

Summary and Conclusions

Young people in custody have significant health problems including high rates of mental illness, drug and alcohol abuse and other risk taking behaviours. Improving the health status of this population is challenging as many come from highly disadvantaged backgrounds with high rates of child abuse, trauma, neglect, and a significant proportion have parents with a history of incarceration, drug and alcohol dependence and low socio-economic status. Many of these young people are no longer in school and do not seek healthcare in the community. Being in custody provides an opportunity to improve the health status and life skills of these vulnerable young people. Strengthening our response to reduce inequalities and associated poor health among young people requires all sections of government to work together to provide youth specific services and opportunities for marginalised young people as early as possible. Reducing exposure to the criminal justice system through diverting young people into health treatment and support may reduce risk factors associated with the causes of crime. Providing holistic alcohol and other drug treatment and mental health services, addressing family violence, stable housing and improving opportunities could make a significant contribution to improving the health of young people and make a positive contribution to society. Juvenile Justice and Justice Health are committed to using the findings of this research to continue building the evidence-base to guide policy and practice and to improve the health and well-being of this disadvantaged population.

Key findings

The health problems and indicators of social disadvantage among 2009 YPICHS participants are summarised below:

- **Socio-economic disadvantage:** Over 27% of YPICHS participants had been placed in care as a child; this was significantly higher among young women and Aboriginal young people. Low educational attainment was common with only 38% of participants in school prior to custody and an average age of leaving school of 14.4 years. Nearly half (45%) of participants had ever had a parent in prison and 10% currently had a parent in prison. Aboriginal young people were twice as likely to have ever had a parent in prison compared to non-Aboriginal young people (61% vs 30%).
- **Sexual health:** Almost all (95%) young people reported having had sex, with the average age of first having sex significantly younger for Aboriginal young people compared to non-Aboriginal young people (13.1 years vs 13.6 years). Nearly one-third (30%) of young women had been pregnant and only 39% of young people reported always using condoms with casual sexual partners.
- **Alcohol:** The majority (93%) of young people had experienced being drunk, and Aboriginal young people reported first being drunk at a younger age than non-Aboriginal young people (13.2 years vs 13.6 years). Two-thirds (66%) of young people reported being drunk at least weekly in the year prior to custody. Six in ten (61%) young people identified that their alcohol consumption had caused them problems in the past year, with significantly more Aboriginal young people identifying this than non-Aboriginal people (71% vs 52%).
- **Drugs:** Most (89%) young people in custody reported having used illicit drugs, with significantly higher rates among Aboriginal young people (93% vs 85%). The most common illicit drug used by all young people was cannabis (87%) followed by ecstasy (41%) and amphetamines (29%). Two-thirds (65%) of young people had committed crime to obtain drugs or alcohol and a similar proportion (69%) were intoxicated at the time of their offence.
- **Mental health:** The majority (87%) of young people were found to have at least one psychological disorder, and nearly three-quarters (73%) were found to have two or more psychological disorders. Young women were significantly more likely than young men to have an attentional or behavioural disorder (82% vs 68%), an anxiety disorder (54% vs 28%), a mood disorder (56% vs 19%) or two or more psychological disorders (92% vs 70%). Aboriginal young people were significantly more likely than non-Aboriginal young people to have an attention or behavioural disorder (75% vs 65%) or an alcohol or substance use disorder (69% vs 58%).
- **Child abuse and trauma:** Over half (60%) of young people had a history of child abuse or trauma. Significantly more young women reported a history of abuse than young men (81% vs 57%). A high proportion of young women had been physically (61%) or sexually abused (39%).
- **Intellectual ability:** Intellectual ability in the range indicating possible intellectual disability was common with one in five (20%) Aboriginal young people assessed as having a possible intellectual disability (IQ scores less than 70), significantly higher than the 7% found for non-Aboriginal young people. One-third (32%) of the young people scored in the borderline range for intellectual ability (IQ 70 to 79), again with a higher proportion of Aboriginal than non-Aboriginal young people (39% vs 26%).

The 2009 YPICHS highlights the poorer health status of participants compared to young people of a similar age in the broader Australian community. It should be noted, however, that for some young people, detention provides an opportunity to improve their diet, participate in more regular exercise and address mental health or drug and alcohol problems. This may be easier to achieve in custody than in community settings.

Implications for policy

The 2009 YPICHS provides important information to inform policy and practice across a range of sectors. Disadvantage in education, housing and employment is clearly demonstrated among the juvenile detainee population. Strategies to address retention in education and provision of employment skills and opportunities are beyond the scope of this report, but it is hoped that the data it presents will inform policy-making in these areas.

This report describes the significant over-representation of Aboriginal young people in custody. Identifying the reasons for this is an important step towards implementation of policies and programs that better support Aboriginal young people to avoid entanglement in the criminal justice system. A report on the disparities in health and socio-economic factors for Aboriginal and non-Aboriginal adult prisoners has recently been published which provides further evidence for the long-term implications of involvement in the criminal justice system (Indig et al., 2010b). The 2009 YPICHS findings can support the development of programs at all levels of the criminal justice system, from prevention and diversion programs in the courts and communities, to health interventions in custody and integration programs to support young Aboriginal offenders post-release from custody.

Another important area for policy development is the early detection of young people with mental health or drug and alcohol problems. Early detection programs can selectively target disadvantaged communities where young people have less opportunity to avoid contact with the criminal justice system. Justice Health operates a court-based diversion program in a number of children's courts to identify young people with mental illness who would be better cared for in mental health treatment than in custody. Justice Health and Juvenile Justice are also involved in the Youth Drug and Alcohol Court Program which attempts to divert young offenders with drug and alcohol problems into treatment programs. Both of these services are clearly delivering value to the young people they reach and their further expansion should be considered.

Juvenile Justice and Justice Health have primary responsibility for disseminating the findings of the 2009 YPICHS. This includes sharing the information with stakeholders including government, non-government and consumer groups who work in the health and criminal justice systems. In particular, provision of findings to the young people themselves is essential to empowering them to access health services in the community, improve their health literacy and make better choices to improve their health.

Given the short stays for the majority of detainees, the focus of health service provision by Justice Health is on screening, assessment and referral. This means that the responsibility for providing health treatment to this patient group does not commence and conclude with Justice Health. Depending on the length of stay in custody, Justice Health provides an avenue for identification of health needs, an opportunity to commence treatment, and assistance in the establishment of linkages in the community for ongoing care. The implication is that improvement of outcomes for this patient group over the longer term requires integration, or at a minimum, the development of effective linkages between services provided to young people while in custody and those provided before and after custody.

There are already a number of examples of these linkages being established, particularly in the areas of release planning within mental health, drug and alcohol and population health. Furthermore, in recent years Justice Health has expanded court-based services in the community to divert mentally ill young people into treatment prior to entering custody. As such the framework for integration between health services in the community and health services provided in custody has been established. The findings of the YPICHS suggest a key strategy to improve the health status of young people in custody is to bolster this integration.

Limitations

Limitations of the 2009 YPICHS data should be kept in mind when considering the results of this study and their implications. The survey included an extensive array of physical health tests, a lengthy health questionnaire and psychological tests. It is possible that some young people became fatigued completing all components of the survey and may have taken less care with their responses in order to complete the survey more quickly. All participants were given numerous breaks during survey implementation and provided with food and beverages, so it is believed this effect was minimal.

The survey was also limited by only recruiting 40 young women. With such a small sample size, extrapolation of survey results about young women in custody should be made with caution. A further limitation is that translation services were not available for non-English speaking juvenile detainees and they were not included in the survey. Another limitation was that not all the psychometric instruments used in the study (such as the ones used to measure child abuse, intellectual disability and mental illness) have been validated for use with Aboriginal populations, so results compared by Aboriginality must be interpreted with caution.

Future directions

Since the 2003 YPICHS, Justice Health has enhanced the Youth Drug and Alcohol Court program, and introduced the Community Integration Team and the Addiction Medicine Service. During this time Justice Health has taken responsibility for the healthcare of young people in custody and has significantly expanded its staffing. Developments in and improvements to health service delivery to young people in custody in NSW have improved access to treatment in many areas. The constantly evolving field of health service delivery nevertheless requires ongoing examination of the health status of this patient population and continued expansion and refinement of the evidence base upon which to build policy and practice.

With a vision for a community in which young people can participate without re-offending, Juvenile Justice continues to work closely with Justice Health and in 2007, established a Programs Branch. The primary aim of this branch is to develop and implement evidence-based rehabilitation programs that assist young people to decrease their reoffending and increase their capacity to successfully reintegrate into their communities.

The 2009 YPICHS includes two significant enhancements on the 2003 YPICHS. The first is a follow-up survey at 3, 6 and 12 months after the baseline survey (reported here). The follow-up surveys will be reported separately and will include important information regarding post-release behaviour. The second is a five-year study which required young people to consent to their data being linked across a number of health, criminal justice and associated data collections to determine longer-term outcomes for young offenders. This will also be the subject of a separate report.

The outcomes of the 2009 YPICHS will be disseminated through conference presentations and staff development meetings. They will also be disseminated through the preparation and submission of papers to peer-reviewed scientific journals, in which more detailed analyses will examine the relationships between the various data presented in this report, and in which hypothesis testing will be undertaken.

Subjecting these data to peer review will ensure that their utility is maximised through the clear elucidation of research, policy and practice implications. A summary of the findings will also be presented in a user-friendly format to the young people who participated in the survey and for young people in custody interested in the findings.

Conclusion

Almost all young people in custody return to the communities from which they were detained. The clear implications of this fact are that: (i) good juvenile detainee health is good public health; (ii) good public health will make good use of the opportunities presented by the population held in detention centres; and (iii) detention centres can and should contribute to the health of communities by helping to improve the health of some of society's most disadvantaged and marginalised young people.

The findings from the 2009 YPICHS identify a number of important health disparities for young people in custody compared with their counterparts in the community. The findings from this survey will be used to inform policy development and service delivery planning to improve the health status of this vulnerable population.

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Young People In Custody Health Survey (YPICHS) 2009

Baseline Questionnaire



JUSTICE HEALTH | NSW HEALTH
STATEWIDE SERVICE

Juvenile Justice NSW and Justice Health, 2009

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Physical Health Assessment

CONFIDENTIAL

CMIS NUMBER:

Date of birth: / /

Participant first two initials: (first name) (last name)

Interviewer's Initials:

Time commenced (24-hour clock): : hrs

Time finished (24-hour clock): : hrs

Juvenile Justice Centre: _____

Interview date: / /

Spoken Introduction: *Hello, my name is*

I work for the Young People in Custody Health Survey. Firstly I will be doing a physical assessment, which involves taking some measurements, like blood pressure, weight and height. We will do an eyesight test and a hearing test.

A urine specimen will be collected, which will be used to test for general health and will be sent to the laboratory to test for Chlamydia and Gonorrhoea.

A blood test will be taken to test for a number of different indicators of health. We will be looking for levels that show how healthy you are and possible problems you may have that we can help you with. The tests that will be carried out will be discussed with you before the blood is taken so that you understand what tests we are doing.

Any questions you may have about this please feel free to ask. You will be receiving a lot of information today so at times you may feel a little unsure about what we are doing or saying. This is normal and can happen to anyone and it is very important to us that you understand what we are saying. If you feel unsure about what we are saying or do not understand some of the information we are telling you please let us know, we are happy to explain anything you are unsure of. This will help us to make sure we are explaining things in a way that young people can understand.

1. PHYSICAL HEALTH CHECK

(Please conduct 3 blood pressure measurements on the non-dominant arm 2 minutes apart.)

- a) Blood pressure 1 (sitting)
- | | | | | | | |
|-----------------|--|--|---|------------------|--|--|
| | | | / | | | |
| <i>Systolic</i> | | | | <i>Diastolic</i> | | |
- Blood pressure 2 (sitting)
- | | | | | | | |
|-----------------|--|--|---|------------------|--|--|
| | | | / | | | |
| <i>Systolic</i> | | | | <i>Diastolic</i> | | |
- Blood pressure 3 (sitting)
- | | | | | | | |
|-----------------|--|--|---|------------------|--|--|
| | | | / | | | |
| <i>Systolic</i> | | | | <i>Diastolic</i> | | |

(Please include a decimal point for measurements below)

- b) Height (no shoes) (cm).....

--	--	--	--
- c) Weight (no shoes, clothed) (kg)..

--	--	--	--
- d) Waist measurement (cm).....

--	--	--	--
- e) Hip Measurement (cm).....

--	--	--	--
- f) Peak flow 1st reading (LPM).....

--	--	--
- Peak flow 2nd reading (LPM).....

--	--	--
- Peak flow 3rd reading (LPM).....

--	--	--
- (All Peak flow readings conducted standing)
- g) Blood glucose results (mg/dl).....

