS) data to explore the factors associated with taking drugs. Chapter 3 then describes how a sampling frame of young people considered resilient was developed for Stage 2 of the research.

The Offending, Crime and Justice Survey

The 2003 OCJS is a random probability sample survey of self-reported offending of the general household population aged from 10 to 65 in England and Wales. The survey provides a unique picture of the extent and nature of offending and of drug use across this age range.

The main sample comprised 10,079 people and the response rate was 74 per cent. The number of young people was boosted to around a half (N=4,574) as this is a group of key interest to which the drugs module was also asked. Fieldwork took place from January to July 2003. The first part of the interview was interviewer-administered; the second part – including the more sensitive questions – was self-administered. Computer-assisted techniques were used.

As well as measuring drug prevalence, the OCJS is the first survey of this scale to ask young people a series of comprehensive questions on truancy, parents, attitudes, offending behaviour and other health, lifestyle and risk factors that are key for this study. In addition to this the OCJS is a longitudinal survey where 96 per cent of the respondents have agreed to be re-contacted for further research.

Quantitative research studies, with large datasets, on factors associated with drug use in the UK are limited. Modelling has been carried out, for example, using the British Crime Survey (BCS), but has been constrained by the small set of socio-economic variables that it measures. The 2003 data come from the first year of OCJS. The OCJS was selected for the current study as it offered an opportunity to build a model of drug use which considers not only socio-economic characteristics but a variety of behavioural and personality characteristics.

Logistic regression models

Exploratory logistic regression modelling was carried out in order to study the factors associated with taking drugs. Logistic regression enables one to establish which variables are statistically related to a given dependent variable when all under examination have been considered. For example, serious offending is associated with drug use and it is also associated with truanting; truanting is therefore also associated with drug use. With logistic regression one can look at serious offending and truanting together and establish how much each is associated with taking drugs independently from each other. This technique determines associations between variables but does not imply a causal relationship. The first step before carrying out the logistic regression modelling is to examine the data available and study which factors can be used in the models as independent variables.

The independent variables included in the models

The independent variables were selected first of all as a result of the literature review, these being the ones that have been previously acknowledged as being associated with taking

drugs. The OCJS questionnaire was carefully examined in order to operationalise[11] as many of the factors found in the literature as possible. The factors found were operationalised and a list of uncorrelated[12] variables was finally made to be used in the models (see Appendix A for further details).

To ease the analysis, the variables found in the literature were grouped into several broad categories. In some cases these categories are not mutually exclusive, however, they aid the understanding of the possible factors that are associated with taking drugs. Table 2.1 illustrates the variables found in the survey and how these would fall within the categories found in the literature; it also serves as a look-up table for areas of enquiry that could be covered in future sweeps of the survey or other drugs surveys. Four key aspects were important for the selection of possible factors.

- The factors for use in the model had to be things that are changeable and, therefore, factors policy could have an impact on (e.g. family disturbance, self-esteem, attitudes) rather than those that are fixed (e.g. gender, age, ethnicity). Models would then be run for the different gender types, ages, ethnic groups and so on to see whether there are different associated factors depending on demographics.

- In theory the risks factors have to be there before the drugs are taken. However, in practice, for some of the factors, it is difficult to assess whether they happen before, after or alongside drug use, for example anti-social behaviour or offending.

- The OCJS uses several attitudinal scales and questions that can all be hypothesised to be tapping to some degree into the same concept/s. In these cases Principal Components Analysis was used as a data reduction technique: "by calculating scores for each underlying dimension and substituting them for the original variables" (Hair *et al.*, 1995:367). Principal Components Analysis is a multivariate statistical method which aims to determine whether or not the interrelationships (correlations) among a large number of observed variables can be explained in terms of common underlying dimensions, known as components. Thus the aim of principal components analysis is, firstly, to identify these separate dimensions of the observed variables' structure and secondly to determine the extent to which each variable is explained by each dimension.

- The OCJS asks different questions from respondents depending on their age group. For this reason separate models were used for those aged from 10 to 16 and those aged from 17 to 24. This also serves to examine the predictors at different stages of a life cycle of young people.

This section provides a detailed description of the independent variables, those factors that were identified in the survey as possibly associated with taking drugs and those that were not included in the models. Appendix A provides details on how the variables were used and/or components formed and outlines the factors that were finally included in the models and how these were coded.

[11] A series of research operations or procedures to assign units of analysis to the categories of a variable in order to represent conceptual properties (see Appendix A for further details).
[12] Factors not associated with each other are necessary as independent variables to be used in regression models.

Table 2.1: Factors associated with drug use found in the literature and those available in the OCJS and used in the logistic regression models

Literature	OCJS variables used in the 10-16 models	OCJS variables used in the 17-24 models	Available but did not use in models
Biological or psychological including demographics			
Genetic predisposition	Sensitive	Sensitive	
	Unhelpful		
	Easily bored		
		Impulsive	
Gender			Models run by gender
Age			Models run by age
Ethnicity			Models run by ethnicity
Life events i.e. death or divorce in family			
Self-esteem			
Hedonism (sensation seeking)			
Mental disorder or depression			Could also be an outcome of drug taking
Behavioural or attitudinal			
Lawbreaking (delinquency)	Serious offending	Serious offending	
Anti-social behaviour (conduct disorder)	Serious anti-social behaviour	Anti-social behaviour	
	Minor anti-social behaviour		
Educational disturbance	In trouble at school (incl. truanting and exclusion)	Truanted or excluded from school	
Early onset of smoking	Early smoking	Early smoking	
Early onset of alcohol use	Early alcohol use	Early alcohol use	
Attitude towards drug use			Attitudes towards drugs too dependent on whether a person has tried them already or not
Alienation (rebellion)			
Low religiosity			Respondents asked what religion they belonged to, not level of affiliation with that religion
Dealing with drugs			Variable too associated with young people who have already used drugs
Interpersonal relationships			
Lack of family bonding (poor relationships)	Parents don't know who friends are		
			How well young people get on with parents: because of various combinations of parents a young person could have, it makes this variable too complex and would lose too many respondents
Parental management (parental control)	Weak parental attitude towards bad behaviour		
			Parents' attitude to alcohol use, too much sample would be lost, only asked to those that had alcohol
	Bad parental management		
	Parents been in trouble	Parents been in trouble	

Literature	OCJS variables used in the 10-16 models	OCJS variables used in the 17-24 models	Available but did not use in models
Family disturbance (conflict)			Family make up, there are some questions on who brought a person up, however, very complex and would not have enough cases
			Parents fight or argue: too much of the sample was lost, only asked of those that live with parents
Peers in trouble or using drugs	Older friends		
	Friends been in trouble	Friends been in trouble	
Low social support network		Not having someone to talk to	
		Belonging to a few or no groups	
	Little or no social support network	Little or no social support network	
Environmental and economic			
Socio-economic status (poverty)	Free school meals	Free school meals	
		NEET (not in education, employment or training)	
			Models run by income
			Not enough cases to run model by social class
School management	Poor school management		
Neighbourhood disorder	High disorder as perceived by the interviewer	High disorder perceived by the interviewer	
			Disorder as perceived by the respondent: it was felt that if the respondent was involved in anti-social behaviour we could get biased judgement
Things to do in the area	Few things to do in the area		
Drugs availability			

The model fitting strategy

Logistic regression serves the basic purpose of estimating the relationship between a single non-metric (categorical) dependent variable, such as answers yes and no to a question on whether the respondent has taken drugs, and a set of independent variables, for example, family disturbance, truanting, serious offending and so on. For this study the Likelihood-Ratio Test Forward Stepwise Selection has been chosen (see Appendix B for further information) to run the logistic regression models. A scaled weight was used in the modelling procedure to adjust for survey design and non-response.

Outcomes of multivariate analysis

The results of multivariate analysis are highly dependent on the independent and dependent variables that are available for analysis. When interpreting the results it is important to keep in mind Table 2.1, the variables that are identified in the literature as having a relationship with taking drugs and are not measured by the OCJS.

The key findings of the exploratory logistic regression are presented in Table 2.2. The numbers in the 'sig' column indicate the order of importance for those factors that are significant at five per cent level. The OCJS estimates are subject to sampling error, so, findings may be arrived at by chance. Statistical significance is used to identify how accurate the finding is believed to be, a five per cent significance level means that there is a one in twenty chance of incorrectly identifying a factor as associated with drug use when in fact it is

not. The Nagelkerke R Square is a goodness-of-fit test, a measure of how well the model fits the data, the value ranges between nought and one, the bigger the value the better the model. The estimate provides a measure of the variance of the dependent variable explained by the independent variables; if multiplied by 100 it provides a percentage of variance explained.

The model for the 10- to 16-year-olds showed that of the factors under consideration eight were associated with taking any drug: serious anti-social behaviour; weak parental attitude towards bad behaviour; being in trouble at school (including truanting and exclusion); having friends in trouble; being unhelpful; early smoking; not getting school meals and minor anti-social behaviour.

The remit of the research was also to assess to what extent the factors found in the main models are significant for different subgroups of the population defined by their more fixed (socio-economic) characteristics, for example, gender, age, social class and ethnic group. The models were run by gender, ethnic group, household income and type of accommodation. In the 10 to 16 age group there were only enough respondents to run the models by gender and by type of accommodation (see Table 2.2). The results of the subgroup analysis showed that serious anti-social behaviour, weak parental attitude towards bad behaviour, being in trouble at school, having friends in trouble and early smoking also appeared in most subgroup analysis.

A further aim of the research was to assess to what extent the factors found in the main model are significant for users of different levels of drug use. In the 10 to 16 age group there were insufficient Class A drug users in the sample to run the models by level of drug use.

The key findings of the logistic regression for the 17- to 24-year-olds showed that six variables were associated with taking any drug (see Table 2.3): anti-social behaviour; early smoking; being in trouble at school; being impulsive; being un-sensitive and belonging to few or no groups. More or less the same variables were found when looking at different levels of drug use; the model for taking Class A drugs showed that in this case being sensitive did not enter the model and having friends in trouble did. It is important to note that the models for the 17- to 24-year-olds do not include parental variables as they were not asked the same questions about their parents as those aged from 10 to 16.

As with the 10 to 16 model anti-social behaviour is a key variable being the one that comes out in most of the models and with the highest association which also appeared in most subgroup analysis (see Tables 2.3 and 2.4). Other key associated variables with use of any drug that are common to most subgroup analysis models are: early smoking; being in trouble at school (including truanting and exclusion); and belonging to few or no groups.

Subgroup analysis by ethnic group was not possible given the low number of drug-taking respondents from ethnic minority groups included in the sample.

Table 2.2: Factors associated with use of any drug ever amongst 10- to 16-year-olds, main model, gender and type of household

10- to 16-year-olds	**Main model**	**Male**	**Female**	**Council**	**Non-council**
Factors associated with drug use	Order of importance[1]	Order of importance[1]	Order of importance[1]	Order of importance[1]	Order of importance[1]
Personality					
Sensitive			*6*		
Unhelpful	*5*		*2*		*5*
Easily bored			*5*		
Behaviour and attitudes to drugs					
Serious offending					
Serious anti-social behaviour	*1*	*1*	*1*	*1*	*1*
Minor anti-social behaviour	*8*	*4*		*2*	
In trouble at school (incl. truanting and exclusion)	*3*	*5*			*3*
Early smoking	*6*	*3*		*6*	*7*
Early alcohol use					
Interpersonal relationships					
Parents don't know who friends are					
Weak parental attitude towards bad behaviour	*2*	*2*	*3*	*4*	*2*
Bad parental management					
Parents been in trouble					
Older friends					
Friends been in trouble	*4*	*7*	*4*		*4*
Low social support network					
Environmental and economic					
Free school meals	*7**				*6**
Poor school management				*3*	
High disorder perceived by the interviewer		*6**			
Few things to do in the area				*5*	
Nagelkerke R Square	*.371*	*.370*	*.407*	*.417*	*.374*

Notes:

1. The numbers in the 'Order of importance' column indicate the order of importance for those factors that are significantly associated with drug use at the five per cent level.
2. * In the main model and for non-council residents the odds of taking drugs were higher for those not receiving free school meals. For males the odds of taking drugs were higher for those in low disorder areas.
   See Appendix A and B for further information.

Table 2.3: Factors associated with use of any drug ever amongst 17- to 24-year-olds, main model, gender and type of household

17- to 24-year-olds	**Main model**	**Main model**	**Male**	**Female**	**Council**	**Non-council**
	Any drug	**Class A**	**Any drug**			
Factors associated with drug use	Order of importance[1]	Order of importance[1]	Order of importance[1]	Order of importance[1]	Order of importance[1]	Order of importance[1]
Personality						
Sensitive	*5**		*3**		*3**	
Impulsive	*4*	*6*	*5*			*5*
Behaviour						
Serious offending					*4**	
Anti-social behaviour	*1*	*3*	*1*	*1*	*1*	*1*
Truanted or excluded from school	*3*	*1*	*4*	*5*	*2*	*3*
Early alcohol use						
Early smoking	*2*	*4*	*2*	*3*		*2*
Interpersonal relationships						
Parents been in trouble						
Friends been in trouble		*2*				
Not having someone to talk to				*2*		
Belonging to few or no groups	*6*	*5*	*6*	*4*		*4*
Little or no social support network						
Environmental and economic						
Free school meals						
High disorder perceived by the interviewer						
NEET (not in education, employment or training)						
Nagelkerke R Square	*.167*	*.153*	*.219*	*.133*	*.232*	*.150*

Notes:
1. The numbers in the 'Order of importance' column indicate the order of importance for those factors that are significantly associated with drug use at the five per cent level.
2. *In the main model, model for males and those that lived in council housing the odds of taking drugs were higher for those that were less sensitive. For those that lived in council housing the odds of taking drugs were higher for those who had not committed a serious offence in the last year.
See Appendix A and B for further information.

Table 2.4: Factors associated with use of any drug ever amongst 17- to 24-year-olds, main model and by income of head of household

17- to 24-year-olds	**Main model**	**Under 10,000**	**10,000 to 14,999**	**15,000 to 19,999**	**20,000 to 29,999**	**30,000 +**
Factors associated with drug use	Order of importance[1]	Order of importance[1]	Order of importance[1]	Order of importance[1]	Order of importance[1]	Order of importance[1]
Personality						
Sensitive	*5**				*2**	*3**
Impulsive	*4*					*1*
Behaviour						
Serious offending						
Anti-social behaviour	*1*	1		1	*4*	*2*
Truanted or excluded from school	*3*		2	2	*1*	
Early alcohol use						
Early smoking	*2*	3			*3*	
Interpersonal relationships						
Parents been in trouble						
Friends been in trouble						
Not having someone to talk to						
Belonging to few or no groups	*6*					
Little or no social support network						
Environmental and economic						
Free school meals						
High disorder perceived by the interviewer		2	1			
NEET (not in education, employment or training)						
Nagelkerke R Square	*.167*	*.305*	*.358*	*.125*	*.267*	*.177*

Notes:

1. The numbers in the 'Order of importance' column indicate the order of importance for those factors that are significantly associated with drug use at the five per cent level.
2. * The odds of taking drugs were higher for those that were less sensitive.

See Appendix A and B for further information.

The logistic regression models indicate that behavioural and attitudinal variables have a great deal to contribute to understanding the associated factors for taking drugs. For the 10- to 16-year-olds the analysis shows that key factors associated with taking any drug were:

- **serious anti-social behaviour;**
- **weak parental attitude towards bad behaviour;**
- **being in trouble at school (incl. truanting and exclusion);**
- **friends in trouble;**
- being unhelpful;
- **early smoking;**
- not getting school meals; and

- minor anti-social behaviour.

And for the 17- to 24-year-olds:

- **anti-social behaviour;**
- **early smoking;**
- **being in trouble at school (incl. truanting and exclusion);**
- being impulsive;
- being un-sensitive; and
- **belonging to few or no groups.**

Previous modelling of drug use with large datasets in the UK which used mostly socio-demographic variables and very few behavioural and attitudinal variables, accounted for around 20 per cent of the variance (see Chivite-Matthews *et al*., 2005). Some of the models presented in this chapter account for up to 42 per cent of the variance representing a marked improvement over previous models. However, a considerable amount of variance remains unexplained. Arguably the improvement in the explained variance could also be due to the younger age group in which they are based (10 to 16); the prevalence of use of any drug is relatively high[13] in the 16 to 24 age group, and this effectively may mean that models run in the younger age group (10-16) will be better at identifying those that start earlier who may belong to a more uniform group and therefore have more of the risk factors in common.

The subgroup analysis by socio-economic groups and levels of drug use clearly showed that the variables highlighted in bold above tend to also come up in the other models and that there is little difference between the factors found by subgroup analysis or by levels of drug use.

Discussion

The results from this analysis support the findings of many previous studies that truants are more likely to take drugs, commit anti-social behaviour and offend (for example Roe *et al*., 2005; Mori, 2004; and, McAra, 2004). Several reasons make this group particularly suitable for early interventions.

- Truanting can be identified at a very early stage allowing for very early interventions before the drug, offending or behavioural problems develop into serious problems.
- Truants are clearly identifiable as they are in schools, as opposed to 'drug addicts', 'offenders', 'children with drug addicted parents', 'children with behavioural problems', which are normally much more hidden populations.
- Given that education is compulsory the group 'truants' will include all of the other groups of interest within it: 'children with drug addicted parents'; 'children with behavioural problems'; 'children in care'; 'children that offend'; and so on.
- Any new policy initiative could identify truants and work as a preventative measure for all of the other related issues: problems at home; problems at school; problems with peers; personality issues such as self-esteem; drug addiction; anti-social behaviour; and offending.
- It does not matter if truanting comes before or after the other behavioural patterns (drug addiction, anti-social behaviour and offending), what is important is that these issues are related and that truanting is the way in which these children at risk can be identified early.

The findings also suggest that initiatives to strengthen parenting skills may help to prevent drug use. The research uses a series of attitudinal questions to measure parental attitude towards bad behaviour.

[13] Of those aged from 16 to 24 27.8 per cent had taken a drug in 2003/04; see Chivite-Matthews *et al*. (2005)

- Would parents mind if they found out you had started a fight with someone?
- Would parents mind if you skipped school without permission?
- Would parents mind if you smoked cannabis?
- Would parents mind if you wrote things or sprayed paint on a building?

The analysis suggests that the children of parents who display weak attitudes towards 'bad' behaviour are more likely to take drugs. However, findings such as this should be taken with care and understood in the right context as there are definitional issues with what would represent a 'strong' attitude towards bad behaviour. It is also important to point out that not all interventions and initiatives work and that in developing them it would be important to learn from those that do have a long-term effect on preventing drug use, as some may even have the effect of increasing drug use. One of the key reviews on causes and correlates of adolescent drug abuse and implications for treatment (Spooner, 1999) reviewed 216 papers and concluded that all models to predict drug use have limitations and that knowledge-based interventions have had no effect or have actually increased drug use. Spooner points to the failure to see drug use as part of a larger problem and that this can be a barrier to effective intervention. Interventions should not necessarily be drug specific and should take a more interdisciplinary and holistic form.

Limitations of the quantitative work

The results of multivariate analysis are highly dependent on the independent and dependent variables that are available for analysis. When interpreting the results it is important to keep in mind Table 2.1, the variables that are identified in the literature as having a relationship with taking drugs and that are not measured by the OCJS and therefore were not taken into account in the models presented. Table 2.1 can help in the development of new questions for future sweeps of the OCJS or other new surveys so that more of the hypothesised risk factors found in the literature can be measured and used in future modelling.

The OCJS provided a good opportunity to explore many personality, behavioural, interpersonal relationships, environmental and economic factors together. The logistic regression models presented in this chapter are of an exploratory rather than a confirmatory nature, the principal aim being to explore which variables are statistically related to taking drugs when all under examination have been considered. This technique determines associations between variables but does not imply a causal relationship. To study causality in more detail further modelling of a more confirmatory nature is recommended.

Stage 2 of the research

Rather than looking at the factors associated with using drugs, the next stage of the research looks at 'resilient' young people and, to learn from their experiences, explores possible common emerging themes that make them resilient. Purposive[14] sampling was carried out. In order to choose a sample that could be labelled as 'resilient' the study used the OCJS models derived in this chapter and looked for respondents that had all or some of the associated factors with taking drugs but according to the survey did not take drugs. Once identified these respondents were interviewed by the qualitative team. Further details on the sampling, fieldwork and reporting are provided in the following chapters.

[14] In purposive sampling the cases to be included in the sample are picked on the basis of a judgement of their typicality. In this way a sample is built that is satisfactory to the specific needs of the research question.

3 Methodology for the qualitative component (Stage 2)

Stage 2 of the research was a qualitative study of young people's resilience to drug use. This chapter describes the methods used in carrying out this component.

Sample selection

The key aim of the qualitative work was to explore the nature of resilience among a sample of young people considered to be 'at risk' of using drugs. It was decided to focus on the experiences of those aged from 10 to 18 at the time when they were interviewed for the 2003 OCJS. Once the logistic regression models had been run, the analysis was able to identify those people who, according to the model, should have been taking drugs but were not. The respondents included were those who scored highly in the key associated variables but did not take drugs.

