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*Smoking,  
Alcohol  
& Drug Use*  
*among*  
*YOUNG PEOPLE*

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NOVEMBER 2003



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# ***Smoking, Alcohol & Drug Use among Young People***

**NORTH EASTERN HEALTH BOARD**

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October 2003

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# Executive Summary

## Introduction

This study was undertaken in 2002 as a follow-up to the study undertaken in 1997 (*Adolescent Drug Use in the North Eastern Health Board*). As a result of that study, the Board implemented a range of strategies and services to tackle the issues of adolescent alcohol, drug and tobacco misuse. It is essential to measure and monitor health related behaviours on an ongoing basis so that areas for action are identified and appropriate strategies planned and implemented with the end goal of improving the health of the population. This study is part of that process.

## Aims and Objectives

The aims and objectives of the study were as follows:

- 1 To document the prevalence and patterns of both licit and illicit drug use in the post-primary population of the NEHB region
- 2 To present a profile of users and drugs being used within this age-group
- 3 To compare these findings with those found in a similar study conducted in 1997
- 4 To provide useful information to assist targeted health promotion campaigns

## Methods

- 1,426 adolescents attending 24 post-primary schools in the NEHB region completed a confidential questionnaire
- The sample was stratified by the different types of post-primary schools and by county to ensure a representative sample
- The classes and the schools were selected randomly
- The adolescents were aged from 12 to 19 years inclusive

## Results

### Smoking

There has been a significant decrease in the proportion of adolescents smoking since the 1997 study.

- The overall lifetime prevalence rate (ever smoked a cigarette) in the 2002 study was 50.8% compared to 57.1% in 1997
- The lifetime prevalence rate among males witnessed a decline from 56.0% in 1997 to 47.2% in 2002
- The decline among females, however, was not as considerable (59.0% in 1997 - 56.4% in 2002)
- The average age at which the adolescents in 2002 had their first cigarette was 12 years. This was the same as in 1997
- 18.2% were regular smokers in 2002 compared to 30.7% in 1997. This represents a reduction of 40.7% from 1997
- Among females, 21.6% were regular smokers in 2002 compared to 32.2% in 1997
- Among males, 16.0% were regular smokers in 2002 compared to 29.7% in 1997
- Regular smokers in 2002 smoked more cigarettes daily than did regular smokers in 1997
- 83.6% of the regular smokers aged less than 18 years of age indicated that they buy their cigarettes themselves, despite the fact that it is illegal to sell cigarettes to persons under the age of 18 years

## Alcohol

Whilst there was a slight decrease in the proportion of adolescents drinking alcohol compared to 1997, there was an increase in binge drinking and drunkenness.

- In 2002, the lifetime prevalence for alcohol consumption (ever having consumed a full alcoholic drink) was found to be 71.3%. In 1997 the rate was 72.5%
- 53.7% were regular drinkers (consuming one or more drinks per week) in 2002 compared to 57.3% in 1997
- This slight decrease was evident across all ages (as outlined in the figure below) as well as across both sexes:



- 56.4% of females were regular drinkers in 2002 compared to 51.9% of males
- Across all ages, 27.2% reported that they were drunk on ten or more occasions compared to 24.0% in 1997
- By age 17, 56.3% of adolescents reported in the 2002 study that they had been drunk ten or more times
- Males in 2002 were more likely to drink beer and cider than females, whilst females were more likely to drink spirits, bottled cocktails and shots
- Most of the drinking was done at weekends
- In 2002, 30.0% of drinkers reported having more than five drinks on a Saturday night. In 1997, this was reported by 27.1%. The percentage of drinkers having more than ten drinks on a Saturday doubled from 1997 to 2002 (3.5% vs. 6.9%)
- Pubs, followed by off-licenses, were the most common places where the adolescents bought their alcohol
- 36.2% of those aged less than 16 years buy their alcohol in off licenses and 27.7% in pubs

## Illicit Drugs

There was an increase in the proportion of adolescents misusing illicit drugs in 2002 compared to 1997, with cannabis the main drug of misuse.

- Overall, the lifetime prevalence (i.e. taken an illicit drug at least once in their lives) was 41.2% in 2002 compared to 34.9% in 1997
- Among males, the lifetime prevalence was 40.8% in 2002 compared to 36.7% in 1997
- Among females the rate was 41.8% compared to 32.0% in 1997

- 15.1% of the adolescents reported that they misuse drugs regularly (i.e. at least once in the previous month) compared to 11.9% in 1997
- 16.2% of males in 2002 misused drugs regularly compared to 12.8% in 1997
- 13.4% of females in 2002 misused drugs regularly compared to 10.5% in 1997
- Adolescents in Co. Monaghan had the highest rate of regular misuse at 19.9%
- Adolescents in Co. Cavan had the lowest rate of regular misuse at 9.3%
- 56.7% of all respondents in 2002 indicated that they had been offered at least one drug compared to 46.4% in the 1997 study
- Discos (46.0%) and the street (45.9%) were the most commonly reported places where drugs were offered
- Regular smokers and regular drinkers were more likely to be offered drugs, to have taken drugs and be regular users of drugs
- The drugs most commonly misused in 2002 by regular misusers were cannabis (12.5%), glue/solvents (2.5%) and ecstasy (1.3%). There was very little use of other drugs
- The most commonly indicated reason why young people take drugs was because “*the people they hang around with do it*” (58.6%)

## Conclusions

- 1 This study indicates that there has been a significant decrease in the number of adolescents smoking cigarettes in the NEHB region since 1997
- 2 The use of alcohol by adolescents in the NEHB region is a major problem with an increase in binge drinking and drunkenness since 1997
- 3 More adolescents are misusing drugs in the NEHB region since 1997. Cannabis is the main drug of misuse

# Chapter 1

## *Introduction*

In 1997, the North Eastern Health Board undertook a study, which examined the prevalence of smoking, alcohol and drug use among young people in the region. The information gleaned from that study served to facilitate the effective planning and delivery of programmes to combat the use of drugs, both licit and illicit, within this population. It is vital that up-to-date information is made available so that parents, health professionals and those working in education are aware of the current extent and the changing patterns of drug use. To this end, a second study examining drug use within the adolescent population in the north-eastern region was conducted in 2002. It is intended that the information from this report will build on that of 1997, thereby providing a greater understanding of the degree to which young people in the region are using drugs and how the patterns of drug use have changed over the five-year period.

### **1.1 Aims & Objectives**

The aims and objectives of the study were as follows:

- 1 To document the prevalence and patterns of both licit and illicit drug use in the post-primary population in the NEHB region
- 2 To present a profile of users and drugs being used within this age-group
- 3 To compare these findings with those found in a similar study conducted in 1997
- 4 To provide useful information to assist targeted health promotion campaigns

## Chapter 2

# *Methodology*

The study population consisted of those attending the 58 post-primary schools in the region. From these, 24 schools were randomly selected for inclusion in this study. The sample was stratified by county (Cavan, Monaghan, Louth, Meath) and by type of school (secondary, vocational/community college, comprehensive/community school) in order to ensure that a representative sample of post-primary pupils across the region was included in the study.

Once selected, the principal of each school was contacted and after explaining the nature of the study, their permission was sought to involve the school in a survey of licit and illicit drug use. Only one school declined to participate and, therefore, a replacement school was selected. Once permission was granted, the school supplied the list of the classes in the school and a random sample of three classes from each school was then selected by the Department of Public Health. A suitable date and time was then arranged with each principal for a Research Officer from the Department of Public Health to visit and administer the questionnaire. If they so wished, the Principal also distributed and collected parental consent forms to those pupils in the selected classes.

Questionnaires were distributed to 1428 students and these were completed during a class period under the supervision of the Research Officer from the Department of Public Health, who explained the purpose of the survey and highlighted the confidential nature with which their responses would be treated. Questionnaires were coded, entered and analysed by the Department of Public Health using the JMP statistical package.

### **2.1 Instrument**

The questionnaire used in the survey was similar to that used in the previous survey in 1997. Some amendments, however, were made and the version used in this study is presented in Appendix A. The questionnaire was constructed using previously published questionnaires and included many of the recommendations of the EMCDDA European Expert Group on Drug Surveys (1999).

In addition to items relating to smoking, alcohol consumption and illicit drug use, items relating to dietary habits, exercise regimens and road safety behaviours were also included. Furthermore, two standardised scales for measuring depressive symptomatology and self-esteem were also included in the questionnaire (Centre for Epidemiological Studies – Depression Scale (CES-D); Rosenberg Self-Esteem Scale (RSE)). For the purposes of this report, the findings with regard to diet, exercise and road safety will not be described. In addition, results from the CES-D and RSE will also be published at a later date.

A number of demographic details were also contained within the questionnaire, including for example, the number of people living at home, parents' occupations and whether respondents had a part-time job. Social class was measured by virtue of the categorisation of the occupation of respondents' fathers according to the 1996 Census classification scheme (see Appendix B) and, where unavailable, that of the mother was calculated and entered.



## Chapter 3

# Literature Review

Adolescence is a period of many transitions, incorporating physical, cognitive, personal and social status changes. Essentially, it involves a process of confrontation with diverse tasks of development and with demands on development. Many adolescents prove resilient in the face of these challenges and demands; on the other hand, many engage in behaviours that involve risk and, for a minority, this risk-taking can have serious adverse consequences. Adolescence is, therefore, significant in terms of the development of health-related behaviours since it is a time when many new behaviours are explored, some of which may become established and continue through to adulthood.