--	--	--
- h) Hours since last ate?
- 1 - 2 hours 1
- 3 - 4 hours 2
- More than 5 hours ago 3
- Don't know 4

2. URINALYSIS

- a) Urine sample taken.....No 0
..... Yes 1

	No	Yes	Value
b) Microalbuminuria	<input type="checkbox"/> 0	<input type="checkbox"/> 1	
c) Protein	<input type="checkbox"/> 0	<input type="checkbox"/> 1	
d) Blood	<input type="checkbox"/> 0	<input type="checkbox"/> 1	
e) Ketones	<input type="checkbox"/> 0	<input type="checkbox"/> 1	
f) PH	<input type="checkbox"/> 0	<input type="checkbox"/> 1	
g) Leucocytes	<input type="checkbox"/> 0	<input type="checkbox"/> 1	
h) Nitrites	<input type="checkbox"/> 0	<input type="checkbox"/> 1	
i) Glucose	<input type="checkbox"/> 0	<input type="checkbox"/> 1	
j) Bilirubin	<input type="checkbox"/> 0	<input type="checkbox"/> 1	
k) Urobilinogen	<input type="checkbox"/> 0	<input type="checkbox"/> 1	

3. BLOOD SAMPLE

- a) Blood Sample Taken:No (**GO TO d**) 0
..... Yes 1
- b) Time Blood Sample Taken.....

		:		
--	--	---	--	--
- c) Fasting Blood Sample?No 0
..... Yes 1
- d) If no blood sample taken, why?
- Could not find veins 1
- Refused 2
- Dislike of Needles 3
- Concerned about DNA testing 4
- Concerned about drug testing 5
- Other (Specify)_____

4. VISUAL ACUITY

a) Do you currently wear glasses or contact lenses to correct, or partially correct your eyesight?No 0
 Yes 1

b) If **YES**, What sight problems do your glasses or contact lenses correct or partially correct?
 Astigmatism 1
 Short – sightedness 2
 Long – sightedness 3
 Don't Know 4
 Other (Specify) _____

Must be standing exactly 6 metres from chart.

[Interviewer: If normally wears spectacles test to be performed with glasses on. Start at the top of the chart. Please do for each eye individually, then for both together, as per charts below.]

Note: one mistake on each line is acceptable. If, more than one mistake tick 'no'.

	Left Eye			Right Eye		
	No	Yes	Value	No	Yes	Value
Line 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/60	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/60
Line 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/36	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/36
Line 3	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/24	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/24
Line 4	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/18	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/18
Line 5	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/12	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/12
Line 6	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/9	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/9
Line 7	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/7.5	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/7.5
Line 8	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/6	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/6
Line 9	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/6	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/6
Line 10	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/5	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/5

	Both Eyes		
	No	Yes	Value
Line 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/60
Line 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/36
Line 3	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/24
Line 4	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/18
Line 5	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/12
Line 6	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/9
Line 7	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/7.5
Line 8	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/6
Line 9	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/6
Line 10	<input type="checkbox"/> 0	<input type="checkbox"/> 1	6/5

Hearing Assessment

- Is anyone in your family, or any relative deaf or hard of hearing? Yes 1
No 2
 Don't Know 3
- Have you ever had ear infections or dizziness? Yes 1
No 0
- Do you have difficulty hearing? Yes 1
 No (*GO TO Q6*) 0
- If YES, Which ear? Left 1
 Right 2
Both 3
- Do you wear Hearing aids? Yes 1
No 0
- Do you ever have ringing in the ears? Yes 1
 No (*GO TO Q8*) 0
- If yes, Which ear? Left 1
 Right 2
Both 3
- Have you been exposed to any of the following loud noises?

	A lot	A little	Not at all
Tractor or farm machinery			
Trail bike or motor bike			
Amusement Machines			
Rock music (as a band member)			
Rock concerts and/or clubs			

- Do you listen to loud music (such as with an ipod) or games with headphones? Yes 1
No 0
- If YES, How many hours per week would you do this?
 < 1 Hour 1
 Between 1 - < 6 hours 2
 Between 6 - <10 hours 3
 10 or more hours 4

11. Ear examination results

	Left ear	Right ear
Normal canal	<input type="checkbox"/> 0	<input type="checkbox"/> 0
Abnormal canal	<input type="checkbox"/> 1	<input type="checkbox"/> 1
<i>If abnormal canal, any of the following present?</i>		
Red	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Narrowed	<input type="checkbox"/> 2	<input type="checkbox"/> 2
Discharge	<input type="checkbox"/> 3	<input type="checkbox"/> 3
Wax occluding	<input type="checkbox"/> 4	<input type="checkbox"/> 4
Other _____	<input type="checkbox"/> 5	<input type="checkbox"/> 5
Normal drum	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Abnormal drum	<input type="checkbox"/> 2	<input type="checkbox"/> 2
Unable to see drum	<input type="checkbox"/> 3	<input type="checkbox"/> 3
<i>If abnormal Drum, any of the following present?</i>		
Wet perforation	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Dry perforation	<input type="checkbox"/> 2	<input type="checkbox"/> 2
Tympanosclerosis/scarring	<input type="checkbox"/> 3	<input type="checkbox"/> 3
Acute otitis media	<input type="checkbox"/> 4	<input type="checkbox"/> 4
Otitis media with effusion	<input type="checkbox"/> 5	<input type="checkbox"/> 5
Other _____	<input type="checkbox"/> 6	<input type="checkbox"/> 6

12. Audiometry – Right ear

Frequency	Normal (<25 DB)	Mild (26-40 DB)	Moderate (41-60 DB)	Severe (>60 DB)
0.5KHZ	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
1 KHZ	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
2 KHZ	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
4 KHZ	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
6 KHZ	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

13. Audiometry – Left ear

Frequency	Normal (<25 DB)	Mild (26-40 DB)	Moderate (41-60 DB)	Severe (>60 DB)
0.5KHZ	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
1 KHZ	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
2 KHZ	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
4 KHZ	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
6 KHZ	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

Physical Health Questionnaire

CONFIDENTIAL

CMIS NUMBER:

Date of birth: //

Participant first two initials: (first name) (last name)

Interviewer's Initials:

Time commenced (24-hour clock): : hrs

Time finished (24-hour clock): : hrs

Juvenile Justice Centre: _____

Interview date: //

Spoken Introduction: *Hello, my name is*

I work for the Young People in Custody Health Survey. All the answers that you give to the questions in the questionnaire will remain confidential but if at any time you tell me something that would make me believe that you or anyone else is in danger of being harmed, then I will need to notify someone about this. If at any time you feel uncomfortable answering any of the questions please let me know.

The completed questionnaire will not be accessed by any of the centre staff and cannot be identified as yours by any person other than the staff working on the survey, as your name and identification number are not on the questionnaire.

INTERVIEWER'S INSTRUCTIONS

1. All UPPER CASE TEXT should be read out for each question.
2. All text [in italics] are guidelines for the interviewer
3. For all responses please mark the corresponding box with an X
4. All open responses, where a box is provided, should be written in the box and three lines have been given for the response.
5. If the answer states 'Go to Qx', please move to this next question.
6. If the respondent is unsure of what response to give, try to prompt without guiding the answer.

1. DEMOGRAPHICS/CUSTODY

- 1.1 In the 6 MONTHS before coming into custody in what town or suburb did you spend most of your time?
*[Interviewer: If interstate, specify state.
 Code postcode if known in the boxes provided]*

Suburb _____

Postcode

State

- 1.2 In which country were YOU born?
 Australia (**GO TO Q1.4**) 1
 Other (Specify) _____

- 1.3 If born overseas, in what year did you **FIRST** arrive in Australia?

- 1.4 In which country was your **MOTHER** born?
 Australia 1
 Don't Know 2
 Other (Specify) _____

- 1.5 In which country was your **FATHER** born?
 Australia 1
 Don't Know 2
 Other (Specify) _____

- 1.6 What language is **MAINLY** spoken in your home?
 English 1
 Other (Specify) _____

- 1.7 Are there any other languages spoken in your home?
 No 0
 Yes 1
 If YES (Specify) _____

- 1.8 What cultural or ethnic background do you relate to?

- 1.9 Are you of aboriginal or Torres Strait islander origin?
 No 0
 Aboriginal 1
 Torres Strait Islander 2
 Aboriginal & Torres Strait Islander 3

- 1.10 Are you currently on remand OR have you been sentenced to a control order?
 Sentenced control 1
 Remand 2
 Both remand and control 3
 Trying to meet bail conditions 4
 Appeal 5
 Don't know 6

- 1.11 How many times have you been in custody?

- 1.12 How old were you when you first went into custody? (*INTERVIEWER: for either remand or control*)

2. EDUCATION/OCCUPATION

- 2.1 In the 6 MONTHS, before coming into custody were you going to school? No 0
 Yes (**GO TO Q2.4**) 1

- 2.2 What CLASS/YEAR were you in when you left school? CLASS/YEAR

- 2.3 At what AGE did you leave school?

- 2.4 What CLASS/YEAR were you in when you LAST attended school in the community?
 CLASS/YEAR

- 2.5 In the 6 MONTHS before coming into custody, how often did you cut or skip class without permission?
 Never 1
 Once or twice 2
 3 or 4 times 3
 5 times or more 4

- 2.6 Have YOU EVER been suspended from school?
 No (**GO TO Q2.8**) 0
 Yes 1

- 2.7 How MANY TIMES were you suspended?

- 2.8 Have you EVER attended a special school or a special class at school?
 No (**GO TO Q2.10**) 0
 Special school 1
 Special class 2

- 2.9 What special school or special class did you attend?

- 2.10 Have you ever been excluded from a school?
 No (**GO TO Q2.12**) 0
 Yes 1
- 2.11 If YES, how many times were you excluded?

- 2.12 In the 6 MONTHS BEFORE coming into custody were you going to tafe?
 No (**GO TO Q2.14**) 0
 Yes 1
- 2.13 What type of Tafe course were you enrolled in? (Specify)
- 2.14 In the 6 MONTHS before coming into custody were you working?
 No (**GO TO Q2.17**) 0
 Yes 1
- 2.15 What was your last job BEFORE COMING INTO CUSTODY? (Specify)
- 2.16 What type of work was this?
 Full time 1
 Part time 2
 Casual 3
 CDEP 4
 Volunteer Work 5
 Work for the dole 6
- 2.17 In the 6 MONTHS before coming into custody were you receiving any allowances or benefits?
 No (**GO TO Q2.19**) 0
 Yes 1
- 2.18 What allowances or benefits were you receiving?
 Newstart 1
 Youth allowance 2
 Austudy 3
 Abstudy 4
 Other (Specify) _____
- 2.19 Are you going to school WHILE IN CUSTODY? No (**GO TO Q2.21**) 0
 Yes 1

2.20 What CLASS/YEAR are you IN CUSTODY?..... CLASS/YEAR

2.21 What do you plan to do when you LEAVE CUSTODY? (Specify)

3. LIVING ENVIRONMENT

- 3.1 Who was MAINLY responsible for raising you/ looking after you when you were growing up? [Interviewer: Tick all that apply]
- Mother 1
 Father 2
 Stepmother 3
 Stepfather 4
 Grandmother 5
 Grandfather 6
 Aunt 7
 Uncle 8
 Brother(s) 9
 Sister(s) 10
 Step brother(s)/sister(s) 11
 Foster family 12
 Other Adults (Specify) _____
- 3.2 Are your (biological) parents, by this I mean your NATURAL PARENTS:
 Living together (**GO TO Q3.4**) 1
 Separated or divorced (**GO TO Q3.4**) 2
 Have never lived together (**GO TO Q3.4**) 3
 One or both of your parents have died 4
 Don't know who your parents are (**GO TO Q3.4**) .. 5
 Other (Specify) _____
- 3.3 If PARENT OR PARENTS DECEASED, which of your parents has died?
 Mother 1
 Father 2
 Both 3
 Don't know 4
- 3.4 Were EITHER of your parents EVER sent to prison?
 No (**GO TO Q3.8**) 0
 Yes 1
 Don't know (**GO TO Q3.8**) 2

- 3.5 Which parent (s)?
 Mother 1
 Father 2
 Both 3
 Stepmother 4
 Stepfather 5
- 3.6 Are EITHER of your parents CURRENTLY in prison?
 No (**GO TO Q3.8**) 0
 Yes 1
- 3.7 Which parent (s)?
 Mother 1
 Father 2
 Both 3
 Stepmother 4
 Stepfather 5
- 3.8 What type of accommodation were you living in IMMEDIATELY BEFORE COMING INTO CUSTODY?
[Interviewer: tick one only]
 In the family home 1
 Renting 2
 Unsettled lodgings (eg. squat, B&B, Hostel-refuge, caravan) 3
 Sleeping on the streets 4
 Sharing with friends 5
 Other (Specify) _____
- 3.9 In the six months before coming into custody, how many times did you move house? (*Note: this includes coming in and out of custody*)
 None, lived in the same place whole time 1
 Moved once 2
 Moved 2 - 3 times 3
 Moved 4 - 5 times 4
 Moved 6 or more times 5
 No fixed accommodation 6
- 3.10 (*If previously been in custody*) Last time you were released from custody, did you have any problems with your accommodation within 6 months of being released? No 0
 Yes 1
- 3.11 BEFORE THE AGE OF 16, were you EVER placed in care? by this I mean did you spend ANY part of your childhood living away from your natural parents?
[Interviewer: this does not include juvenile detention or being homeless.]
 No (**GO TO Q3.16**) 0
 Yes 1