- In the 10- to 16-year-old age group, there were those who scored highly on serious anti-social behaviour, weak parental attitude towards bad behaviour, being in trouble at school (including truanting and exclusion), having friends in trouble, being unhelpful.
- In the 17- to 18-year-old age group they were those who scored highly on anti-social behaviour, early smoking, being in trouble at school, being impulsive and being sensitive.

All of these young people were included in the sampling frame for Stage 2. Checks were then made between the 2003 and 2004 data set and young people who reported in the 2004 OCJS that they had used drugs since 2003 were removed from the sample. A total of 421 young people remained in the sample (293 aged from 10 to 16, 128 aged from 17 to 18).

The primary selection criterion related to the 'factors associated with drug use'. Within the overall sampling frame (n=421) young people were grouped according to the strength and type of associated variables they reported.[15] This refined the sampling frame to 152 young people (99 aged from 10 to 16, 53 aged from 17 to 18). The sample was selected to ensure coverage of the range of predictive factors identified by the multivariate analysis, specifically targeting those identified as at 'high risk' of using drugs, – those who scored highly on the associated factors or had many of the associated factors. While the sample selection was also monitored to ensure diversity in age, gender and ethnicity the focus on predictors of drug use meant quotas were not set for these.

Recruitment

Recruitment of respondents and the interviews were carried out by NatCen and BMRB, in accordance with the Data Protection Act. Each organisation recruited those respondents who it had interviewed for the OCJS and who at the time had agreed to be approached for further research.

Both organisations employed the same approach to recruitment. Securing parental/guardian consent and fully informed consent from the young people were key components of the research strategy. A different approach was taken to recruit young people depending on their age. The three recruitment processes followed are laid out in the flowchart in Appendix H.

Attempts were made to contact approximately one hundred young people to achieve a sample of fifty. Non-response to telephone calls was the main reason for an approach being

[15] The process followed in making this selection is described fully in Appendix C.

unsuccessful. There were also a small number of cases where young people actively refused to take part.

There was ongoing communication between NatCen and BMRB during the recruitment process to monitor, assess and achieve diversity in the overall sample.

A total of fifty young people were interviewed for this study. They came from a range of socio-economic backgrounds and geographical locations in England. Only one young person from a minority ethnic group was interviewed. However, attempts were made to contact all of those included in the refined sample frame from minority ethnic backgrounds. There were the same reasons for non participation within this group as within the sample as a whole – non-response to approach telephone calls being the main explanation. Table 3.1 presents the gender and age profile of young people interviewed.

Table 3.1: Age and gender profile of sample

Age (yrs)	Male	Female	Total
12	2	0	2
13	5	0	5
14	2	1	3
15	1	6	7
16	3	1	4
17	2	3	5
18	4	4	8
19	6	5	11
20	3	2	5
Total	28	22	50

Research design

The findings presented in the remaining chapters of this report are based on face-to-face in-depth interviews with 50 young people. Interviews were carried out using a topic guide developed in consultation with the Home Office (see Appendix D).[16]

The topic guide was designed to explore the 'whys' and 'hows' of resilience to drug use, taking account of the social context in which young people were based. In line with the overall aims of the study the following topics were among those explored in the interviews.

- Current circumstances/context in which young people were based – identifying possible risk and protective factors for drug use.
- Young people's views and attitudes towards drugs and their users.
- Young people's exposure to and experiences of drug-related situations.
- Young people's decision-making around drugs.
- Strategies used to deal with drug-related situations.

Initial fieldwork was conducted by researchers working in pairs. This provided further opportunities for the topic guide and fieldwork strategies to be reviewed and, if necessary, modified, and meant that early learning was shared within the team. The fieldwork was conducted using responsive and probing questioning to ensure that all relevant issues were explored in detail. Interviews were tape-recorded, with respondents' agreement, for full verbatim transcription. This was essential for detailed and rigorous analysis, and meant that

[16] Hypothetical scenarios (see Appendix B) were also developed to facilitate in-depth exploration of young people's views of reasons why people might choose to use drugs and strategies that could be used to refuse them. This provided young people with an opportunity to think beyond their immediate circumstances and experiences.

full concentration could be given to the respondent's account and to exploratory and in-depth questioning. Carrying out sensitive research with young people requires particular attention to ethical considerations. A document addressing these had been drawn up for previous work carried out by NatCen with young people. The position outlined in this document was adhered to for the course of fieldwork and guided the recruitment strategy adopted (see Appendix F).

Data analysis

Verbatim transcripts of the interviews were analysed using 'Framework'. Framework is a qualitative analysis method, developed at NatCen, which uses a thematic approach to classify and interpret qualitative research data. Through familiarisation with the transcripts key topics and issues that emerged from the data were identified. A series of thematic charts were set up, each one relating to a different thematic issue. Data from each transcript were then summarised into the appropriate thematic chart.

Having ordered the data in this way, patterns, relationships and contradictions were looked for in the data. Both 'within case' and 'between case' analysis were carried out. Using the former, for example, the key factors that had influenced a young person's decision to remain resilient to drug use were identified. And with the latter, for example, comparisons were made between the experiences of those who had only ever been offered drugs by strangers and those who had been offered by friends.

The use of quotes and case studies

Verbatim quotes from young people and case studies are used throughout this report. To ensure that the anonymity of respondents is always preserved, specific details which might identify respondents have sometimes been omitted or changed. In particular, all names are fictitious.

4 Young people's exposure to and views about drugs

Introduction

This chapter presents a brief profile of why young people in the study are considered resilient to drug use. They are 'resilient' in terms of having had opportunities to use drugs and by the nature of the decisions they have made when faced with these opportunities. It also explores the wider context in which they made their decisions about their use, in terms of their views about drugs and what they perceived to be the reasons why other people might choose to use them.

In addition to having access to drugs, other factors can also put young people 'at risk' of using. The final section identifies features of these young people's lives that might be considered to be putting them at further 'risk'.

Opportunities to use drugs and decisions made

To be termed resilient, young people needed to have had the opportunity to use drugs and to (almost) always have chosen not to use them. Young people fell into one of three groups according to the nature of these opportunities and the decisions they made when faced with them.[17]

There were young people who had:

- been directly offered drugs but had never used;
- been directly offered drugs and had used cannabis on one/two occasions;
- avoided direct offers of drugs and had never used.

Directly offered drugs but had never used

The first group of young people had been directly offered drugs on one or more occasions and had been in other situations where they could have accessed them, but had always refused them. This ranged from those who had only ever been directly offered once to those for whom offers of drugs were a regular occurrence, for example where they spent time with friends who smoked cannabis and were regularly passed the *'spliff'* as it made its way around the group. Offers came from both friends and strangers. Accounts of offers from the former tended to be of cannabis, whereas those from strangers involved a range of drugs including cannabis, cocaine, Ecstasy and *'whatever I wanted'.* The streets, friends' homes, pubs, nightclubs, school, house parties and local parks were all locations where offers had been made. In some cases young people lived in areas where drugs were dealt openly on the streets. One respondent said he was *'guaranteed'* to be offered cannabis and other drugs when walking through a certain part of his local area.

Louise is 16 and has been *'surrounded by drugs all* [her] *life'*. In the area where she grew up a lot of people used and her friends used to smoke cannabis in front of her regularly. She was offered it frequently when they spent time together on the streets and at parties. The joint would be passed around the group and she would be offered it. She never used it and sometimes would just *'sit on the side'* as this was happening. When she was 14 her boyfriend and his friends used to ask her to go and smoke cannabis with them when they were at school. Again she always said no.

[17] Five young people who were considered not to be 'resilient' were removed from the sample. Two used cannabis on a regular basis. Three others had never had the opportunity to access drugs. Nobody they knew used drugs and they did not know where they could access them.

Directly offered drugs and had used cannabis on one or two occasions

The second group of young people had been directly offered drugs on a number of occasions and had been in situations where they could have accessed them. As with the previous group offers came from both friends and strangers, and happened in a range of locations and involved a variety of drugs. However, these young people had accepted and used cannabis once or twice. Use tended to have been limited to *'a drag'* or *'a couple of puffs'* and was not perceived to have had any effect on them. Where they had smoked more, they reported limited positive effects, such as feeling *'lightheaded and nice',* but focused on the negative effects. Positive experiences were always followed by negative ones, either within the context of the same incident of use or a subsequent one. Negative effects included feeling nauseous, vomiting and, in one case, *'collapsing'*. In explaining why they had used drugs young people said that they had been curious about their effects or that they were *'drunk'* at the time. One respondent said that she had smoked it by mistake, she had thought the *'spliff'* was a cigarette. Another that she had been *'upset'* and *'vulnerable'* after a relationship break-up and had decided to try cannabis when *'drunk'*.

Despite having used cannabis once or twice, these young people were still 'resilient' to drug use. Other than on these rare occasions, they had frequent opportunities to use drugs but decided not to. Their own experience of using drugs tended to have consolidated their resilience.

Jean is 18 and has been offered *'weed'* and cocaine by friends. One group of friends use cocaine when they go to the pub and others smoke weed regularly, some on a daily basis. Sometimes when they are taking cocaine in the pub they keep it *'hush hush'* from Jean but she knows she could ask for it if she wanted to. Whenever she has been offered it she has always said *'no'*. When her other friends smoke weed they just pass it around the group and whoever wants it, takes it. She has been offered it regularly and has tried it once. She was drunk at the time and decided that *'you can't knock it until you've tried it'*. She *'only had a couple of puffs'* and it had no effect. She does not smoke tobacco and thinks she *'probably didn't do it properly anyway'*. Since that occasion she has always refused offers of both *'weed'* and cocaine.

Avoided direct offers of drugs and had never used

The third group of young people had been in situations where they could have accessed drugs but had never been directly offered them. They had consciously taken action to avoid offers by avoiding or removing themselves from situations where this would have happened. They avoided people who they knew used drugs and locations where they were used. They had friends, peers or family members who used drugs but had distanced themselves from them. They stayed away from locations where they knew drugs were being taken (these avoidance strategies are discussed in more detail in Chapter 6).

Mary is 15. While none of her very close friends use drugs, some of her friends from school smoke cannabis when she is at parties with them. She has never directly been offered it but *'knew that if* [she] *wanted to get involved*, [she] *could'*. When people she knows are smoking it in school she stays away from them so that they will not offer it to her.

Young people's views of drugs

The decisions young people made about their drug use are explored in subsequent chapters. Underlying these decisions however, were the views they had of drugs and the reasons why people use them.

Friends, peers, parents, siblings, members of the community, school and the media were all noted as sources of information about drugs and formed the basis of young people's views of them. Respondents in this sample had all been exposed to other people's drug use and tended to draw on these experiences in describing their views about drugs. In some cases

they did not know anyone personally who had used drugs other than cannabis. Where this was the case, they drew on information they had gathered from the media, school or from exposure to members of their wider community who used the range of drugs.

Views of drugs and users

Young people varied in their attitudes towards different drugs and those who used them. In the course of their interviews they distinguished between cannabis and 'other' drugs (those referred to were Ecstasy, cocaine, heroin and, in a couple of cases, 'poppers', 'magic mushrooms' and LSD). There were four broad categories of views held within the sample (these cut across each of the three groups identified in Chapter 3).

- 'Cannabis use is ok but other drug use is not'
- 'Cannabis use is ok and so is the use of Ecstasy and cocaine in certain situations, but heroin use is not'
- 'Cannabis use is not really ok, but it is not as bad as other drug use'
- 'All drug use is bad'

'Cannabis use is ok but other drug use is not'

First were those who considered the use of cannabis to be broadly acceptable, but other drug use unacceptable. They did not associate cannabis with being harmful to the health or general wellbeing of users. This view was based on the experiences of people they knew who used it. For example, a respondent who had never used drugs herself said that among her friends smoking cannabis was *'a social thing'*. While she did not want to engage in its use, she did not have a problem with them using it. Cannabis was described using phrases such as *'it's not a big drug'*, *'there isn't much harm in* [it]*'*, *'it's not that bad for you'* and *'it's just a laugh'*. When asked to rate alcohol, cannabis, Ecstasy, cocaine and heroin on a scale of one to ten in terms of harm, a thirteen-year-old said that alcohol would be two, cannabis three or four and all other drugs nine or ten. In some cases respondents said that their view of cannabis as being less harmful than other drugs was, in part, influenced by the change in the government legislation around its legal status. In some cases the law was misinterpreted, for example that it was now legal for people over the age of eighteen to use cannabis.

In contrast to their views on cannabis, the group held negative attitudes about other drugs such as Ecstasy, cocaine and heroin. They tended to group them together and saw them as *'the bad ones'*. They described people who use them as *'freaks'*, *'tramps'*, *'horrible'* and *'dirty'*. Using these drugs was strongly associated with becoming addicted, committing crime and the risk of ill health and death. Unlike with cannabis use, they did not consider it acceptable for their friends to use these drugs. In some cases they said that if this happened they would no longer be friends with them.

'Cannabis use is ok and so is the use of Ecstasy and cocaine in certain situations, but heroin use is not'

In a rare case one respondent, who had never taken a drug, did not categorise drugs other than cannabis as all being the same. He distinguished between cocaine and Ecstasy on the one hand, and heroin on the other. He considered heroin to be *'dirty'*. However he thought people could take Ecstasy and cocaine on a night out for *'enjoyment'*.

'Cannabis use is not really ok, but it is not as bad as other drug use'

The third group of respondents held similar views about drugs such as Ecstasy, cocaine and heroin as the first group. However, they were more ambiguous in their views of cannabis. While it was *'not as bad'* as the other drugs, its use was still not considered acceptable. As with the first group cannabis was not associated with an immediate risk of death and this distinguished it from the other drugs. However, it was thought to be addictive and to have negative effects on users. These included respiratory system problems from smoking and that people *'wasted'* their lives when stoned, being unmotivated to do anything. Its status as an illegal substance and the risk involved in being caught with it by the police also made its use unacceptable.

'All drug use is bad'

Finally there were those who made no distinction between different types of drugs. The use of any drug was considered to be unacceptable. They were all perceived to be harmful to the user's health and potentially addictive. Irrespective of their drug of choice all users were referred to as *'low lifes'* and *'pathetic'* and were associated with behaving aggressively.

Reasons why other people may use drugs

While not choosing to use drugs themselves, respondents identified a number of reasons why *other* (young) people might choose to use drugs. They tended to identify more than one motivation but these are presented individually here.

An escape from problems

Drugs were perceived to help *'ease the pain'* of or offer *'escapism'* from problems such as work or school pressures, bereavement, family break-up or other relationship problems. For example, a respondent who had never used drugs herself, considered her brother's cannabis use to be his way of coping with their parents' break-up. Cannabis was strongly associated with helping users relax and cope with stress.

Drugs were also perceived to help alleviate more general feelings of depression. Where people had *'a bad life'*, were *'unhappy'* or '*depressed'* then they might use drugs to make them feel better and *'happy'*.

Alleviate boredom

Life could sometimes be boring for young people and drugs could offer an alternative to this boredom. A respondent who had been offered cannabis frequently but had never used it, thought that people in her school took drugs when they came to school to make it *'more interesting'*. School was *'depressing'*, '*boring'* and *'bland'* and that taking drugs *'made it more fun'* for them.

'The buzz'

A range of positive physical and psychological effects of using drugs were identified as motivations for using. The effects noted included getting *'high'*, getting a *'head trip'*, going off to *'another world'* or giving the user more energy.

To feel more confident

Linked to the buzz some drugs offered was a perception that they would make people feel more confident. For example thinking that cocaine helps people enjoy themselves by making them *'loosen up'*.

To ease physical pain

Cannabis was associated with pain relief by some respondents and in one case was referred to as a '*medicine'*. Young people had heard stories in the media about people, who would not otherwise use drugs, smoking cannabis to alleviate physical pain.

'To look hard'

While not a view held by respondents, it was thought that other young people might associate taking drugs with looking *'hard'* or *'cool',* and that this would influence their decision to use. For example that a *'boy'* may take them to be *'the bigger man'* in front of his friends, or that they want to *'show off'* to them. To impress members of the opposite sex was also mentioned in this context.

To fit in

A recurring theme was that people would use drugs to fit in with their friends rather than risk being '*the odd one out'*. By engaging in an activity that everyone else in a particular friendship group was doing then a young person would *'get on in the crowd'*. If they decided to abstain, they risked being excluded. A respondent who had never used drugs suggested that using

drugs might even be the way some groups of friends *'bond'*;abstention would therefore mean exclusion from the group.

Peer pressure

Linked to wanting to fit in was the concept of peer pressure. A person may begin to use a drug if their friends are using and become *'pushy'* about it. Younger people were seen to be particularly vulnerable to this. For example one fourteen-year-old said that people his age would use because of *'peer pressure'* but that for older people it would be a *'personal choice'*. As with wanting to look 'hard' or to fit in, in some cases this was associated with spending time with *'the wrong crowd'* where drug use was prevalent and valued.

Curiosity

Respondents thought that by being exposed to other people's use some young people would be curious about the effects of drugs. One respondent, who had been offered cannabis on a few occasions but had never used, said his friends had tried it once '*to see what it's like'*.

Following the example of others

Having a parent or another family member who was a drug user was perceived to explain why some people would use drugs. Where a child saw a parent smoking cannabis, it was thought that this might encourage the child to smoke cannabis too.

Illustrations of motivations for use

The following case studies illustrate that young people tended to note more than one reason why other people might choose to use drugs.

Michael is 20 and has never used drugs. He thinks people who use heroin or cocaine are looking for *'a more extreme high'* than those who use cannabis. In general he thinks that while some people take drugs to *'escape'* their problems, others take them to *'enhance'* it.

Julie is 15 and has never used drugs. She thinks people take Ecstasy to feel *'happy'*, and that people may decide to try drugs in general because all of their friends are doing it and they do not want to be *'the odd one out'*. Also they may want *'to look hard'* in front of people they know.

Rory is 18 and has never used drugs. He thinks that some people may use drugs because they want to see what the effects are like. With drugs like Ecstasy they take them in a club so that they can *'dance away'*. Kids in his school who hang around with older people use cannabis to try and *'fit in'* with them.

Risks other than opportunity to use

In addition to having the opportunity to use drugs, some young people reported personal circumstances which could be considered to be putting them at further risk of using drugs. Respondents did not make the link between their own circumstances and the risk of using. However, some of the problems they faced reflected those that others in the sample thought might motivate people to use drugs. These included some of the problems they said people might use drugs to escape.

Problematic family relationships

Family break-up was an issue faced by many of those in the sample. This was not always presented in problematic terms, with young people maintaining contact and good relations with both parents. It had been problematic in some cases though. For example, where they had stopped talking to a parent because of the circumstances of the break-up (for instance where a parent had an affair) or having lost contact with them as they had moved away.

Familial substance use

Alcoholism and problematic drug use by parents and siblings respectively was reported by respondents. Coping with a parent who was an alcoholic presented a range of problems. These sometimes included having to take responsibility for the upbringing of younger siblings and violence within the home. Where siblings were engaged in problematic drug use this included cannabis and heroin use. This created tensions within the family and was perceived to have had a negative effect on the family unit.

Getting into trouble with the police or in school

Young people had been in trouble with the police and in school. Contact with the police ranged from receiving informal warnings for drinking in public places or being rowdy to being arrested for assault or vandalism.

In school they had been in trouble for truanting and other *'bad behaviour'*. This included smoking, fighting, shouting at teachers and general *'playing up'* or being *'an idiot'* in class. In some cases this had led to one or more periods of exclusion. In a rare case a respondent's parent had to attend the Welfare Court and pay a fine as a result of her truanting. In some cases young people attributed their behaviour to problems they were having, for example reacting to a family break-up or being bullied.

Mental health issues

Periods of clinical depression or feeling *'low'* were reported by some respondents. One respondent spoke about not knowing *'what the point of being alive is'* and that he found it difficult to cope with life on a day-to-day basis. Another had been on Incapacity Benefit for over a year because of his depression.

Boredom

Where respondents were not in education, paid employment or parenting their daily routines were characterised by boredom. They lived in areas where amenities for young people were limited and could not afford to pay to keep themselves entertained.

Alcohol use

Young people's use of alcohol could indicate their being at risk of using illicit drugs. First because when under the influence of alcohol they might be more susceptible to accepting offers of drugs (see Chapter 6), and second because it might indicate a propensity for using mood altering substances. Alcohol use was described in much less problematic terms to that of illicit drug use. The nature and level of alcohol use varied within the sample. Where young people drank alcohol they included those who drank it socially and tended not to get '*drunk*', except on rare occasions and those who drank socially but generally did so to *'get pissed'* or *'legless'*. There was also a rare case where a male described a problematic pattern of drinking. He drank every weekend often experiencing blackouts. He had drunk particularly heavily when he was about fourteen to help him cope with problems. He found it helped him to forget about them, albeit temporarily.

