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"At least I'm not drink-driving": Formative research for a social marketing campaign to reduce drug-driving among young drivers

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Keywords

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“At least I’m not drink-driving”: Formative research for a social marketing campaign to reduce drug-driving among young drivers

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Keywords: Drug-driving, Social marketing, Risk perception, Cannabis, Qualitative

Abstract

This paper reports on a qualitative study designed to examine young drivers’ knowledge and attitudes regarding drug-driving, as the formative research for a potential drug-driving social marketing program in the Australian Capital Territory (ACT). Drug driving has been found to be associated with motor vehicle accidents, particularly among younger drivers. However, the potential for social marketing in this area has received little attention. This study found that young people were not aware of the effects of drugs on driving, formed their perceptions of risk (both of getting caught and of impaired driving) based on other people’s experiences, and felt that there were potential benefits to drug driving and substantial barriers to the alternative behaviours (such as using public transport).

1. Introduction

In 2008, there were 1463 road deaths in Australia, a rate of 6.8 deaths per 100,000 people (Department of Infrastructure, 2009). More than two-thirds (1076) of these deaths were males; and 276 of the 997 deaths among motor vehicle occupants were people aged 17–25 years. Road traffic accidents are one of the two leading specific causes of disease and injury burden in people aged 15–24 years (AIHW, 2008). Because the youth of our nation account for a disproportionate number of road crash victims, the cost to the health system, the economy, and society in general is extremely high.

There are a number of factors that have been found to be associated with motor vehicle accidents and fatalities. Speeding and drink-driving have long been recognised as major contributors to road accidents, and have been targeted with both community education campaigns and legislation. Other causes, such as fatigue and inattentiveness, have received less attention as behaviour change in these areas has been found to be difficult, and both are difficult to legislate and enforce. Drug use has been found to be another factor that has been associated with motor vehicle accidents (both prescription and illicit drugs), particularly among younger drivers. However it has been suggested that in the general community there is little knowledge of the effects of, and legal position regarding, drug-driving (Ingram et al., 2001).

1.1 The drugs

There are three common illegal drugs which drivers can currently be tested for: tetrahydrocannabinol (THC), the active component in cannabis; the stimulant methylamphetamine, also known as speed; and 3,4-methylenedioxy-N-methamphetamine (MDMA), also known as ecstasy. Drugs such as these can lead to changes in cognitive performance and impair brain functioning, therefore impairing driving ability (Austroads, 2000). This means that drivers who have consumed these substances are more likely to take risks, and are less able to make correct decisions or properly control their vehicle. Although the exact prevalence of drug driving is difficult to quantify, 31% of drivers killed in Victoria in 2003 tested positive to drugs other than alcohol (Arrive Alive, 2007). The most recent national data from the 2007 National Drug Strategy Household Survey shows that one in five recent illicit drug users over the age of 14 report having driven a motor vehicle while under the influence.

According to NSW Health (2007), cannabis is the most commonly used illicit drug in Australia, with people under the age of 29 being the most frequent users. Approximately 35% of the NSW population report having tried cannabis, with





13% reporting using cannabis in 2005 (NSW Health, 2007). In the ACT, it is also the most commonly found drug (other than alcohol) in drivers tested for substance use (Transport ACT, 2007).

Research on drug driving has been undertaken in four Australian states (NSW, QLD, VIC, WA). This research (reviewed below) has consistently found that some specific population groups present higher rates of drug driving than the general population and in some studies, higher proportions than drink-driving. For example, Lenton and Davidson (1999) found that a high percentage dance party attendees in WA had either driven or were a passenger of someone who had used an illicit substance at their last rave; such results suggest the need for further research into the attitudes and behaviours of at-risk groups in order to allow for specifically targeted efforts to reduce the incidence of drug driving in Australia.