- 3.12 Who were you placed in care by?
 Department of Community Services (DOCS) 1
 Court order 2
 Other (Specify) _____ 3
- 3.13 Where was this placement?
 Foster care 1
 With other family members (eg, aunts) 2
 In a home 3
 Adopted 4
 Other care (Specify) _____
- 3.14 How many TIMES were you placed in care?
- 3.15 How OLD were you when you were FIRST placed in care?
- 3.16 Do you have ANY children of your own?
 No (**GO TO SECTION 4**) 0
 Yes 1
- 3.17 How OLD WERE YOU when your first child was born?
- 3.18 How MANY children do YOU have?
- 3.19 Thinking about your FIRST child, who have they lived with SINCE THEY WERE BORN?
[Interviewer: Tick all that apply]
 You 1
 You and your partner 2
 Your partner 3
 Their mother and/or father 4
 Your mother and/or your father 5
 Other relatives 6
 Your friends 7
 Foster family 8
 Adopted family 9
 Child welfare institution 10
 Don't know 11
 Other (Specify) _____

- 3.20 Who is your FIRST child CURRENTLY LIVING WITH? (while you are in custody)
[Interviewer: Tick all that apply]
- You 1
 - You and your partner 2
 - Your partner 3
 - Their mother and/or father 4
 - Your mother and/or your father 5
 - Other relatives 6
 - Your friends 7
 - Foster family 8
 - Adopted family 9
 - Child welfare institution 10
 - Don't know 11
- Other (Specify) _____

- 3.21 Thinking about your SECOND child, who have they lived with SINCE THEY WERE BORN?
[Interviewer: Tick all that apply]
- You 1
 - You and your partner 2
 - Your partner 3
 - Their mother and/or father 4
 - Your mother and/or your father 5
 - Other relatives 6
 - Your friends 7
 - Foster family 8
 - Adopted family 9
 - Child welfare institution 10
 - Don't know 11
- Other (Specify) _____

- 3.22 Who is your SECOND child CURRENTLY LIVING WITH? (while you are in custody)
[Interviewer: Tick all that apply]
- You 1
 - You and your partner 2
 - Your partner 3
 - Their mother and/or father 4
 - Your mother and/or your father 5
 - Other relatives 6
 - Your friends 7
 - Foster family 8
 - Adopted family 9
 - Child welfare institution 10
 - Don't know 11
- Other (Specify) _____

- 3.23 Thinking about your THIRD child, who have they lived with SINCE THEY WERE BORN?
[Interviewer: Tick all that apply]
- You 1
 - You and your partner 2
 - Your partner 3
 - Their mother and/or father 4
 - Your mother and/or your father 5
 - Other relatives 6
 - Your friends 7
 - Foster family 8
 - Adopted family 9
 - Child welfare institution 10
 - Don't know 11
- Other (Specify) _____

- 3.24 Who is your THIRD child CURRENTLY LIVING WITH? (while you are in custody)
[Interviewer: Tick all that apply]
- You and your partner 1
 - You 2
 - Your partner 3
 - Their mother and/or father 4
 - Your mother and/or your father 5
 - Other relatives 6
 - Your friends 7
 - Foster family 8
 - Adopted family 9
 - Child welfare institution 10
 - Don't know 11
- Other (Specify) _____

- 3.25 Did you ever receive any parenting education? No 0
 Yes 1

4. FAMILY HISTORY

- 4.1 Does ANYONE YOU LIVE WITH have a physical, mental, or emotional problem or limitation that affects their daily life?
No (**GO TO SECTION 5**) 0
 Yes 1
- 4.2 Which of these people YOU LIVE WITH have a problem(s) or limitation?

a) Who has the problem or limitation?	1.....	2.....	3.....
b) What problem or limitation do they have?			
d) How does this problem affect them?			
d) Were you responsible for helping to look after them?	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
e) Do these problems affect you?	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
f) How do these problems affect you?			

5. HEALTH STATUS

- 5.1 Have you EVER been told by a HEALTH PROFESSIONAL you HAVE HAD or HAVE any of the following illnesses/ conditions? *[Interviewer: Tick all that apply]*
- Allergy (Specify) _____ 1
- Asthma 2
- Diabetes 3
- Epilepsy 4
- Heart problems 5
- Kidney problems 6
- High blood pressure 7
- Poor eyesight 8
- Cancer/tumours (Specify) _____ 9
- Hepatitis A 10
- Hepatitis B 11
- Hepatitis C 12
- HIV 13
- Tonsillitis 14
- Back problems 15

- Gastroenteritis 16
- Ear infections 17
- Chest infections 18
- Skin infection (Specify) _____ 19
- Acne/pimples 20
- Parasitic infestations 21
- German measles (rubella) 22
- Mumps 23
- Measles 24
- Chicken pox 25
- Whooping cough 26
- Glandular fever 27
- Other (Specify) _____

- 5.2 Have you had your childhood immunisations? by this I mean immunisations you had when you were UNDER FIVE and at about 12 YEARS OF AGE?
- No 1
- Yes, only when I was under 5 years 2
- Yes, only when I was about 12 years 3
- Yes, under 5 years and about 12 years 4
- Don't Know 5
- 5.3 Have you had a tetanus injection in the LAST 5 YEARS?No 0
 Yes 1
 Don't Know 2
- 5.4 Have you had any of the following immunizations/ vaccinations in the LAST 5 YEARS?

	Yes	No	Don't know
Tetanus Booster	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rubella (MMR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whooping cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. DISABILITY/HEALTH PROBLEMS

6.1 Do you CURRENTLY have any health problems or disabilities that have troubled you for about 6 MONTHS OR MORE?
 No (GO TO SECTION 7)..... 0
 Yes 1

6.2 What is this health problem or disability?
Problem/Disability 1

6.3 How does this problem limit your activities?
[Interviewer: prompt if necessary eg. unable to exercise. If not limiting, write not limiting]
Limitation

6.4 Is there ANOTHER health problem or disability you would like to tell me about?
 No (GO TO SECTION 7) 0
 Yes 1

6.5 What is this health problem or disability?
Problem/Disability 2

6.6 How does this problem LIMIT your activities?
[Interviewer: prompt if necessary eg. unable to exercise. If Not limiting, write not limiting]
Limitation

6.7 What activities did you cut down on in the LAST 2 WEEKS, because of this problem?
[Interviewer: if didn't cut down, write not applicable, N/A]
Activity

7. MEDICATION

7.1 Are you CURRENTLY taking any medications, which have been given to you by a DOCTOR or a NURSE? (eg: pills, creams, and lotions etc)
 No (GO TO Q7.3) 0
 Yes 1

7.2 Can you tell me what medications you HAVE BEEN given by the doctor or nurse in the LAST 2 WEEKS?

7.3 Did you take any medications in the last 2 weeks that were not prescribed for you?
 No (GO TO SECTION 8) 0
 Yes 1

7.4 If YES, please specify the types of medication you've taken?

8. ASTHMA

[Interviewer: If responds YES has asthma in Section 5 Health Status, complete this section.]

8.1 When did you LAST have an asthma attack or difficulties BREATHING?
 < 1 month ago 1
 1 - <3 months ago 2
 3 - < 6 months ago 3
 6 - < 12 months ago 4
 1 year or more ago 5
 Don't know 6

8.2 Approximately how many times have you had an asthma attack or difficulty breathing in the last 3 months?

8.3 Have you EVER been to hospital for asthma? No (GO TO Q8.5) 0
 Yes 1

8.4 How MANY TIMES have you been to hospital for asthma?

8.5 Have you EVER been prescribed MEDICATION for asthma?
 No (GO TO Q8.8) 0
 Yes 1

- 8.6 Are you CURRENTLY taking ANY MEDICATION for asthma?
 No (GO TO Q8.8) 0
 Yes 1
- 8.7 What MEDICATIONS are you taking and HOW OFTEN do you have to take them?
[Interviewer: tick numbered boxes only]
- Medication 1: _____
 Daily or more than daily 1
 More than 4 times/month (weekly) 2
 2 - 4 times/month 3
 Monthly 4
 Less than monthly 5
- Medication 2: _____
 Daily or more than daily 1
 More than 4 times/month (weekly) 2
 2 - 4 times/month 3
 Monthly 4
 Less than monthly 5
- Medication 3: _____
 Daily or more than daily 1
 More than 4 times/month (weekly) 2
 2 - 4 times/month 3
 Monthly 4
 Less than monthly 5
- 8.8 Do you have a written asthma plan?No 0
 Yes 1

9. DENTAL HEALTH

- 9.1 Did you brush your teeth YESTERDAY? Yes 1
 No (GO TO Q9.4) 2
- 9.2 How many times did you brush your teeth YESTERDAY?
- 9.3 Did you use toothpaste?No 0
 Yes 1
- 9.4 In the last 12 MONTHS, how often have you had a toothache?
 Very often 1
 Often 2
 Sometimes 3
 Hardly ever 4
 Never (during the last 12 months) 5
 Don't know 6

- 9.5 In the last 12 MONTHS, have you had other problems with your teeth or gums other than a toothache?
 No (GO TO Q9.8) 0
 Yes 1
 Don't know (GO TO Q9.8) 2
- 9.6 What problem (s) did you have (with your teeth or gums)?

- 9.7 Have you seen a DENTAL PROFESSIONAL about any of these problems?
No 0
 Yes 1
- 9.8 How long is it since you LAST SAW ANYONE about your teeth or gums?
 2 weeks ago or less 1
 2 weeks and less than 3 months 2
 3 months and less than 6 months 3
 6 months and less than 12 months 4
 12 months and less than 2 years 5
 2 years or more 6
 Never 7
 Don't know 8
- 9.9 Thinking of your LAST dental visit, where did you attend?
 Dentist in custody 1
 School dental clinic 2
 Area health service 3
 AMS/Aboriginal dental service 4
 Dental hospital or hospital service 5
 Private dentist 6
 Orthodontist 7
 Other (Specify) _____
- 9.10 How many times did you see a dental professional about your teeth or gums in the last 12 MONTHS?
 None 0
 Once (GO TO Q9.12) 1
 Twice (GO TO Q9.12) 2
 Three times (GO TO Q9.12) 3
 More than three times (GO TO Q9.12) 4

9.11 If NONE, What is the main reason for not visiting the dentist in the LAST 12 MONTHS?

[Interviewer: Tick all that apply.]

The cost of dental visits 1

You believed no treatment was needed 2

Transport is a problem 3

You have given up going to the dentist 4

Waiting list/difficulty getting an appointment 5

You are nervous about going to the dentist 6

You did not have a dentist or know where one .. 7

You did not think dental visits very important 8

You were too busy 9

Forgot/didn't think/ no one reminded you..... 10

Other (Specify) _____

9.12 In general, would you say your teeth are:

Excellent 1

Very good 2

Good 3

Fair 4

Poor 5

10. PHYSICAL INJURY

10.1 Have you EVER had any accidents or injuries for which you may have seen a DOCTOR OR NURSE or GONE TO HOSPITAL?

[Interviewer: If > four injuries include the four most serious]

..... No (GO TO Q10.2) 0
 Yes 1

	Injury 1(a)	Injury 2 (b)	Injury 3 (c)	Injury 4 (d)
1. What was the injury?				
2. How did the injury happen?				
3. What were you doing when the injury occurred?				
4. Where were you when you were injured?				
5. What treatment did you receive?				
6. When did this injury Occur?	<1 month ago <input type="checkbox"/> 1 1 - <6 months ago <input type="checkbox"/> 2 6 mths <2 yr ago <input type="checkbox"/> 3 2 - <5 years <input type="checkbox"/> 4 5 years or more <input type="checkbox"/> 5	<1 month ago <input type="checkbox"/> 1 1 - <6 months ago <input type="checkbox"/> 2 6 mths <2 yr ago <input type="checkbox"/> 3 2 - <5 years <input type="checkbox"/> 4 5 years or more <input type="checkbox"/> 5	<1 month ago <input type="checkbox"/> 1 1 - <6 months ago <input type="checkbox"/> 2 6 mths <2 yr ago <input type="checkbox"/> 3 2 - <5 years <input type="checkbox"/> 4 5 years or more <input type="checkbox"/> 5	<1 month ago <input type="checkbox"/> 1 1 - <6 months ago <input type="checkbox"/> 2 6 mths <2 yr ago <input type="checkbox"/> 3 2 - <5 years <input type="checkbox"/> 4 5 years or more <input type="checkbox"/> 5
7. Were you in custody or in the community?	Custody <input type="checkbox"/> 1 Community <input type="checkbox"/> 2	Custody <input type="checkbox"/> 1 Community <input type="checkbox"/> 2	Custody <input type="checkbox"/> 1 Community <input type="checkbox"/> 2	Custody <input type="checkbox"/> 1 Community <input type="checkbox"/> 2
8. Do you have any lasting injury or disability?	No (Go to Q10.2) <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1 Don't Know <input type="checkbox"/> 2	No (Go to Q10.2) <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1 Don't Know <input type="checkbox"/> 2	No (Go to Q10.2) <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1 Don't Know <input type="checkbox"/> 2	No (Go to Q10.2) <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1 Don't Know <input type="checkbox"/> 2
9. What are these lasting injuries or disabilities?				