Conclusion

Being resilient to drug use means that someone is at risk of using drugs and has chosen not to become a user. Young people in this sample all had the opportunity to use drugs and, in some cases, displayed features which could suggest they were at further risk of using. The range of reasons they identified other people may have for using drugs reflects those found elsewhere, as identified in Chapter 2. Despite this they chose not to engage in their use (except in some very limited way in some cases). The subsequent chapters explore the factors influencing this resilience.

5 Motivations for not using drugs

Introduction

This chapter explores young people's reasons for not using drugs. They identified a range of factors as having influenced their decision not to use. These fell into four broad categories.

First those broadly related to their lifestyle aspirations and relationships:

- other people's disapproval;
- legal consequences;
- role as parent;
- career aspirations.

Second were those related to the practicalities of being a user:

- availability of time;
- financial cost.

Third were those related to the physical and psychological effects of drugs:

- personal experiences with drugs;
- current health conditions/difficulties;
- fear of effect on health;
- fear of addiction;
- fear of losing control.

Finally were those related to some of the perceived benefits of using drugs:

- sources of 'buzz';
- sources of support/coping mechanisms.

Underlying these factors were the young people's views about drugs and what it meant to be a drug user. To varying degrees these young people held negative views about both (see Chapter 4). These led to an overall lack of attraction to drugs. In some cases young people asserted that they did not need to use *any* drugs because they were content with their lives or because they did '*not need drink or drugs to have a good time*'. In others, the negative views of drugs had been shaped by other people's bad experiences with drugs. In particular where the young person could relate to the drug user's situation, where they could *'imagine it happening to them'*.

Young people's reasons for not wanting to use drugs

Young people usually cited a few of these reasons as having shaped their decision not to use rather than a single one. It was evident from the way in which they discussed the factors that they were very much interlinked. However, for ease of discussion of these factors they are presented individually.

Other people's disapproval

Young people thought that significant people in their lives would disapprove if they used drugs. Concerns about the consequences of this disapproval influenced their decision not to take drugs. Family, friends, peers, partners, teachers and sports coaches were all noted in this context. Young people's perception that these people would disapprove was based on knowledge of their views, which were ascertained in some cases through discussions about drugs. In others, it was based on assumptions of their views. Parents fell into both of these categories, with one young person describing the dangers of drugs being '*drilled into them*',

whilst another imagined that '*any parent should be disappointed in their child*' if they used drugs. Friends, teachers and team coaches were more likely to have explicitly expressed their negative views of drugs. There were examples of teachers and team coaches warning about the consequences of drugs on health, and friends viewing drug taking as '*something you shouldn't do*'.

Whether it was family, friends or others, what these individuals had in common was that they were important to the young people's lives. These people's views mattered because their disapproval could have negative consequences for the respondents. The negative consequences varied across the groups.

From family there was the fear of losing practical support, for example, being thrown out of the family home or losing *'perks'* such as birthday and Christmas presents, holidays, and money. In terms of friends and peers there was the anxiety of being '*laughed at'* (as they had seen them do at other drug users) or being dropped (as they themselves had done to former friends when they had started to use drugs). With partners there was the prospect of having to face their '*disgust*'. And with sports coaches there was the chance of being dropped from the team as a result of failing a drugs test.

Where young people came from a family in which someone had been a drug user, they were particularly concerned about their family's disapproval. In some of these cases the young person seemed as concerned about the consequences of their possible drug use on the people they cared about as they were for themselves. One respondent's brother had started stealing from their relatives. Such experiences had made these young people protective of their families and decide that they would '*hate them to go through it again*'. Consequently they had decided not to use drugs.

Legal consequences

The thought of breaking the law and the possible consequences of doing so deterred some young people from using drugs. These consequences ranged from immediate ones such as getting caught and having to go to court, to more longer-term ones such as the impact that a criminal record may have on their lives in the future, for example on their career aspirations: *'When you go for a job, they always ask you "have you had any trouble with the police?', and you'd have to say, then you're more likely not to get a job'*.

Some of these young people had been in trouble with the police before, though none for a drugs-related incident. However, not wanting to break the law by taking drugs was evident among those who had broken the law previously as well as among those who had not.

Role as a parent

Being a parent was not perceived to be compatible with using drugs. The mothers in the sample gave two main reasons for this. First, looking after a child left them with little free time to undertake such activities. Second, they did not want to do anything that would place their child at risk. This could be either in terms of the respondent dying as a result of drug use and leaving the child to grow up without a mother. Or, as one respondent had witnessed happen to another mother, they could have their child removed from them because they were seen as an unfit parent because they were using drugs.

Wanting to have children in the future could also act as a deterrent to drug use. Respondents noted the need to stay healthy in order to have children. Also they were conscious of the need to lead a life that would allow them to be a positive role model for their children, which did not include becoming a drug user.

Career aspirations

To achieve their career aspirations young people thought they needed to do well in their education and this was perceived to be incompatible with drug use.

There were three ways in which using drugs was perceived to be incompatible with achieving career aspirations. First was where young people were aiming to follow a career that required academic qualifications, which they thought drug use would prevent them from obtaining. For example, one respondent referred to a boy at her school who had smoked cannabis, then had started missing classes, and had left school without any qualifications. Second was where job aspirations required young people to be physically fit (for example to be a sports coach) and consequently they wanted to avoid putting their health at risk by using drugs. Third were those for whom having a criminal record as a result of being caught with drugs would be a distinct disadvantage or even prohibit entry into their chosen profession, for example joining the police force.

Others took a more general view. They were not concerned about the impact of being a drug user on a particular career aspiration, rather that it would lead to what they perceived to be more general failure in life. For the school-age respondents such anxieties led to aspirations for the future. As a thirteen-year-old respondent put it, he did not want to end up *'selling the Big Issue'*. For the older respondents the concern was much more immediate. An eighteen-year-old who had left school and was currently working in a supermarket stated that he didn't '*want to be stuck in a job like this…I want to aim for a job with a higher wage'*.

Availability of time

There was the perception that drug taking was a time-consuming activity. This applied to both cannabis and other drugs. One respondent spoke about some friends who '*do dope…every day all the time…..they're always stoned'*. Another recalled seeing her cousin '*do coke….that's all she would do all da*y'. These young people made extensive use of their spare time – to follow hobbies, do part-time jobs and undertake voluntary work. They described, for example, balancing schoolwork with a Saturday job or football training five times a week and attending college. This left them with little time for other pursuits, namely going to or being in places where they might take drugs.

Cost

While never a reason given in isolation, lacking the monetary means to buy drugs contributed to some respondents' motivation not to become involved in drug use. Even if they had wanted to use drugs, they would not have had the money to do so. This reason was only noted where young people were being offered drugs in exchange for money. Offers of drugs, in particular cannabis, did not tend to involve a request for payment. Where a *'spliff'* was being shared within a group of friends, young people did not report there having been an expectation for money to change hands.

Those young people for whom drugs held no attraction saw them as a '*waste of money*'. Instead they offered various alternatives for spending their money, for example, paying for driving lessons or buying clothes.

Personal experiences with drugs

As discussed in Chapter 4 those young people who reported having used cannabis once or twice were considered 'resilient'. Their own experience with drugs had made them decide not to use again.

Some had been ill as a result of taking drugs. One respondent described '*hallucinating and being sick'*. Others talked about '*throwing up everywhere*'. As a consequence they spoke about having '*learnt their lesson'* and that they would not use again.

A non-effect appeared to be just as effective as a bad experience with drugs in discouraging future use. Respondents complained that the drug had had no effect on them, which had left them wondering what the '*fuss was about*'. With their curiosity abated, they did not plan to use again.

Current health condition/difficulties

Health problems influenced some young people's decision not to use drugs. In one case a respondent had been informed explicitly by his doctor that his medication was incompatible with drug use. More usual were cases where drug use could aggravate the young person's condition, for example if they had respiratory problems or allergies, and the young person was exercising their own judgement not to use drugs.

Fear of effect on health

The fear of damaging health now and in the future was noted as another reason not to use drugs. Respondents mentioned a whole spectrum of concerns about the harm that drugs could do to their health. There were those who liked being healthy and '*staying in shape'*. Others believed that drugs could cause illnesses such as those linked to respiratory problems or by developing abscesses from injecting. At its extreme, drug use was associated with death. They described drugs as a way of '*paying to kill yourself*'. Associations with death were always made with reference to drugs such as cocaine, heroin or Ecstasy, and not cannabis. As one respondent put it: '*haven't heard of anyone dying of weed*'.

The impact of Class A drugs on health was perceived to be greater than that of cannabis. These views were informed by the young people's encounters with Class A drugs. They tended to involve individuals in the community or in the media. One respondent mentioned a fourteen-year-old boy he knew of in his area who had '*injected that stuff' into his arm'* and others recalled seeing television programmes showing people getting '*hooked*' on heroin or hearing on the news about a boy who had died after taking a '*bad pill*'. These cases involved neither people who respondents were close to nor situations that they could necessarily relate to. However, it was the severity of the consequences of the '*harder drugs*' that influenced these young people's decisions not to use drugs.

Fear of addiction

The fear of becoming addicted was cited as another reason for not using drugs. Addiction meant '*losing everything*' or '*ending up on the street*'. While addiction tended to be associated with Class A drugs, concerns about addiction seemed to discourage young people from experimenting with other drugs too. There was a perception that using cannabis could lead to using Class A drugs. This perception was evident amongst even those young people who were used to seeing their friends '*smoking pot*' and had not noticed any changes in their drug using behaviour.

Some young people also avoided tobacco, fearing that it could lead to cannabis use, which in turn could lead to Class A drugs. This was based on the experience of friends who had been tobacco smokers before starting to use cannabis. While tobacco was seen as a 'gateway' drug, alcohol was not. The link appeared to be related to the route of administration (i.e. smoking) rather than the physical effects of the substance involved.

Fear of losing control

Young people were concerned that if they used drugs they would lose control of themselves. They worried about making a fool of themselves, doing something they would regret, or leaving themselves vulnerable as a consequence of using drugs. The latter tended to be noted by female respondents.

Where this was a concern young people tended to be the one amongst their group of friends who could be described as the '*responsible one*'. For example, on a night out he or she was the one who looked after everybody and ensured that others got home safely. To play this role required him/her to remain in control.

One young person, who admitted drinking a considerable amount and having used cannabis once, offered a different perspective on the issue. He explained that because it was important for him to remain in control, he drank alcohol rather than using cannabis. He could drink more alcohol before he would lose control compared to the amount of cannabis it would take to have the same effect.

Sources of 'buzz'

As discussed in Chapter 4 respondents offered a range of explanations for why they thought people use drugs. These included: *'to feel more confident', 'to feel happy', 'to get a buzz', 'to escape'*. They welcomed these attributes but maintained that they themselves derived the same benefits from alternative sources – alcohol and hobbies.

Alcohol was perceived to offer similar advantages to those provided by drugs. It allowed them '*to socialise, relax and feel a bit more confident*', or helped them to '*feel happy'*. They offered a variety of reasons for opting to drink alcohol rather than getting involved in illicit drug use. First, it was legal so they were not at risk of being arrested. Second, alcohol was considered a safer drug. While it offered similar advantages to using illicit drugs (such as the 'buzz'), it presented fewer health risks. Third, drinking alcohol was an activity that significant others (such as family and friends) were not perceived to disapprove of. Under-age drinkers also expressed this view, explaining that parents did not mind and allowed them to drink at home or on special occasions.

The thrill that young people derived from their hobbies was cited as another alternative source of 'buzz' to drug use. One respondent used a drug analogy to describe his passion for sport, claiming that it was *'sort of like a drug cos when you start, you can't stop, cos it's just really enjoyable*'.

Sources of support/coping mechanisms

As noted in Chapter 3 respondents believed that people might use drugs because they help them to cope with the stresses of life. These young people were familiar with such stresses themselves. However, as with sources of 'buzz', they stated that they had alternative sources of support and coping mechanisms that helped them to deal with life and their problems – they cited three main sources.

First were family or friends. Having support, be it a single close friend or an extensive group of family and friends, meant that they had someone to turn to when things got difficult in their lives. One respondent's best friend had a very difficult family situation and used cannabis to cope. The respondent sympathised with her friend and considered herself '*lucky*' to have a good family life. Her admission that if her family were not there for her she probably would take drugs herself, underlines the importance of supportive relationships in keeping young people away from drugs.

Second was alcohol or tobacco. Rather than get involved with illicit drug use, some young people reported that they turned to alcohol or tobacco to help them cope with stresses in their lives. One example of this was a respondent who dealt with a rough time at school by '*drinking a lot*' as it was the only '*way to forget a bit*'. Another case involved a respondent who coped with the stresses of bringing up a child by calming herself with '*coffee and a fag*'.

Other sources of stress relief included using a punch bag, going for a bike ride, or going to the beach to '*chill out*'.

Illustrations of young people's reasons for not using drugs

The following case studies illustrate that young people tended to note more than one reason why they chose not to use drugs and how these reasons could be interlinked.

Katie is 19 and has been offered cannabis at parties by her boyfriend's friends *'several times'*. She has always said no because she has been *'brought up not to use drugs*' and thinks her parents would be disappointed if she took them. She knows the effects of drugs *'aren't good'* through stories about drugs at school, in the papers and on TV. She has never been offered any drug other than cannabis but if she were she would be too scared to take them because she thinks they are a lot more addictive.

Phil is 19 and was offered '*spliff'* at school several times. Although he felt *'peer pressure'* to accept he always said no because he had '*better things'* to spend his *'money'* and *'time'* on. When he was tempted he considered it was the wrong thing to do because that was what his parents taught him. Also he did not want to get caught by the police or get a *'record'*.

Daniel is 12 and has never used drugs because he wants to be a footballer and if his football manager found any players smoking drugs he would kick them off the team. He does not want to become addicted to drugs, spend all his money on them or *'lose years of his life in prison'* because of them. His mum always tells him that he is not to take drugs and he listens to her because she has a friend who died from taking drugs.

Conclusion

Young people offered a range of motivations for not becoming involved in illicit drug use. It was usual that a few of these factors had been at play in the young person's thinking at arriving at their decision. For example concerns about aggravating their own health difficulties and the reaction of their family may have swayed one respondent's choice. Whilst for another having alternative sources of support and the lack of finances might have been the critical factors. Also, the various factors were usually interlinked. For example, a respondent may be concerned about the health consequences of using drugs on their career aspirations, or the consequences of breaking the law on their role as a parent.

These thought processes were driven by the young person's feelings about what it meant to be a drug user. To varying degrees they held negative images of drug users. They described drug users as *'dim, loopy, droopy, dopey'*, or as being *'dirty'*, or as '*really white and skinny, pale and weak'*. Also, they described drug users as *'losers'* and recalled the drug users that they had known at school as being the ones who were now not at college with them. In other words, the drug users' image and lifestyle was not how they saw themselves. It was the gulf – perceived or real – between how they saw themselves and how they saw the drug users that appeared to be the underlying factor in keeping these young people resilient to drug use.

6 Experiences of and strategies for refusing drugs

All young people in this sample had the opportunity to use drugs. This chapter explores the strategies they used to refuse drugs. It also identifies factors that they perceived to have made it easier or more difficult for them to make these refusals. These were related to the broad context in which offers were made and certain characteristics of the young people.

Refusal strategies

There were two types of refusal strategies reported. First were those based on actively saying *'no'* and second avoiding drug-related situations or offers. Within these broad strategy types, young people identified a range of ways of refusing drugs. While these tended to be based on their own experiences, some were strategies that they *suggested* young people could use when faced with offers of drugs. These suggestions were made both spontaneously and in response to the hypothetical situations provided to them in the course of the interview.[18]

There was no difference in choice of refusal strategy between those who had been directly offered drugs but had never used, those who had been offered drugs and had used on one or two occasions and the strategies suggested by those who had avoided direct offers of drugs and had never used (see Chapter 4). Rather, members of these three groups drew on the continuum of strategies to facilitate their resilience.

Underlying their decisions about which refusal strategy to use was a need to minimise the risk of there being negative consequences for them in making the refusal, while ensuring that they did not use the drug on offer.

Active refusal strategies – saying 'no'

The first type of refusal strategies were those that involved an active refusal to an offer of drugs. In making these refusals young people were concerned with causing as little offence as possible to those making the offer, minimising the risk of being challenged about their decision and avoiding confrontation. They tended not to criticise other people's decisions to use, while making it clear that it was their decision not to use. They spoke about being *'polite'* yet firm in getting their point across. For example a respondent said to her friend *'I know you choose to do it, but I choose not to'*.

There was a range of ways of saying *'no'.* Rather than simply saying *'no'*, young people tended to give one or more reasons for a refusal. Despite having given a wide range of reasons for not wanting to use drugs *per se* (see Chapter 5), these were not reflected in the reasons they gave when saying *'no'*. Young people tended to choose reasons that made it clear in a succinct way that they did not want to use drugs.

Refusals included comments such as, *'no, I don't want to'*, *'no*, *'I'm alright without'* or *'I don't feel like it'.* Other refusals involved a more explicit statement about their views of drugs, such as, *'no, I don't like it* [cannabis]*'* or *'it* [taking drugs] *doesn't appeal to me'.* More practical reasons were also used. For instance, they said that they could not accept as they did not '*have any money'* or had somewhere else to be. Health conditions were used, for example that they had respiratory problems such as asthma. This was perceived to be particularly effective in refusing cannabis. For example, if they did not smoke cigarettes for health reasons, then it would be easily accepted that they could not smoke cannabis.

[18] Hypothetical drug-related situations (see Appendix B) were used in the depth interviews to help young people think beyond their own experiences and elicit suggestions of refusal strategies.

Where they did not want to give their real reasons for not accepting an offer of drugs, young people sometimes made up reasons that could not easily be called into question. For example they pretended to have a health condition that made cannabis use unpleasant or dangerous. One male respondent pretended that he was joining the military and did not want to risk testing positive on an impending blood test.

While young people tended to want to avoid confrontation when making a refusal, some reported more forceful strategies. This happened in two contexts. First where young people held particularly negative views about drugs and their users. They described being *'insulted'* or *'disgusted'* by offers of drugs. When faced with an offer they would tell the person to *'fuck off'*. In some cases making a clear statement that they were against the use of drugs, '*I'm not that type of girl* [that uses cannabis]*'*. Second was where respondents felt that those making the offers of drugs had been too persistent and they needed to be confrontational to get their point across. Where this happened they used verbally aggressive responses to offers such as, telling a stranger to *'piss off'*. In one case, a young male respondent reported getting into *'a scuffle'* when offered Ecstasy by a stranger. The stranger had been particularly persistent and though the respondent had said *'no'* a few times, he kept offering. Eventually a friend intervened to support the respondent and a *'scuffle'* broke out.

While not used by any respondents, it was also suggested that young people could engage in a discussion with friends about the dangers of drugs as a way of refusing drugs. They suggested explaining why they did not want to use drugs and to try and convince their friend offering not to use either. As one young person suggested, refusing in this way would mean they would not be *'offending anyone'* and that preventing others from using was the right thing to do.

Illustrations of saying 'no'

Phrases used by respondents

'No mate cheers'/'No I'm alright mate'
'No I don't want to'/'I'm sorry, I don't want it'
'No I don't want it, I don't feel like it'
'Oh no, sorry, I haven't got the money'
'I know you choose to do it. I choose not to do it [cannabis]*'*
'No, I've got to go in two minutes, I don't want to get into trouble'
'No I have to go to the cinema'
'No I've got this lesson, so I'm going'
'No, I need to go to the toilet'
'No haven't tried [cannabis] *yet. I don't want to do it yet. I'll do it in my own time'*
'No it (weed) doesn't appeal to me'
'No I'm not that kind of girl [that uses cannabis]*'*
'No I'm alright, I don't do drugs'
'You don't ever, ever put that stuff in my face'
'No thanks, I'm not like that [using coke]*'*

Suggested phrases[19]

No, it's not something I want to get involved in
No I have a bad cold/throat
No I have to be home in ten minutes and my mum would smell it [cannabis] *on me*
I tried it in the past and it affected me badly, I don't want to go through the horrible experience again
I've lost my mates and I need to find them as I'm staying in a friend's house
No, why are you doing that?

[19] These phrases were reported in the third person when young people were suggesting what other people could say to refuse drugs. They are not verbatim quotes but have been changed to the first person for ease of reading.

Avoidance-based refusal strategies

Avoidance-based strategies were used by young people to avoid direct offers of use by staying away from situations that they associated with drugs. They were also used to avoid direct offers when drugs were being used in their presence.

Avoiding drug-related situations

Where young people wanted to completely avoid offers of drugs, they sought to pre-empt and avoid situations where they thought drugs would be used – this involved both people and locations that they associated with drug use.

They tried not to mix with others who were known to use drugs. First were peers from their school, college or local area. Certain groups of young people were identified and associated with drug use and, as a result, respondents did not mix with them; for example a *'gang'* of pupils who smoked cannabis during school or others who spent time in *'the town'* smoking it. Second were friends. In some cases young people changed their friendship groups if they became involved in drug use. Once drug use became a common feature of their friends' social lives, respondents were no longer interested in being their friends. One young person said she decided to *'not hang around*' with friends from college any more when they started to use Ecstasy regularly.