1.2. *The driving*

Various studies have examined the nature of drug driving trips, that is, where the drivers were travelling to and from, and the reasons why drug driving occurred. Raves and nightclubs have been the focus of research, with one study reporting that 10% of nightclub attendees said they would knowingly drive or be driven by someone under the influence of drugs – mainly on that particular night, suggesting that it is not uncommon for drug driving to take place from the nightclub (Degenhardt et al., 2006). These results, while assumptive on the participants' behalf, are supported by the comments from over 80 rave attendees in Western Australia, 20 of whom reported that their driver had used drugs before driving to the rave (Lenton and Davidson, 1999).

Other studies have asked respondents to describe either their most common driving destination and origin (while under the influence), or the nature of their most recent drug driving experience. These results provide further insight into the various locations drug drivers are driving from and to. Hawkins et al. (2004) found that the most common place to take drugs and drive from (out of a sample of 205 drug users) was a friend's house (40%) or their own home (35%). However, location varied according to drug type: ecstasy, speed, cocaine and LSD were more likely to be taken at a club; and cannabis was more likely to be consumed at a friend's house. Half of the respondents reported that their destination was 'home', followed by 'a friend's place' (15%). However, unlike origins, destinations did not vary by drug type. Friday, Saturday and Sunday (in that order) were the days on which drug driving was most likely to occur; and the most common time period for drug driving was 9 pm–3am (37%) followed by 3 pm–9 pm (34%).

Reasons for driving to these events were examined by Duff and Rowland (2006) in their interviews with club and rave attendees in Victoria (n = 455). Convenience was the most commonly reported reason for driving after using illicit drugs, followed by there being no other available transport.

Few participants indicated that they drove because they did not feel anything was wrong with the behaviour, indicating that while driving under the influence was common, attendees may be still aware of the potential risks of doing so. Driver awareness or concern was also evident in the qualitative investigations by (Lenton and Davidson, 1999); while this data may be somewhat outdated, it provides evidence that drug users do 'care' about whether or not their driver has consumed drugs, however the level of concern does seem to range considerably between participants.

1.3. *The deterrents*

In the ACT (as in all Australian jurisdictions), drug driving is prohibited – therefore if police have reasonable suspicion of drug use, they may compel a driver to provide a blood or urine sample for testing. Despite this, "such testing generally occurs as a matter of course only if a driver has already been involved in a road crash" (Transport ACT, 2007). Therefore, in ACT (and indeed nation-wide), there is currently a low actual and perceived risk of being caught due to the lack of drug testing resources and little public knowledge that drug testing is even possible (Transport ACT, 2007). As a result, legislative strategies and their legal consequences alone are not thought to be effective behavioural deterrents for drivers (Costello et al., 2004); and social marketing has been posited as a potentially powerful tool for



reducing drug-driving levels. The current study (funded by the ACT NRMA Road Safety Trust) was designed to examine knowledge and attitudes regarding drug-driving among young drivers in the ACT.

2. Implication for social marketing

This study was the first phase of a two-year project designed to develop communication materials (print media) that will deter young people living in the ACT from drug driving. A social marketing framework will be used to develop communication materials which could be utilised in a wider range of circumstances (e.g., a broader target group). The materials development will also utilise the expertise of the research team, as well as relevant literature, to ensure that the message content and style is appropriate for the target group. This stage of the study used focus groups to determine what young people in the ACT knew about drug driving legislation, their perceptions of the effects of drugs on driving, their perceptions of the benefits and barriers to behaviour change, and to determine what messages would be effective in targeting young people under 25 years old. This formative research is an essential step of the social marketing process in order to understand the target group's current knowledge and attitudes and their readiness to change.

3. Methodology

Six focus groups (three male-only and three female-only) were conducted with young people in the ACT to discuss drug-driving, and specifically to gain insight into their knowledge, attitudes and perceptions of risk associated with drug driving. Each group consisted of between six and eight people (aged 18–25 years) from the ACT, with two groups recruited from each of the following: Road Ready Driving School, Canberra Institute of Technology and the Australian National University. Participants were recruited via posters (placed around the campuses), emails that were sent out to student email lists, and direct promotion of the study by several staff members in each location.