10.2 In the PAST 12 MONTHS have you had a physical injury that was deliberately caused by:

- No physical injury in last 12 months 0
- A detainee in custody 1
- Father 2
- Mother 3
- Police 4
- Boyfriend/girlfriend 5
- Stranger 6
- Or another person (Specify) _____

11. HEAD INJURY

Next, we will ask you a few questions about times you may have received an injury to your head.

- 11.1 Have you ever had a head injury where you became unconscious or "blacked out"?
-No (**GO TO SECTION 12**) 0
-Yes 1

- 11.2 How many TIMES has this happened?.....

Can you tell me about the most severe head injury you have had.

MOST SEVERE HEAD INJURY

- 11.3 What caused you to become unconscious? (Specify)
- [Interviewer: if necessary you can prompt. Eg. Car crash, hit in a fight.]*

- 11.4 For how long were you unconscious?
- [Interviewer: unprompted]*
- Only a brief moment 1
- Between 10 - <30 minutes 2
- Between 30 minutes – 24 hours 3
- More than 24 hours 4
- Don't know 5

- 11.5 When did this occur?
- [Interviewer: unprompted]*
- Within last week 1
- 1 - 4 Weeks ago 2
- 1 - 6 Months ago 3
- Over 6 months and less than 2 years ago 4
- 2 Years ago or more 5
- Don't know 6

- 11.6 Did you go to the hospital?No 0
-Yes 1

- 11.7 Did you have any of the following problems as a result of these head injuries?
- No problems (**GO TO SECTION 12**) 1
- Weakness in any part of the body 2
- Poor concentration 3
- Memory loss 4
- Problems finding the right words when speaking ... 5
- Problem with coordination/balance 6
- Personality/behavioural changes 7
- Anxiety or depression 8
- Headache 9
- Other (Specify) _____

- 11.8 Which of these effects have not gone away (resolved)?
- No problems 1
- Weakness in any part of the body 2
- Poor concentration 3
- Memory loss 4
- Problems finding the right words when speaking ... 5
- Problem with coordination/balance 6
- Personality/behavioural changes 7
- Anxiety or depression 8
- Headache 9
- Other (Specify) _____

12. SF 12

- 12.1 In general, would you say your health is:
- Excellent 1
- Very good 2
- Good 3
- Fair 4
- Poor 5

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
12.2 Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, playing golf.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
12.3 Climbing several flights of stairs	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

During the PAST 4 WEEKS, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

12.4 Accomplished less than you would like	All of the time <input type="checkbox"/> 1 Most of the time <input type="checkbox"/> 2 Some of the time <input type="checkbox"/> 3 A little of the time <input type="checkbox"/> 4 None of the time <input type="checkbox"/> 5
12.5 Were limited in the kind of work or other activities	All of the time <input type="checkbox"/> 1 Most of the time <input type="checkbox"/> 2 Some of the time <input type="checkbox"/> 3 A little of the time <input type="checkbox"/> 4 None of the time <input type="checkbox"/> 5

During the PAST 4 WEEKS, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

12.6 Accomplished less than you like	All of the time <input type="checkbox"/> 1 Most of the time <input type="checkbox"/> 2 Some of the time <input type="checkbox"/> 3 A little of the time <input type="checkbox"/> 4 None of the time <input type="checkbox"/> 5
12.7 Did work or other activities less carefully than usual	All of the time <input type="checkbox"/> 1 Most of the time <input type="checkbox"/> 2 Some of the time <input type="checkbox"/> 3 A little of the time <input type="checkbox"/> 4 None of the time <input type="checkbox"/> 5

- 12.8 During the PAST 4 WEEKS, how much did pain interfere with your normal work (including both work outside the home and housework)?
- Not at all 1
A little bit 2
Moderately 3
Quite a bit 4
Extremely 5

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much during the past 4 weeks:

12.9 Have you felt calm and peaceful	All of the time <input type="checkbox"/> 1 Most of the time <input type="checkbox"/> 2 Some of the time <input type="checkbox"/> 3 A little of the time <input type="checkbox"/> 4 None of the time <input type="checkbox"/> 5
12.10 Did you have a lot of energy	All of the time <input type="checkbox"/> 1 Most of the time <input type="checkbox"/> 2 Some of the time <input type="checkbox"/> 3 A little of the time <input type="checkbox"/> 4 None of the time <input type="checkbox"/> 5
12.11 Have you felt down	All of the time <input type="checkbox"/> 1 Most of the time <input type="checkbox"/> 2 Some of the time <input type="checkbox"/> 3 A little of the time <input type="checkbox"/> 4 None of the time <input type="checkbox"/> 5
12.12 Has your physical health or emotional problems interfered with your social activities (like visiting friends, relative, etc)	All of the time <input type="checkbox"/> 1 Most of the time <input type="checkbox"/> 2 Some of the time <input type="checkbox"/> 3 A little of the time <input type="checkbox"/> 4 None of the time <input type="checkbox"/> 5

13. SMOKING

- 13.1 Have you EVER smoked a cigarette? No (**GO TO Q13.20**) 0
..... Yes 1
- 13.2 How OLD were you when you FIRST started smoking cigarettes?
- 13.3 In the 12 months before coming into custody how often did you smoke cigarettes?
- Never 0
Almost everyday or everyday 1
3 - 4 Days a week 2
1 - 2 Days a week 3
Fortnightly 4
Monthly 5
Less than once a month 6
- 13.4 On the days that you smoked in the 12 months before coming into custody, about how many cigarettes did you usually smoke?
-
- 13.5 What types of cigarettes do you prefer?
- Tailor made 1
Roll your own 2
Both 3
No preference 4
- 13.6 In the 12 months before coming into custody had you quit smoking or tried to quit smoking?
- No (**GO TO Q13.8**) 0
..... Yes 1

13.7 If yes, tried to quit in the 12 months before coming into custody, did you use nicotine patches nicotine gum or medication to quit smoking?
No 0
Yes 1

13.8 Do you currently smoke cigarettes?No (**Go to Q13.11**) 0
Yes 1

13.9 How often do you currently smoke?
 Almost everyday or everyday 1
 3 - 4 Days a week 2
 1 - 2 Days a week 3
 Fortnightly 4
 Monthly 5
 Less than once a month 6

13.10 On the days that you smoke, about how many cigarettes do you usually smoke?

13.11 If not currently smoke, will you smoke when you are released?
No (**Go to Q13.20**) 0
Yes 1

13.12 Are you planning to give up smoking?
 No 0
 Yes, but not in the next 3 months 1
 Yes, within the next 3 months 2

13.13 Would you like to quit smoking?No 0
Yes 1

13.14 Do you feel you need help to quit smoking?
No (**GO TO Q13.16**) 0
Yes 1

13.15 What sort of assistance would help you?

13.16 Have you received help or treatment to quit smoking since coming into custody?
No (**GO TO Q13.19**) 0
Yes 1

13.17 Who did you receive help or treatment from?
 GP 1
 Counsellor 2
 Psychologist 3
 Nurse 4
 Other (Specify) _____

13.18 Have you ever received nicotine replacement patches in custody?
No 0
Yes 1

- 13.19 (If under 18 years), Where do you mostly get your tobacco from?
- Shop 1
- Vending machine 2
- Friends 3
- Family 4
- Other (Specify) _____
- 13.20 Do either of your parents smoke cigarettes? No 0
 Yes 1
- 13.21 Do you think staff should be allowed to smoke in the centre?
 No 0
 Yes 1

14. ALCOHOL

- 14.1 Have you EVER tried alcohol?
 No (**GO TO Q14.20**) 0
 Yes 1
- 14.2 Have you EVER had a FULL drink of alcohol? (eg. a glass of wine, a whole nip of spirits, a glass of beer, etc)
 No (**GO TO Q14.20**) 0
 Yes 1
- 14.3 How OLD were you when you had your FIRST FULL drink of alcohol?
- 14.4 Have you EVER been drunk?
 No (**GO TO Q14.7**) 0
 Yes 1
- 14.5 How OLD were you when you were drunk for the FIRST TIME?
 Cannot remember 1
- 14.6 In the 12 MONTHS BEFORE COMING INTO CUSTODY, how often were you drunk?
- Never 1
- Less than monthly 2
- Monthly 3
- Weekly 4
- Daily or almost daily 5

- 14.7 When you drink alcohol, what type of alcohol would you USUALLY have to drink?
[Interviewer: unprompted]
- Cask wine 1
- Bottled wine 2
- Regular strength beer (>4% ALCM/Vol) 3
- Mid strength beer (3-3.9% Vol/Vol) 4
- Low strength beer (1-2.9% Vol/Vol) 5
- Premixed spirits in a can (eg. UDL,) 6
- Bottled spirits and liqueurs 7
- Premixed bottles 8
- Cider 9
- Home brewed wine 10
- Fortified wine, port, vermouth, sherry, etc. 11
- Other (Specify) _____
- 14.8 How often during the last year (before you were in custody), did you have a drink containing alcohol?
- Never (**GO TO Q14.18**) 1
- monthly or less 2
- 2 - 4 times a month 3
- 2 - 3 times a week 4
- 4+ times a week 5
- 14.9 How MANY DRINKS containing alcohol did you have on a TYPICAL DAY when you were drinking?
[Interviewer: Use prompt card to answer]
- 1 or 2 1
- 3 or 4 2
- 5 or 6 3
- 7 to 9 4
- 10 or more 5
- 14.10 How OFTEN did you have 6 OR MORE drinks on ONE occasion?
- Never 1
- Less than monthly 2
- Monthly 3
- Weekly 4
- Daily or almost daily 5

How often during the last year (before you were in custody):

14.11 Have you failed to do what was normally expected of you because of drinking?	Never <input type="checkbox"/> 1 Less than monthly <input type="checkbox"/> 2 Monthly <input type="checkbox"/> 3 Weekly <input type="checkbox"/> 4 Daily or almost daily <input type="checkbox"/> 5
14.12 Were you unable to stop drinking once you have started?	Never <input type="checkbox"/> 1 Less than monthly <input type="checkbox"/> 2 Monthly <input type="checkbox"/> 3 Weekly <input type="checkbox"/> 4 Daily or almost daily <input type="checkbox"/> 5
14.13 Were you unable to remember what happened the night before because you had been drinking?	Never <input type="checkbox"/> 1 Less than monthly <input type="checkbox"/> 2 Monthly <input type="checkbox"/> 3 Weekly <input type="checkbox"/> 4 Daily or almost daily <input type="checkbox"/> 5
14.14 Did you need a first drink in the morning to get yourself going after a heavy drinking session?	Never <input type="checkbox"/> 1 Less than monthly <input type="checkbox"/> 2 Monthly <input type="checkbox"/> 3 Weekly <input type="checkbox"/> 4 Daily or almost daily <input type="checkbox"/> 5
14.15 Did you have a feeling of guilt or remorse after drinking?	Never <input type="checkbox"/> 1 Less than monthly <input type="checkbox"/> 2 Monthly <input type="checkbox"/> 3 Weekly <input type="checkbox"/> 4 Daily or almost daily <input type="checkbox"/> 5

14.16 Have you or someone else ever been injured as a result of your drinking?

No 1

Yes, but not in the last year 2

Yes, during the last year 3

14.17 Has a relative or a friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?

No 1

Yes, but not in the last year 2

Yes, during the last year 3

14.18 Has your alcohol use caused you any problems in the past year? (*i.e.: with school, friends, health, police, parents*)

.....No 0

.....Yes 1

14.19 (*If under 18 years*), Where do you mostly get your alcohol from?