Among the behaviours often initiated during adolescence is experimentation with alcohol, tobacco and illicit drugs. As visible correlates of adulthood, behaviours such as these have a powerful attraction for adolescents: “engaging in such behaviours can serve to mark a transition in status, their occurrence representing a developmental change toward, or a claim upon, a more mature status” (Jessor & Jessor, 1977). Alcohol consumption, smoking and illicit drug use, however, appear to be far from innocuous behaviours and may have extensive ramifications, affecting users’ physical, psychological, social, financial and economic well-being. Young people, by virtue of their developmental status and their varied emotional and social needs, are less adept at contending with these substances and are, therefore, more liable to experience a range of negative outcomes.

### 3.1. Physiological Effects of Drug Use

In Ireland, approximately 7,000 people die each year from smoking-related illnesses. Smoking causes 90% of lung cancer deaths, 25% of deaths from heart disease and about 75% of deaths from bronchitis and emphysema (ASH, 2001). In relation to alcohol, between 1989 and 1999, alcohol consumption per capita in Ireland increased by 41% (Strategic Taskforce on Alcohol, 2002). A study of alcohol-related attendance in Accident & Emergency departments showed that alcohol was a factor in 25% of cases (Brasil & Sheehan, 2001). Alcohol has also been shown to be a causal factor in accidental falls, suicide, homicide and accidents (Rossow, Pernanen & Rehm, 2001) as well as fatal road traffic accidents (National Safety Council, 2002). Furthermore, alcohol disorders are the main cause of admissions to psychiatric hospitals in Ireland, especially for males (Daly & Walsh, 1999).

Illicit drug use is also associated with a range of adverse physical, psychological and social outcomes. While heroin is the focus of much attention, other illicit drugs such as cannabis, inhalants and cocaine also have harmful effects. Inhalants can cause death from heart or respiratory failure and long-term side-effects include permanent organ damage as well as impaired information-processing abilities. There are also health complications associated with cocaine use, including disturbances in heart rhythm, respiratory failure and neurological effects, such as strokes and seizures. Many of the health consequences of smoking tobacco are also evident in relation to cannabis, for instance, chronic cough, bronchitis and emphysema and an increased risk of lung and other cancers.

### **3.2. Drug Use & Psychosocial Factors**

Problems with substance abuse often occurs co-morbidly with other psychological problems including conduct disorder, attention deficit hyperactivity disorder, specific learning difficulties, mood disorders, anxiety disorders, schizophrenia and bulimia (Carr, 1999). The relationship between these psychological problems and substance use problems is multifaceted. They may precede drug use problems and contribute in some way to the development of drug-using behaviour, or, drug abuse may precipitate or maintain these psychological problems.

A substantial body of research suggests that smoking and depression co-occur more frequently than would be expected by chance. General population surveys in adolescents have typically demonstrated a significant association between current smoking and depressive symptoms (Kandel & Davies, 1986) and in an epidemiologic sample, smokers had a substantially higher lifetime prevalence rate for major depression than did non-smokers (Breslau, Kilbey & Andreski, 1991). In a study conducted in Portugal, it was found that alcohol consumption among adolescents was consistently associated with depressive symptoms (Coelho, Martins & Barros, 2002). Rohde, Lewinsohn & Seeley (1996) found that increased alcohol use was associated with increased lifetime occurrence of depressive disorders and disruptive behaviour disorders, as well as drug use disorders and daily tobacco use. They also found that more than 80% of adolescents with alcohol abuse/dependence also had some other form of psychopathology and co-morbidity was associated with an earlier age of alcohol disorder onset.

A study in the U.S.A. found that past-month marijuana use was nearly twice as likely and use of other illicit drugs was four times more likely for adolescents with serious emotional problems than for adolescents with low levels of emotional problems (U.S Department of Health & Human Services, 1999). In England, it was found that among adolescents (aged 12-16 years) referred to a child psychiatry clinic, high rates of behavioural symptoms (oppositional and delinquent), emotional symptoms (mostly depressive), family dysfunction and a variety of adverse life events were evident among those abusing volatile substances (solvent abuse, glue sniffing, and inhalant abuse) in comparison to those not abusing volatile substances. Compared to a control group, volatile substance users were more behaviourally disturbed (Swadi, 1996).

Highly co-morbid relationships have been found between conduct disorders and substance use problems. Armstrong & Costello (2002), in a review of the literature, found that 60% of adolescents with substance use/abuse or dependence had a co-morbid diagnosis. Conduct disorder and oppositional defiant disorder were the most commonly associated disorders, followed by depression. Illicit drug use amongst adolescents has also been shown to be significantly related to school dropout and having lower academic and occupational expectations (Brook et al., 2002), as well as delinquency and antisocial behaviours in adulthood (Brook et al., 1996).

The directionality of the relationship between drug use and psychopathological outcomes is not clear-cut. There may be a common diathesis, which serves to increase the risk of both drug use and psychopathology. The risk diathesis model holds that genetic predispositions interact with a variety of psychosocial, behavioural, and contextual risk factors to cause both drug use and psychiatric disorders (Brook et al., 1990). Thus, drug-using behaviours in adolescence may be part of a pattern of problematic behaviour involving both personal and contextual factors and may, as a result, be linked to various psychopathological disturbances.

### **3.3 Relationship between Licit & Illicit Drug Use**

Numerous studies have shown that adolescents who drink or smoke are more likely to experiment with

illicit drugs and, as a result, alcohol and tobacco have been described as ‘gateway’ drugs. Gateway drugs are drugs that serve as the “gate” or path that typically precedes the use of illicit drugs. It is thought that the gateway drugs serve as social and psychological precursors, rather than as biochemical precursors, to the use of other drugs. Evidence comes from a cross-sectional study by Kandel and Yamaguchi (1993) using retrospective reporting of age of first experimenting with different substances by 17 and 18-year-olds. For males, alcohol was more important in the progression from licit to illicit drugs, but for females cigarettes were more important. For both sexes, marijuana use followed the use of licit substances and preceded cocaine and crack use for those who progressed onto these substances. In the U.S.A., the 1995 National Household Survey on Drug Abuse study found that adolescents of high-school age who either smoked or drank during the past month were much more likely to use other drugs. Use of any illicit drug was reported by 35.3% of cigarette smokers but only by 4.7% of non-smokers; drinkers were more likely to use any illicit drug than were non-drinkers (27% vs. 4.3%). In a study conducted in Ireland, Cahill et al. (1999) found that 39% of those who had smoked a cigarette had also taken cannabis versus 4% among those who had not smoked. Furthermore, 34% of those who had drunk alcohol in contrast to 1.4% of those who had not, reported having taken cannabis. Siqueira & Brook (2003) found that early adolescent cigarette smoking was directly associated with illicit drug use and problems with drug use, while Lewinsohn et al., (1999) found that having ever been a smoker in adolescence is associated with a higher risk of subsequent alcohol, cannabis, hard drug and multiple drug use during young adulthood. They also found that among daily smokers, earlier smoking onset predicted future substance use problems.

Nonetheless, most smokers and users of alcohol do not proceed to illicit drug use. This implies that there are other variables that explain why some smokers and drinkers use illicit drugs and others do not.

### **3.4. Risk Factors for Substance Use**

Risk factors for adolescent substance use problems encompass a broad range of personal, intra-familial, environmental and socio-cultural factors. Hawkins, Catalano & Miller (1992) developed a multiple-risk factor theory and listed 17 categories of risk, arguing that the greater the number of categories present, the greater the risk of drug abuse. These factors are temperament and genetic predisposition; early and persistent problem behaviours; academic failure; low commitment to school; family drug-taking behaviour; parenting skills; family conflict; low family bonding; peer rejection in early childhood; deviant peer-group membership in adolescence; alienation and rebelliousness; favourable attitudes to drug use; early onset of drug use; laws and norms favourable to drug use; drug availability; poverty and neighbourhood disorganisation.

Age is considered to be a central factor in the development of problems with alcohol, tobacco and illicit drugs. As noted earlier, adolescence is regarded as the period of heightened risk of initiation of substance use. In a longitudinal study conducted by Chassin et al. (1996), a significant increase in smoking from adolescence to young adulthood was found followed by a non-significant decline after the mid-twenties. In the study by Kandel & Yamaguchi (1993) cited above, age of first use of any substance was found to be linked to further progression of use of other substances.

A range of intrapersonal factors have also been explored as risk factors for the development of drug misuse problems. Conrad, Flay & Hill (1992) found that smoking onset among young people was strongly related to low self-efficacy and self-esteem. Difficult temperament in childhood, sensation-seeking, novelty-seeking and a low level of harm avoidance in adolescence have also been found to be related to drug problems (Hawkins, Catalano & Miller, 1992). Wills & Stoolmiller (2002) found that substance use was higher among

adolescents who showed increases in poor self-control and lower among those who showed increases in good self-control over a three-year period.

Attitudes towards alcohol, smoking and illicit drugs have also been explored since there is a body of evidence to support the notion that cognitions are generally related to behaviour, (Aronson, Wilson & Akert, 2002). Keene, James & Willner (1998) found that drug use is related to social context and that social group membership is likely to influence drug-related attitudes and behaviour. In a study conducted in Ireland, Bryan et al., (2000) found that younger respondents were generally less likely to agree with statements related to the dangerous consequences of illicit drugs. Furthermore, they noted that studies show that among those who have tried illicit drugs, opinions about the risks associated with illicit drug use are less likely to be considered credible.

Peer influence is regarded as an influential factor in the development of drug using behaviour. Dinges & Oetting (1993) found that young people who used drugs had friends who also used those same drugs, but were considerably less likely to have friends who did not use drugs, while Conrad, Flay & Hill (1992) observed that young people who smoke tend to have friends who smoke and who express approval of the behaviour. Peer substance use has also been shown to distinguish light from moderate use of illegal substances among adolescents (Kandel & Davies, 1992). O’Fathaigh (1990) found that 58% of the school pupils surveyed were with friends when they had their first cigarette and 35%-50% reported that their friends would not mind if they smoked cigarettes. The North Eastern Health Board (1997) found that adolescents choose friends to correspond with their own usage preferences, rather than changing their drug-taking patterns simply to respond to friends’ pressure.