Avoiding certain locations was also identified as a strategy for refusing. For some, this meant not going to certain pubs, nightclubs and parks. For example, one respondent said he did not want to go to nightclubs where they played *'certain music'* because he associated it with Ecstasy use. Another stayed away from a local park because it was where groups of young people gathered to smoke cannabis. This type of avoidance allowed young people to keep their friends even if they were engaged in drug use by not spending time with them when they were using, or were in the places where they used.

Avoiding direct offers of drugs

Young people cited ways by which they had avoided direct offers of drugs and, in turn, the need to make a direct refusal in situations where drugs had been present. *'Walking away'* from situations involving drugs either to go home or to see other non-drug users was a strategy used. Similarly, young people pretended to need to leave the situation before a direct offer was made for reasons such as *'going to the toilet*', needing to find someone or because they had to be *'home soon'*.

Avoiding directly saying 'no' could also be achieved by not acknowledging an offer. For instance, when friends or peers passed around *'a spliff'* without verbalising the offer of drugs, it was possible for young people to tacitly refuse by passing it on. Ignoring offers of drugs was also noted. For example, one young person pretended he *'hadn't heard'* an offer of cannabis and carried on talking to someone else and *'just ignored it'.*

'Faking' acceptance

Although not a strategy ever used by respondents, they suggested that people could pretend to accept an offer of drugs. They could accept a drug but did not have to use it. It could be put in a bin, given to someone else or put down the toilet at the next convenient opportunity. Otherwise they could *'pretend to use them'* by simulating smoking cannabis or pretending to swallow a pill.

Factors that made it easier or more difficult to refuse drugs

Refusals were not made in a social vacuum and some tended to have used a variety of different refusal strategies to deal with offers of drugs. There were a number of factors related to the context in which offers were made that impacted on how easy or difficult young people found it to make a refusal and, in some cases, the type of strategy used.

Key factors were:

- who made the offers;
- who the young person was with when offers were made

There were also a number of underlying factors:

- how comfortable they were with being the *'odd one out'*;
- their reputation as a tobacco smoker or alcohol drinker ;
- their age;
- whether they were under the influence of alcohol;
- the type of drug offered.

Who made the offers

Whether offers came from friends or strangers could impact on young people's experiences of refusing drugs.

Offers made by friends

Having friends offer drugs could make it easier or more difficult for young people to refuse drugs. Friends who made it easier respected a young person's decision not to use and did not try to coerce them or convince them to accept. Where this happened, young people did not perceive there to be any negative consequences to refusing such as being called names, being left out of a group or losing friends. Drug use tended to be only one of a number of activities that their friendship group engaged in together. Rejecting an offer of drugs did not equate with a rejection of the friendship group, meaning that they could still *'speak to and be friends'* with those who made the offer. In these cases saying *'no'* was an adequate refusal strategy to use. For example, one respondent told her friends who had offered her cannabis, that she *'didn't want to'* join them and they *'just left it'.* Another that his friends *'weren't bothered'* when he said *'no'* and just kept talking to him.

However, offers made by friends did not always facilitate smooth refusals. Some found it very difficult to say *'no'* when their friends offered. Friends persistently tried to *'badger'* and push them into accepting offers. In some cases friends who were *'high'* did not listen to refusals. This made it more difficult because it meant that people were more insistent in their offers and multiple refusals had to be made. Young people needed to be more forceful in the refusal strategies they used in these circumstances and often referred to using a combination of active refusal strategies and *'walking away'*. For example, one young female respondent had repeatedly told her friends she did not want to use cocaine. Despite this they made her a line of it and again offered it to her. This made her feel under more pressure to use, as it became clear that they were not going to listen to her verbal refusals so eventually she walked away from the situation.

Refusing friends potentially had negative consequences making it difficult for young people to do. They thought that they would be excluded and lose their friends if they did not do what everyone else was doing, and that their friends would laugh at and insult them, taking *'the Mickey out of them'*. Some had been called a *'geek'*, a *'woosie'* a *'boffin'* or *'sad'* when they had refused in the past. Finally they were concerned that they would cause '*an argument*' or offend their friends.

Offers made by strangers

Refusing offers of drugs made by strangers rather than friends was regarded as easier by some and more difficult by others.

Where young people considered it easier this was because they perceived there to be a lack of consequences for doing so. Unlike with friends, they did not care what a stranger thought of them. Typically they knew they would *'never see them again'* and did not have to justify their decision not to use. There would be no broader consequences such as losing friendships. Offers from strangers were also perceived to be less tempting. They *'could be*

giving you anything'. Here, fuelled by media images, concerns were based on strangers having tampered with drugs, providing something that could be particularly harmful or even fatal to them.

On the other hand, refusing strangers could be more difficult than friends. They were viewed as much more likely to become verbally or physically aggressive and *'have a go'*. Feeling *'scared'* or *'threatened'* by offers from strangers was often noted. Though physical or verbal attacks had rarely been experienced, it was a recurring theme when discussing dealing with offers from strangers.

Who young people were with when offers were made

Irrespective of the source of an offer, having been with friends who do not use drugs or those who do impacted on how easy or difficult young people found it to refuse.

Being with friends who did not use made refusing easier in three ways. First they offered respondents an alternative place to go or activity to do, and this could be used when making a refusal. Second they had discouraged respondents from using when they had been tempted to try out of curiosity. Third they provided support when offers were *'particularly persistent'*. They helped to make it clear that when a respondent said *"no' they meant 'no"*. It was suggested that by endorsing their decision and making their own refusal they could *'settle'* the situation. Underlying each of these was that respondents felt more confident in their decision and their ability to refuse when they were with another person who also chose not to use. They did not feel isolated or *'on their own'*.

Being with friends who were using when offered tended to make refusing more difficult. They felt *'compelled to try and join in'* and *'embarrassed'* to be the only one not using. Unlike with friends who did not use, they felt little support for their decision to abstain. This was particularly acute when they were with a crowd they did not know and their only friend there was using. There were cases, however, where friends who used had endorsed their decision not to use. For example, a respondent's friends had discouraged her from trying cannabis when offered by another friend at a party, despite regularly using themselves.

Underlying factors that affected refusal

'Happy to be the odd one out'

While a sense of being alone or *'being different'* from friends could make refusing drugs more difficult (see Chapter 4), it could also be an empowering feeling. Young people liked that they were the one looking after themselves or *'behaving properly'* by not taking drugs. For one young person saying *'no'* felt *'better than you'd think'*. For another it demonstrated having the *'guts'* to be able to stand up for himself. They felt comfortable *'standing their ground'* and if those offering did not like being refused it was *'their problem'*. One young person described how she would rather *'get called names than take drugs'*. Advice given to others was to say *'no'* firmly and always *'sticking to your guns'*, having the *'courage'* to be different.

Reputation as a tobacco smoker or alcohol drinker

A young person's reputation for using other substances (alcohol and tobacco) impacted on their experiences of refusing drugs.

Having a reputation for not drinking alcohol and, in particular, not smoking cigarettes made it easier for young people to refuse drugs. Where a young person had *'set their standards'* by not using tobacco or alcohol, friends and peers tended to assume that they would not want to use drugs. For example, if someone did not smoke tobacco it was assumed they would not want to smoke cannabis.

Where young people were known to smoke cigarettes or drink alcohol, they found it more difficult to say *'no'*. Others sometimes assumed that they were more likely to want to use illicit

drugs, because they had shown that they liked to use legal ones and offers were more persistent.

Reputation as resilient to drug use

Linked to establishing a reputation for not using alcohol or tobacco was building a similar reputation for not using illicit drugs. As a young person built a reputation for abstinence, offers were made less frequently and refusals accepted more readily. For example, a young person described how it had been difficult to refuse cannabis when, as she put it, people were *'pushing it in my face'*. However she found that the more she said *'no'*, the *'easier it was getting to say it'*. Similarly, by establishing himself as a non-user, another respondent's friends knew he would ask if he ever wanted to try it, and so was not offered by them any more.

Age

Some of the older respondents had found it easier to refuse drugs as they got older. This was linked to being comfortable with being the odd one out and establishing a reputation as a non-user, as discussed above. They thought that being older made them less susceptible to being influenced by other people into doing things they did not want to.

Being drunk

Drinking alcohol sometimes made it easier to refuse. Young people could say that they were *'drunk'* or had enough of a *'buzz'* from alcohol, which had been considered an acceptable reason by those making the offer. However, being under the influence of alcohol was a key reason given by those who had tried cannabis on one or two occasions (see Chapter 4). When they were *'drunk'*, young people felt more susceptible to accepting offers of drugs. Alcohol reduced their willpower and made them make decisions they would not have made while sober – *'when you're drunk everything seems like a good idea'.*

Type of drug offered

The type of drug being offered impacted on the ease with which young people made refusals in two ways. First was that with some drugs young people found it easier to refuse as they were more certain that they did not want to engage in their use. As outlined in Chapter 4 young people varied in their views of drugs. Among some of those who expressed less negative views of cannabis, refusing cannabis was a bit more difficult than other drugs. They were positive that they did not want to use drugs other than cannabis but were sometimes tempted to use cannabis.

Second was that young people considered refusing drugs such as heroin and cocaine to be more socially acceptable among their friends and peers than refusing cannabis. Where cannabis use was perceived to be *'normal'*, widespread and at times *'harmless'* making refusals was more difficult. Respondents felt more pressure to accept from their friends and peers. On the other hand refusing heroin or cocaine was something supported even by those who smoked cannabis regularly.

Illustrations of experiences of refusing and refusal strategies

Below are three illustrations of young people's actual and suggested refusal strategies and the factors they felt made it easier or more difficult to refuse.

Nicola is 19 and has tried cannabis once by *'accident'*, she had thought the *'spliff'* was a roll up cigarette and had taken a drag. After that the same people offered it to her a few times. She kept *'point blank'* saying *'no'* over and over to make sure people knew she was not interested in using. She thinks her friends were *'surprised'* that she was being different to the rest of the crowd and that they had quite a bit of *'respect'* for her. If her friends had not respected her decision she thinks it would have been harder to say *'no'*. She thinks she still would not have given in to the pressure though and would have stuck with her decision. She would advise other young people who do not want to use, not to use just to be in with the crowd. They will be the '*bigger person*' for saying *'no'*.

Caroline is 17 and has never used an illicit drug. Her friends smoke *'pot' 'all the time'* and she has been offered it often. When they smoke it she just walks away because she does not like the smell. They do not call her names when she does this as *'they're not like that'*. Her best friend has never taken it either. She thinks this has made it easier for her to say *'no'* as she has *'always been with at least one person in a group who doesn't so* [she] *kind of aren't on* [her] *own'*. Her friends have never tried to push her into it but she can imagine that there must be peer pressure for some people. Her friends now also know that she has asthma so they try not to smoke *'pot'* around her.

Ben is 19 and has never used drugs. He has been offered cannabis *'loads'* of times and Ecstasy a few times. *'Pretty much everyone'* in his area takes drugs including cannabis, cocaine, heroin and Ecstasy. He was first offered cannabis when he was aged about 14 by his friends. While he thinks some people might feel pressured by their friends to use drugs, his friends never tried to *'force'* him into using. If he said *'no they just took it as no'*. On one occasion he was *'actually going to'* smoke cannabis, but his other friends who did not use cannabis *'stopped'* him. Instead of going with the friends who were using, he went with them to do something else instead. A few of his *'mates'* that he used to *'doss with'* at that stage started to use drugs a lot and used to rob people's homes for money to buy drugs. He *'don't like getting mixed in with people that do drugs'* so he stopped spending time with them and being their friend. He has also been offered Ecstasy by strangers in his area but has always just said *'no, I'm not interested'* to them and that has been fine.

Conclusion

In making their refusals to offers of drugs young people wanted to minimise the risk of repercussions to their refusals. These were in terms of damaging friendships and causing arguments or fights. If possible they did not want to offend the person making the offer, at times emphasising that they respected other people's decisions to use drugs while hoping they in turn would respect their decision not to use. Where this was not the case more confrontational strategies were called into play.

Being confident about their decision not to use and the context in which the offer was made, supported by the people they were with, and not feeling threatened in terms of the consequences a refusal would have, all facilitated an easier refusal process.

7 Illustrations of resilience: case studies

Introduction

Previous chapters have outlined the various components of resilience: the factors that put young people at risk of using drugs; the reasons why these young people have chosen not to use; the strategies they have used in making these refusals; and the factors that have influenced the way in which they have dealt with opportunities to use.

Through the use of case studies, this chapter explores the complexities involved in being resilient and how different factors come into play at different stages and in different contexts for young people. The case studies selected do not match to 'types' of young people. Rather there was variation in the nature of resilience across the sample. They were selected to illustrate diversity in terms of young people's risks, reasons for saying *'no'*, strategies used to refuse and factors perceived to impact on their experiences of refusals.

As in previous chapters, to ensure that the anonymity of respondents is always preserved, specific details which might identify respondents have sometimes been omitted or changed. In particular, all names are fictitious.

Case study A

Ed is 17 and lives at home with his parents and two siblings. He is at college full-time and has a part-time job in his local pub. He regularly goes out with his mates and enjoys having a few drinks but does not like to drink *'too much'*. Both friends and strangers have offered him *'spliff'* on a number of occasions but he has never used it or any other illegal drug. He thinks there is probably *'no harm with weed but the other* [drugs]*, they can seriously damage you'*. He used to think all drugs *'messed with your head and sent you doolally'* but *'everyone* [he] *knows pretty much'* uses cannabis. He does not think it has done them any harm and had begun to think that it is not *'really that bad'*. Despite this, he still does not want to use it.

Ed's sister was a crack user. She started off using cannabis and moved on to crack. Ed worries that if he started to use cannabis he would follow a similar route. His sister's crack use caused a lot of rows and stress for his family. If his parents found out that Ed was using drugs they would go *'spare'* and he would hate for them to have the same worry again. While happy to work there part-time, Ed does not want to work in the pub all his life. He wants to qualify from college and work with computers. He feels that if he uses drugs he will not do as well in college and this, in turn, will affect his chances of getting a good job.

Five years ago when Ed was initially offered a drag of a *'spliff'* by his friend he was a *'bit tempted'* to try it because he did not want to be *'the odd one out'*. He decided not to and just said *'no thanks mate'*, his friend asked *'are you sure?'* and he said *'yeah, honestly I'm fine'*. He has never felt any pressure from his friends to try '*spliff*'. The more he refused, the easier it was as his friends got to know that he was not interested. He likes that it made him feel like *'the sensible one'* and feels *'proud'* that he is the one *'not messing with* [his] *head'* by using. He also thinks that his friends respect him for making the choice not to use and may even be envious of him. Refusing drugs from a stranger was even easier as he did not care what the stranger thought of him. When a stranger offered him *'pills'* on the way into a nightclub he said *'no thanks mate'* and thought *'what a loser'* for trying to sell drugs to random people and *'mess with other people's lives'*.

Case study B

Matt is 14, at school and lives with his mum. His parents broke up a couple of years ago and he does not see much of his dad. The area where he lives is *'pretty boring'* but he prefers it to where he lived before. That was a '*loud area where drug dealers are'*. Last year Matt was getting into a lot of trouble. He was suspended from school a few times for bad behaviour and truanting, and had received a formal caution from the police. He has also been *'battered'* regularly in school.

Quite a few of Matt's friends smoke *'weed'* and a couple of other kids in his class take *'pills'*. Matt thinks taking pills is *'dirty'* and that they make you go *'loopy and dopey'*. While not as bad as drugs like Ecstasy and heroin, he thinks smoking weed can still ruin a person's life. Each spliff *'takes away a few minutes from your life'* and if he were caught with it he could get *'a few years in prison'* or into *'big trouble'* at school. When his friends are stoned he thinks they look *'immature'* and *'stupid'*.

As well as the negative physical and psychological effects of drugs, Matt has a number of other reasons for his decision not to use. He has grown up over the past year and now *'acts* [his] *age, not* [his] *shoe size'*. He wants to continue to get the *'respect'* his mum shows him when he behaves well. He is very close to his mum and since his parents' break-up he sees himself as *'the man of the house'* and does not want to cause more trouble for his mum. He wants to get a good job, a nice flat and girlfriend and to get these things he has to do well in his school exams. If he uses drugs he does not think he will achieve this.

He regularly gets offered *'weed'* by his mates and on one occasion was offered cocaine by someone who he did not know. He has never taken an illicit drug and to date, has never held a *'spliff'*. Sometimes when he is offered weed by his friends he thinks about taking it. It is as if there is an '*angel'* on one shoulder and a *'devil'* on the other. The *'devil'* tells him to take '*spliff'* as it would *'taste nice'* and he would get *'high'*. On the other side the *'angel'* tells him it would *'ruin his life'* and make him *'not a very nice person'*.

His friends sometimes make it difficult for him to say *'no'* as they try to push him into using. They call him a *'chicken'* and have blown smoke in his face after he has said *'no, thanks'* to a *'spliff'* a few times. He finds it easier to say *'no'* when he is with at least one other friend who is also refusing. This makes him feel more confident that they are just *'doing* [their] *own thing'*. Sometimes to avoid the more difficult situations he pretends he needs to go to the toilet when they are going to have *'a spliff'*. He says he will meet them wherever they are going and joins them when they have finished. He thinks the more often he refuses, the easier it will be as his mates will get used to him refusing.

Case study C

Nicky is 15 and lives with her mum and dad and four siblings. She is very close to her mum and gets on well with her dad. She likes school but finds it a lot of *'pressure'* preparing for her GCSEs. When she gets stressed about her work she chats to her mum or friends and that makes her feel better. She wants to do well in her exams as she hopes to become a teacher. She used to hang out in a local park drinking with friends and has been in trouble with the police for drinking.

She thinks drugs are *'bad'* because they *'spoil people's lives'*, they put drugs into their system that will end up putting them in a *'hospital bed'*. She does not think *'puff'* is as bad for people's health as drugs like cocaine and heroin. She associates cocaine and heroin with *'druggies'* who are *'skinny, pale and weak'*. Her friends and boyfriend regularly smoke *'puff'* and her cousin is a regular cocaine user.

She is regularly offered *'puff'* and *'bud'* by her friends and boyfriend. Where offers come from friends she finds it easy just to say *'no'* and does not feel pressured by them. However, at parties when she does not know everyone, she sometimes finds it more difficult because she

does not know how people will react. She had been curious about the *'buzz'* it offered and when she was drunk decided to give it a go. She tried it when she was with a good friend who she trusted but did not feel anything from it. She would not have tried it if a stranger had given it to her as she would not know what they might have put in it. She has not touched it since as she is no longer curious about the effects. Instead she likes to get her *'buzz'* from alcohol. She also enjoys smoking cigarettes. Now, when her boyfriend offers her *'puff',* she has an alcopop instead. She prefers the effects of alcohol and thinks it is not as bad for her as *'puff'* as it does not damage her lungs.

As well as the negative physical effects, she does not want to use because her parents said that if they found out she did drugs she would be *'out of the house basically'*. Also she worries that it will ruin her chances of becoming a teacher; she would do less study for her exams and might get a criminal record.

Case study D

Jo is 18 and lives with her four-year-old daughter. She got into a lot of trouble when she was younger for fighting. Her mother is an alcoholic and Jo left home at sixteen because of physical violence. Older friends took her in until she got her own flat and were like *'parents'* to her. Her boyfriend and friends smoke *'weed'* regularly. Mick, her best mate, was a *'heroin addict'* but has stopped using. Other friends from her area use crack and her younger brother uses *'everything'*.

While she does not want to engage in its use, Jo thinks cannabis could be *'alright'* but that drugs such as heroin and cocaine were the *'hard ones'* and could *'kill you'*. When she was 14 Jo was drunk and at a party. People were passing some *'pot'* around and she decided to try it. After smoking it she began to feel ill and ended up being *'really sick'* and had to be sent home. She has never wanted to try it since.

In addition to her own negative experience of *'pot'* Jo does not want to use drugs because she is scared that she will die. She also considers people who depend on drugs to get a kick out of life to be *'weak'* and to have *'lowered themselves'*. Being a mother, she is also concerned about the effect any drug use will have on her child. Her daughter is the most important thing in her life and she does not want to put her at risk.

When she was younger Jo's friends and boyfriend regularly offered her *'pot'* and she would just say *'no'*. She was always confident about saying *'no'*, even if she were the only one not using. She has always felt that people should *'respect'* other peoples' decisions about drugs. As she has got older she has found that people offer her drugs less and less. While she is still around people when they were using, her friends *'knew not to offer'* her.

Case study E

Peter is 13 and lives at home with his mum, dad, older brother and younger sister. He is in school but has been excluded three times for fighting. He has been sent to 'Anger Management' lessons and now finds it much easier to control his anger. Since he has *'calmed down'* he has changed his friends. He used to have the *'wrong friends'* who would *'influence [him] in bad ways'*. Now he hangs around with people who are *'good'* and say *'don't'* to him when he is about to do something wrong.