Shop 1

Parents 2

Friends 3

Siblings/other family members 4

Other (Specify) _____

14.20 Have you felt that any of the following people ever had problems such as family, health, work or law due to their use of alcohol? (Tick all that apply)

Mother 1

Father 2

Husband/Wife/Partner 3

Children 4

Other family members 5

Close Friends 6

Other (Specify) _____ 7

14.21 in the PAST 12 MONTHS, did any person affected by ALCOHOL...

	Yes	No
Verbally abuse you	<input type="checkbox"/> 1	<input type="checkbox"/> 0
Physically abuse you	<input type="checkbox"/> 1	<input type="checkbox"/> 0
Put you in fear	<input type="checkbox"/> 1	<input type="checkbox"/> 0

15. DRUG USE

15.1 Type of Drug	Ever used? Y/N	Age first used In years	How often did you use it in THE 12 months before coming into custody? Please code as below	Age of escalation in use	How did you use it (Smoke, ingest, inhale, injection etc.)	Has your drug use caused you any problems in the past year? (i.e.: with school, friends, health, police, parents)
a) Cannabis						No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
b) Heroin						No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
c) Other opiates (eg. pethidine, morphine)						No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
d) Your Methadone/Buprenorphine						No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
e) Other's Methadone/Buprenorphine						No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
f) Amphetamines/speed						No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
g) Ice (Methamphetamines)						No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
h) Cocaine/coke						No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
i) Ecstasy/Designer drugs						No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
j) LSD/Acid						No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
k) Tranquillisers/Benzodiazepines						No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
l) Steroids						No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
m) Anaesthetics (eg. GHB, Ketamine)						No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
n) Volatile inhalants (eg. amyl nitrate)						No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
o) Volatile solvents (eg. petrol, glue)						No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
p) Other (Specify) _____						No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
q) Other (Specify) _____						No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
<p>Coding for frequency of use: More than daily (1), daily (2), 3 - 6 times per week (3), 1 - 2 times per week (4), 2 - 3 times per month (5), once per month (6), once or twice (7), other Specify</p> <p>(If never tried drugs GO TO Q15.14)</p>						

15.2 SEVERITY OF DEPENDENCE

If (drug) use occurred more than once per week in the 12 months prior to custody, please ask the following:

In the past six months:	Cannabis	Heroin	Amphetamines/ice	Other (Specify)
1. Did you think your use of (drug) was out of control?	Never/almost never <input type="checkbox"/> 0 Sometimes <input type="checkbox"/> 1 Often <input type="checkbox"/> 2 Always/nearly always <input type="checkbox"/> 3	Never/almost never <input type="checkbox"/> 0 Sometimes <input type="checkbox"/> 1 Often <input type="checkbox"/> 2 Always/nearly always <input type="checkbox"/> 3	Never/almost never <input type="checkbox"/> 0 Sometimes <input type="checkbox"/> 1 Often <input type="checkbox"/> 2 Always/nearly always <input type="checkbox"/> 3	Never/almost never <input type="checkbox"/> 0 Sometimes <input type="checkbox"/> 1 Often <input type="checkbox"/> 2 Always/nearly always <input type="checkbox"/> 3
2. Did the prospect of missing a fix/shot of (drug) make you anxious or worried?	Never/almost never <input type="checkbox"/> 0 Sometimes <input type="checkbox"/> 1 Often <input type="checkbox"/> 2 Always/nearly always <input type="checkbox"/> 3	Never/almost never <input type="checkbox"/> 0 Sometimes <input type="checkbox"/> 1 Often <input type="checkbox"/> 2 Always/nearly always <input type="checkbox"/> 3	Never/almost never <input type="checkbox"/> 0 Sometimes <input type="checkbox"/> 1 Often <input type="checkbox"/> 2 Always/nearly always <input type="checkbox"/> 3	Never/almost never <input type="checkbox"/> 0 Sometimes <input type="checkbox"/> 1 Often <input type="checkbox"/> 2 Always/nearly always <input type="checkbox"/> 3
3. Did you worry about your use of (drug)?	Never/almost never <input type="checkbox"/> 0 Sometimes <input type="checkbox"/> 1 Often <input type="checkbox"/> 2 Always/nearly always <input type="checkbox"/> 3	Never/almost never <input type="checkbox"/> 0 Sometimes <input type="checkbox"/> 1 Often <input type="checkbox"/> 2 Always/nearly always <input type="checkbox"/> 3	Never/almost never <input type="checkbox"/> 0 Sometimes <input type="checkbox"/> 1 Often <input type="checkbox"/> 2 Always/nearly always <input type="checkbox"/> 3	Never/almost never <input type="checkbox"/> 0 Sometimes <input type="checkbox"/> 1 Often <input type="checkbox"/> 2 Always/nearly always <input type="checkbox"/> 3
4. Did you wish you could stop using (drug)?	Never/almost never <input type="checkbox"/> 0 Sometimes <input type="checkbox"/> 1 Often <input type="checkbox"/> 2 Always/nearly always <input type="checkbox"/> 3	Never/almost never <input type="checkbox"/> 0 Sometimes <input type="checkbox"/> 1 Often <input type="checkbox"/> 2 Always/nearly always <input type="checkbox"/> 3	Never/almost never <input type="checkbox"/> 0 Sometimes <input type="checkbox"/> 1 Often <input type="checkbox"/> 2 Always/nearly always <input type="checkbox"/> 3	Never/almost never <input type="checkbox"/> 0 Sometimes <input type="checkbox"/> 1 Often <input type="checkbox"/> 2 Always/nearly always <input type="checkbox"/> 3
5. How difficult would you find it to stop or go without (Drug)?	Never/almost never <input type="checkbox"/> 0 Sometimes <input type="checkbox"/> 1 Often <input type="checkbox"/> 2 Always/nearly always <input type="checkbox"/> 3	Never/almost never <input type="checkbox"/> 0 Sometimes <input type="checkbox"/> 1 Often <input type="checkbox"/> 2 Always/nearly always <input type="checkbox"/> 3	Never/almost never <input type="checkbox"/> 0 Sometimes <input type="checkbox"/> 1 Often <input type="checkbox"/> 2 Always/nearly always <input type="checkbox"/> 3	Never/almost never <input type="checkbox"/> 0 Sometimes <input type="checkbox"/> 1 Often <input type="checkbox"/> 2 Always/nearly always <input type="checkbox"/> 3

- 15.3 What factors influenced your decision to FIRST use an illicit drug (including cannabis)?
[Interviewer: Tick all that apply]
- Friends used/offered by a friend (peer pressure) ... 1
 - Wanted to see what it was like (curiosity) 2
 - To feel better/to stop feeling unhappy 3
 - To take a risk 4
 - To do something exciting 5
 - Family problems (eg: parents separated, didn't get on with parents) 6
 - Work/school/relationship problems 7
 - Traumatic experience (eg: sexual or physical assault, death of someone close) 8
 - To lose weight 9
 - For fun 10
 - Because it was available 11
 - Don't know 12
 - Other (Specify) _____
- 15.4 Have you EVER committed a crime to get drugs and/or alcohol?
 No 0
 Yes 1
- 15.5 For your CURRENT offence, were you under the influence of DRUGS at the time of the offence?
 No 0
 Yes 1
- 15.6 For your CURRENT offence, were you under the influence of ALCOHOL at the time of the offence?
 No 0
 Yes 1
- 15.7 Have you ever injected drugs?
(Note: If they indicated history of injection on previous page, tick yes; if not, please ask.)
 No (**GO TO Q15.14**) 0
 Yes 1
- 15.8 About how OLD were you when you FIRST injected drugs? (*this included being injected by someone else*).....
- 15.9 Have you injected drugs in the LAST 12 MONTHS?..... No (**GO TO Q15.13**) 0
 Yes 1

- 15.10 In the last 12 months, how often did you share injecting equipment (syringe, spoon, tourniquet etc) – either using someone else's or lending yours to another person?
 Never 1
 Once 2
 A few times 3
 Often 4
- 15.11 How often would you be the first to use the injecting equipment?
 Never 1
 Sometimes 2
 Always 3
 Don't know 4
- 15.12 When did you last share needles or injecting equipment?
 <1 month ago 1
 1 - <6 months ago 2
 6 months - <2 year ago 3
 2 - <5 years ago 4
 5 years ago or more 5
- 15.13 Have you ever used needle and syringe program (NSP) services in the community?
 No 0
 Yes 1
 Don't know 2
 Never heard of NSP's 3
- 15.14 Have you felt that any of the following people ever had problems such as family, health, work or law due to their use of illicit drugs?
(Tick all that apply)
- Mother 1
 - Father 2
 - Husband/Wife/Partner 3
 - Children 4
 - Other family members 5
 - Close Friends 6
 - Other (Specify) _____ 7
- 15.15 In the PAST 12 MONTHS, did any person affected by DRUGS...

	Yes	No
Verbally abuse you	<input type="checkbox"/> 1	<input type="checkbox"/> 0
Physically abuse you	<input type="checkbox"/> 1	<input type="checkbox"/> 0
Put you in fear	<input type="checkbox"/> 1	<input type="checkbox"/> 0

16. DRUG TREATMENT

[Interviewer: This section is for YES responses to ALCOHOL AND DRUG USE]

- 16.1 Have you EVER received treatment for a drug or alcohol problem (eg. gp, detox or rehab centre, methadone, narcotics anonymous, alcoholics anonymous)?
 No (GO TO 16.8) 0
 Yes 1
- 16.2 If yes, where did you receive treatment for your drug or alcohol problem?
 Community only 1
 Custody only 2
 Both community and custody 3
- 16.3 If yes, have you ever been on a methadone or buprenorphine program?
 Yes, am on it now 1
 Yes, in the past 2
 No, but on the waiting list 3
 No, never 4
- 16.4 Have you EVER been in a Detoxification or rehabilitation Centre for alcohol or drug problems?
 No (GO TO Q16.6) 0
 Yes 1
- 16.5 How long did you stay (days)?
- 16.6 What OTHER DRUG AND ALCOHOL services have you received help or treatment from?
 [Interviewer: prompt if required]
 GP 1
 Narcotics Anonymous 2
 Alcoholics Anonymous 3
 Outpatient Counselling 4
 Youth Workers 5
 Psychiatrist 6
 Psychologist 7
 Other Counsellor (Specify) 8
 Other (Specify) _____
- 16.7 If received help or treatment for a drug or alcohol program while in custody, who did you receive help from?
 Doctor 1
 Counsellor 2
 Psychologist 3
 Nurse 4
 Other (Specify) _____

- 16.8 Do you think that you need help for your drug and/ or alcohol problems while in custody?
 No 0
 Yes 1

17. SEXUAL HEALTH

- 17.1 Have you EVER had sex? (by this I mean vaginal, anal or oral sex. this does not include masturbation.)
 No (GO TO Q17.28) 0
 Yes 1
- 17.2 How OLD were you when you FIRST had vaginal, anal or oral sex?
 Age first time:
 Vaginal Anal Oral
- 17.3 How MANY TIMES have you EVER had, vaginal, anal or oral sex ?
 Number of times:
 Vaginal Anal Oral
- 17.4 In your LIFETIME how many different people have you had VAGINAL sex with?
 None (GO TO Q17.6) 0
 1 1
 2 2
 3 - 5 3
 6 - 10 4
 11 - 20 5
 21 - 50 6
 51 - 100 7
 Over 100 8
- 17.5 Was this with males or females?
 Males 1
 Females 2
 Both 3
- 17.6 In your LIFETIME how many different people have you had ORAL sex with?
 None (GO TO Q17.8) 0
 1 1
 2 2
 3 - 5 3
 6 - 10 4
 11 - 20 5
 21 - 50 6
 51 - 100 7
 Over 100 8

- 17.7 Was this with males or females?
- Males 1
- Females 2
- Both 3

- 17.8 In your LIFETIME how many different people have you had ANAL sex with?
- None (**GO TO Q17.10**) 0
- 1 1
- 2 2
- 3 - 5 3
- 6 - 10 4
- 11 - 20 5
- 21 - 50 6
- 51 - 100 7
- Over 100 8

- 17.9 Was this with males or females?
- Males 1
- Females 2
- Both 3

- 17.10 In the PAST 12 MONTHS how many different people have you had VAGINAL OR ANAL sex with?
- None 0
- 1 1
- 2 2
- 3 - 5 3
- 6 - 10 4
- 11 - 20 5
- 21 - 50 6
- 51 - 100 7
- Over 100 8

- 17.11 In the PAST 12 MONTHS how many different people have you had ORAL sex with?
- None 0
- 1 1
- 2 2
- 3 - 5 3
- 6 - 10 4
- 11 - 20 5
- 21 - 50 6
- 51 - 100 7
- Over 100 8

- 17.12 When you have VAGINAL OR ANAL sex with CASUAL PARTNERS how often do you use condoms?
- Never 0
- Less than half the time 1
- More than half the time 2
- Always 3