Parental factors have been extensively explored. Findings of numerous studies show strong associations between parental use of drugs and adolescent involvement (Conrad, Flay & Hill, 1992). Parents may act as role models and in cases of serious abuse may be less capable and less involved caregivers, thus increasing the motivations to seek alcohol and other substances as a source of support or relief from problems (Durkin, 1995). A lack of clear rules prohibiting drug abuse, a lack of consistent parental supervision and a lack of consistent consequences for rule-breaking may lead initially to experimental drug use and later to habitual drug taking (Kandel & Andrews, 1987).

Social disadvantage has also been highlighted as a risk factor for the initiation and maintenance of drug-using behaviour. Poverty, low socio-economic status, high population density and high crime levels may create an environment within which drug abuse may thrive. An association has been found between neighbourhoods showing physical deterioration and levels of illegal drug dealing (Fagan, 1988).

Other influential factors include the availability of drugs to young people and the degree of regulation regarding availability.

Thus, it seems that multiple social, psychological, and biological factors influence drug-taking behaviour and may play different functions at different points in the progression and play different roles for different people.

### **3.5. National Policies**

In recent years, strategies in relation to dealing with the issue of alcohol, smoking and illicit drug use have been produced by the government. The *“National Drugs Strategy: Building on Experience 2001-2008”*

endorsed Ireland's existing approach to tackling the drugs issue by focussing on the four pillars of supply reduction, prevention, treatment and research. The overall aims of the strategy include reducing the availability of illicit drugs, promoting a greater awareness, understanding and clarity of the dangers of drug misuse and having timely and comparable data on the extent and nature of drug misuse in Ireland. The health strategy, *"Quality & Fairness: A Health System for You"* (2001) identified the implementation of the National Drugs Strategy by 2008 as the action required.

The *"National Alcohol Policy"* was introduced in 1996 with the aim of reducing the level of alcohol-related problems and of promoting moderation for those who wish to drink. In May 2002, the Strategic Task Force on Alcohol produced the *"Strategic Task Force on Alcohol Interim Report"*. A range of initiatives have been introduced such as guidelines for developing a school substance policy, an educational programme for GPs to raise awareness and improve detection and treatment of alcohol problems in general practice and the Responsible Serving of Alcohol (RSA) Programme for those working in the bar trade.

*"Towards a Tobacco Free Society: Ireland, A Smoke-Free Zone"* (2000) proposed an integrated strategy for tackling the tobacco problem and promoting a tobacco-free society. Objectives include significantly increasing the number of people who stop smoking each year and providing protections to reduce the level of passive smoking.

### **3.6. Prevalence of Licit & Illicit Drug Use**

In this section, studies outlining the prevalence of drinking, smoking and illicit drug use will be presented. Firstly, findings from a European perspective will be outlined, highlighting how Ireland performs in relation to other countries. Secondly, the results from a number of prevalence studies conducted at local and regional level throughout the country will be described.

#### **3.6.1 European Studies: ESPAD**

The first large-scale *European School Survey Project on Alcohol and other Drugs* (ESPAD) was conducted in 1995 when data concerning alcohol, smoking and drug use were collected in 26 European countries. The main purpose of the ESPAD project is to collect comparable data on alcohol, tobacco and drug use among 15 to 16-year-old students throughout Europe and to study trends in alcohol and drug habits among young people within each country and also to compare the trends between countries. The most recent ESPAD report was conducted in 1999 (report published in 2000) when over 80,000 students from 30 countries in Europe participated in the survey.

##### **(a) Illicit Drug Use**

Lifetime use of any illicit drug ranged from 3% to 36% across countries. The surveys showed that cannabis was the most widely used illegal substance. The figures vary across countries ranging from a lifetime prevalence rate of 1% to 2% in Cyprus and Romania to 35% in France, the Czech Republic and the UK. In Ireland, the lifetime prevalence rate for cannabis was found to be 32%. Overall, the lifetime prevalence of cannabis use was twice as common in Ireland than the average for all ESPAD countries (16%). France had the highest percentage of students who reported using cannabis in the previous month (22%). In Ireland, this was reported by 15% of respondents. Small gender differences were noted, with more males than females in most countries reported having used cannabis in the previous month.

Illicit drugs other than cannabis were much less used according to these surveys. Lifetime use of any illicit

drug other than cannabis ranged from 2% in Cyprus to 12% in the UK. Lifetime use of amphetamines was reported by 1% to 8%, with the UK reporting the highest percentage (Ireland: 3%), and the lifetime rate for ecstasy was reported by 1% to 6% of respondents. Latvia reported the highest lifetime prevalence rate for ecstasy use (6%), while Ireland featured in second place at 5%. In relation to cocaine, figures for lifetime use were found to be between 1% and 3%, with the Netherlands and the UK reporting the highest rate of cocaine use (Ireland: 2%). Lifetime use of inhalants was highest in Ireland (22%) and Greenland (19%). Overall, the lifetime use of inhalants in Ireland was over twice the average rate across all countries (9%).

#### (b) Tobacco Use

More than half of the students in all ESPAD countries indicated that they had smoked a cigarette at least once in their lives. The highest lifetime prevalence rates were found in Greenland and the Faroe Islands where approximately 85% had smoked. In Ireland, 73% of students indicated that they had smoked a cigarette, which is above the overall average of 69%. The highest prevalence of students who reported having smoked at least one cigarette per day in the previous 30 days was found in Greenland (57%). In Ireland, this was reported by 25% of respondents, which is just below the overall average (26%). In many countries, more girls than boys reported smoking in the last 30 days, including Ireland as well as the UK, France, Italy, Norway and Greenland.

#### (c) Alcohol Use

The average lifetime prevalence rate for alcohol use was found to be 89%. In Ireland, 92% of students reported that they had drunk alcohol. In nearly all countries, less than 50% of the students indicated that they consumed alcohol on 40 or more occasions in their lives, with the exception of Denmark where it was reported by 59% of students. In Ireland, 40% of respondents reported this and similar rates were found in the UK (47%), Greece (42%), and the Czech Republic (41%).

Approximately 64% of students in Denmark reported that they had drunk five or more drinks in a row in the preceding 30 days. Ireland featured in third position at 57%. In the majority of countries, more than half of the students had been drunk at least once in their lifetime. The largest proportion was found in Denmark (89%). Among the Irish students, 72% indicated that they had been drunk at least once their lives and 37% reported that they had been drunk more than 10 times. Across all countries, 22% reported having been drunk more than ten times in their lives, with the highest rates found in Denmark (57%), Finland (43%) and the UK (41%). With regard to where they drank, 39% of students from Ireland indicated that they drank in a bar/pub on their last drinking day (average across surveys: 16%).

### **3.6.2. National Studies**

In recent years, there have been numerous studies examining drug usage among young people in both urban and rural parts of the country. Most of these studies, however, have been conducted at a regional level and differ in their methodology, sample size, types of questions asked and the age-groups surveyed, thereby creating difficulties in making meaningful comparison between studies.

One of the most comprehensive early studies was conducted by Grube & Morgan (1986), who examined licit and illicit drug use in Dublin among 13 to 17-year-old post-primary students. They found that lifetime prevalence for smoking was 67%, and 24% were regular smokers (smoked at least one cigarette daily). In relation to alcohol, lifetime prevalence was 65%, and 39% had been drunk at least once in their lives. In all, 22% had taken an illicit drug and 8% had used one drug on more than two occasions in the previous month or had used more than one drug.



In Cork, it was found that, among post-primary students aged 15 to 17 years, 72% had smoked a cigarette and 25% were regular smokers. Lifetime prevalence for alcohol was found to be 78%, and 51% were classified as regular-occasional drinkers. Furthermore, 51% had felt drunk at least once in their lives and 30% indicated that they usually sourced their alcohol in pubs. Lifetime prevalence for cannabis was highest of all illicit drugs at 15%, and 9% used cannabis at least once in the previous month (O’Fathaigh, 1990).

In the Western Health Board, Kiernan (1995) surveyed post-primary students aged 13 to 18 years of age. Also included in this study was a sample of early school-leavers. Lifetime prevalence for both smoking and drinking was 67% and almost half (48%) of the sample had felt drunk. Beer was the preferred drink among boys, while girls preferred spirits. Approximately 25% reported that they had ever taken at least one illicit drug and cannabis and solvents were the drugs most likely to have been used, with lifetime prevalence rates of 16% and 14%, respectively.

The North Eastern Health Board (1997) conducted a quantitative study to assess the prevalence and pattern of licit and illicit drug use among post-primary students in the region. A qualitative study was conducted to provide information on the experience and knowledge of young people in relation to drugs and to explore the barriers and motivating factors to illicit drug use. For all ages, 31% were regularly smoking, with more females regularly smoking than males. Furthermore, 57% were regular drinkers and 24% had been drunk more than ten times. In relation to illicit drugs, 12% were regular users and cannabis was the drug most frequently used. Further elaboration of the findings of this study will be conducted in the results section of this report. In the qualitative study, eighteen focus groups were held, comprising young people aged 13 to 19 years including early school leavers and first-year students attending third-level institutions in the north-eastern region. It was found that drugs were readily available and, for many, drug use was an accepted part of youth culture. Not all young people, however, were using drugs and, therefore, availability by itself was not a motivating factor. Solvents were used among younger adolescents, while cannabis, ecstasy and LSD were the drugs most in use among older adolescents. Of these, cannabis was perceived as innocuous and, at times, more socially acceptable than alcohol, less addictive than tobacco and unlikely to have adverse long-term effects. While the focus of the study was on illicit drugs, alcohol, according to many, was a far greater problem. Overall, the pattern of use was recreational rather than habitual; illicit drugs, mainly cannabis, were generally taken as part of normal social gatherings or on special occasions.