Focus groups have been used effectively in the past for in depth investigations of young people's attitudes towards alcohol and other drugs (Ballon et al., 2004; Kefford et al., 2005; McCormack Brown et al., 2001). The use of focus groups to thoroughly elicit and elaborate sensitive information is well documented (Sharma, 2004; Dunne and Somerset, 2004). Evidence suggests that the group context serves to facilitate, rather than inhibit, the disclosure of information, particularly for sensitive or taboo topics like alcohol and drugs (Beyea and Nicoll, 2000; Morrow et al., 2000). Focus groups also preserve the meaning of data through utilising the language of young people (Wilkinson, 1998), as their own words and thoughts can become lost in the formalised and structured language of quantitative questionnaires, which may not be relevant to the concerns of young people. This was seen as an important aspect of the methodology due to the nature of and disclosure surrounding drugs. Qualitative research is also the most appropriate approach for a topic such as this where little is known, as it allows for a free and wide-ranging discussion of issues in order to identify the salient considerations.

A comprehensive discussion guide was developed by the research team and guided by the key findings from a literature review and preliminary findings from an online survey. All participants were given information about the project prior to the focus groups and provided written consent for their participation and for the audio-recording of the discussions. Two younger research assistants (with focus group facilitation experience and training) facilitated the focus groups, as similarity between the participants and the facilitator was thought to increase participants' comfort with discussing drugs and related topics. The focus groups were audio-recorded, transcribed, and analysed thematically using NVivo software. Due to the nature of the focus group process, and the assurance of participant confidentiality, individual participants were not identified in the focus group transcripts. The study protocol was approved by the university's Human Research Ethics Committee.

4. Results

4.1. Perception of risk

Participants generally agreed that some 'hard' drugs would have a negative impact on driving ability. However, many expressed the belief that some drugs were safer than others and that some (but not all) illicit drugs were actually less



dangerous than alcohol. Marijuana was most commonly perceived as being the 'safest' drug in the context of driving (although one female participant felt that speed or ecstasy would be safer than marijuana).

It's like your risk is great depending on what drug your one. Like ice is crazy but if you just smoke a bit of dope it's not that bad. . . it just depends on the person. (TAFE, Male)

Marijuana's probably the best. It has like the least effect and you're sort of mellowed out and you might be a bit paranoid so probably drive slower. (TAFE, Male)

. . . to me marijuana slows your reaction time hugely and so, I don't know – speed or ecstasy – I don't know which one, but I wouldn't choose marijuana. (University, Female)

Not only did participants not recognise the deleterious effect of some drugs on driving ability, many expressed the view that they (or others) perceived that certain illicit drugs actually served to improve their driving skills. These comments predominantly referred to the increased alertness from ecstasy or speed, or the slowing down effects of marijuana.

Well maybe there's no knowledge about it, it's only campaigns about drink driving, but no one knows. You might think speed makes you more alert so it makes you a better driver. (University, Female)

Stuff that's more an upper rather than . . . gives you more energy rather than stuff lets you mellow out and see things. That's maybe why people think that's ok because they think they need more energy so they're probably more alert. (TAFE, Male)

Those participants who did believe that illicit drugs can impair driving abilities, however, also felt that other young people were generally unaware of how they can specifically alter driving behaviours and increase risk of harm. Further, one female participant highlighted that hearing about drivers using methamphetamine type substances to stay awake while driving may cause young people to believe that it is not as bad as alcohol.