Peter thinks that cannabis is *'nothing serious'* but Ecstasy *'and that lot'* are as they could kill people. He does not want to use drugs because of this risk of death and because he thinks users do not do well in life. He wants to do well in school and get a good job. He also worries about getting *'locked up'* if he is caught with drugs.

He knows *'idiots'* in his class and people from the *'other side'* of his village who smoke cannabis. He thinks that most people are *'allowed to smoke cannabis'* and it is talked about a lot in his school and on the local buses. Peter has never been directly offered drugs. When he hears other people talking about drugs he tries not to listen and *'turns around and leaves'* before they start using. He also avoids his local park where he knows other kids from his area hang out to smoke cannabis. He finds it easy to stay away from drugs as none of his new friends are interested in them either. He thinks this would change if any of his friends used. He would find it hard to be laughed at for not joining in. He thinks he would always make sure that he is not friends with anyone who uses drugs.

8 Discussion: facilitating resilience

Introduction

This report has demonstrated that resilience involves a complex interplay of factors that influence both these young people's decisions not to use drugs and their ability to put these into practice. Using theories developed in the field of 'Cognitive and Social Psychology' this chapter discusses factors identified in Stage 2 of the research that facilitate or impede resilience. It concludes by examining the potential implications for policy.

Factors facilitating resilience

In describing their views about drugs, their motivations for not using them, their experiences of and strategies for refusing drugs, and the broader context in which they are based, young people identified a range of factors that impede or facilitate their resilience. While these factors were not described by young people in the terms 'risk' or 'protective' factors, they reflect the types of factors defined as such in Chapter 1. There were four aspects of these young people's experiences in which these factors were manifest.[20] First were their motivations for not wanting to use drugs, which could be seen as protective factors. Second were the reasons they suggested that other people may have for using drugs, which could be seen as risk factors. Third were factors relating to their own circumstances which may put them at risk of using drugs. Finally were the factors that made it easier or more difficult for them to refuse drugs, these could be considered either risk or protective. The interplay of these factors in young people's resilience is complex. Young people reported different combinations and numbers of these factors as impacting on their resilience. The same factor could have varying degrees of significance in influencing different young people's decisions about their use. (These complexities were illustrated through the use of case studies in Chapter 7).

In the following sections, the findings presented in Chapters 4, 5 and 6 that explore the nature of these young people's resilience are discussed within the context of three interrelated theories. These theories are concerned with the thoughts that influence young people's decisions and subsequently the factors that facilitate them in putting these decisions into practice. The three theories are:

- schema theory (Bartlett, 1932, 1958; Mandler, 1984; Piaget, 1970);
- self-regulation theory (Baumeister and Heatherton, 1996; Karoly, 1993; Thompson, 1994; Cochran and Tessor, 1996); and
- self-efficacy theory (Bandura, 1977, 1986).

These theories are strongly interrelated, but they are presented separately here for ease of understanding. Each section outlines the salient points of each theory and demonstrates their relevance to explanations provided by the resilient young people.

There are a range of reasons why I have decided that drugs are not for me – schema theory

Schema theory suggests that all people have a set of categorical rules or a script that they use to organise their knowledge about a particular concept in order to interpret the world. New information is processed according to how it fits into these rules, which are also known as a *schema*. These schemas can be used to help people perceive, interpret and predict situations occurring in the social context in which they are based (Bartlett, 1932, 1958; Mandler, 1984; Piaget, 1970). For example, a schema for the drug "Ecstasy" would contain both static and dynamic knowledge. The static information would allow a young person to recognise what "Ecstasy" is, tell him/her that it is an illegal drug associated with a certain

[20] Each of these are discussed fully in Chapters 4 through 7.

youth scene (i.e. the dance scene and the associated genre of music). Dynamic (changeable) information may relate to the price and purity of it and the effects of it on the user.

Most schema theorists argue that an individual does not have just one body of knowledge available, but rather a network of context-specific bodies of knowledge that people apply to specific situations (Mandler, 1984). Although schemas are relatively stable knowledge structures, a person's schema is able to assimilate new information and is subject to change according to the input of new information.

There appears to be evidence of the young people in the current study operating a '*drugs as harmful to self'* schema in order to remain resilient, (i.e. they make their decisions about their own use based on a collection of thoughts, knowledge and ideas in which drugs tend to be perceived to have potentially harmful effects for them). Support for this can be found within their *motivations for not using drugs*. The fear of significant others' (parents, extended family or friends) disapproval and the potential legal consequences appear to be interpersonal motivations to remain resilient. Furthermore, the cited fear of effect on health, fear of losing control and fear of addiction suggest motivations related to the potential physical and psychological impact of drug use. Finally, as some young people discussed that their personal experiences with drugs (hallucinating and vomiting) made them decide not to use again, this suggests evidence of the schema being developed according to new information and experience. Conceptualised together, these examples appear to support the concept of a '*drugs as harmful to self'* schema that contains knowledge related to the internal and external impact of drugs on the young person, which tend to be focused on a belief that drug use would have negative effects on them.

There are things that I need to do to get what I want and achieve my goals; using drugs is not one of these things – self-regulation theory

Self-regulation theory refers to the internal and external process that allows individuals to carry out goal-focused actions over time, and in different social contexts. This includes the initial selection of goals, their planning monitoring and evaluation, and the subsequent modification of behaviour in order to achieve these goals in a satisfactory manner (Baumeister and Heatherton, 1996; Karoly, 1993; Thompson, 1994). As a key component of self-regulation theory, goals are desired states or situations that people strive to achieve or avoid. Goals can be approach-focused (aquisitional) or avoidance-focused (inhibitory) (Cochran and Tessor, 1996).

Approach goals concern the successful achievement of a particular state or situation and involve approach behaviour. Avoidance goals are concerned with the reduction of a state or situation and involve avoidance behaviour (Cochran and Tessor, 1996). For example, an approach goal for individuals who wishes to stop using cannabis may be to improve their physical fitness as a result of stopping using it. In contrast, an avoidance goal would be to avoid all places and people associated with cannabis use.

There is evidence to suggest that the young people in the current study employed three forms of *approach goals* in order to justify and maintain their resilience. First, there were ways in which drug use was perceived as incompatible with their career aspirations. That is, young people suggested that if they were to use drugs this may prevent them from attending classes and, in turn, stop them achieving the qualifications necessary to follow their chosen career path. Second, some young people made extensive use of their spare time to play sports, pursue hobbies and work in part-time jobs. As a result, this left them little time to go to or be involved in situations where drug use may take place.

Finally, third, the young people who were parents suggested that such a role was not compatible with using drugs. It was reported that parenthood left little free time to engage in drug use and that such behaviour was perceived to have serious consequences for the parents (and child). These ranged from the young person dying and the child growing up without a parent, to the child being removed from their custody if they were perceived to be 'unfit parents'. As failure to maintain these approach goals appears to be strongly related to

long-term personal consequences, this suggests that they may be very effective tools in assisting these young people to remain resilient.

Interrelated to goal behaviours are three self-regulation styles: intact/effective self-regulation; underregulation; and misregulation. It is suggested that 'underregulated' individuals fail to control their behaviour and behave in a disinhibited manner, whereas, 'misregulated' individuals often utilise lots of effort to avoid certain behaviours and outcomes. However, the strategies they select are frequently misplaced and ineffective resulting in the ironic effect of making the avoided behaviour or outcome often more likely to occur (Baumeister and Heatherton, 1996).

While not the focus of this study, the findings suggest that a number of the '*reasons other people may use drugs'* cited by the young people may be related to 'underregulated' or 'misregulated' behaviour. To illustrate, using drugs for '*the buzz'* or to '*alleviate boredom'* were reasons suggested for other peoples' drug use that may be related to underregulated behaviour, for example, where a person will do anything for *'a buzz'*, such as using drugs, irrespective of the potential harm to themselves. Regarding misregulation, '*using drugs to escape personal problems', 'to fit in'* or *'to look hard'* may all be examples of this behaviour; for example, deciding to use drugs to escape problems may in fact cause even more problems for the young person than originally existed.

I can always do what I decide I want to do, so if I don't want to use drugs then I won't use them – self-efficacy theory

In contrast to the examples above, people with *effective* or *intact self-regulation* have a strong sense of self-efficacy. Self-efficacy can be conceptualised as people's beliefs about their capabilities of putting their decisions about what they want to do into practice. It is proposed that strong self-efficacy enhances feelings of accomplishment and overall wellbeing in people (Bandura, 1977, 1986).

Strong self-efficacy may be demonstrated in a social context through effective self-management behaviours such as assertiveness and functional problem solving skills. The findings suggest strong self-efficacy within the resilient young people that is demonstrated in the strategies that they utilise to refuse drugs. The young people discussed a range of assertive responses to offers of drugs, conceptualised as being polite but firm *'I know you choose to do it, but I choose not to'*. Their assertive skills appears to be particularly tested when refusing persistent offers of drugs from friends.

Operating concurrently with their assertive skills appears to be an effective rational problem solving style. For example, the young people talked about a decision making process regarding what strategy to utilise that involved weighing up and minimising the risk of any negative consequences their refusal may have (i.e. the potential to jeopardise friendships). In addition, considering the impact of drug use on personal finances and current health conditions were further examples of a rational problem solving style.

The outcome of remaining resilient to drugs was discussed in terms of '*being happy to be the odd one out'* and '*feeling like the bigger person for saying no'*. They were successful on two levels – first they managed to refuse an offer of a drug, and second they did not compromise their position within a friendship or relationship, for example. This provides support for the suggestion of strong self-efficacy resulting in feelings of wellbeing and mastery.

These three theories and how they relate to the current study's findings have been presented separately for clarity and coherence. However, they are not mutually exclusive but rather are interrelated. The findings suggest that where young people are resilient the three processes may run concurrently: they operationalise a schema in which they view drug use as harmful to themselves and therefore a behaviour in which they do not want to engage, alongside which they have developed a set of resilience-focused goals. They then draw on a strong sense of self-efficacy so that they are able to put this decision not to use into practice. Within this context resilience would appear to be subject to both change and reinforcement depending on the social context in which young people are based.

Policy implications

As discussed in Chapter 1, one of the targets of the Government's updated National Drug Strategy (2002) is to reduce frequent illicit drug use among young people. This is reflected in *Every Child Matters: Change for Children* (Department for Education and Skills (DFES), Home Office, Department of Health, 2004) which proposes a better-integrated delivery of children's services to improve outcomes for children and young people. One of its aims, to be achieved through the *Be Healthy* initiative, is to encourage young people to choose not to engage in illicit drug use.

This research has identified a sample of young people who appear to adopt a number of inter-related strategies in order to remain resilient to illicit drug use. As a result, a number of policy implications have been identified to encourage, promote and facilitate young people's resilience. Addressed individually below, these implications relate to ways of helping young people reinforce a resilience to drugs schema, develop appropriate approach goals, and acquire and maintain strong self-efficacy skills. It is essential to reiterate that the findings of this study are based on the views and experiences of a group of young people who have chosen *not* to use drugs. It is therefore beyond the scope of this report to consider the policy implications for when young people choose to use drugs.

Develop and maintain an effective resilience to drugs schema

- This report has shown that young people gather information about drugs and their effects from a variety of sources. A strategy of providing accurate information, using relevant appropriate language could help provide young people with the facts necessary to begin developing a *resilience to drug use schema*. However, in a context where young people are exposed to a variety of perhaps conflicting sources of information it would appear necessary that the information or the individual responsible for delivering it be perceived as both credible and reliable.
- The young people in this report have diverse individual and social backgrounds (representing a mix of age, gender and socio-economic circumstances). Therefore, the broad range experiences that they have identified to help them remain resilient may be usefully shared to create a reliable and credible information source for others.

Develop and maintain appropriate approach goals

- Appropriate agencies could help young people develop their awareness of goals by demonstrating the relevance of current behaviour to their future plans. A number of approaches could be potentially utilised to develop goal awareness such as highlighting the links such as those young people in the current study make between using drugs and being able to achieve their longer-term lifestyle strategy. Evidence suggests that it is helpful for young people to 'own' their goals (by taking an active role in their development) and that they are appropriately matched to the young person's abilities and needs.
- Finally, for young people to maintain belief in a resilient lifestyle, it would appear necessary that any goals set are ultimately achievable (for long term career goals it may be motivational to identify short-term milestones towards success). However, this strategy will also present challenges for those working with young people in areas of high unemployment and/or social deprivation, where the identification of some long-term goals may not always be immediately credible when set in their social context.

Develop and maintain strong self-efficacy

- It is evident that the young people in this research had developed and employed appropriate life skills (e.g. behaving assertively and developing effective problem solving skills) to deal with drug-related situations in order to maintain a decision not to use drugs. If life skills' training were to be provided, the findings would suggest that any course material is relevant to the reality and social world in which the individual young person exists. The young people in this research have used their life-skills in a range of contexts, therefore it would appear that any life skills training should be flexible and appropriate to a range of issues and situations that are not just focused on drug use. To achieve this, it

may be practical to base life skills training within a citizenship education context. This may help promote and develop skills that are transferable to a number of contexts which may increase their likelihood of use, and provide the young person with the confidence and opportunity to practice (in situations that may not be as challenging as refusing the offer of drugs). This in turn may reinforce the idea that such skills are indeed useful tools to own, maintain and utilise.

The three areas above complement each other and operate concurrently. Therefore, for resilience to drug use to be developed and maintained, all three issues need to be addressed. For example, a young person can receive accurate, credible and accessible information in order to develop a *resilience to drugs schema*. However, without the accompanying goals and life-skills necessary to develop a strong sense of self-efficacy, these schemas may be redundant. This in turn may make long-term resilience a difficult concept for young people to attain.

Appendix A: Selecting the independent variables for the logistic regression models

Selection of the independent variables

A discussion of the selection of the independent variables is covered in Chapter 2. This appendix provides details of how the independent and dependent variables were formed for the two age groups covered and provides tables outlining the final variables that went into the models and how these were coded.

Detailed description of the independent variables

Many of the independent variables were merged into components. The OCJS uses many attitudinal scales and questions that can all be hypothesised to be tapping to some degree at the same concept/s. In these cases Principal Components Analysis was used as a data reduction technique: 'by calculating scores for each underlying dimension and substituting them for the original variables' (Hair *et al*., 1995:367). Principal components analysis is a multivariate mathematical method which aims to determine whether or not the interrelationships (correlations) among a large number of observed variables can be explained in terms of common underlying dimensions, known as components. Thus the aim of principal components analysis is, firstly, to identify these separate dimensions of the observed variables structure and secondly to determine the extent to which each variable is explained by each dimension.

10- to 16-year-old models

Strengths and difficulties

A set of personality questions were asked of the respondents. They were all answered on a four-point agreement scale: agree strongly, agree slightly, disagree slightly and disagree strongly (H1Sada – H1Sade).

Table A1.1

	Loadings		
Variables	**Component 1**	**Component 2**	**Component 3**
I usually do what I am told	.827		
I am usually helpful towards others	.824		
I worry a lot		.790	
I get upset if I see people who are sad or hurt		.776	
I am easily bored and find it hard to concentrate			.969
Variance explained	34.012	25.504	15.153

All three components were used in the logistic regression and were named as follows:

1 = Helpfulness/good nature
2 = Sensitivity
3 = Boredom

Serious offending

The derived variable Seroffyr was used to categorise young people according to whether or not they had committed a serious crime in the last year. Serious crimes include theft of a vehicle, domestic or commercial burglary, commercial or personal robbery, theft from a person, assault with injury or dealing in Class A drugs. Non-serious crimes were not included as these included offences that were more open to subjective perception such as attempting to steal things or stealing from school/work.

Anti-social behaviour

Respondents were asked a set of questions about anti-social behaviour they had committed (B1FarB, B1NosB, B1NghB, B1GrfB, B1BulB, B1JoyB and B1WepB). The recall period for all questions was 12 months and answered as 'yes' or 'no'.

Table A1.2

	Loadings	
Variables	**Component 1**	**Component 2**
Have you been joyriding in a car that either you or someone else broke into?	.693	
Have you written things or sprayed paint on a building, fence, train or anywhere else that you shouldn't have?	.612	
Have you tried to avoid paying the correct fare when travelling on public transport?	.544	
Have you carried a knife or other weapon for your own protection or in case you got into a fight?	.487	
Have you picked on or bullied another school pupil?		.722
Has a neighbour complained because they were annoyed by your behaviour or noise in or near your home?		.649
Have you been noisy or rude in a public place so that people complained or you got into trouble?	.447	.519
Variance explained	27.377	14.707

Both components were used in the logistic regression and were named as follows:

Component 1 – Serious anti-social behaviour
Component 2 – Less serious/minor anti-social behaviour

In trouble at school

These questions were asked about being in trouble at school. One question asked how often young people had been in trouble at school (H1Bad). There were also three questions that were aggregated into one variable which looked at whether young people were frequent truants or had been suspended or excluded from school (H1Bunk, H1Expl and H1Susp). Frequent truancy was categorised as three times or more in the last year for those still at school and more than ten times ever for those no longer at school. PCA was run on these two variables.

Table A1.3

	Loadings
Variables	**Component 1**
In the last 12 months how often have you been in trouble with the teachers at school for behaving badly or doing something wrong?	.798
Is/was young person a frequent truant or suspended or excluded from school?	.798
Variance explained	63.76

Component 1 was named 'in trouble at school'.

Early cigarette use

This question (D1smag) asked young people who said they had ever smoked a cigarette at what age they first smoked. Those who said they had first smoked at age 11 or under were categorised as early smokers (7.2% of 10- to 16-year-olds). Young people who gave an age younger than five were excluded from the analysis as the validity of their responses is questionable.

A new variable was created which categorised those who started smoking aged 11 and under into 'early smoker', and those who started smoking after 11 or those that had never had a cigarette as 'not early/never'.

Early alcohol use

This question (A1Firs) asked young people who said they had ever drunk alcohol at what age they first drank it. Those who said they had first drunk alcohol at age 11 or under were categorised as early alcohol drinkers (17.5% of 10- to 16-year-olds). Young people who gave an age younger than five were excluded from the analysis as the validity of their responses is questionable.

A new variable was created which categorised those who started drinking aged 11 and under into 'early alcohol use', and those who started drinking after 11 or those that had never had an alcoholic drink as 'not early/never'.

Parental attitudes

This is a set of questions asking respondents to what extent their parents minded them committing certain behaviours (H1MinB – H1MinE). All the questions are answered on a three- point scale: 'yes a lot', 'yes a little' and 'no, not at all'.

Table A1.4

Variables	Loadings Component 1
Would parents mind if they found out you had started a fight with someone?	.593
Would parents mind if you skipped school without permission?	.796
Would parents mind if you smoked cannabis?	.744
Would parents mind if you wrote things or sprayed paint on a building?	.806
Variance explained	54.757

Component 1 was named 'parental attitudes'.

Parental management

This is a set of statements about parental management (H1Atta – H1Atte) as perceived by the respondents. All are answered on a yes/no scale. The 'my parents often argue or fight with each other' variable was removed as many people were lost from the analysis whose parents were not together (H1Attg).

Table A1.5

Variables	Loadings Component 1
My parents usually listen to me when I want to talk	.731
My parents usually praise me when I have done well	.664
My parents usually treat me fairly when I have done something wrong	.641

My parents usually want to know where I am when I'm not at home	.592
Variance explained	43.415

Component 1 was named 'parental management'.

Parents in trouble

These two variables asked respondents if their parents had ever been in trouble with the police (not including driving fines) or been sent to prison (H1Poli, H1Pris). Questions were answered as yes/no.

Table A1.6

Variables	**Loadings Component 1**
As far as you know, have your parents/guardians ever been in trouble with the police?	.850
As far as you know have your parents/guardians ever been sent to prison?	.850
Variance explained	72.168

Component 1 was named 'parents in trouble'.

Older friends

This variable asked young people whether their friends were older, younger, mixed ages or about the same age (H1MatO). This was recoded into two categories 'some older' and 'none older'. The assumption was made that those who said mixed ages had some older friends and those who said younger or the same age had no older friends.

Friends in trouble

These three questions asked young people if their friends or siblings had written graffiti, skipped school or been in trouble with the police in the last 12 months. The first two questions were answered as yes/no. The question about trouble with the police was answered on a five-point scale: none of them, a few of them, quite a lot of them, nearly all of them, all of them.

Table A1.7

Variables	**Loadings Component 1**
Have any of your siblings/close friends written things or sprayed paint on a building, fence or wall in the last 12 months?	.703
Have any of your siblings/close friends played truant or skipped school in the last 12 months?	.740
Have many of your closest friends have been in trouble with the police in the last 12 months?	.734
Variance explained	52.681

Component 1 was named 'friends in trouble'.