A study conducted among 13 to 18 year-olds by the Mid-Western Health Board (1998) found that 58% had smoked in their lifetime and 29% currently smoked. Furthermore, a higher percentage of females than males were current smokers (33% vs. 25%). With regard to alcohol, 82% had consumed alcohol and 68% were current drinkers. Moreover, 54% had been drunk at least once and more males than females reported having been drunk; 11% were 13 years or younger when they got drunk for the first time. Lifetime prevalence for illicit drug use was 30% (34% among males; 25% among females) and 12% were currently using at least one drug (14% among males; 10% among females). Cannabis and inhalants had the highest lifetime prevalence (19%, 14%, respectively) and rate of current use (8%, 3%, respectively). In addition, 34% had been offered cannabis, 24% had been offered inhalants and 8% had been offered cocaine. Smokers were more than twice as likely than non-smokers to use illicit drugs (56% vs. 24%). For each of the illicit drugs surveyed, perception of danger was inversely related to drug use. The more dangerous they perceived the drug to be, the less likely they were to have used it. Respondents were also more likely to use a particular drug if their friends had used it.

Cahill et al., (1999) conducted a survey among 13 to 18-year-olds in Kildare and west Wicklow and found

that lifetime prevalence for smoking was 67%, and for alcohol, lifetime prevalence was 81%. Of the illicit drugs surveyed, cannabis was the most commonly reported drug used (lifetime prevalence: 28%; current use: 12%), while overall, the lifetime prevalence for illicit drug use was 36%. In addition, it was found that a statistically greater number of smokers than non-smokers had used cannabis (39% vs. 4%) and alcohol (94% vs. 56%), as well as a range of illicit drugs.

The latest national survey, the *Health Behaviours in School-Aged Children Survey (HBSC)*, was conducted in 2002 by the Centre for Health Promotion Studies at NUI Galway. A previous HBSC survey was carried out in 1998 and, collectively, these surveys provide national lifestyle data on school-going children aged 10-17 years. In 2002, 41% indicated that they had smoked a cigarette, corresponding to 40% among boys and 42% among girls. Furthermore, 19% reported that they were current smokers (17% boys; 20% girls). These figures represent a reduction in both lifetime and current smoking levels from the 1998 study. In 1998, the lifetime prevalence was 49% (51% boys; 48% girls) and 21% reported being current smokers (21% for both boys and girls). With regard to alcohol, in 2002, 40% of respondents noted that they had never had an alcoholic drink (31% in 1998) while 25% had a drink in the last month (25% for both boys and girls). In total, 30% reported having been 'really' drunk (31% boys; 30% girls). Furthermore, it was found that 7% of boys and 5% of girls had been drunk more than ten times in their lifetime and no significant social class differences were observed. Overall, 12% reported that they had taken cannabis (14% boys; 12% girls). Furthermore, 11% indicated that they had used cannabis in the last twelve months (13% boys; 10% girls).



## Chapter 4

# Results

In this chapter, the findings of the 2002 study will be presented. Firstly, demographic results will be given, followed by findings related to smoking, alcohol consumption and illicit drug use. Within each section, comparative results obtained in the 1997 study will be specified and similarities and disparities will be highlighted.

### 4.1 Demographic Details

In total, 1426 adolescents completed a questionnaire (99.9% response rate). Table 1 outlines the percentage of respondents attending schools in each county and, as evident from this table, almost 37% (n= 526) were registered in schools in Co. Meath and over 31% (n= 447) were attending schools in Co. Louth. These figures are broadly in line with the total proportion of pupils registered in each county, with 31% (n= 9158) attending schools in Co. Meath, 34% (n= 9946) attending in Co. Louth, 16% (n= 4828) attending in Co. Cavan and 19% (n= 5711) attending schools in Co. Monaghan.

Table 1 Distribution of respondents according to county

County of Origin	N	%
Cavan	247	17.3
Monaghan	206	14.5
Louth	447	31.3
Meath	526	36.9
Total	1426	100.0

Table 2 presents the ages of those who participated in this study. The mean age of respondents was 15.1 years (S.D.= 1.6)<sup>1</sup>. The youngest stated age was 12 years, while 19 years was the oldest stated age. Overall 5.7% (n= 81) were aged 18 years or older.

<sup>1</sup> S.D. = standard deviation

Table 2 Distribution of respondents according to age-group

Age Group	N	%
≤ 13 years	245	17.2
14 years	298	20.9
15 years	259	18.2
16 years	271	19.0
≥ 17 years	336	23.6
Not stated	17	1.2
Total	1426	100.0

As shown in Table 3, almost 60% (n= 851) of respondents were male. This may be explained by the fact that, among the schools randomly selected, there was a higher proportion of males than females in attendance (56.9% males vs. 43.1% females).

Table 3 Distribution of respondents according to gender

Gender	N	%
Male	851	59.7
Female	560	39.3
Not stated	15	1.1
Total	1426	100.0

As shown in Table 4, the largest numbers of respondents were attending vocational schools/community colleges (29.4%, n= 419) and this is in line with the proportion of pupils attending vocational schools/community colleges in the region (33.4%, n= 9893).

Table 4 Distribution of respondents according to type of school attended

Type of School	N	%
Vocational School/Community College	419	29.4
Boys' Secondary School	336	23.5
Girls' Secondary School	236	16.6
Mixed Secondary School	230	16.1
Community/Comprehensive School	205	14.4
Total	1426	100.0

Overall, 84.4% (n= 1204) of respondents stated that they live with both their parents; 93.7% (n= 1335) reported that their mother lives with them and 87.0% (n= 1241) indicated that their father lives with them at home.

Table 5 outlines the social class of the parents of respondents. As depicted, just less than one-third of respondents were classified as social class 1-2 and over one-third as social class 3-4.

Table 5 Distribution of respondents according to social class of parents

	Social Class 1-2	Social Class 3-4	Social Class 5-6	Social Class 7	Unknown
%	31.7	35.3	10.4	8.1	14.5
N	452	504	148	115	207

Overall, as shown in Table 6, a higher percentage of respondents in this study were classified as social class 1-2 than would be expected from the results of the 1996 Census, while a lower percentage were classed as social class 5-6 in this study compared to Census 1996. There are a number of plausible reasons for this outcome. Firstly, the question format used in this questionnaire was not identical to that used in the 1996 Census form. Secondly, respondents were often non-specific in terms of stating their parents' job and, thirdly, those who belong to lower socio-economic groups are less likely to attend second-level education.

Table 6 Comparison of the distribution of social class groupings according to Census 1996 and the present study

	S.C. 1-2 (%)	S.C. 3-4 (%)	S.C. 5-6 (%)	S.C. 7 (%)	Unknown (%)
<b>2002 Study</b>	31.7	35.3	10.4	8.1	14.5
<b>Census 1996</b>	24.9	42.0	23.0	10.0	-

Overall, this study may be described as including a representative group of adolescents from each county and school type and according to age-groups in the region. As a result of the randomisation and stratification procedures used in this study, it may be stated with confidence that this sample is broadly representative of adolescents attending secondary schools in the NEHB region.

## 4.2 Smoking

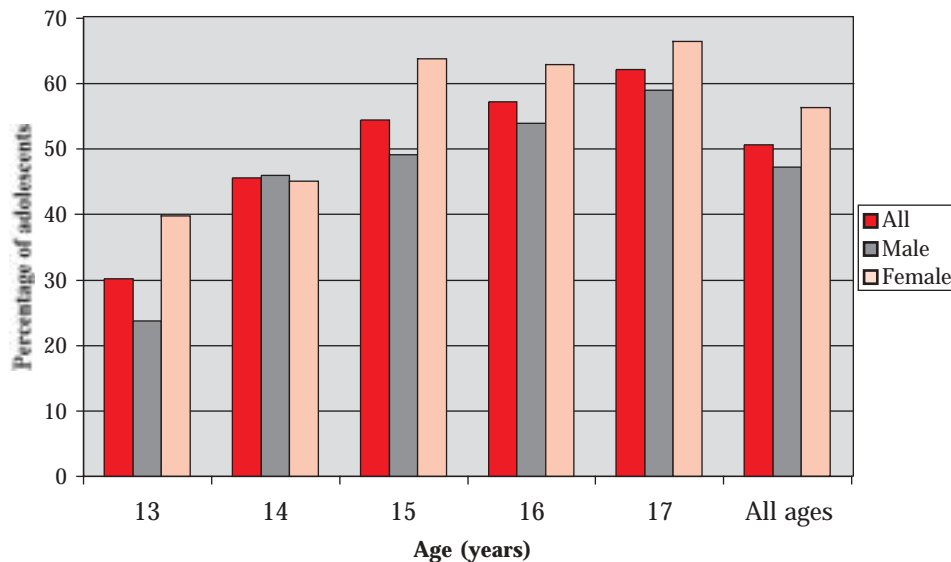
This section examines smoking practices among the respondents to this survey. Firstly, the lifetime smoking prevalence rate is described, followed by an examination of smoking patterns and additional aspects such as where young people buy cigarettes, who buys them, as well as who else in their homes smoke.

### 4.2.1. Lifetime Smoking Prevalence

As illustrated in Figure 1, the lifetime smoking prevalence rate across all age groups was calculated as 50.8% (n= 725). In this study, the lifetime smoking prevalence rate is defined as ever having smoked a full cigarette. Therefore, just over half of the respondents to this survey indicated that they had smoked a full cigarette.

The overall lifetime smoking prevalence rate among females was found to be statistically greater than that obtained among males (56.4% vs. 47.2%,  $p < 0.001$ ). A statistically significant age difference with regard to smoking prevalence was also evident ( $p < 0.01$ ). At thirteen years, 30.2% ( $n = 73$ ) reported having smoked a whole cigarette while, at sixteen years, the lifetime smoking prevalence rate was 57.2% ( $n = 155$ ).