That sort of goes back to the advertising as well. The advertising the drink driving, they're advertising that you get slower and your reaction time slows down but they don't advertise, if you don't know, what it feels like to take a drug. You wouldn't know what the consequences are. (TAFE, Female)

Also some drugs, say speed, you hear about truck drivers using speed, so there's also a kind of 'maybe it's not as bad as say alcohol' because people have used it to stay awake. (University, Female)

4.2. Perceived benefits and facilitators to drug driving

When discussing the reasons for drug driving, some participants mentioned the overall reduced costs of taking drugs in comparison to drinking. This was not simply a financial consideration, but a complex weighing up of a combination of potential 'costs'. For many drug driving was seen as a more 'cost effective' alternative to drink driving due to: the relatively low financial costs of drugs compared to alcohol (with both perceived to produce a relatively similar experience); the perceived lower likelihood of being caught for drug driving compared to drink driving; the acknowledged negative effects of alcohol on driving performance (which, unlike the effects of drug driving, are well known among participants). For a group who perceive the use of some form of substance (licit or illicit) as an essential part of their night out, the decision is seen as one of which substance to use rather than whether to abstain.

I do think that people think that they're being good, they're not drink driving, they're drug driving. I think people think 'at least I'm not drink driving' which sounds shocking but . . . (TAFE, Female)

Yeah, drive out to Civic, have a few pills, still have a good night, and it's a pretty cheap night realistically compared to paying for drinks and then drive home after. (TAFE, Male)



I used to work at a club, a few years ago and that was among the other workers there, I don't know, people going to the clubs that they would think that was a substitute for drinking and if they were going to drive it was more convenient to drive and take ecstasy . . . (TAFE, Female)

Some participants felt that because drug taking was often a part of everyday life (whether as an addiction or regular social activity), driving automatically became part of that experience. This view was only evident among males, with the only female participant making mention of this referring to her male peers.

I know being at college people are going to take drugs, it's not an addiction, it's a social thing, and for them then to get in a car and drive is another step whereas if its in a group where it's really common that it's occurring then that step becomes easier because they're under the influence a lot more. So it becomes a part of their everyday life, so why wouldn't it become part of their driving life. It's just easy to make that step. Does that make sense? (University, Male)

I've got neighbours before, who just smoke weed every night and it's nothing unusual to sit around and talk, drink and smoke weed and they talk pretty normal, I think they're just used to it, and after that they just drive. (Driving Course, Male)

Driving was seen by some as a necessary or automatic step within the overall drug taking experience. It was not viewed as an action which young people 'decided' to do, rather it was expected in order for people to reach their drug taking destination or home again.

That it's like driving becomes a necessity, it's so much part of our lives, so if you've still got drugs in your system, you just have to drive somewhere, you just need to get somewhere. I don't think it's more a case of 'I'm stoned so now I'm going to drive to my mates place to get even more stoned'. (University, Male)

Or to work and because they're working . . . they take something, usually coke and they'll be 'I'm working, and then I have to get home' and that's just the habit. (TAFE, Female)

Others mentioned that taking illicit drugs is not a planned experience, and therefore drivers may not be prepared or have planned to use an alternative method of transport.

Sometimes it's a spontaneous thing as well. It might be, I don't know, you just haven't really thought about it and then you might drive but you haven't thought about the [drugs] you've taken (TAFE, Female)

They want to be able to take drugs but they don't want to plan to be able to get home or wherever they're going at the end of the night. (Driving Course, Male)

They might have planned but the thing about drugs and alcohol, it's really difficult to stick to what you have come up with, like you shouldn't drive. (Driving Course, Female)

4.3. Perceived barriers to not drug driving

As stated above, for most of these young people, not using a (licit or illicit) substance is not seen as a viable option. Thus, the discussion about not drug-driving focused solely on the barriers to not driving (rather than not taking drugs). The lack of reliable and appropriate alternative transport options was raised consistently and repeatedly as a primary reason why young people drug drive. These were often discussed in the context of the geographical spread of Canberra and the difficulty it causes when trying to get home from a night out. While participants were able to identify other transport methods (public transport, taxis or walking), these were mentioned only in their inadequacy as an alternative to driving while under the influence.