17.13 If NEVER or LESS THAN HALF THE TIME, then why?

- 17.14 When you have sex with your REGULAR partner do you use condoms?
- Never 0
- Less than half the time 1
- More than half the time 2
- Always 3

17.15 If NEVER or LESS THAN HALF THE TIME, then why?

- 17.16 When you have sex WHAT TYPES of contraceptives do you use to prevent pregnancy? [*Interviewer: tick all that apply*]
- None 1
- Oral contraceptives (pills) 2
- Condom 3
- Depo provera 4
- Implanon (implant) 4
- Intrauterine contraceptive device (iucd) 5
- Diaphragm 6
- Other (Specify) _____

- 17.17 Have you EVER had sex to get drugs or money?
- No (**GO TO Q17.19**) 0
- Yes 1
- Don't want to say 2
- Can't Remember 3

17.18 In your LIFETIME, how many times has this happened?

- 17.19 Have you EVER worked as a sex worker? No (**GO TO Q17.24**) 0
- Yes 1

- 17.20 What VENUES did you work when you were paid to have sex? (read all the options, and tick as many as you need.)
- Street work 1
- Small 'house' 2
- Escort agency 3
- Massage 4
- Brothel 5
- Private operator 6
- Pimp/madam 7
- Other (Specify) _____

- 17.21 WHAT PERIOD OF TIME OVERALL were you working as a sex worker?
- Less than 1 month 1
- 1 - 6 Months 2
- 6 - 12 Months 3
- 1 - 2 Years 4
- 2 - 3 Years 5
- 3 - 5 Years 6
- > 5 years 7

- 17.22 How OFTEN did you use condoms while working as a sex worker when having vaginal OR ANAL sex?
- Never 0
- Less than half the time 1
- More than half the time 2
- Always 3

17.23 If never or less than half the time, then why?

- 17.24 Do you have any symptoms at the moment that makes you think you may have a sexually transmitted infection? (Interviewer: this is for people not currently receiving treatment)
- No (**GO TO Q17.26**) 0
- Yes 1
- Don't know 2
- Don't want to say 3

17.25 What symptoms are they?

17.26 Have you ever had any of the following?

Disease	Ever have?	Were you diagnosed in custody or the community	Have you received treatment for this problem?
a) Cold sores	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	Custody <input type="checkbox"/> 1 Community <input type="checkbox"/> 2 Both <input type="checkbox"/> 3	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
b) Genital warts	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	Custody <input type="checkbox"/> 1 Community <input type="checkbox"/> 2 Both <input type="checkbox"/> 3	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
c) Chlamydia	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	Custody <input type="checkbox"/> 1 Community <input type="checkbox"/> 2 Both <input type="checkbox"/> 3	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
d) Genital herpes	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	Custody <input type="checkbox"/> 1 Community <input type="checkbox"/> 2 Both <input type="checkbox"/> 3	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1

e) Pubic lice or crabs	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	Custody <input type="checkbox"/> 1 Community <input type="checkbox"/> 2 Both <input type="checkbox"/> 3	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
f) Gonorrhoea	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	Custody <input type="checkbox"/> 1 Community <input type="checkbox"/> 2 Both <input type="checkbox"/> 3	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
g) HIV	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	Custody <input type="checkbox"/> 1 Community <input type="checkbox"/> 2 Both <input type="checkbox"/> 3	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
h) Syphilis	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	Custody <input type="checkbox"/> 1 Community <input type="checkbox"/> 2 Both <input type="checkbox"/> 3	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
i) Non-specific urethritis	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	Custody <input type="checkbox"/> 1 Community <input type="checkbox"/> 2 Both <input type="checkbox"/> 3	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
j) Other (Specify) _____	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	Custody <input type="checkbox"/> 1 Community <input type="checkbox"/> 2 Both <input type="checkbox"/> 3	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1

- 17.28 Have you ever had sex against your will?
- No 0
- Yes 1
- Don't want to say 2

- 17.29 Are you aware of other detainees having sex while in custody?
- No 0
- Yes 1
- Don't want to say 2

- 17.30 Do you think that condoms or dental dams should be available in custody?
- No 0
- Yes 1
- Don't want to say 2

18. WOMENS HEALTH

- 18.1 How old were you when you had your first menstrual period?
- Not started menstruating (**GO TO Q18.14**) 0

- 18.2 Have you ever had a pap smear?
- No (**GO TO Q18.7**) 0
- Yes 1

- 18.3 How often do you have a pap smear?
- Once only 1
- Twice a year 2
- Yearly 3
- Once every two years 4
- Other (Specify) _____

- 18.4 Where was your last pap smear done?
 In custody 1
 In the community 2
- 18.5 When was your last pap smear?
 Less than six months ago 1
 6 - <12 Months ago 2
 12 Months - <2 years ago 3
 2 - <4 Years ago 4
 4 Years or more ago 5
 Can't remember 6
- 18.6 Do you know what the result of the pap smear was?
 Normal 1
 Abnormal 2
 Don't know 3
- 18.7 Have you EVER been pregnant?
 No (**GO TO Q18.14**) 0
 Yes 1
 Unsure 2
- 18.8 How OLD were you first got pregnant?
- 18.9 Have you EVER had a termination of pregnancy?
 No (**GO TO Q18.12**) 0
 Yes 1
- 18.10 How many terminations have you had?
- 18.11 How old were you when you first had a termination of pregnancy?
- 18.12 Have you ever had any miscarriages?
 Yes 1
 No (**GO TO Q18.14**) 2
- 18.13 How many miscarriages have you had?
- 18.14 Have you had the cervical cancer vaccine? No 0
 Yes 1

19. TATTOOING/BODY PIERCING

- 19.1 Do you have ANY body piercing or tattoos?
 No (**GO TO SECTION 20**) 0
 Yes 1

	No of.	Where were they done?	Were they all done by a professional?
<i>Tattoos</i>		Custody <input type="checkbox"/> 1 Community <input type="checkbox"/> 2 Both <input type="checkbox"/> 3	No (GO TO Q19.2) <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
<i>Body Piercing</i>		Custody <input type="checkbox"/> 1 Community <input type="checkbox"/> 2 Both <input type="checkbox"/> 3	No (GO TO Q19.5) <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1 Location: _____

- 19.2 If the tattoos were done by a NON-PROFESSIONAL was the equipment cleaned BEFORE USE?
 New equipment (**GO TO Q19.5**) 1
 Cleaned 2
 Not cleaned (**GO TO Q19.4**) 3
 Don't know if cleaned (**GO TO Q19.5**) 4
- 19.3 IF EQUIPMENT CLEANED, how was this done?
 Wiped 1
 Soaked in bleach 2
 Boiling water 3
 Cold water 4
 Other (Specify) _____
- 19.4 If NOT CLEANED, why was it not cleaned?
 Not enough time 1
 Nothing to clean it with 2
 Did not think cleaning was necessary 3
 Other (Specify) _____
- 19.5 If the body piercing was done by a NON-PROFESSIONAL was the equipment cleaned BEFORE USE?
 New equipment (**GO TO SECTION 20**) 1
 Cleaned 2
 Not cleaned (**GO TO Q19.7**) 3
 Don't know if cleaned (**GO TO SECTION 20**) 4
- 19.6 If EQUIPMENT CLEANED, how was this done?
 Wiped 1
 Soaked in bleach 2
 Boiling water 3
 Cold water 4
 Other (Specify) _____

- 19.7 If NOT CLEANED, why was it not cleaned?
- Not enough time 1
- Nothing to clean it with 2
- Did not think cleaning was necessary 3
- Other (Specify) _____

20. HEALTH EDUCATION

- 20.1 Have you EVER attended a health education/ program or group?
-No 0
-Yes 1

- 20.2 Have you EVER attended any health education/ programs or groups while IN CUSTODY?
- No (GO TO Q20.5) 0
- Yes 1

- 20.3 What health education/program or group was this?
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- 20.4 Who ran or managed this health education/program or group?
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- 20.5 Have you EVER had individual health education sessions (one to one) while in custody?
- No (GO TO Q20.7) 0
- Yes 1

- 20.6 Who gave you this health education?
- | |
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- 20.7 Do you EVER visit the clinic just TO SEE OR TALK to the nurse when you DID NOT REALLY have a health problem?
- Never 1
- Hardly ever 2
- Sometimes 3
- Often 4
- Most of the time 5

- 20.8 Do you EVER try to visit the clinic but not been able to be seen?
- Never 1
- Hardly ever 2
- Sometimes 3
- Often 4
- Most of the time 5

- 20.9 Do you think that there are SUFFICIENT health services provided by the clinic IN CUSTODY?
-No 0
- Yes (GO TO Q20.11) 1

- 20.10 What OTHER health services should be available at the Centre?
- | |
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- 20.11 Can you tell me THREE WAYS you can catch HIV?
- 1
- 2
- 3

- 20.12 Can you tell me THREE WAYS you can catch Hepatitis B?
- 1
- 2
- 3

- 20.13 Can you tell me THREE WAYS you can catch Hepatitis C?
- 1
- 2
- 3

- 20.14 While AT SCHOOL, did you have any lessons or parts of lessons that were about smoking?
- No, not even part of a lesson (GO TO Q20.16) ... 1
- Yes, part of a lesson 2
- Yes, one lesson 3
- Yes, more than one lesson 4

- 20.15 What were the THREE MAIN THINGS you learnt about smoking?
- | |
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- 20.16 While AT SCHOOL, did you have any lessons or parts of lessons about drinking?
- NO, not even part of a lesson (**GO TO Q20.18**) 1
- Yes, part of a lesson 2
- Yes, one lesson 3
- Yes, more than one lesson 4

20.17 What were the THREE MAIN THINGS you learnt about drinking?

- 20.18 While AT SCHOOL, did you have any lessons or parts of lessons that were about illicit drugs such as marijuana, ecstasy, heroin, amphetamines, hallucinogens, and cocaine?
- NO, not even part of a lesson (**GO TO Q20.18**).. 1
- Yes, part of a lesson 2
- Yes, one lesson 3
- Yes, more than one lesson 4

20.19 What were the THREE MAIN THINGS you learnt about illicit drugs?

- 20.20 While AT SCHOOL, did you have any lessons or parts of lessons about sexually transmitted infections?
- NO, not even part of a lesson (**GO TO SECTION 21**) 1
- Yes, part of a lesson 2
- Yes, one lesson 3
- Yes, more than one lesson 4

20.21 What were the THREE MAIN THINGS you learnt about sexually transmitted infections?

21. MENS HEALTH

[Interviewer: The following questions are for males only]

- 21.1 Do you know how to properly examine your testicles ("balls") for lumps?
-No 0
-Yes 1
- 21.2 Have you EVER examined your testicles for abnormal lumps?
-No (**GO TO SECTION 23**) 0
-Yes 1
- 21.3 How OFTEN do you examine them?
- Once only 1
- Weekly 2
- Monthly 3
- Less than this 4

22. PHYSICAL ACTIVITY

- 22.1 Prior to custody, How OFTEN did you usually play sport or do exercises?
- Never 1
- Less than once a week 2
- Two or more times a week 3
- Everyday 4
- 22.2 Prior to custody, When you do vigorous exercises, how long do you usually spend?
- Less than 21 minutes 1
- 21 - 39 minutes 2
- 40 - 60 minutes 3
- More than 1 hour 4
- 22.3 In the PAST 2 WEEKS how often have you exercised or played sport or games that made you sweat and breathe hard (eg: basketball, netball, football, SOCCER, jogging or similar activities)?
- Daily 1
- Three or more times a week 2
- Once a week 3
- Not at all 4
- 22.4 Over the past 12 MONTHS, not counting physical education classes at school, did you take part in an organised sport?
-No 0
-Yes 1
- 22.5 Do you feel that there are enough recreational activities available for you to do in your free time in the community, like movies, disco, sports, and places to go?
-No 0
-Yes 1

22.6 What do you like to do in your free time in the community?

22.7 Do you feel that there are enough recreational activities available for you to do in your free time, in custody?
No 0
Yes 1

22.8 What do you like to do in your free time in custody?

23. SUN PROTECTION

Thinking about sunny days in summer (when you are not in custody), when you are outside for an hour or more between 11am and 3pm, how often would you do any of the following?