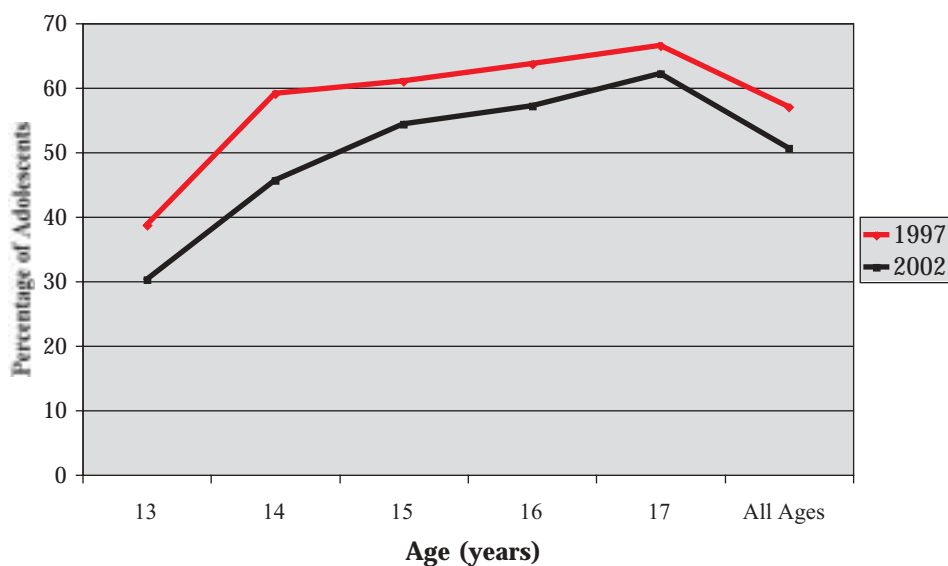
Figure 1 Lifetime smoking prevalence amongst adolescents



The overall mean age at which respondents indicated that they had their first cigarette was 12.1 years ( $s.d. = 1.9$ ). The mean age reported by males was 11.9 years ( $s.d. = 2.0$ ) while, among females, the mean age reported was 12.3 years ( $s.d. = 1.7$ ), which corresponded to a statistically significant difference ( $p < 0.01$ ). Thus, males indicated that they smoked their first cigarette at a younger age than females.

Figure 2 illustrates lifetime smoking prevalence rates as found in both the 1997 and 2002 studies. Across all age groups, figures for the 1997 study are significantly greater than those obtained in the 2002 study.

Figure 2 Comparison of lifetime smoking prevalence between 1997 and 2002

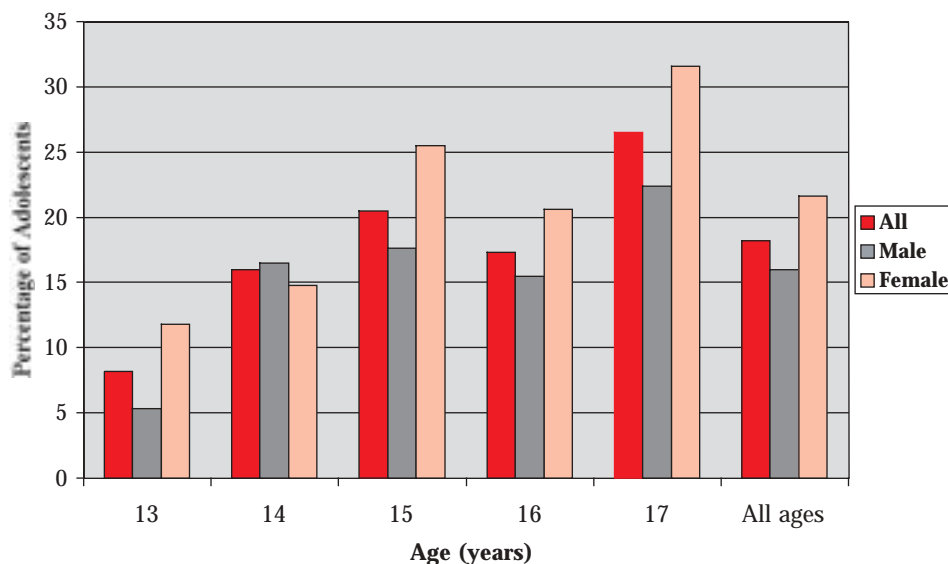


The overall lifetime prevalence rate in the 2002 study (50.8%) represents a 6.3% fall from the figure obtained in the 1997 study (57.1%) (95% CI: 2.7-9.8). The lifetime prevalence rate among males witnessed a significant decline of 8.7% from 56.0% to 47.2% (95% CI: 4.0-13.4). The decline of 2.6% among females (59.0% - 56.4%), however, was not significant, (95% CI: -0.3 - 8.2).

#### 4.2.2. Regular Smoking

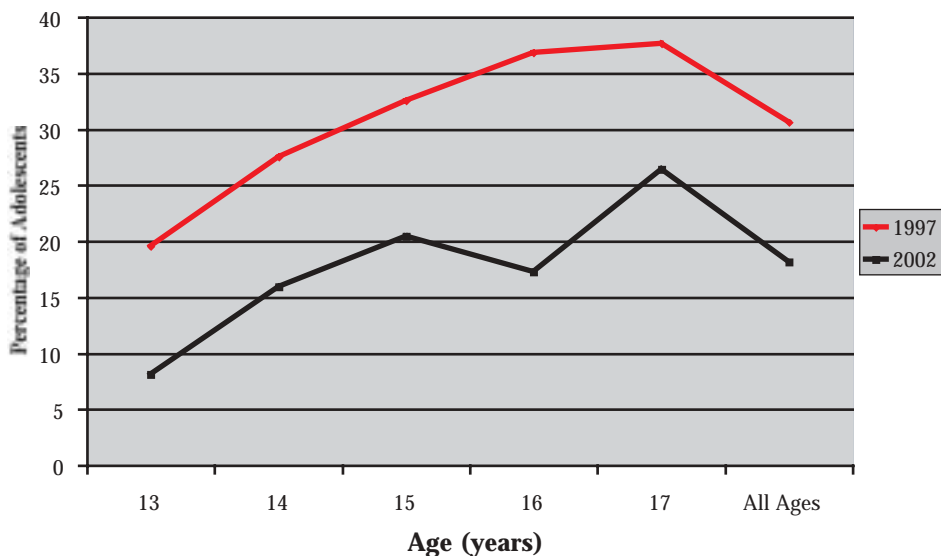
For the purposes of this study, adolescents who indicated that they smoke at least one cigarette per day are categorised as regular smokers. In total, 18.2% (n= 260) of adolescents reported that they smoke at least one cigarette per day. As illustrated in Figure 3, more females than males indicated that they were regular smokers (21.6% of females vs. 16.0% of males) and this gender difference was found to be statistically significant ( $p < 0.01$ ). In addition, a statistically significant age difference was observed with regard to regular smoking ( $p < 0.001$ ) with older respondents more likely to be regular smokers than younger respondents.

Figure 3 Prevalence of regular smoking amongst adolescents according to age category



The prevalence of regular smoking in 2002 represents a statistically significant 41% decrease from the figure obtained in 1997. In the 1997 study, 30.7% (n= 466) of adolescents indicated that they were regular smokers. This corresponded to a rate of 32.2% (n= 200) among females and a rate of 29.7% (n= 263) among males, which resulted in a non-significant gender difference. As illustrated in Figure 4, a significantly greater proportion (overall difference= 12.5%; 95% CI: 9.4-15.6) of adolescents in the 1997 study indicated that they were regular smokers than in the 2002 study.

Figure 4 Regular smoking according to age-group for 1997 and 2002 studies



#### 4.2.3. Regular Smoking & County of Residence

In terms of county of residence, across all age groups, Cavan and Meath demonstrated the highest prevalence of regular smoking in the NEHB in 2002, however, the rate was not statistically greater than in the other two counties. In total, 20.6% (n= 51) of all respondents registered in schools in Cavan indicated that they were regular smokers, as did 20.3% (n= 107) of respondents from Meath.

As illustrated in Figure 5, in the under-16 age-group, the greatest percentage of regular smoking was also among respondents from Cavan (17.6%, n= 23) and from Meath (19.4%, n= 48). On the other hand, in the older age-group (16+), Louth (27.3%, n= 38) and Cavan (24.6%, n= 28) demonstrated the highest prevalence of regular smoking.

These results vary from those obtained in the 1997 study when Meath and Louth demonstrated the highest prevalence of regular smokers in the region. In the under-16 age-group in 1997, the highest prevalence of regular smokers were in counties Monaghan (31.8%, n= 60) and Meath (26%, n= 38), while in the older age-group, the highest prevalence was among respondents from Meath (41.1%, n= 78) and Louth (39.8%, n= 125).