Public transport (buses) were viewed as useless as they finish running well before the participants are ready to travel home (11 pm) or are seen as dangerous to be travelling on late at night. Furthermore, bus trips still require some walking distance to reach a specific house.



Cut it off at 11. We all got to the party but no one could get home on it. You can't leave a party at 11! (TAFE, Female)

It doesn't go to all areas It sort of just goes to the main bus terminals. Like it stops at 10pm which is not cool for people who want to party, you want to be out to 2. . . If you can get somewhere you can't get home (University, Female)

But not even that, when it's a suburb centre it's like a bus from civic to Belco [it's called town centre] with all the suburbs around there, you might still have a 6 k walk or whatever it is. (University, Male)

Over the Christmas period, the city provides a 'night bus' which collects people from major entertainment venues. However, this was still viewed as ineffective due to the limited times and destinations (and the fact that it only runs for a short period once a year).

We have nightrider but that only goes to the bus interchanges. But it's only every two hours or something. It's pretty terrible. Canberra is the capital city of Australia. It should have decent transport, I reckon. It's ridiculous. It's stupid. (University, Male)

They do that from the Christmas/New Year time, they call it the night rider, but the only do it one time of the year. (Driving Course, Male)

Taxis were seen by most participants as too expensive, as inconvenient due to the waiting time required, and by some (females) as too dangerous to be travelling in when alone.

Because Canberra is so separated so if you live in Tuggeranong or you live in Belconnen and you're going out in Civic it's going to cost you 80 dollars to get home. (TAFE, Female) Sometimes people will pressure other people into driving under the influence because they don't want to have to pay for a taxi. (Driving Course, Female)

This year, they got a taxi home, there was one in Civic, she got a taxi home and the taxi driver raped her. So you don't want to be in a taxi by yourself and you don't want to be walking home by yourself. (University, Female)

Walking was also seen by females as too dangerous; and for all participants the overall spread of Canberra was seen as not conducive to walking;

And its dangerous walking around at night. (University, Female)

I guess Canberra's so spread out. Most suburbs are quite far and there's quite a lot of drugs on Saturday night in town so I'm sure they would probably drive if they have to get home. I'm just speculating. (University, Male)

Staying at a friend's place was the only alternative to driving that was perceived to have any negative consequences. However, this was only an option for those few people who had friends residing close to the entertainment precinct.

I have a friend whose house is really really close to the clubs and just crash there and wait for it to wear off and then drive home the next morning. I mean I've got a few friends like that, when we've been out drinking and that sort of stuff, 'oh well, x's place is just around the corner, let's go crash at X's,. (University, Female)

4.4. The influence of past behaviours

Many of the male participants highlighted how past drug driving experiences would contribute to the carefree attitude towards this behaviour. The fact that they had driven under the influence of drugs without having an accident gave them a sense that this was a safe behaviour and one they could engage in competently.



. . .because if they've done it once they've done it before and then they will continue to do it because they know they can do both and be safe, probably. (Driving Course, Male)

If you do it more often you're going to be more in control, more aware of the effects and you're going to be more confident in driving. (Driving Course, Male)

Importantly, they also noted that any experience of being tested or caught for drug driving would increase their perception of risk of being tested in the future.

Because if I had been tested before I'd assume it would be more likely to happen. (University, Male)

I guess I've tried more drink driving so I'm probably more scared of drink driving than I am of drug driving. (Male TAFE)

5. Discussion

Commonly-utilised theories of health behaviour change – such as the Health Belief Model (Becker, 1974) and Protection Motivation Theory (Rogers, 1975) – emphasise the central importance of perceived risk (or 'threat appraisal' in Protection Motivation Theory). That is, in order for an individual to change their behaviour they have to perceive that the threatened event is both severe and probable. In the case of drug-driving, then, young people would need to believe that the consequences of drug driving (impaired driving and/or being caught and charged) are both severe and likely to occur.