Free school meals

Free school meals is often used as a proxy indicator for vulnerability/poverty. The question asks respondents if they ever received free school meals or vouchers for free school meals between the ages of 10 and 16 (H1Meal). Responses to this question are yes/no.

School management

This was a set of questions about the respondents' perception of management in their school (H1Scha – H1Sche). All questions were answered with a yes/no response.

Table A1.8

Variables	Component 1	Loadings
My school has clear rules about behaviour		.674
My teachers praise me if I do good work		.629
It is easy to play truant or skip lessons at my school		-.622
I have seen pupils hit teachers at my school		-.374
Variance explained		34.434

Component 1 was named 'school management'.

Interviewer assessment of disorder

This is a set of questions answered by the interviewer on the appearance of the area surrounding the property that the respondent lives in (Rubbcomm, Vandcomm, Poorhou, Hhoucond). Questions about the relative condition of the property and type of property were not used due to subjectivity and varying differences in condition of the same types of property (Acctype and Relcond).

Questions asking how common litter, vandalism and poor-condition homes are were answered on a four-point scale: very common, fairly common, not very common, and not at all common. The question asking about the condition of the property was on a five-point scale: very good, fairly good, neither good nor bad, fairly bad, very bad.

Table A1.9

Variables	Loadings Component 1
How common is litter or rubbish in the immediate area?	.871
How common is vandalism, graffiti or damage to property?	.889
How common are homes in poor condition?	.903
Is the house/flat in good or poor condition?	-.685
Variance explained	70.813

Component 1 was named 'interviewer disorder'.

Neighbourhood

These questions were part of a set of questions asking respondents about their neighbourhood. Specifically they asked respondents about whether friends and family lived in the neighbourhood and what activities there were in the area. Friends and family questions were answered on a scale with increasing numbers of people (not including people the young person lived with) (G1Crel, G1Frnd). Frequency of seeing friends was answered on an increasing scale (from 6 or more times a week to less than once a month) (G1Frof). Things to do in the area was answered as: lots of things to do, quite a lot to do, not very much to do, nothing at all to do (G1Todo). Finally there was also a question on whether the young people belonged to any groups and clubs in the area (G1Belg). A list of different groups was answered with a 'yes' or 'no'. 'Yes' responses were summed to give a number of groups belonged to as an indication of involvement in activities in the area.

Table A1.10

Variables	Loadings Component 1	Component 2
How many of your relatives live within a 15-20 minute walk or 5-10 minute drive?	.547	
How many of your friends live within a 15-20 walk or 5-10 minute drive?	.797	
How often do you see friends during the evenings or at weekends?	.717	
How much do you think there is for you to do in this area?		.753
Have you belonged to any groups, clubs or organisations during the last 12 months?		.726
Variance explained	29.504	23.385

Component 1 was named 'social support network' and component 2 was named 'activities in the area'. Both were used in the logistic regression.

17- to 24-year-old models

Strengths and difficulties

These were a set of personality questions about the young people (H1Risa – H1Risi). They were all answered on a four-point agreement scale: agree strongly, agree slightly, disagree slightly and disagree strongly. Two variables from the set of questions were not included. 'I have at least one person who I can always talk to about my problems' was not included as it was decided that the variable could be measuring number of friends rather than personality (H1Risg). Also 'I am nervous in new situations. I easily lose my confidence' was removed as it was decided that it is a double-barrelled question, and people could reply differently depending on which statement they were responding to (H1Risf).

Table A1.11

Variables	Loadings Component 1	Component 2
I like taking risks in life	.307	-.372
I often say things without thinking	.679	
I always give in to temptation	.621	
I get bored easily	.661	
I easily lose my patience with people	.681	
I think carefully about the consequences before making decisions		.595
I get upset if I see other people suffering		.813
Variance explained	29.87	16.023

Both components were used in the logistic regression and were named as follows:

Component 1 = Impulsivity/risk taking
Component 2 = Sensitivity/thoughtfulness

Serious offending

The derived variable Seroffyr was used to categorise young people according to whether or not they had committed a serious crime in the last year. Serious crimes include theft of a vehicle, domestic or commercial burglary, commercial or personal robbery, theft from a person, assault with injury or dealing in Class A drugs. Non-serious crimes were not included as these included offences that were more open to subjective perception such as attempting to steal things or stealing from school/work.

Anti-social behaviour

These were a set of questions about anti-social behaviours young people have committed (B1B1FarB, B1NosB, B1NghB, b1GrfB, B1JoyB, B1WepB). The recall period for all questions was 12 months and answered as 'yes' or 'no'.

Table A1.12

Variables	Loadings Component 1
Have you been joyriding in a car that either you or someone else broke into?	.540
Have you written things or sprayed paint on a building, fence, train or anywhere else that you shouldn't have?	.591
Have you tried to avoid paying the correct fare when travelling on public transport?	.382
Have you carried a knife or other weapon for your own protection or in case you got into a fight?	.584
Has a neighbour complained because they were annoyed by your behaviour or noise in or near your home?	.412
Have you been noisy or rude in a public place so that people complained or you got into trouble?	.637
Variance explained	28.386

The component was named 'anti-social behaviour'.

Frequent truancy/suspension/exclusion

This is an aggregate of three questions into one variable which looked at whether young people were frequent truants or had been suspended or excluded from school (H1Bunk, H1Expl and H1Susp). Frequent truancy was categorised as more than ten times ever.

Early cigarette use

This question (D1smag) asked young people who said they had ever smoked a cigarette, at what age they first smoked. Frequencies were run and it was decided to categorise those who said they had first smoked at age 11 or under as early smokers (8.8% of 17-to 24-year-olds). Young people who gave an age younger than five were excluded from the analysis as the validity of their responses is questionable.

A new variable was created which categorised those who started smoking aged 11 and under into 'early smoker', and those who started smoking after 11 or those that had never had a cigarette as 'not early/never'.

Early alcohol use

This question (A1Firs) asked young people who said they had ever drunk alcohol at what age they first drank it. Frequencies were run and it was decided to categorise those who said they had first drunk alcohol at age 11 or under as early alcohol drinkers (9.6% of 17-24 year olds). Young people who gave an age younger than five were excluded from the analysis as the validity of their responses is questionable.

A new variable was created which categorised those who started drinking aged 11 and under into 'early alcohol use', and those who started drinking after 11 or those that had never had an alcoholic drink as 'not early/never'.

Parents in trouble

These two variables asked respondents if their parents had ever been in trouble with the police (not including driving fines) or been sent to prison. Questions were answered as yes/no.

Table A1.13

Variables	Loadings Component 1
As far as you know, have your parents/guardians ever been in trouble with the police?	.868
As far as you know have your parents/guardians ever been sent to prison?	.868
Variance explained	75.312

Component 1 was named 'parents in trouble'.

Friends in trouble

This question asked young people how many of their closest friends had been in trouble with the police in the last 12 months (H1Fren). This was answered on a five-point scale: none of them, a few of them, quite a lot of them, nearly all of them, all of them.

Having someone to talk to

This variable was originally part of the above strengths and difficulties series of questions (H1Risg). However, it was felt that it should be used on its own. This question asked the extent of agreement with the statement 'I have at least one person who I can always talk to about my problems'.

Belonging to groups

This question asks whether the young people belong to any groups and clubs in the area (G1Belg). A list of different groups was answered with a 'yes' or 'no'. 'Yes' responses were summed to give a number of groups belonged to as an indication of involvement in activities in the area.

Social support network

These questions were part of a set of questions asking respondents about their neighbourhood. Specifically they asked respondents about whether friends and family lived in the neighbourhood (G1Crel and G1frnd). Friends and family questions were answered on a scale with increasing numbers of people (not including people the young person lived with).

Table A1.14

Variables	Loadings Component 1
How many of your relatives live within a 15-20 minute walk or 5-10 minute drive?	.797
How many of your friends live within a 15-20 walk or 5-10 minute drive?	.797
Variance explained	63.518

Component 1 was named 'social support network'.

Free school meals

Free school meals is often used as a proxy indicator for vulnerability/poverty. The question asks respondents if they ever received free school meals or vouchers for free school meals between the ages of 10 and 16 (H1Meal). Responses to this question are yes/no.

Not in education, employment or training (NEET)

This is a classification used by DFES and is derived from the variable L1Stat. This categorises young people according to whether or not they were in education, employment or training in the last week.

Interviewer assessment of disorder

This is a set of questions answered by the interviewer on the appearance of the area surrounding the property that the respondent lives in (Rubbcomm, Vandcomm, Poorhou, Hhoucond). Questions about relative condition of the property and type of property were not used due to subjectivity and varying differences in condition of the same types of property (Acctype and Relcond).

Questions asking how common litter, vandalism and poor condition homes are, were answered on a four-point scale: very common, fairly common, not very common, and not at all

common. The question asking about the condition of the property was on a five-point scale: very good, fairly good, neither good nor bad, fairly bad, very bad.

Table A1.15

Variables	Loadings Component 1
How common is litter or rubbish in the immediate area?	.883
How common is vandalism, graffiti or damage to property?	.885
How common are homes in poor condition?	.901
Is the house/flat in good or poor condition?	-.691
Variance explained	71.321

Component 1 was named 'interviewer disorder'.

Coding of the final set of dependent variables used in the logistic regression models

Table A1.16 Variables used in the 10 to 16 year olds model

Variable	Variable name	Values			
		0	1	2	3
Dependent variable					
Ever taken any drug	Eanydrug	No, never	Yes, have taken		
Independent variables					
Biological or psychological					
Sensitivity	Sensive	Variable is interval. High value = sensitive.			
Helpfulness	Helpful	Variable is interval. High value = helpful.			
Boredom	Bored	Variable is interval. High value = easily bored.			
Behavioural or attitudinal					
Serious offending	Seroffyr	Not in last year	Yes, in last year		
Serious anti-social behaviour	ASBser	Variable is interval. High value = Serious anti-social behaviour.			
Minor antisocial behaviour	ASBminor	Variable is interval. High value = Minor antisocial behaviour.			
In trouble at school	Schtroub	Variable is interval. High value = Been in trouble at school.			
Early smoking	Earlysmo		Not early or never used	Early use	
Early alcohol use	Earlyalc		Not early or never used	Early use	
Attitude to cannabis use	Attcan		Not wrong	A bit wrong	Very wrong
Interpersonal relationships					
Parents know who friends are	H1matp		None of them	Some of them	All of them
Parental attitudes	Paratts	Variable is interval. High value = parents have strong attitude towards bad behaviour.			
Parental management	Parman	Variable is interval. High value = good parental management.			

Variable	Variable name	Values			
		0	1	2	3
Parents been in trouble	Partroub	Variable is interval. High value = been in trouble.			
Older friends or not	H1mato	None older	Some older		
Friends been in trouble	Frentrob	Variable is interval. High value = Been in trouble.			
Social support network	Socsupp	Variable is interval. High value = Lots of friends and relatives nearby.			
Environmental and economic					
Free school meals	H1meal	No	Yes		
School management	School	Variable is interval. High value = Good school management.			
Interviewer disorder	Intdis	Variable is interval. High value = High disorder.			
Things to do in the area	Activity	Variable is interval. High value = More things to do.			

Table A1.17 Variables used in the 17- to 24-year-olds model

Variable	Variable name	Values				
		0	1	2	3	4
Dependent variable						
Ever taken any drug	Eanydrug	No, never	Yes, have taken			
Independent variables						
Biological or psychological						
Sensitivity	Sensitiv	Variable is interval. High value = Sensitive.				
Impulsivity	Impulse	Variable is interval. High value = Impulsive.				
Mental disorder	Depress	Never suffered	Yes, suffered			
Behavioural or attitudinal						
Serious offending	Seroffyr	Not in last year	Yes, in last year			
Anti-social behaviour	Antisoc	Variable is interval. High value = Anti-social behaviour.				
Truancy /exclusion	Frtruexc	Never truanted/ excluded	Truanted/ excluded			
Early alcohol use	Earlyalc		Not early or never used	Early use		
Early smoking	Earlysmo		Not early or never used	Early use		

Variable	Variable name	Values				
		0	1	2	3	4
Interpersonal relationships						
Parents been in trouble	Partroub	Variable is interval. High value = Been in trouble.				
Friends been in trouble	H1fren	None	A few	Quite a lot	Nearly all	All
Have someone to talk to	H1risg		Disagree strongly	Disagree slightly	Agree slightly	Agree strongly
Belong to groups	Belong	Variable is interval. Number of groups up to 12.				
Social support network	Socsupp	Variable is interval. High value = Lots of friends and relatives nearby.				
Environmental and economic						
Free school meals	H1meal	No	Yes			
Interviewer disorder	Intdis	Variable is interval. High value = High disorder				
NEET (not in ed, employ or training)	NEET	Not NEET	NEET			

Appendix B: Factors associated with drug use, the logistic regression models

Exploring factors associated with use of any drug

This appendix provides details of the logistic regression models carried out in order to explore the factors associated with taking drugs. Logistic regression enables one to establish which variables are statistically related to a given dependent variable when all under examination have been considered. This technique determines associations between variables but does not imply a causal relationship.

Methodology

The model fitting strategy

Logistic regression serves the basic purpose of estimating the relationship between a single non-metric (categorical) dependent variable and a set of independent variables.

"'It differs from multiple regression, however, in that it directly predicts the probability of an event occurring….Probability values can be any value between zero an one, but the predicted value must be bounded to fall within the range of zero and one. To define a relationship bounded by zero and one, logistic regression uses an assumed relationship between the independent and dependents variables that resembles an S-shaped curve….At very low levels of the independent variable, the probability approaches zero. As the independent variable increases, the probability increases up the curve, but then the slope starts decreasing so that at any level of the independent variable, the probability will approach one but never exceed it." (Hair *et al*., 1998:277)

Therefore, this model is inherently non-linear, whereby the error term of a discrete variable follows this binomial distribution instead of a normal distribution. Therefore, the statistical tests based on the assumptions of normality are invalid. Added to this, the variance of a dichotomous variable is not constant and therefore, it creates instances of heteroscedasticy. For these two main reasons, multiple regression cannot be used to predict dichotomous variables.

As the model is not linear, an iterative algorithm is necessary for parameter estimation. Logistic regression compares the probability of an event occurring (a person taking drugs) with the probability of it not occurring (a person not taking drugs). This odds ratio[21] can be expressed as:

[21] It is important not to confuse 'probability' with 'odds ratio'. 'Odds ratio is the comparison of the probability of an event to the probability of the event not happening, which is used as the dependent variable in logistic regression' (Hair *et al*., 1998:242) 'The odds of an event occurring are defined as the ratio of the probability that it will occur to the probability that it will not' (Norusis 1993a:6).

Figure B.1: Adapted from Norusis (1993a:6)

$$\text{Prob (event)} = \frac{1}{1 + e^{-Z}}$$

$$\text{Prob (no event)} = 1 - \text{Prob (event)}$$

$$\text{Odds} = \frac{\text{Prob (event)}}{\text{Prob (no event)}} = e^{B_0 + B_1X_1 + B_2X_2 + \ldots + B_pX_p}$$

Where:

e is the base of the natural logarithms, approximately 2.718

B0 and B1 are coefficients estimated from the data

Z = B0 + B1X1 + B2X2 +…+BpXp

X is the independent variable

Then e raised to the power Bi is the factor by which the odds change when the ith independent variable increases by one unit. If Bi is positive, this factor will be greater than 1, which means that the odds are increased; if Bi is negative, the factor will be less than 1, which means that the odds are decreased. When Bi is 0, the factor equals 1, which leaves the odds unchanged.

As the relationship between the independent and the dependent variable is not linear, rather than using the least squares method (used in multiple regression) the maximum likelihood procedure is used in an iterative manner; this enables ONE to find the 'most likely' estimates for the coefficients. Therefore, the likelihood value is used when calculating a measure of the overall fit, instead of the sum of squares (as used in multiple regression).

As in multiple regression, there are several sequential methods for specifying the logistic regression model in SPSS: entering variables into the model at will; forward stepwise; and backward stepwise.

For this study the Likelihood-Ratio Test Forward Stepwise Selection has been chosen. Stepwise works in the same way as in multiple regression. There are, however, two statistics that can be used to determine variables to be removed from the model, (instead of the F value in multiple regression) the Wald Statistic and the Likelihood-ratio (LR) test.

When modelling, two issues are important to bear in mind: "None of the algorithms results in a 'best' model in any statistical sense….The model will always fit the sample better than the population from which it is selected" (Norusis, 1993a:14-15).

The logistic regression was based on the 2003 data and a scaled weight was used in the modelling procedure.

Assumptions of logistic regression

The two key assumptions of logistic regression are: that there is no multicollinearity among the independent variables and that nominal variables are transformed into dummy variables. Normality of the independent variables distribution is desirable but if not met it does not challenge significantly the validity of the results.

How to interpret the tables

The tables presented include seven key statistics:

Wald – Contains values for the Wald statistic, which is used with large sample sizes with known degrees of freedom (column df), whether or not the coefficient is likely to be zero in the population. The Wald statistic provides an indication of what factors are most important. Please note that for the presentation of results instead of the odds ratio the logistic regression models tables present the Wald statistic to indicate the relative strength of the association between each independent variable and the dependent variable. The main reason for this is that the models use a combination of binary and ordinal independent variables which makes it more difficult to interpret the relative importance of each of the independent variables using odds ratio values.

Sig – Significance of the Wald statistic, significant if <0.05. *Indicates that the factor is significant at the five per cent level.

B – It contains the estimated regression coefficients for the variables, which enables one to build the equation Z used in the logistic regression model. As has been seen, e raised to the power Bi is the factor by which the odds change when the ith independent variable increases by one unit. However, it is important to point out that in the models presented in this paper, the independent variables are measured in different scales and one-unit change in parental management is not the same as one-unit change in neighbourhood disorder. Therefore, unless the coefficients are standardised, one cannot determine for sure which variable has the strongest effect by looking at this statistic. The plus or minus sign in B provides us with the direction of the relationship.

Number of cases in the model or respondents that each model is based on.

Classification Table – Is another way of assessing how well the model predicts the observed outcomes. It shows how many people who take drugs are predicted correctly by the model, how many of those who didn't take drugs and how many were correctly predicted overall. The table does not show the distribution of estimated probabilities, it only shows whether the estimated probability is greater or less than one-half.

The Nagelkerke R square is a goodness-of-fit test – Is "a measure of how well the model fits the data. It is based on the squared differences beween the observed and predicted probabilities. A small observed significance level for the goodness-of-fit statistic indicates that the model does not fit well" (SPSS 1998 MS Office software help option)

-2 Log Likelihood: – The first statistic named as such illustrates its value when only the constant is in the model. Each time a new variable enters the model, it shows the improvement in the -2 Log likelihood. "A good model is one that results in a high likelihood of the observed results. This translates to a small value for -2LL. (If a model fits perfectly, the likelihood is 1 and -2 times the log likelihood is 0)" (Norusis 1993a:10)

Table B.1: Factors associated with use of any drug ever and Class A drug use amongst 10- to 16-year-olds

10- to 16-year-olds	Use of any drug			Class A		
	Wald	sig	ß	Wald	sig	ß
Personality						
Sensitive				8.3	*3**	-.909
Unhelpful	7.9	*5*	-0.33			
Easily bored						
Behaviour and attitudes to drugs						
Serious offending						
Serious anti-social behaviour	47.3	*1*	0.67	22.2	*1*	.670
Minor anti-social behaviour	3.9	*8*	0.20			
In trouble at school (incl. truanting and exclusion)	10.2	*3*	0.33			
Early smoking	6.5	*6*	0.86			
Early alcohol use				12.5	*2*	2.881
Interpersonal relationships						
Parents don't know who friends are						
Weak parental attitude towards bad behaviour	24.7	*2*	-0.43			
Bad parental management						
Parents been in trouble						
Older friends						
Friends been in trouble	13.4	*4*	0.37			
Low social support network						
Environmental and economic						
Free school meals	5.3	**7*	-0.83			
Poor school management						
High disorder perceived by the interviewer						
Few things to do in the area						
Total number of cases in the model/total number of users	*1080/123*			*1092/13*		
Classification table % of correct prediction of users	*28.2*			*0*		
Nagelkerke R Square	*.371*			*.338*		
Initial - 2 log likelihood x/reduced to x	*748.9/527.0*			*122.304/82.482*		

Notes:

1. The numbers in the 'sig' column indicate the order of importance for those factors that are significant at the five per cent level.
2. * indicates that in this model the relationship between this factor and taking drugs went in the opposite direction. In the model for use of any drug the odds of taking drugs were higher for those not receiving school meals. In the model for use of Class A drugs the odds of taking drugs were higher for those less sensitive.