Figure 5 Percentage of regular smokers in each NEHB county by age

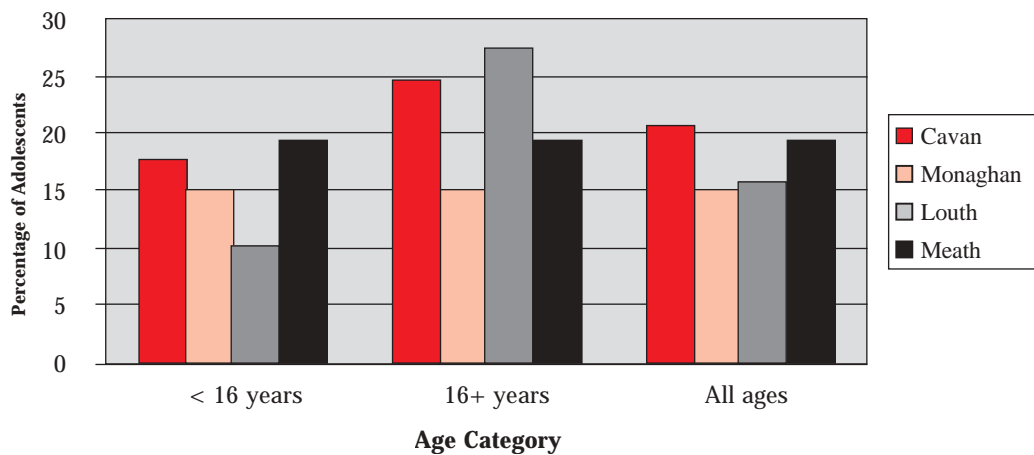
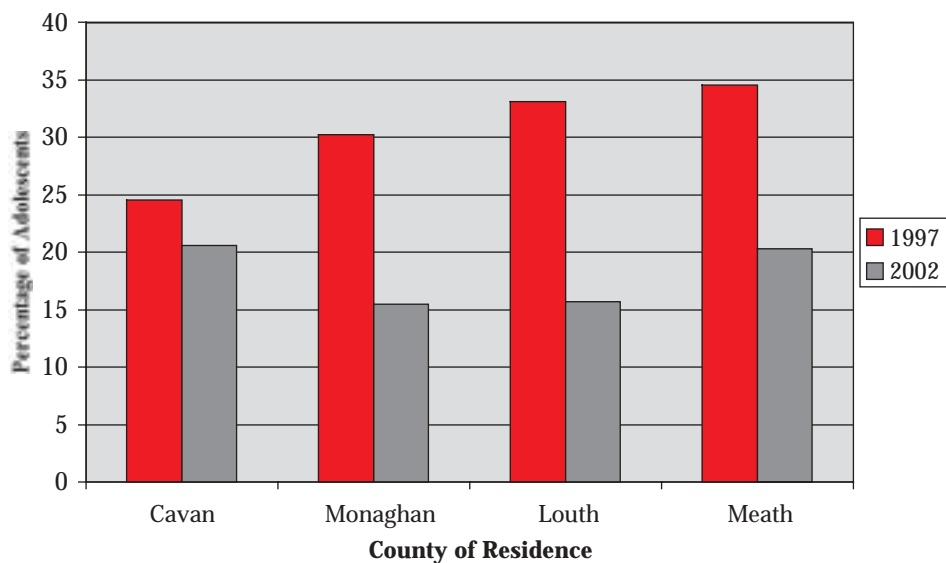


Figure 6 illustrates the percentage of adolescents from each county who indicated that they were regular smokers in the 1997 and 2002 studies. For each county, a lower percentage of adolescents reported that they were regularly smoking in 2002 than did those in 1997. As shown, counties Monaghan and Louth yielded the largest decline between these two studies.

Figure 6 Distribution of regular smoking according to each county for 1997 and 2002



#### 4.2.4 Regular Smoking & Social Class

Table 7 presents the distribution of respondents who are regular smokers according to social class. As shown, similar percentages of respondents from social classes 1-2, 3-4 and 5-6 reported that they were regular smokers.

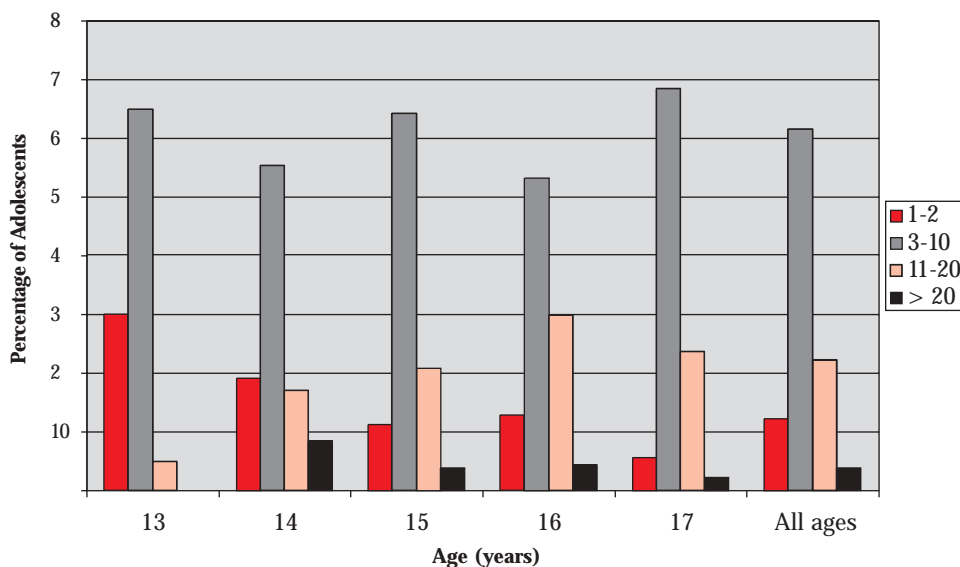
Table 7 Distribution of regular smokers according to social class

	Social Class 1-2	Social Class 3-4	Social Class 5-6	Social Class 7	Not Stated
<b>Percentage</b>	16.2	17.7	16.9	20.9	23.7
<b>N</b>	73	89	25	24	49

#### 4.2.5. Intensity of Smoking Practices

For adolescents who reported that they were regular smokers (n= 260), Figure 7 presents the quantity of cigarettes smoked daily. The most commonly reported quantity of cigarettes smoked by regular smokers across all age-groups was between 3 and 10 per day (61.5%, n= 160). Furthermore, 93.5% (n= 243) of all regular smokers reported that they had smoked over 100 cigarettes in their lifetime. A steady increase with age was observed with regard to the number of adolescents smoking 11-20 cigarettes per day up to 16 years of age, when 29.8% (n= 14) indicated that they smoke that amount per day. Very few of the regular smokers in this study reported that they smoke more than twenty cigarettes per day, (3.8%, n= 10).

Figure 7 Quantity of cigarettes smoked daily by regular smokers according to age



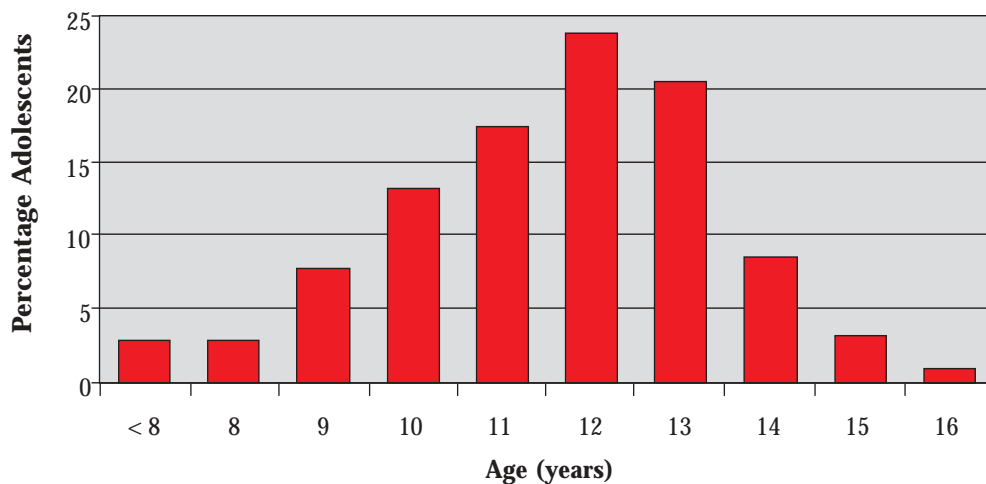
In the 1997 study, the most commonly reported number of cigarettes smoked by regular smokers was also 3-10 per day, (43.6%, n= 203), however, a greater percentage of regular smokers in 1997 than in 2002 indicated that they smoked 1-2 cigarettes per day (32.4% in 1997 vs. 12.3% in 2002). Thus, regular smokers in 2002 seem to be smoking more cigarettes daily than did regular smokers in 1997.

#### 4.2.6. Age of Smoking Initiation

Among regular smokers, the mean age at which they reported having their first cigarette was 11.6 years (s.d.= 1.8) and the median age was 12 years of age. As illustrated in Figure 8, 13.1% (n= 34) of regular smokers smoked their first cigarette before they were 10 years of age.



Figure 8 Age at which regular smokers had their first cigarette



The mean age at which regular smokers had their first cigarette was found to be significantly younger than for those who were not regular smokers (11.6 yrs vs. 12.5 yrs,  $p < 0.01$ ).

In the 1997 study, the mean age at which regular smokers had their first cigarette was 12.0 years (s.d. = 2.0) and the median age was found to be 12 years. Furthermore, 10.6% ( $n = 49$ ) of adolescents in the 1997 study smoked their first cigarette before ten years of age. Thus, regular smokers in 2002 indicated that they had their first cigarette at the same age as did regular smokers in 1997.

#### 4.2.7 How Cigarettes are Purchased

Over 85% (85.4%,  $n = 222$ ) of all regular smokers indicated that they buy their cigarettes themselves. Although it is illegal to sell cigarettes to persons under the age of 18 years (Health Act, 2001), 83.6% ( $n = 193$ ) of regular smokers aged less than 18 years reported that they buy cigarettes themselves, while just 15.2% ( $n = 35$ ) indicated that someone else buys cigarettes for them. Among regular smokers aged 18 years or older ( $n = 25$ ), all but one respondent (96%,  $n = 24$ ) reported that they buy cigarettes themselves.

In the 1997 study, 86.3% ( $n = 402$ ) of regular smokers indicated that they bought cigarettes themselves. In 1997, cigarettes could legally be sold to persons over the age of 16 years. Nonetheless, among regular smokers in 1997 aged less than 16 years, 81.3% ( $n = 174$ ) reported that they bought their cigarettes themselves.