	Never	Rarely	Sometimes	Usually	Always
23.1 Wear a hat OR CAP?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
23.2 Wear clothes covering most of your body (including arms and legs)?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
23.3 Deliberately wear less or briefer clothing so as to get some sun on your skin?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
23.4 Wear maximum protection sunscreen (30+)?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
23.5 Wear SUNGLASSES	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
23.6 Stay mainly in the shade?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
23.7 How often would you spend most of your time inside?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

23.8 What is the SPF (Sun Protection Factor) of the sunscreen you usually use on a sunny day in summer?
 Don't use sunscreen 0
 SPF 12 or lower 1
 SPF 15 2
 SPF 30+ 3
 Can't remember/don't know 4

23.9 How OFTEN do you use sun block or sunscreens IN CUSTODY?
 Never 0
 Rarely 1
 Sometimes 2
 Usually 3
 Always 4

23.10 If never, rarely or sometimes why do you not use sun block IN CUSTODY?

23.11 On AVERAGE how many hours do usually you spend outside each day?
 None 0
 < 1 hour 1
 1 - 2 hours 2
 > 2 hours less < 4 hours 3
 > 4 hours < 6 hours 4
 > 6 hours 5

23.12 Over the LAST SUMMER, did you get sunburn that was sore or tender the next day?
 Not at all 0
 Yes, just once 1
 Yes, two or more times 2
 Yes, 4 or more times 3

24. NUTRITION

These Questions are about what you would normally eat BEFORE YOU CAME INTO CUSTODY?

How many times a week did you:	Never	1 or 2 times per week	3 or 4 times per week	Every day
24.1 Eat Breakfast	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
24.2 Eat Fresh Fruit	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
24.3 Drink fruit juice	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
24.4 Eat green salad	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
24.5 Eat fresh vegetables	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
24.6 Eat a hamburger, meat pie, hot dog or sausage?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
24.7 Eat potato chips/ crisps	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
24.8 Eat biscuits, doughnuts, chocolate bars, ice cream, pie or cakes?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
24.9 Eat takeaway food	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
24.10 Drink milk	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

24.11 IN THE COMMUNITY, when you are thirsty, what did you usually drink?

- Water 1
 Soft drink 2
 Fruit Juice 3
 Cordial 4

Other (Specify) _____

Since you've been in custody, what do you eat?

How many times a week did you:	Never	1 or 2 times per week	3 or 4 times per week	Every day
24.12 Eat Breakfast	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
24.13 Eat Fresh Fruit	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
24.14 Drink fruit juice	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
24.15 Eat green salad	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
24.16 Eat fresh vegetables	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
24.17 Eat a hamburger, meat pie, hot dog or sausage?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
24.18 Eat potato chips/ crisps	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

24.19 Eat biscuits, doughnuts, chocolate bars, ice cream, pie or cakes?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
24.20 Eat takeaway food	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
24.21 Drink milk	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

24.22 Since you've been in custody, when you are thirsty, what did you usually drink?

- Water 1
 Soft drink 2
 Fruit Juice 3
 Cordial 4
 Other (Specify) _____

25. LIFESTYLE

25.1 HOW MANY BEST FRIENDS OR CLOSE FRIENDS do you have, by this we mean the people that you trust and confide in.

They are friends that you see or hang out with at school, work or tafe or outside custody. They can include cousins, brothers and sisters.

[Interviewer: record number in boxes provided.]

Close Friend (s)

25.2 How many of these friends are RELATED to you?

25.3 What are the AGES of your closest friends?

1. 2. 3. 4.

25.4 How many of your close friends:	None	A few	Most	All
a) Smoke cigarettes	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
b) Drink alcohol	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
c) Have tried marijuana	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
d) Have tried drugs other than marijuana	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
e) Break the law	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
f) Have been in custody	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

25.5 How many of your close friends have done the following:	None	A few
a) Cut or skipped school without permission	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b) Dropped out of school	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c) Been suspended from school	<input type="checkbox"/> 1	<input type="checkbox"/> 2
d) Worked for an employer or at odd jobs	<input type="checkbox"/> 1	<input type="checkbox"/> 2

25.6 Which of the following statements, best corresponds to your situation with your close friends	True	Mostly True	Mostly False	False
a) My close friends push me to succeed and to do interesting things that I would not do by myself.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
b) When I make a decision, I take my close friends' opinion into account.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
c) My close friends sometimes push me to do foolish or stupid things.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

25.7 HOW OFTEN do you talk to your close friends about yourself or your problems?

- Never 0
 Once in a while (Once or twice a month 1
 Often (Once or twice a week 2
 Nearly every day 3

25.8 OTHER THAN YOUR CLOSE FRIENDS, do you have anyone else in particular you can talk to about yourself or your problems?

- No (**GO TO Q25.10**) 0
 Yes 1

25.9 What is their relationship to you?

(Tick all that apply)

- Mother 1
 Father 2
 Stepmother 3
 Stepfather 4
 Brother 5
 Sister 6
 Grandparent 7
 Other Relative 8
 A friend of the family or a friends parent 9
 Parents' boyfriend/girlfriend 10
 Teacher 11
 Coach/leader (eg: Scout, Guide or church) 12
 Other (eg: Family Doctor) 13

25.10 In the LAST 6 MONTHS, how often have you been in a physical fight?

- Never (**GO TO Q25.13**) 1
 Once 2
 2 or 3 times 3
 4 or 5 times 4
 6 or more times 5

25.11 The LAST time you were in a physical fight, who did you fight with?

- A stranger 1
 A friend or someone I know 2
 A boyfriend or girlfriend 3
 A parent, brother, sister or other family 4
 Someone else (unspecified) 5

25.12 Did you need to be treated by a doctor or nurse because of any of the fights you had in the LAST 6 MONTHS?

- No 0
 Yes 1

BULLYING is when another person or a group of people, pick on someone, or say nasty and unpleasant things, hits, kicks, threatens, sends nasty notes, ignores them and things like that.

25.13 Have you EVER been bullied?

- No (**GO TO Q25.21**) 0
 Yes 1

25.14 Where have you been bullied?

(Tick all that apply)

- School 0
 At home 1
 On the streets 2
 In custody 3
 Other (Specify) _____ 4

25.15 When was the last time you were bullied?

- In the last month 0
 Between 1 - <3 months ago 1
 Between 3 - <6 months ago 2
 Between 6 - <12 months ago 3
 Between 1 - <2 years ago 4
 Between 2 - <5 years ago 5
 5 or more years ago 6

25.16 HOW OFTEN were you bullied?

- Once in a while (Once or twice a month) 1
 Often (Once or twice a week) 2
 Nearly every day 3
 Other (Specify) _____ 4

25.17 Who bullied you? (Tick all that apply)

- Parents/guardians 0
 Siblings..... 1
 Other family members 2
 Older peers/friends 3
 Younger peers/friends..... 4
 Other (Specify) _____ 5

- 25.18 How old were the people who bullied you?
(Tick all that apply)
- Older than me 0
- About the same age 1
- Younger than me 2
- 25.19 What gender were the people who bullied you?
- Males 0
- Females 1
- Both males and females 2
- 25.20 How did you feel about being bullied?
- Made you sad 1
- Made you angry 2
- Doesn't bother you 3
- Stressed you out 4
- Other (Specify) _____ 4
- 25.21 Have you EVER bullied other kids? No (GO TO SECTION 26) 0
..... Yes 1
- 25.22 How OFTEN have you bullied other kids?
- Once in a while 1
- Often 2
- Nearly every day 3
- 25.23 Where did this happen?
(Tick all that apply)
- School 0
- At home 1
- On the streets 2
- In custody 3
- Other (Specify) _____ 4
- 25.24 Who did you bully?
- Younger Males 1
- Same age males 2
- Older males 3
- Younger Females 4
- same age females 5
- Older females 6
- 25.25 How did you feel when you bullied other kids?
- | |
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26. WEIGHT/BODY IMAGE

- 26.1 How do you describe your weight?
- Very underweight 1
- Slightly underweight 2
- About the right weight 3
- Slightly overweight 4
- Very overweight 5
- 26.2 Which of the following are you trying to do about your weight?
- Lose weight 1
- Gain weight 2
- Stay the same weight 3
- Not trying to do anything about my weight 4
- 26.3 During the LAST 4 WEEKS (30 days), did you eat less food, fewer calories, or foods low in fat to lose weight or to keep from gaining weight?
- No (GO TO Q26.5) 0
- Yes 1
- 26.4 On how many days in the LAST 4 WEEKS have you done this?
- 26.5 During the LAST 4 WEEKS (30 days), did you go without eating for 24 hours or more (also called fasting) to lose weight or to keep from gaining weight?
- No (GO TO Q26.7) 0
- Yes 1
- 26.6 On how many days in the LAST 4 WEEKS have you done this?
- 26.7 During the LAST 4 WEEKS (30 days) did you vomit or take laxatives to lose weight or to keep from gaining weight?
- No (GO TO SECTION 27) 0
- Yes 1
- 26.8 On how many days in the LAST 4 WEEKS have you done this?
- 26.9 How do you think your weight has changed since coming into custody?
- Increased a lot 1
- Increased a little 2
- Stayed the same 3
- Decreased a little 4
- Decreased a lot 5

27. MENTAL HEALTH

- 27.1 Have you ever been admitted to a mental health unit or ward in a hospital?
No 0
Yes 1
- 27.2 Have you ever been seen by a mental health nurse in the courts?
 No (**GO TO Q27.4**) 0
 Yes 1
Don't know 2
- 27.3 If yes, was the service helpful for your mental health or legal problems?
No 0
 Yes 1
Don't know 2
- 27.4 Do you feel you CURRENTLY have any emotional, behavioural or mental health problem (s) for which you have not received counselling or treatment?
No (**GO TO SECTION 28**) 0
 Yes 1
- 27.5 What problems are these?

- 27.6 Have you wanted counselling or treatment for this/ these problems while in custody?
No 0
 Yes 1
- 27.7 What counselling or treatment do you think may help you with these problems?

- 27.8 Why have you not accessed services for these problems?
 Did not know who to go and see 1
 Afraid of what the doctor would say or do 2
 Thought the problem would go away 3
 Didn't have time 4
 Too embarrassed 5
 Didn't think anyone could help 6
 Other (Specify) _____

28. K10

Instructions: The following ten questions ask about how you have been feeling in the LAST 4 WEEKS.

<i>In the LAST 4 WEEKS, about how often did you feel.....?</i>	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a) Tired out for no good reason?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
b) Nervous?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
c) So nervous that nothing could calm you down?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
d) Hopeless?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
e) Restless or fidgety?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
f) So restless you could not sit still?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
g) Depressed?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
h) Everything was an effort?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
i) So sad that nothing could cheer you up?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
j) Worthless	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

29. SUICIDE AND SELF HARM

I am going to ask you some questions about self-harm and suicide. The act of trying to kill yourself is called attempting suicide. Questions about suicide will be asked shortly.

First I am going to ask you some questions about self-harm, which is the act of deliberately hurting or injuring yourself, BUT NOT trying to kill yourself.

- 29.1 Have you EVER considered hurting or injuring yourself?
 No (**GO TO Q29.5**) 0
 Yes 1
- 29.2 Did you consider hurting or injuring yourself in the LAST 12 MONTHS?
 No (**GO TO Q29.4**) 0
 Yes 1
- 29.3 Did you make a plan about how you would hurt or injure yourself in the LAST 12 MONTHS?
No 0
 Yes 1

- 29.4 SINCE YOU HAVE COME INTO CUSTODY, have the times that you have considered or planned to hurt or injure yourself:
- Greatly decreased 1
- Somewhat decreased 2
- Stayed the same 3
- Somewhat increased 4
- Greatly increased 5
- 29.5 Have you EVER INTENTIONALLY OR DELIBERATELY hurt or injured yourself?
- No (**GO TO Q29.14**) 0
- Yes 1
- 29.6 Have these self-harm incidents happened in the community or in custody?
- The community 1
- In custody 2
- Both 3
- 29.7 Did you intentionally or deliberately hurt or injure yourself in the LAST 12 MONTHS?
- No (**GO TO Q29.13**) 0
- Yes 1
- 29.8 During THE LAST 12 MONTHS how many times did you actually hurt or injure yourself?
- Never 1
- 1 Time 2
- 2 or 3 time 3
- 4 or 5 times 4
- 6 or more times 5
- Don't Know 6
- 29.9 what methods did you use in the LAST 12 MONTHS to deliberately hurt or injure yourself? *[Interviewers: Unprompted. Tick all that apply and record any others not listed]*
- Eating foreign objects 1
- Cigarette burns 2
- Lighter burns (smilies) 3
- Slashing/cutting of skin 4
- Biting of skin 5
- Attempting to cut off oxygen 6
- Banging head against 7
- Punching/kicking things repeatedly 8
- Stabbing self 9
- Other (Specify) _____
- 29.10 Did you tell anyone that you were thinking of harming yourself?
- No 0
- Yes 1

29.11 Who did you tell?

29.12 If you have hurt or injured yourself in the LAST 12 MONTHS did any attempt result in an injury, poisoning or overdose that had to be treated by a doctor, nurse or an ambulance officer?

..... No 0

..... Yes 1

29.13 SINCE YOU HAVE COME INTO CUSTODY, have the times that you have deliberately hurt or injured yourself?

Greatly decreased 1

Somewhat decreased 2

Stayed the same 3

Somewhat increased 4

Greatly increased 5

Now we are going on to talk about attempted suicide, which is the act of attempting to kill yourself.