It was clear from the participants' discussion that they do not perceive (or do not think their friends perceive) the negative consequences of drug driving to be severe or something that they are susceptible to; conversely, they identified benefits of this behaviour. The participants felt that many young people believed their driving would improve as a result of using marijuana, speed or ecstasy. Although they did not see this as a conscious act of taking drugs to specifically improve their driving performance, they identified characteristics of specific drugs to justify their belief that their driving ability would be improved (e.g., marijuana makes people drive slower because you are relaxed, and speed/ecstasy will improve your driving skills as you are more alert). This was consistent with past literature; however, it was interesting to note that the majority of the discussion centred on marijuana and its effects. Participants wrongly felt that being more relaxed when driving (after using marijuana) was going to positively influence their driving – rather than recognising the increased accident risk due to slowed reaction times.

Furthermore, they felt that there was no information available on how drugs impair driving skills, and thus personal experience played a large role in forming their current beliefs. For instance, if they had regularly driven under the influence of drugs or knew someone who engaged in this behaviour regularly and had not previously had an accident or been caught, they appeared to use this lack of prior negative outcomes to form a perception that the risks were low. Another key factor identified by participants was their lack of knowledge about the legal situation regarding drug driving. Participants were unaware of current drug driving laws in the ACT, and did not know what the penalties would be for drug-driving if caught by police. In addition, very few participants knew how police tested for drug driving and only one person across all groups had seen a mobile drug driving unit actively testing people. Not surprisingly, then, the focus groups revealed that young people did not expect to be tested by police for drugs and thus, were not worried about losing their licence (the only negative consequence that they universally endorsed as likely to deter the behaviour). A previous report by Transport ACT (2007) also highlighted this lack of knowledge surrounding drug driving.

This contrasts to their views on drink driving, which all of the participants perceived as a dangerous behaviour (in terms of both the effect on driving skills and the likelihood of being caught). It was clear that their views on drink driving were informed both by previous experience (such as friends who had been charged with drink driving) and knowledge gained from educational campaigns in the media about the risks of drink driving.

Perhaps the most central concept in health behaviour change models (including those referred to above) is self-efficacy. It is well-established that the likelihood of individuals adopting a desired behaviour is directly related to their



perceived (and actual) ability to undertake the recommended action. In the case of drug driving the recommended action would be not to take drugs and/ or not to drive; with the latter being the approach generally taken in drink driving interventions. The primary barrier identified by participants was the lack of viable transport options; with public transport seen as inconvenient or unavailable, taxis as prohibitively expensive, and walking infeasible. Canberra is geographically sparse with the entertainment district in the centre of Canberra (Civic) a substantial distance from the primary residential areas. This is, of course, not unique to this group of participants; suggesting that similar barriers would be experienced by young people in other locations. This supports research conducted by Duff and Rowland (2006) who found that convenience was the main reason for drug driving, followed by a lack of other transport options.

It is important to note that, as is generally the case with qualitative research, the small sample size and voluntary nature of participation means that the results should be interpreted with caution, particularly if applying the findings to other populations.

The fact that four of the focus groups were recruited from tertiary institutions means that the sample is likely to over-represent the views of those of higher socioeconomic status and education, and that the findings may under-estimate the actual proportion of young people engaging in drug driving. However, given that two of the groups were university students, two TAFE students, and two driving school students, we are confident that the findings represent a wide range of young people in this region.

6. Conclusion

Given that losing their license was the strongest deterrent to drug-driving among our participants – and that levels of knowledge of both the risks of and the penalties for drug-driving were very low – it would appear that a well-designed social marketing campaign, in conjunction with active random roadside saliva testing, would have real potential to reduce rates of drug-driving in the ACT. Such a campaign would need to increase young people's knowledge of the risks of drug driving, address misconceptions about the 'positive' effects of drugs on driving, and include strategies to increase the target audience's self-efficacy for not drug driving.

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