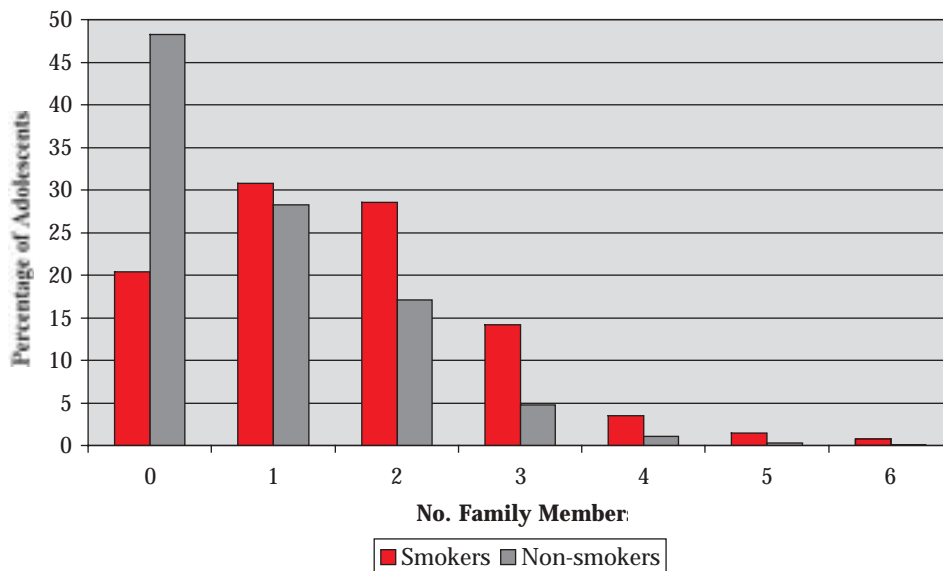
#### 4.2.8. Do Parents Know they Smoke?

Approximately half of those who regularly smoked specified that their parents were aware that they smoke (50.4%,  $n = 131$ ). Among those aged less than 16 years, 40.0% ( $n = 48$ ) reported parental knowledge while this was the case among 59.3% ( $n = 83$ ) of those aged 16 years or older. In 1997, 59.0% ( $n = 197$ ) of regular smokers stated that their parents were aware that they smoked. Among those aged less than 16 years, 42.5% ( $n = 59$ ) reported that their parents were aware and among those aged 16 years or older, 70.8% ( $n = 138$ ) reported that their parents were aware of their smoking habits. Thus, fewer regular smokers in 2002 than in 1997 indicated that their parents were aware that they smoked.

#### 4.2.9. Who Else at Home Smokes?

Among all respondents to this survey, 56.8% (n= 810) indicated that they live with at least one other person who smokes. As illustrated in Figure 9, there were, significant differences between regular smokers and non-smokers ( $p < 0.001$ ). Among regular smokers, 79.6% (n= 207) reported that they share their home with at least one other person who smokes while, among non-smokers, 51.7% (n= 603) stated that someone at home smokes. On the other hand, 20.4% (n= 53) of regular smokers indicated that no-one at home smokes, while this was true for 48.3% (n= 563) of non-smokers.

Figure 9 Number of people living at home who smoke according to smoking status



According to the 1997 results, 63.4% (n= 956) of all respondents indicated that they lived in a home where at least one other family member smokes and this represents a larger figure than that obtained in the 2002 study (56.8%).

#### Factors Affecting Regular Smoking

When multivariate analysis was conducted on the data, the following factors were identified as independent predictors of smoking: having at least one parent who smokes (OR 2.02,  $p < 0.0001$ ), increasing income (OR 1.48,  $p < 0.0001$ ), only one parent living at home (OR 1.58,  $p < 0.0001$ ), increasing age (OR 1.19,  $p < 0.01$ ) and being female (OR 1.42,  $p < 0.003$ ). (OR= odds ratio)

### 4.3 Alcohol Usage

This section outlines the results pertaining to patterns of alcohol consumption among the adolescents surveyed in the region.

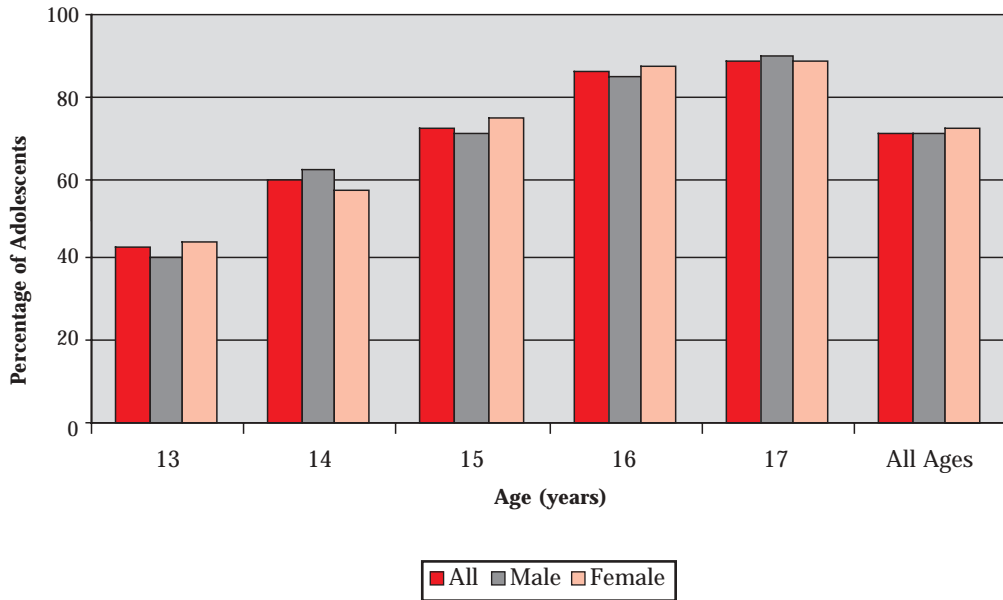
#### 4.3.1. Lifetime Alcohol Consumption

In this study, the lifetime prevalence rate is defined as ever having consumed a full alcoholic drink. Overall, the lifetime prevalence for alcohol consumption was found to be 71.3% (n= 1016).

As shown in Figure 10, among males, the lifetime prevalence rate was 70.7% (n= 602), while, among females, it corresponded to 71.8% (n= 402). Furthermore, the lifetime prevalence rates for males and

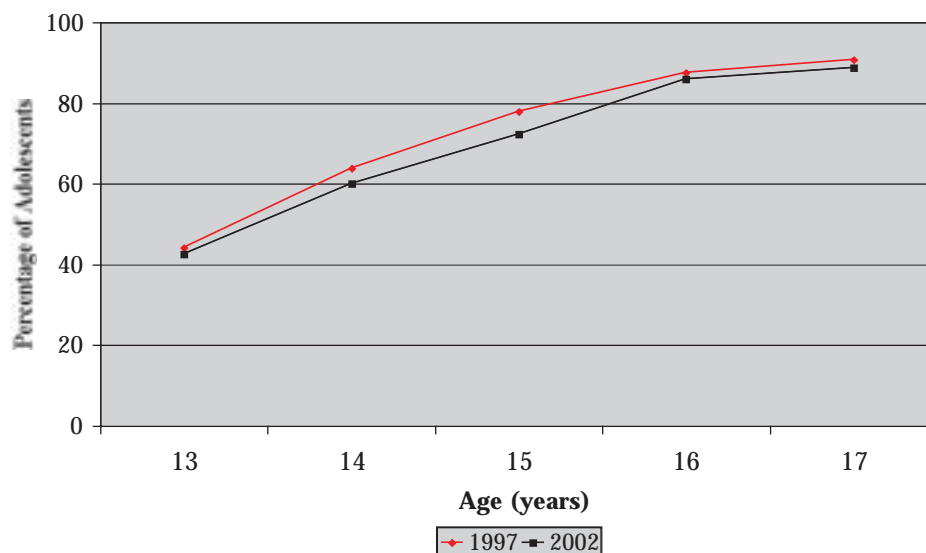
females were similar at all ages. At 13 years, 41.1% (n= 62) of males and 44.1% (n= 41) of females indicated that they had consumed a full alcoholic drink, while this was the case for 89.6% (n= 164) of 17-year-old males and 88.2% (n= 134) of 17-year-old females.

Figure 10 Lifetime prevalence for alcohol consumption according to age-group and gender



In the 1997 study, the overall lifetime prevalence rate was 72.5% (n= 1096), with 73.8% (n= 652) of males and 70.6% (n= 439) of females indicating that they had consumed a full alcoholic drink. As illustrated in Figure 11, the lifetime prevalence rate was slightly higher in the 1997 study than in the 2002 study across all age-groups, however, this difference was not statistically significant.

Figure 11 Comparison of lifetime prevalence for alcohol consumption in 1997 and 2002



Among males, the lifetime prevalence rate was also lower in 2002 than in 1997 within all age-groups. On the other hand, among females there was little difference in rates between the two studies. In fact, among 13 and 14-year-old girls, the lifetime prevalence rate was higher in 2002 than in 1997, but for other ages, the rate either dropped slightly or remained static.