Table B.2: Factors associated with use ever of any drug amongst 10- to 16-year-olds by gender

	Male			Female		
	Wald	Sig	ß	Wald	Sig	ß
Personality						
Sensitive				3.8	*6*	.408
Unhelpful				12.1	*2*	-.685
Easily bored				7.3	*5*	.506
Behaviour and attitudes to drugs						
Serious offending						
Serious anti-social behaviour	25.4	*1*	.707	20.6	*1*	.661
Minor anti-social behaviour	10.2	*4*	.395			
In trouble at school (incl. truanting and exclusion)	7.9	*5*	.396			
Early smoking	11.0	*3*	1.500			
Early alcohol use						
Interpersonal relationships						
Parents don't know who friends are						
Weak parental attitude towards bad behaviour	13.2	*2*	-.429	11.2	*3*	-.427
Bad parental management						
Parents been in trouble						
Older friends						
Friends been in trouble	4.6	*7*	.332	10.0	*4*	.442
Low social support network						
Environmental and economic						
Free school meals						
Poor school management						
High disorder perceived by the interviewer	5.0	*6**	-.396			
Few things to do in the area						
Total number of cases in the model/total number of users	*54 /67*			*533/56*		
Classification table % of correct prediction of users	*27.9*			*28.1*		
Nagelkerke R Square	*.370*			*.407*		
Initial - 2 log likelihood x/reduced to x	*389.789/276.177*			*358.040/ 238.850*		

Notes:

1 The numbers in the 'sig' column indicate the order of importance for those factors that are significant at the five per cent level.

2 * indicates that in this model the relationship between this factor and taking drugs went in the opposite direction. The odds of taking drugs were higher for those in low disorder areas.

Table B.3: Factors associated with use ever of any drug amongst 10- to 16-year-olds by council area

	Council			Non-council		
	Wald	Sig	ß	Wald	Sig	ß
Personality						
Sensitive						
Unhelpful				5.3	*5*	-.315
Easily bored						
Behaviour and attitudes to drugs						
Serious offending						
Serious anti-social behaviour	19.0	*1*	.811	31.2	*1*	.727
Minor anti-social behaviour	11.9	*2*	.781			
In trouble at school (incl. truanting and exclusion)				10.9	*3*	.419
Early smoking	3.9	*6*	1.237	5.3	*7*	.924
Early alcohol use						
Interpersonal relationships						
Parents don't know who friends are						
Weak parental attitude towards bad behaviour	5.0	*4*	-.415	19.6	*2*	-.443
Bad parental management						
Parents been in trouble						
Older friends						
Friends been in trouble				9.6	*4*	.357
Low social support network						
Environmental and economic						
Free school meals				6.2	**6*	-1.283
Poor school management	5.6	*3*	-.515			
High disorder perceived by the interviewer						
Few things to do in the area	5.0	*5*	-.691			
Total number of cases in the model/total number of users	*217/28*			*863/95*		
Classification table % of correct prediction of users	*30.9*			*30.5*		
Nagelkerke R Square	*.417*			*.374*		
Initial - 2 log likelihood x/reduced to x	*152.490/101.219*			*596.391/418.132*		

Notes:

1. The numbers in the 'sig' column indicate the order of importance for those factors that are significant at the five per cent level.
2. * indicates that in this model the relationship between this factor and taking drugs went in the opposite direction. The odds of taking drugs were higher for those not receiving school meals.

Table B.4: Factors associated with use ever of any drug and Class A drug use amongst 17- to 24-year-olds

17- to 24-year-olds	Use of any drug			Class A use		
	Wald	Sig	ß	Wald	Sig	ß
Personality						
Sensitive	7.1	*5	-0.19			
Impulsive	7.5	4	0.20	5.5	6	.192
Behaviour						
Serious offending						
Anti-social behaviour	37.0	1	0.72	10.2	3	.257
Truanted or excluded from school	11.8	3	0.63	19.5	1	.763
Early alcohol use						
Early smoking	13.3	2	1.07	8.7	4	.695
Interpersonal relationships						
Parents been in trouble						
Friends been in trouble				17.1	2	.611
Not having someone to talk to						
Belonging to few or no groups	6.5	6	-0.16	8.4	5	-.236
Little or no social support network						
Environmental and economic						
Free school meals						
High disorder perceived by the interviewer						
NEET (not in education, employment or training)						
Total number of cases in the model/total number of users	*1068/639*			*1072/250*		
Classification table % of correct prediction of users	*80.4*			*16.1*		
Nagelkerke R Square	*.167*			*.153*		
Initial - 2 log likelihood x/reduced to x	*1391.4/1254.6*			*1166.164/1052.672*		

Notes:

1. The numbers in the 'sig' column indicate the order of importance for those factors that are significant at the five per cent level.
2. * indicates that in this model the relationship between this factor and taking drugs went in the opposite direction. The odds of taking drugs were higher for those that were less sensitive.
3. Please note variables on parental management not available for the 17-to 24-year-old models.

Table A2.5: Factors associated with use ever of any drug amongst 17- to 24-year-olds by gender

	Male			Female		
	Wald	Sig	ß	Wald	Sig	ß
Personality						
Sensitive	8.3	*3**	-.316			
Impulsive	6.6	*5*	.302			
Behaviour						
Serious offending						
Anti-social behaviour	16.3	*1*	.584	21.3	*1*	.932
Truanted or excluded from school	7.1	*4*	.686	3.7	*5*	.520
Early alcohol use						
Early smoking	8.9	*2*	1.804	5.0	*3*	.767
Interpersonal relationships						
Parents been in trouble						
Friends been in trouble						
Not having someone to talk to				7.1	*2*	-.458
Belonging to few or no groups	4.8	*6*	-.213	4.8	*4*	-.197
Little or no social support network						
Environmental and economic						
Free school meals						
High disorder perceived by the interviewer						
NEET (not in education, employment or training)						
Total number of cases in the model/total number of users	*507/324*			*561/315*		
Classification table % of correct prediction of users	*86.1*			*68.4*		
Nagelkerke R Square	*.219*			*.133*		
Initial- 2 log likelihood x/reduced to x	*650.312/563.349*			*733.099/677.283*		

Notes:

1. The numbers in the 'sig' column indicate the order of importance for those factors that are significant at the five per cent level.
2. * indicates that in this model the relationship between this factor and taking drugs went in the opposite direction. The odds of taking drugs were higher for those that were less sensitive.

Table B.6: Factors associated with use ever of any drug amongst 17- to 24-year-olds by income of head of household

	Under £10,000			£10,000 to £14,999			£15,000 to £19,999		
	Wald	sig	ß	Wald	sig	ß	Wald	sig	ß
Personality									
Sensitive									
Impulsive									
Behaviour									
Serious offending									
Anti-social behaviour	17.9	1	1.843				4.4	1	.780
Truanted or excluded from school				4.4	2	1.818	4.2	2	1.434
Early alcohol use									
Early smoking	5.6	3	1.676						
Interpersonal relationships									
Parents been in trouble									
Friends been in trouble									
Not having someone to talk to									
Belonging to few or no groups									
Little or no social support network									
Environmental and economic									
Free school meals									
High disorder perceived by the interviewer	12.1	2	.594	8.8	1	1.478			
NEET (not in education, employment or training)									
Total number of cases in the model/total number of users	*219/123*			*55/32*			*115/71*		
Classification table % of correct prediction of users	*74.1*			*81.5*			*100*		
Nagelkerke R Square	*.305*			*.358*			*.125*		
Initial - 2 log likelihood x/reduced to x	*259.120/210.154*			*77.538/59.927*			*143.893/133.298*		

Table B6: Continued from previous page

	£20,000 to £29,999			£30,000 +		
	Wald	sig	ß	Wald	sig	ß
Personality						
Sensitive	5.2	*2**	-.500	5.0	*3**	-.329
Impulsive				9.7	*1*	.472
Behaviour						
Serious offending						
Anti-social behaviour	3.4	*4*	.630	9.0	*2*	.697
Truanted or excluded from school	5.2	*1*	1.347			
Early alcohol use						
Early smoking	5.1	*3*	1.867			
Interpersonal relationships						
Parents been in trouble						
Friends been in trouble						
Not having someone to talk to						
Belonging to few or no groups						
Little or no social support network						
Environmental and economic						
Free school meals						
High disorder perceived by the interviewer						
NEET (not in education, employment or training)						
Total number of cases in the mode/total number of users	*146/80*			*245/160*		
Classification table % of correct prediction of users	*68*			*86.2*		
Nagelkerke R Square	*.267*			*.177*		
Initial - 2 log likelihood x/reduced to x	*181.707/152.368*			*347.255/310.404*		

Notes:

1. The numbers in the 'sig' column indicate the order of importance for those factors that are significant at the five per cent level.

2. * indicates that in this model the relationship between this factor and taking drugs went in the opposite direction. The odds of taking drugs were higher for those that were less sensitive.

Table B.7: Factors associated with use ever of any drug amongst 17- to 24-year-olds by council area

	Council			Non-council		
	Wald	Sig	ß	Wald	Sig	ß
Personality						
Sensitive	5.9	*3**	-.413			
Impulsive				4.9	*5*	.186
Behaviour						
Serious offending	4.6	*4**	-1.301			
Anti-social behaviour	11.8	*1*	1.107	32.3	*1*	.722
Truanted or excluded from school	6.8	*2*	.929	7.4	*3*	.593
Early alcohol use						
Early smoking				12.5	*2*	1.221
Interpersonal relationships						
Parents been in trouble						
Friends been in trouble						
Not having someone to talk to						
Belonging to few or no groups				5.3	*4*	-.166
Little or no social support network						
Environmental and economic						
Free school meals						
High disorder perceived by the interviewer						
NEET (not in education, employment or training)						
Total number of cases in the model/total number of users	*229/144*			*837/494*		
Classification table % of correct prediction of users	*85.9*			*76.6*		
Nagelkerke R Square	*.232*			*.150*		
Initial - 2 log likelihood x/reduced to x	*264.257/226.474*			*1120.451/1022.968*		

Notes:

1. The numbers in the 'sig' column indicate the order of importance for those factors that are significant at the five per cent level.
2. * indicates that in this model the relationship between this factor and taking drugs went in the opposite direction. For people that lived in council housing the odds of taking drugs were higher for those that were less sensitive and those who had not committed a serious offence in the last year.

Appendix C: Qualitative sampling and recruitment strategy

The sampling strategy was focused on achieving range and diversity in the various predictors of drug use identified by the Home Office. The researchers identified a number of groups of young people in both the 10- to 16-year-olds age group and the 17- to 18-year-olds age group who they aimed to recruit. The choice of these groups was based on the need to ensure coverage of the range of predictor variables

10- to 16-year-olds

Sampling frame provided by Home Office based on analysis of 2003 OCJS (n=342).

- Removed all who in OCJS 2004 said they had used drugs (n=295).
- Removed all who in OCJS 2004 said they did not want to be re-contacted (n=293).

Remaining sampling frame (n=293).

Within this frame were 25 young people identified by the Home Office through analysis of the 2003 OCJS as being 'most resilient' to drug use. The researchers aimed to recruit all of these first. They then identified a further seven groups of young people as part of the refined sampling frame. They started recruiting with group 1, exhausting it and then moving to the next group.

The order in which young people were targeted for recruitment

1. Highest risk as identified by analysis of 2003 OCJS (n=25).
2. All those not included in group 1 but who have high-risk 'serious anti-social behaviour' and 'parental attitudes' and 'getting into trouble at school' (n= 1).
3. All those not included in groups 1 or 2 who have medium-risk 'serious anti-social behaviour' and high-risk 'parental attitudes' and 'getting into trouble in school' (n=3).
4. All those not included in groups 1-3 who have high-risk 'serious anti-social behaviour' and 'parental attitudes' and medium-risk for 'getting into trouble at school' (n= 1).
5. All those not included in groups 1-4 who have medium/high for 'serious anti-social behaviour' and 'parental attitudes' and 'getting into trouble at school' and high risk for at least two others (n= 9).
6. All those not included in groups 1- 5 who have medium/high risk for 'serious anti-social behaviour' and 'parental attitudes' and 'getting into trouble at school' and high risk for at least one other (n=15).
7. All those not included in groups 1-6 who have medium/high risk for six of the 'predictors of drug use' (n= 15).
8. All those not included in groups 1-7 who have medium/high risk for five of the 'predictors of drug use' (n=30).
9. All those not included in groups 1-8 who have medium/high risk for four of the 'predictors of drug use'.

17- to 18-year-olds

ALL YP in the sampling frame were considered resilient.

Sampling frame provided by the Home Office based on analysis of 2003 OCJS (n=158)

- Removed all who said in 2004 had used drugs (n=132)
- Removed all who said didn't want to be contacted (n=128)

Remaining sampling frame n= 128

As with the 10- to 16-year-olds age group the researchers identified nine groups of young people who they aimed to recruit. They started recruiting with group 1, exhausting it and then moving to the next group.

The order in which these groups were be targeted for recruitment.

1) Those who have high risk for 'anti-social behaviour' and at least two other high-risk predictors (n=10).
2) All those not included in group 1 who have high risk for 'anti-social behaviour' and are either high/medium risk for at least three other predictor variables (n= 7).
3) All those not included in groups 1 or 2 who have medium risk for 'anti-social behaviour' and at are high risk for at least three other predictor variables (n=3).
4) All those not included in groups 1-3 who have medium risk for 'anti-social behaviour' and two high for two other predictor variables and are medium risk for at least one other (n=6).
5) All those not included in groups 1-4 who have medium risk for anti-social behaviour and are high risk for one other variable and medium for at least another two (n=11).
6) All those not included in groups 1-5 who are low risk for anti-social behaviour but who are high risk for at least three other predictor variables (one of which is early smoking or frequently truanting) (n=6).
7) All those not included in groups 1-6 who are low risk in anti-social behaviour and high risk in at least three other predictor variables (n=1).
8) All those not included in groups 1-7 who are low risk in anti-social behaviour and have high risk in two others and medium risk for at least one other (n=7).
9) All those not included in groups 1-8 who are high risk for early smoking and frequently truanting (n=2).
10) All those not included in groups 1-9 who are high risk for early smoking and medium risk in two others.

Achieved sample: Group by age (at time of 2003 OCJS)

Group	10- to 16-year-olds	17- to 18-year-olds	All ages
1	11	6	17
2	1	2	3
3	0	2	2
4	0	3	3
5	3	4	7
6	2	2	4
7	3	0	3
8	5	3	8
9	2	0	0
Outside groups 1-8/9	n/a	1	3
Total	27	23	50

Appendix D: Topic guide

(P6117) RESILIENCE TO DRUG USE AMONG YOUNG PEOPLE
FINAL TOPIC GUIDE
October 2004

OBJECTIVES

The aim of this study is to explore the factors young people identify as influencing their decision-making around their drug using behaviour. The research aims to:

- explore the social context in which young people are based in relation to drug use;
- explore young people's views and attitudes towards illicit drug use and their users;
- explore young people's experiences and motivations for any illicit drug use in which young people might have engaged;
- identify and explore factors that young people consider to put them 'at risk' of engaging in illicit drug use;
- identify and explore factors that young people consider to be contributing to their not engaging in illicit drug use.

INTRODUCTION*

- Introduce self, NatCen/BMRB, and purpose of study
- Explain about taping and reassure regarding confidentiality
- Inform them about length of interview
- Re-confirm verbal consent to participate once recording begins

* For the young people aged 16 or under carry out the introduction using the information leaflet to cover purpose of study, confidentiality, length of interview, and obtaining verbal consent (once recording).

SECTION A: YOUNG PERSON'S BACKGROUND AND CONTEXT

CURRENT CIRCUMSTANCES

- Current housing situation
  - Who live with, how long lived there
  - What do the people they currently live with do

- Past housing situation
  - Any changes in who they've lived with, where they've lived, reasons for changes in either

- Respondent's current activities (school/work/other)
  - Any changes in activities (e.g. changes of school, move from school to work, change of job)

LOCAL AREA

- How would they describe their local area
  - Likes and dislikes about local area

FAMILY RELATIONSHIPS (differentiate between those that live with them and those that don't)

- Experience of family life
  - How get on
  - Anyone particularly close to
  - How would their family describe them (concentrate on members that the respondent has described as prominent/important in their lives for either positive or negative reasons)

SCHOOL/FURTHER EDUCATION/WORK

Ask everybody

- Experiences and memories of school
  - Likes and dislikes
  - What type of pupil are/were they/how they did/any qualifications
  - Whether made friends, whether a happy time
  - Any experiences of exclusion or absence temporary or permanent
  - Relationship with teachers, how would their teachers describe them
  - Any changes in any of the above over time

In addition, where relevant, for 17- and 18-year-old young people repeat above as appropriate regarding

- experience and memories of further education
  - how compares with their experience and memories of school
- experience of employment
  - how compares with their experience and memories of school and further education

SPARE TIME

- How spend spare time
  - Main/favourite activities
  - How feel about the way they spend their spare time
  - How are decisions made about how they spend their spare time, who makes them (e.g. self/parent/other)
  - What else would they like to do

FRIENDSHIPS

- Current friendships
  - What do they like and dislike about their friends
  - What their friends are like, are they like them
  - Ages of friends
  - Best friend
- Experiences of making friends
- Any changes in friendships as growing up
  - whether any important friendships that they had as growing up are still important to them now or are still in contact with
- How do they think their friends would describe them (probe by different types of friends, e.g. best friend, current friends, old friends)

RELATIONSHIPS

- Current boyfriend/girlfriend/partner
  - Living together
  - How describe their relationship

- Relationship breakdown and separations
- How would their boyfriend/girlfriend/partner describe them

- How would the respondent describe themselves

If there have been variations in how different people in their life have described them or between how they describe themselves and how others describe them

- Why do they think that is the case

EXPERIENCES OF GETTING INTO TROUBLE

- Types of trouble involved in, e.g. at school, in spare time
  - Experiences of being caught, e.g. by parents, police, others
  - Consequences of being caught

ALCOHOL USE

- Alcohol use part of spare time activities

If yes…..

- level and nature of consumption: how much, how often, who with, when, under what circumstances, how feel about it, how others feel about them drinking alcohol

SECTION B: ATTITUDES TO AND DECISION MAKING ABOUT DRUGS AND DRUG USE

DEFINITION OF DRUGS

- How would they define drugs

Make clear what we mean by drugs for this study. Clarify that in this section we are talking about illicit drug use. Give examples from range: glue/aerosol; cannabis; ecstasy; heroin; cocaine; crack cocaine..

EXPOSURE TO OTHER PEOPLE'S DRUG USE

- Do they know anyone who takes drugs

If yes…..

- Who (family, friends, peers – differentiate between friends and peers)
- Types of drugs used
- Views about others' use
- Views about why they use them
- Views about other reasons why people use drugs
- Any variations in views between users of different types of drugs (give example of cannabis vs crack cocaine), and between different types of users (give example of regular vs infrequent)

If no…..

- Do they know of or see drug users elsewhere (e.g. local community, TV, newspapers)
- Who
- Types of drugs used
- Views about others' use
- Views about why they use them
- Views about other reasons why people use drugs

- Any variations in views between users of different types of drugs (give example of cannabis vs crack cocaine), and between different types of users (give example of regular vs infrequent)

SOURCES OF INFORMATION AND KNOWLEDGE OF DRUGS AND DRUG USE

- Sources of knowledge/basis of views

Probe for

- School/education
- Media
- Parents (parental attitudes)
- Friends (attitudes of friends)
- Peers (peer attitudes)
- Other

EXPOSURE TO DRUG USE: SELF

[A] Have been offered drugs

- Environment/context in which offered
  - ***Probe for:*** when, what, where, by whom, why, was this first time, feelings about being offered

- **First use**
  - Environment/context in which used
    - ***Probe for:*** what used, where, who with, what doing
  - What was it like to use
  - ***Motivations for accepting***
  - ***Explore all factors that made them decide not to use, encourage them to reflect on any motivations that they may have mentioned for not using drugs.***
  - ***What was going on in their life at the time.***

- *Have used before but have also refused*
- For each experience of being offered but did not use explore:
  - Context in which was offered
    - **Probe for:** when, what drugs were involved, where, by whom, who else were they with
  - ***Motivations for refusing***
  - ***Explore all factors that made them decide not to use, encourage them to reflect on any motivations that they may have mentioned for not using drugs.***
  - ***What was going on in their life at the time***
  - Strategies used to refuse
  - Reaction of person who offered/other people present
  - Any consequences of refusing

  - Variations in experiences of refusing, what made it different (give examples of refusing a friend vs refusing a stranger at a party, refusing cannabis vs refusing cocaine)

- Differences in situation and context between when used and when refused (e.g. different drug, with different people, different things going on in life)

Have been offered but never used

- For each experience of being offered but did not use explore:
  - Context in which was offered
  - **Probe for:** when, what drugs were involved, where, by whom, who else were they with
  - ***Motivations for refusing***
  - *Explore* ***all factors that made them decide not to use, encourage them to reflect on any motivations that they may have mentioned for not using drugs***
  - ***What was going on in their life at the time***
  - Strategies used to refuse
  - Reaction of person who offered/other people present
  - Any consequences of refusing
  - Variations in experiences of refusing, what made it different (give examples of refusing a friend vs refusing a stranger at a party, refusing cannabis vs refusing cocaine)

[B] Never been offered drugs

- See a time in future when might be offered
  - What would do if offered

If accept….