29.14 Have you ever considered attempting suicide?

..... No (**GO TO Q29.19**) 0

..... Yes 1

29.15 If yes, During the LAST 12 MONTHS, did you consider attempting suicide?

..... No 0

..... Yes 1

29.16 Have you EVER made a plan about how you would attempt suicide?

..... No (**GO TO Q29.18**) 0

..... Yes 1

29.17 During the LAST 12 MONTHS have you made a plan about how you would attempt suicide?

..... No 0

..... Yes 1

29.18 Since you have come into custody, have the times that you have considered or planned to attempt suicide?

Greatly decreased 1

Somewhat decreased 2

Stayed the same 3

Somewhat increased 4

Greatly increased 5

29.19 Have you ever attempted suicide?

..... No (**GO TO Q29.27**) 0

..... Yes 1

- 29.20 During the LAST 12 MONTHS how many times did you actually attempt suicide?
- Never 1
 1 Time 2
 2 or 3 times 3
 4 or 5 times 4
 6 or more times 5
 Don't Know 6
- 29.21 Describe what METHODS you have used to attempt suicide? *[Interviewers: Unprompted, tick responses and record any others not listed]*
- Eating foreign objects (metal etc) 1
 Swallowing poisons 2
 Banging head against 3
 Punching/kicking things repeatedly 4
 Attempted hanging 5
 Attempted to cut off oxygen 6
 Attempted overdose (alcohol) 7
 Attempted overdose (pills) (Specify pills _____) 8
 Attempted overdose (heroin) 9
 Attempted overdose (other) 10
 Attempted overdose (polydrug) 11
 Firearms/gunshot 12
 Stabbing self 13
 Slashing wrists/other body parts 14
 Jumping from a height 15
 Car accident 16
 Other (Specify) _____
- 29.22 Did you tell anyone that you were thinking of committing suicide?
- No 0
 Yes 1
- 29.23 Who did you tell?
- | |
|--|
| |
| |
| |
- 29.24 If you have attempted suicide in the LAST 12 MONTHS did any attempt result in an injury, poisoning or overdose that had to be treated by a doctor or a nurse?
- No 0
 Yes 1
- 29.25 Have these suicide attempts happened in:
- The community 1
 In custody 2
 Both 3

- 29.26 Since you have come into custody, have the times that you have attempted suicide?
- Greatly decreased 1
 Somewhat decreased 2
 Stayed the same 3
 Somewhat increased 4
 Greatly increased 5
- 29.27 Has ANYONE in your school committed suicide?
- No, never 0
 Yes, within the last year 1
 Yes, more than a year ago 2
 I don't know 3
- 29.28 Has ANYONE that you know personally committed suicide?
- No, never 0
 Yes, within the last year 1
 Yes, more than a year ago 2
 I don't know 3

30. COMMUNITY HEALTH SERVICES

- 30.1 WHILE IN THE COMMUNITY, if you feel sick or need health care, who do you USUALLY go to see?
- Never get sick or need health care 0
 Family Doctor 1
 GP (Local Doctor/medical centre) 2
 Local hospital 3
 Community Nurse 4
 Aboriginal Medical Service 5
 Chemist 6
 No-one 7
 Other (Specify) _____
- 30.2 When was the LAST TIME you saw a doctor IN THE COMMUNITY about your own health?
- [Interviewer: Unprompted.]*
- Within the past 3 months 1
 4 - 6 months ago 2
 7 - 9 months ago 3
 10 - 12 months ago 4
 More than 1 year ago but less than 2 years 5
 2 years Ago or longer 6
 Never seen a doctor 7
 Can't remember 8

- 30.3 What was the MAIN REASON you went to the doctor or nurse?
- Illness 1
- Injury or accident 2
- Vaccine or inoculation 3
- Routine check up or physical 4
- Other (Specify) _____

- 30.4 Where did you go?
- Family Doctor 1
- GP (Local Doctor/medical centre) 2
- Local hospital 3
- Community Nurse 4
- Aboriginal Medical Service 5
- Chemist 6
- Other (Specify) _____

- 30.5 Have you EVER had problems seeing a doctor IN THE COMMUNITY, when you felt you needed to?
- No (GO TO Q30.7) 0
- Yes 1

30.6 State reasons:

- 30.7 Has there been a time in the LAST 12 MONTHS when you thought you should get medical care, but did not?
- No (GO TO Q30.10) 0
- Yes 1

- 30.8 What TYPES OF PROBLEMS were you having at the time?
- [Interviewer: Tick all that apply.]*
- Needed a routine check-up 1
- Ran out of prescription medication 2
- Felt sick or had symptoms of a health problem .. 3
- Were injured by an accident 4
- Were injured during a physical fight 5
- Had a problem that could be related to having sex .. 6
- Had a problem that could be related to Severe stress, depression or nervousness 7
- Had a problem that could be related to using, tobacco, alcohol or other drugs 8
- Had a problem that could be related to the way I felt thought or behaved 9
- Other (Specify) _____

- 30.9 What kept you from seeing a health professional when you needed to?
- [Interviewer: Tick all that apply.]*
- Did not know who to go and see 1
- Had no transportation 2
- No one was available to go along 3
- Parent or guardian would not go with you 4
- Didn't want parents to know 5
- Difficult to make appointment 6
- Afraid of what the doctor would say or do 7
- Thought the problem would go away 8
- Couldn't pay 9
- Didn't have time 10
- Thought the doctor would tell your Partner/wife/husband 11
- Too embarrassed 12
- Thought the doctor would report something to the police or other legal authorities 13
- Didn't think a health professional could help 14
- Other (Specify) _____

- 30.10 In the LAST 12 MONTHS, did a health problem get worse because you did not get care that you thought you should?
- No 0
- Yes 1

- 30.11 How MANY TIMES have you been to A hospital Emergency department (Casualty) or the outpatients clinic at a hospital about your own health BUT DID NOT STAY OVERNIGHT?
-

- 30.12 How MANY TIMES have you been to a hospital emergency department (Casualty) or the outpatients clinic at a hospital about your own health and STAYED OVERNIGHT OR LONGER?
-

30.13 Thinking about the THREE MOST RECENT problems, what did you go to hospital for?	1. _____	2. _____	3. _____
30.14 Did you stay overnight or longer?	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
30.15 If admitted, how many days were you in hospital the last time you were in hospital?			

30.16 Do you know about the Arunta telephone helpline in custody?
 Yes 1
No 0

30.17 If YES, have you ever tried to access the Arunta telephone helpline in custody?
 Yes 1
No 0

Community telephone helplines	30.18 Do you know about any of the following?	30.19 Have you EVER used any of these services?
a) Kids help line	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
b) Life line	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
c) Salvo line	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
d) ADIS (Alcohol & Drug Information Service)	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
e) The G line (Gambling)	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
f) Hep C help line	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
g) Quit Line (smoking cessation)	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
h) Family Support	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
i) Beyond Blue	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
j) Internet help lines	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1

The next questions are about your experience receiving healthcare in custody.

30.20 I am satisfied with the healthcare i receive in custody?
 Agree 1
 Not sure 2
 Disagree 3

30.21 If I have a health problem, I can easily see a health professional in custody?
 Agree 1
 Not sure 2
 Disagree 3

30.22 Those who provide my healthcare in custody treat me in a friendly and courteous manner?
 Agree 1
 Not sure 2
 Disagree 3

30.23 Those who provide my healthcare in custody are competent and well-trained?
 Agree 1
 Not sure 2
 Disagree 3

30.24 What things do you t hink could improve healthcare in custody?

30.25 Would you say you used the following: (If Didn't use the service, write N/A in the first box)

	More in custody?	About the same in custody and community	More in community
a) Doctor			
b) Specialist doctor			
c) Nurse			
d) Dentist			
e) Psychiatrist			
f) D&A counselor			
g) Psychologist			
h) Optometrist			
i) Aboriginal health worker			
j) Sexual health worker			

30.26 How would you compare the health services you receive in custody with the community?
 Better in custody 1
 About the same 2
 Worse in custody 3
 Don't know 4

30.27 Any other comments you'd like to make?

31. HEALTH SERVICE APPRAISAL

<i>The following Questions relate to services used SINCE COMING INTO CUSTODY.</i>								
	a) Doctor	b) Nurse	c) Psychiatrist	d) Psychologist	e) Dentist/ Dental Therapist	f) AOD/Drug and alcohol worker/ Doctor	g) Sexual Health Worker	
31.1	Have you seen ANY of the following health care professionals?	Yes <input type="checkbox"/> 1 No → B <input type="checkbox"/> 2	Yes <input type="checkbox"/> 1 No → C <input type="checkbox"/> 2	Yes <input type="checkbox"/> 1 No → D <input type="checkbox"/> 2	Yes <input type="checkbox"/> 1 No → E <input type="checkbox"/> 2	Yes <input type="checkbox"/> 1 No → F <input type="checkbox"/> 2	Yes <input type="checkbox"/> 1 No → G <input type="checkbox"/> 2	Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2
31.2	were these services provided by the aboriginal medical service (AMS)	Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Unknown <input type="checkbox"/> 3	Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Unknown <input type="checkbox"/> 3	Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Unknown <input type="checkbox"/> 3	Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Unknown <input type="checkbox"/> 3	Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Unknown <input type="checkbox"/> 3	Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Unknown <input type="checkbox"/> 3	Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Unknown <input type="checkbox"/> 3
31.3	Thinking about your LAST VISIT to the how would you rate the health care you received?	Good <input type="checkbox"/> 1 OK <input type="checkbox"/> 2 Bad <input type="checkbox"/> 3	Good <input type="checkbox"/> 1 OK <input type="checkbox"/> 2 Bad <input type="checkbox"/> 3	Good <input type="checkbox"/> 1 OK <input type="checkbox"/> 2 Bad <input type="checkbox"/> 3	Good <input type="checkbox"/> 1 OK <input type="checkbox"/> 2 Bad <input type="checkbox"/> 3	Good <input type="checkbox"/> 1 OK <input type="checkbox"/> 2 Bad <input type="checkbox"/> 3	Good <input type="checkbox"/> 1 OK <input type="checkbox"/> 2 Bad <input type="checkbox"/> 3	Good <input type="checkbox"/> 1 OK <input type="checkbox"/> 2 Bad <input type="checkbox"/> 3
31.4	How MANY TIMES have you seen the.....about your health? [Interviewer: Code 0 if no times]							
31.5	Thinking about the LAST VISIT to the What was the reason for the visit?	Specify _____ _____ _____	Specify _____ _____ _____	Specify _____ _____ _____	Specify _____ _____ _____	Specify _____ _____ _____	Specify _____ _____ _____	Specify _____ _____ _____
31.6	Do you feel that when you see the....., the visit is sufficiently private?	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1
31.7	Did you feel the clinic..... who you went to for help or treatment, explained things in a way you could understand?	Never <input type="checkbox"/> 1 Sometimes <input type="checkbox"/> 2 Always <input type="checkbox"/> 3	Never <input type="checkbox"/> 1 Sometimes <input type="checkbox"/> 2 Always <input type="checkbox"/> 3	Never <input type="checkbox"/> 1 Sometimes <input type="checkbox"/> 2 Always <input type="checkbox"/> 3	Never <input type="checkbox"/> 1 Sometimes <input type="checkbox"/> 2 Always <input type="checkbox"/> 3	Never <input type="checkbox"/> 1 Sometimes <input type="checkbox"/> 2 Always <input type="checkbox"/> 3	Never <input type="checkbox"/> 1 Sometimes <input type="checkbox"/> 2 Always <input type="checkbox"/> 3	Never <input type="checkbox"/> 1 Sometimes <input type="checkbox"/> 2 Always <input type="checkbox"/> 3
31.8	Did the give you as much information as you wanted about what you could do to manage your condition?	Never <input type="checkbox"/> 1 Sometimes <input type="checkbox"/> 2 Always <input type="checkbox"/> 3	Never <input type="checkbox"/> 1 Sometimes <input type="checkbox"/> 2 Always <input type="checkbox"/> 3	Never <input type="checkbox"/> 1 Sometimes <input type="checkbox"/> 2 Always <input type="checkbox"/> 3	Never <input type="checkbox"/> 1 Sometimes <input type="checkbox"/> 2 Always <input type="checkbox"/> 3	Never <input type="checkbox"/> 1 Sometimes <input type="checkbox"/> 2 Always <input type="checkbox"/> 3	Never <input type="checkbox"/> 1 Sometimes <input type="checkbox"/> 2 Always <input type="checkbox"/> 3	Never <input type="checkbox"/> 1 Sometimes <input type="checkbox"/> 2 Always <input type="checkbox"/> 3
31.9	As far as you know did thereveal information to others that you feel should have been kept private?	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0 Yes <input type="checkbox"/> 1

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