- Environment/context in which would accept, probe for: place, who by, who with, what offered, what doing

Explore all motivations for accepting, encourage them to reflect on any motivations that they may have mentioned for using drugs.

If refuse….

- Environment/context in which would refuse, probe for: how they think they might feel about refusing, any difference depending on who offers, when, why, what going on in their lives at the time

Explore all motivations for refusing, encourage them to reflect on any motivations that they may have mentioned for not using drugs.

ACTIVITIES

Activity A – To explore protective factors

Part 1

- Show the respondent pictures of two famous people (e.g. two actors, or two singers, or two sport people), where one is a known user of drugs and the other, as far as we know, is not, and explore:
  - Whether they think they use drugs or not
  - Why they think they do or do not
  - What factors do they see as influencing this decision
  - If they see them being at risk of using drugs and why

Part 2

Present two pen pictures, one at a time, and ask them to consider the scenario that the young person in the pen picture is at a party and is offered cannabis. They are seriously considering accepting.

- Why would they choose not to
- Why would they choose to
- Compare the respondents' views about the two pen pictures
- Where appropriate, ask them to compare with their own experiences or other people's experiences that they have already mentioned

- If appropriate, repeat scenario with the drug on offer being cocaine

Activity B – to explore refusal strategies

- Read the scenario in which another young person will be in a position where drugs have been made available to them. Ask respondents to:
  - Think about the various options open to the young person
  - What option do they think they should choose and why
  - How easy/difficult would it be for them to refuse
  - How should they refuse
  - Where appropriate, ask them to compare with their own experiences or other people's experiences that they have already mentioned

ATTITUDES TO FUTURE USE

- Circumstances that might change their decision about future use
  - refuse offer/accept offer first time/accept offer again/stop using

REFLECTIONS ON MAKING CHOICES ABOUT DRUGS

- ***If never used drugs:*** what do they think has kept them from using drugs
- ***If have used drugs:***
  - If currently using infrequently, what do they think kept them from using drugs up until then
  - If currently frequent user, what do they think kept them from using drugs up until then and what might make them become infrequent user/refuse
- What advice would they give to other young people (YP) about making choices about drug use
- Any thoughts about what the Home Office could do to help YP to make choices about drug use

Appendix E: Hypothetical drug-related scenarios

Activity A: to explore protective factors

Part 1

Show the respondent pictures of two famous people (e.g. two actors, or two singers, or two sport people), where one is a known user of drugs and the other, as far as we know, is not. And we would explore:

- Whether they think they use drugs or not
- Why they think they do or do not
- What factors do they see as influencing this decision
- If they see them being at risk of using drugs and why

Part 2

Present each pen picture one at a time and ask them to consider the scenario below:

Pen picture 1

- Jill is 15 years old and is doing very well at school. She is popular with both teachers and pupils.
- As well as being academically bright she is very good at athletics too. She is a member of the running club and absolutely loves going there.
- She's going out with a boy who is older than her so they tend to go out to bars and pubs. Her boyfriend and all his friends, who are also older, usually end up getting drunk. So far Jill has not joined in because she knows her parents would be very angry and she might get dropped from the running club if the school found out.

Pen picture 2

- Kate is 15 years old and is always getting into trouble at school. She thinks it's boring and can't wait to leave.
- She is very close to her older sister, who left school at 14 without any qualifications, and is now a successful hairdresser and owns two salons.
- Kate spends every Saturday helping at one of the salons and is now even helping with the books. Kate wants to do the same as her sister and so can see no point of school and has stopped doing her homework.
- Recently she has been hanging around with what her mum calls the 'wrong crowd' and was caught smoking. Her parents have been called in to talk to the headmaster on a number of occasions.

Pen picture 3

- Neil is 15 years old and is doing very well at school. He is popular with both teachers and pupils.
- As well as being academically bright he is very good at sports too. He plays for the school football team and absolutely loves it.
- He's going out with a girl who is older than him so they tend to go out to bars and pubs. His girlfriend and all her friends, who are also older, usually end up getting drunk. So far Neil has not joined in because he knows his parents would be very angry and he might get dropped from the football team if the school found out.

Pen picture 4

- Nathan is 15 years old and is always getting into trouble at school. He thinks it's boring and can't wait to leave.

- He is very close to his older brother, who left school at 14 without any qualifications, and is now a successful mechanic and runs his own garage.
- Nathan spends every Saturday helping at the garage and is now even helping with the books. Nathan wants to do the same as his brother and so can see no point of school and has stopped doing his homework.
- Recently he has been hanging around with what his mum calls the 'wrong crowd' and was caught smoking. His parents have been called in to talk to the headmaster on a number of occasions.

Scenario

Kate/Jill/Rob/Nathan is at a party and is offered cannabis. S/he is seriously considering accepting.

- Why would he/she choose not to
- Why would he/she choose to
- Compare their views about the two pen pictures

If appropriate, repeat scenario with the drug on offer being cocaine

Activity B: to explore refusal strategies

Present each vignette and:

- Establish what the issue is here
- Consider options and possible consequences
- Choose the best option

Appendix F: Ethical issues

Carrying out depth interviews with young people raises a number of ethical issues that need to be addressed. Sensitive social research has been defined as "research which potentially poses a substantial threat to those who are or have been involved in it" (Lee, 1993; 3). In addition, Renzetti and Lee (1993) identify a number of specific areas of research that should be considered sensitive, one of which is "where the study is concerned with deviance and social control" (Renzetti & Lee, 1993; 6). Carrying out interviews with young people about drug use and other behaviours such as offending therefore placed this study within the realms of sensitive social research. Furthermore, when carrying out research with children or young people, particular care needs to be taken to ensure that stringent ethical standards are maintained which meet the particular needs of this group. The Market Research Society has identified five main reasons for drawing up guidelines specifically for carrying out research among children and young people. These are:

- to protect the rights of children and young people physically, mentally, ethically and emotionally and to ensure they are not exploited;
- to reassure parents and others concerned with their welfare and safety that research conducted under these guidelines is designed to protect the interests of children and young people;
- to ensure good quality research;
- to promote the professionalism and value of research among children, young people and the wider public; and
- to protect the researcher and client by publishing the necessary good practice required to meet their legal and ethical responsibilities.

It is within this context that the researchers' approach to carrying out depth interviews with young people for the study was guided. NatCen has developed a protocol for the necessary procedures for: securing parental/carer/appropriate adult's consent to approach young people (aged under 16) to participate in research; obtaining informed consent of the young people to participate (including providing an information leaflet and explaining clearly confidentiality issues and the voluntary nature of the research (see Appendix G); ensuring confidentiality and the necessary data management procedures. This protocol was adopted for this study.

Confidentiality – NatCen operates to extremely high standards in respect of confidentiality and anonymity. Participants in all their studies are given an assurance that no information that could be used to identify them would be made available without their agreement to anyone outside NatCen. All NatCen staff are made fully aware of the importance of maintaining confidentiality and undertake to abide by relevant codes of practice relating to social research, which include explicit clauses on confidentiality.

One issue to be considered was how the research team should treat their promise of confidentiality if a young person discloses fears or experiences of abuse during the interview. All research with children aged 16 and under carries the potential for disclosure of emotional, physical or sexual abuse. The researchers' sense is that the confidentiality offered to children should be the same as for adult respondents; nevertheless disclosure requires a response from the research team. As suggested by Mahon *et al.* (1996), young people will be assured that no action will be taken by the researcher without consulting and informing them first. The nature of the research may have resulted in young people making requests for help with drug problems (or indeed other problems). In this situation, the research team did not attempt to give advice themselves, but would refer the respondent to a local or national service or helpline, as appropriate. The researchers' obtained leaflets giving contact details of these organisations to give to each young person who took part.

Appendix G: Information leaflet for young person

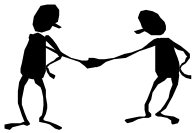
What will happen with what I tell you?
We will write a report about what everyone tells us. We will not say who said what in the report.

NatCen
National Centre for Social Research

Will my name be used? No, we will not use your name.

What if I'm not sure that I want to take part?
You can call us or talk to your parent or carer. You can say no if you don't want to do it. We will not mind.

What if I do want to do it?
You or your parent or carer can tell us and we can arrange a time and place to meet with you.



If you want to ask any questions, you can phone Ini on FREEPHONE 0800 652 9297.
If she is not there,
you can leave a message and she will call you back.

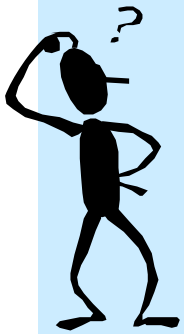
What do you think about drugs?

Why do you think some people use drugs?

Why do you think some people don't use drugs?

Drugs- What do YOU think?
We want to know!

I work for the National Centre for Social Research. My name is _____.



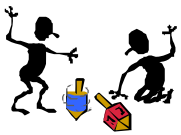
The government has asked us to find out what young people think about drugs and the decisions they make about them.

We want you to take part in our study. It is up to you if you want to take part.

If you do, what you tell us will be helpful for people involved in developing programmes around drugs.

What are you doing?
We are talking to young people around England who took part in the Crime & Justice Survey. We want to know what you think about drugs and the decisions you've made about them.

What would I have to do?
Talk with us about yourself and what your views are about drugs.



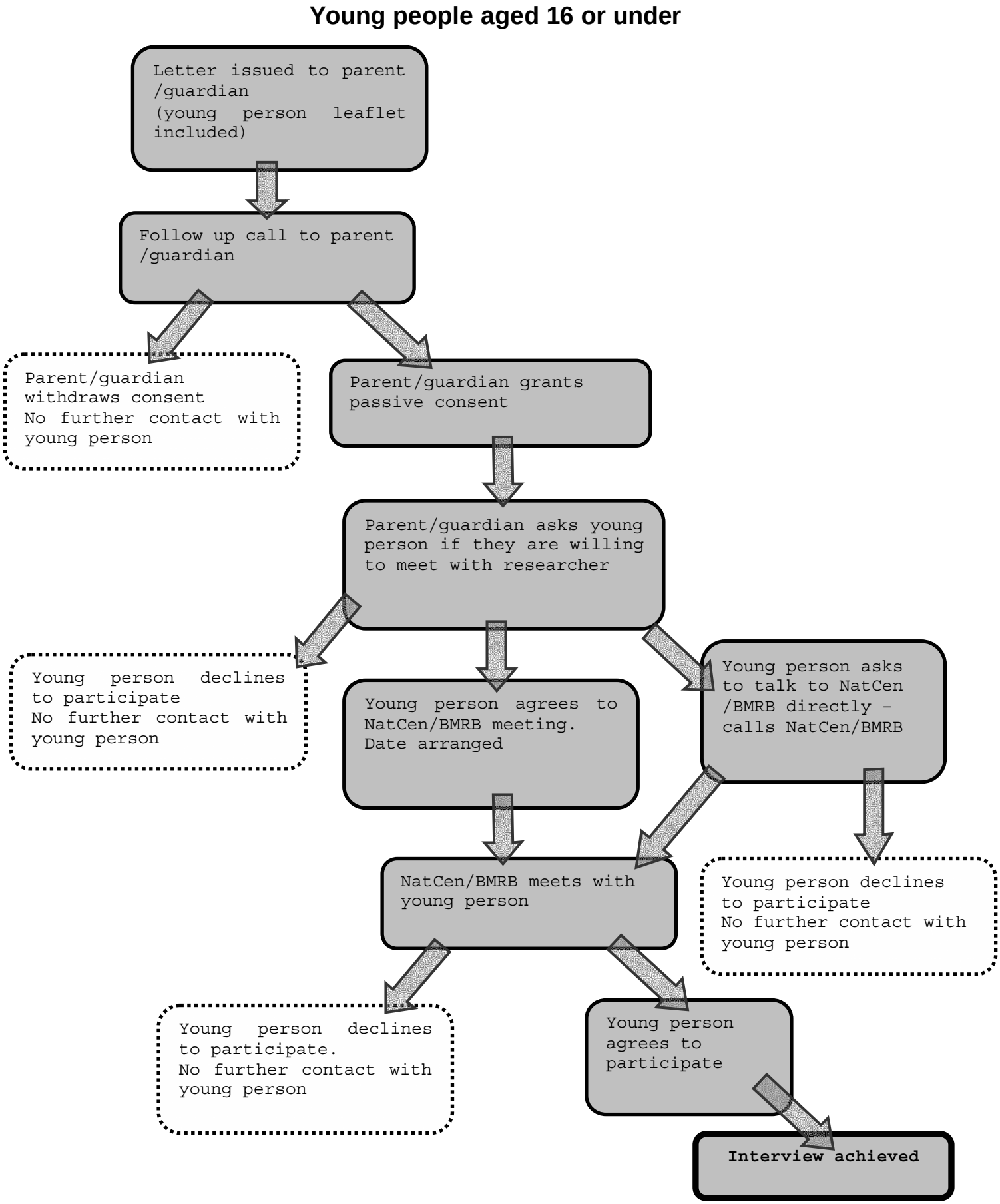
How long will it take?
About one hour.

Will I get anything for taking part?
Yes, we will give you a £20 music token.

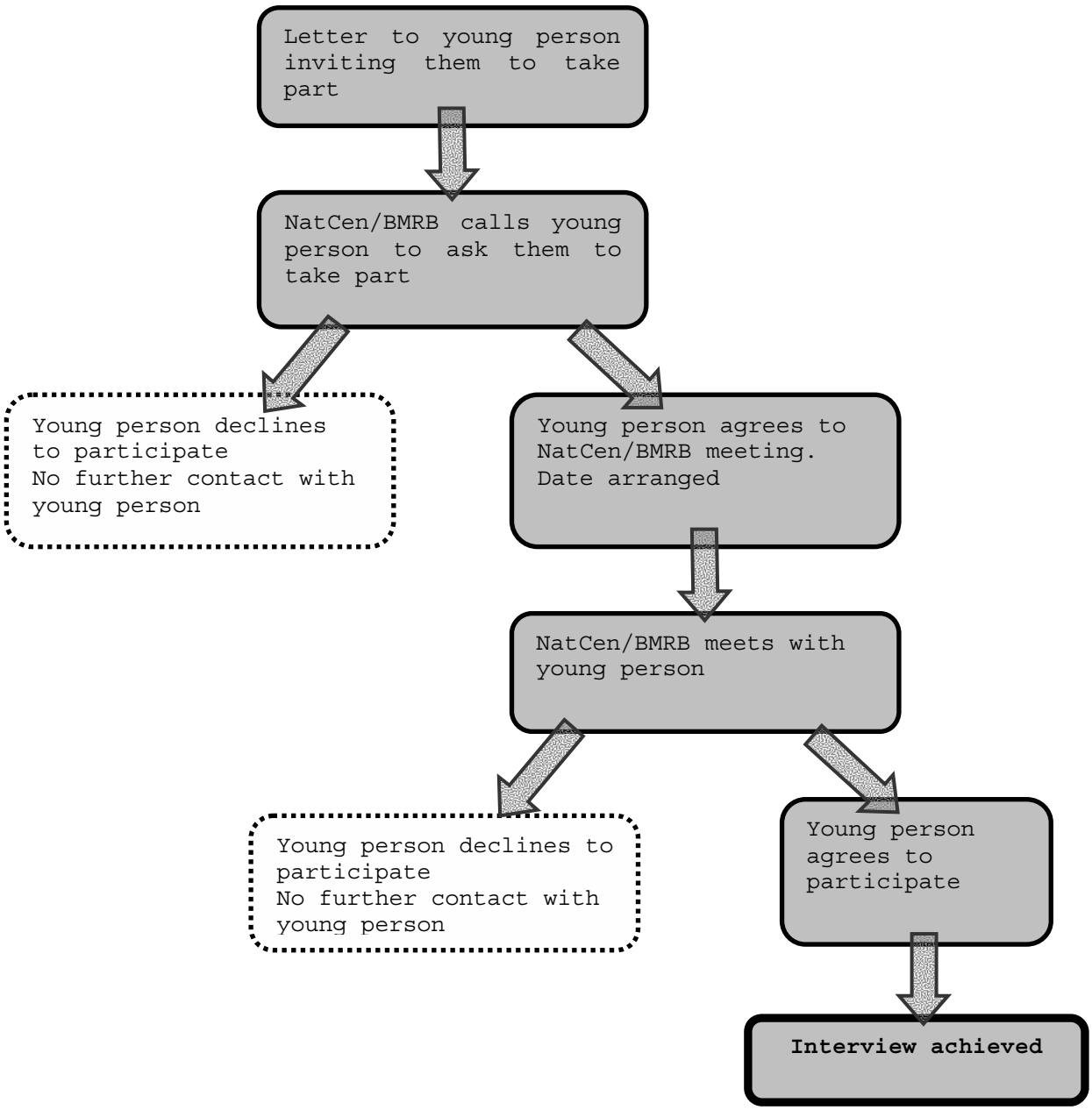
Where will we meet?
We will come to your home to talk to you.

Will you tell anyone what I say?
No – unless you tell us anything about you or someone else being harmed. If you did we would talk to you first before telling anyone else. Otherwise we won't tell anyone anything that you say.

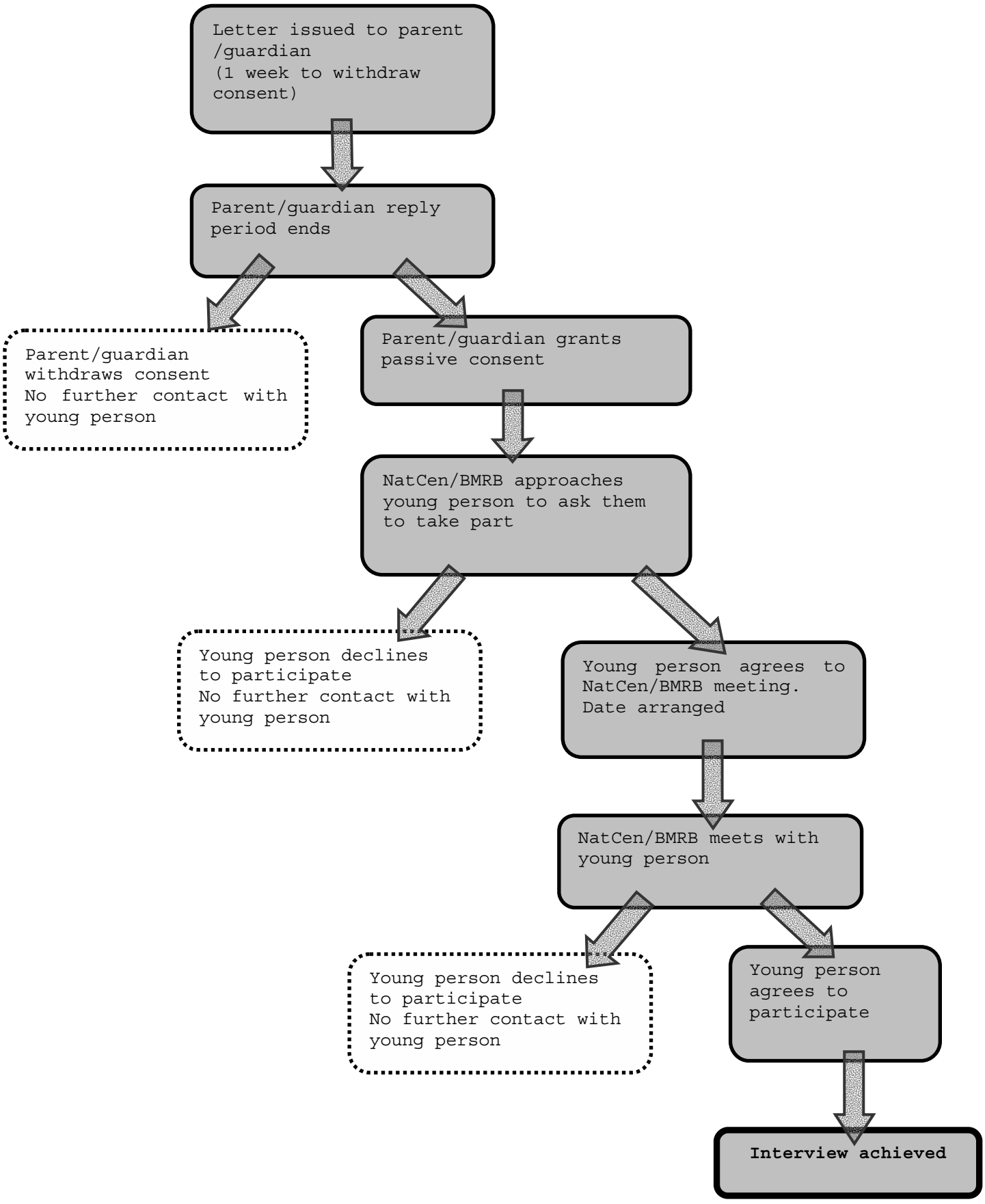
Appendix H: Recruitment flowchart



Young people aged 17 and over (not living with parents)



Young people aged 17 and 18 (living with parents)



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