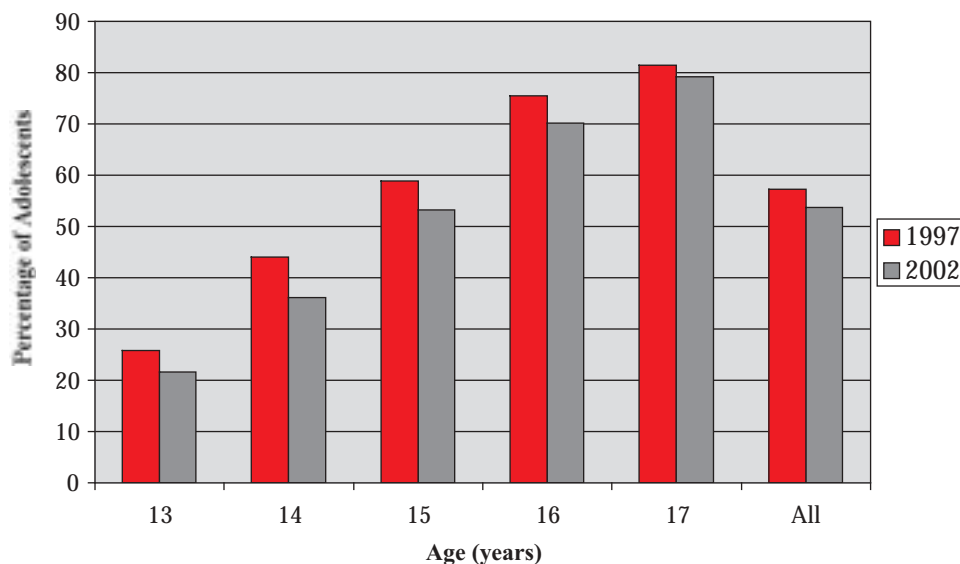
#### 4.3.2. Regular Alcohol Consumption

In this study, regular alcohol consumption has been defined as consuming one or more alcoholic drinks per week. Figure 12 depicts the percentage of respondents from both the 1997 and 2002 studies who reported regular consumption of alcohol.

Overall, 53.7% (n= 766) of respondents in the 2002 study indicated that they were regularly consuming alcohol. At 13 years, 21.6% (n= 53) of adolescents reported regular alcohol consumption and this figure rises incrementally with age, such that by 17 years of age, 79.2% (n= 266) are regular consumers of alcohol. Additional analyses reveal that at 14 years of age, 9.4% (n= 28) of adolescents were consuming 10 or more alcoholic drinks per week and by 17 years, 48.2% (n= 162) were regularly consuming this amount.

As illustrated in Figure 12, the rate of regular alcohol consumption was slightly higher in 1997 than in 2002, however, this difference was not statistically significant. Overall, in 1997, 57.3% (n= 868) of respondents reported regular drinking (53.7% in 2002).

Figure 12 Regular alcohol consumption among adolescents in 1997 and 2002



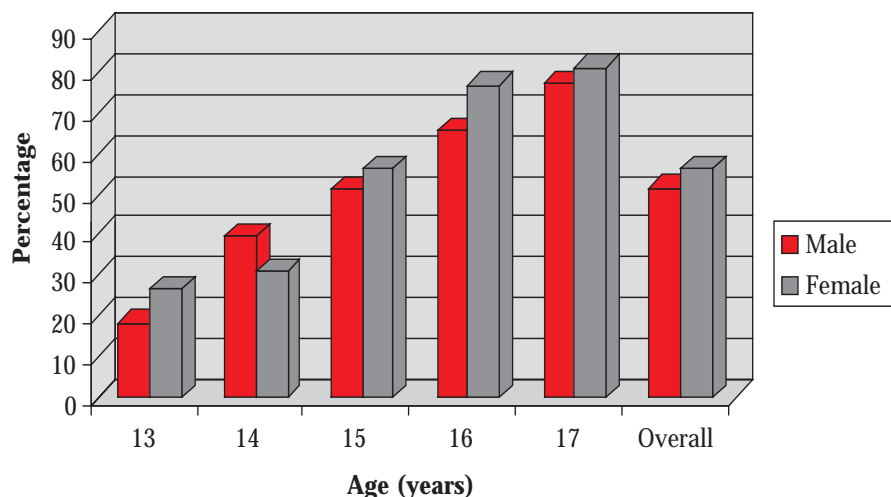
In 1997, at 13 years, 25.8% (n= 96) were regularly drinking alcohol (21.6% in 2002) and by 17 years, 81.5% (n= 281) were regular drinkers (79.2% in 2002). Furthermore, by 14 years, 11.6% (n= 27) of adolescents were regularly consuming 10 or more drinks per week (9.4% in 2002). At 17 years, however, a smaller percentage of adolescents than in the 2002 study indicated that they regularly consumed 10 or more drinks per week, (39.1% in 1997 vs. 48.2% in 2002).

#### 4.3.2. (a) Gender Differences

As illustrated in Figure 13, for all age-groups in the 2002 study, with the exception of 14-year-olds, a higher percentage of females than males reported that they were regular drinkers. This gender difference was, however, not significant. Overall, 56.4% (n= 316) of females and 51.9% (n= 442) of males indicated that they regularly drink alcohol.

This trend did not emerge in the 1997 study when, only at 15 and 17 years, was the rate of regular alcohol consumption slightly higher among females than among males.

Figure 13 Reports of regular alcohol consumption in 2002 according to gender



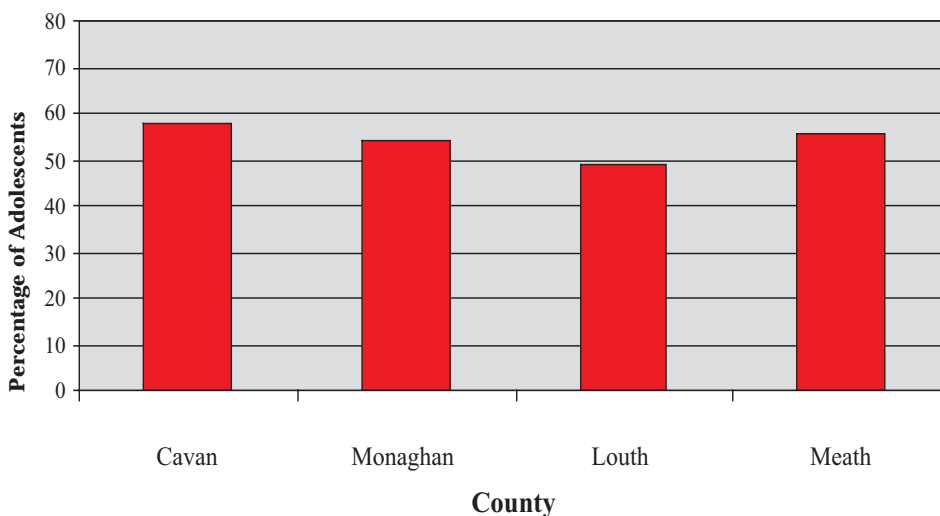
4.3.2. (b) Regular Drinking for at least One Year

Among all adolescents who indicated that they had consumed a full alcoholic drink (N= 1016), 45.9% (n= 466) indicated that they had been regularly drinking for at least one year at the time this survey was conducted. As expected, the percentage of adolescents who indicated that they had been drinking for at least one year increased with age. At thirteen years, 22.1% (n= 23) reported that they had been regular drinkers for a year, however, by 17 years, this figure rises to 70.5% (n= 210).

4.3.2. (c) Regular Drinking According to County of Residence

Figure 14 depicts the percentage of respondents attending schools in each county who regularly consume alcohol. As shown, more than 40% of respondents from each county were regular drinkers.

Figure 14 Distribution of regular alcohol consumers according to county



#### 4.3.2. (d) Regular Alcohol Consumption & Social Class

Table 8 presents the percentage of respondents who were regular drinkers according to their social class. As shown, approximately half of respondents from all social classes indicated that they regularly drink.

Table 8 Distribution of regular drinkers according to social class

	Social Class 1-2	Social Class 3-4	Social Class 5-6	Social Class 7	Not Stated
<b>Percentage</b>	53.3	56.2	46.6	55.7	52.7
<b>N</b>	211	221	69	64	109

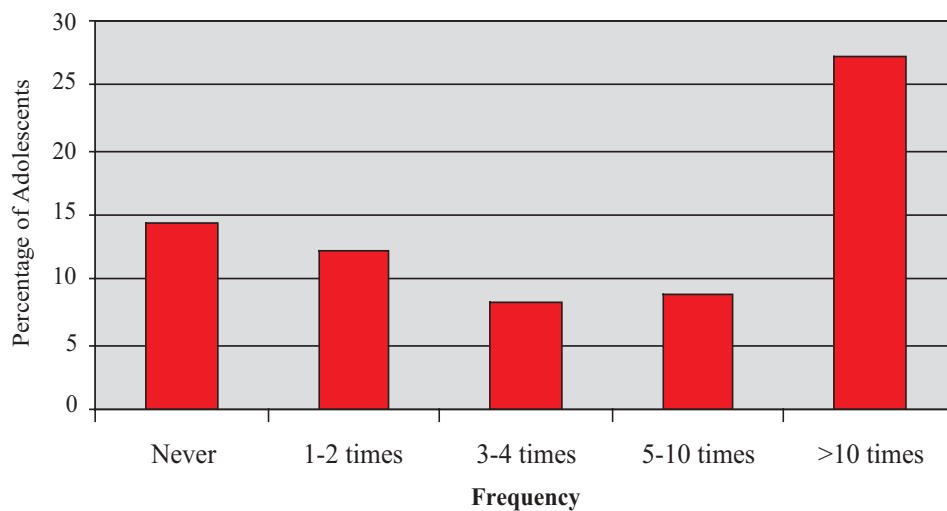
#### 4.3.3. Factors Affecting Regular Alcohol Consumption

When multivariate analysis was conducted on the data, the following factors were identified as independent predictors of regular drinking: increasing age (OR 1.91,  $p < 0.0001$ ) and increasing income (OR 1.36,  $p < 0.001$ ). Gender, social class or having only one parent living at home were not significantly associated with regular drinking.

#### 4.3.4. Reports of Feeling Drunk

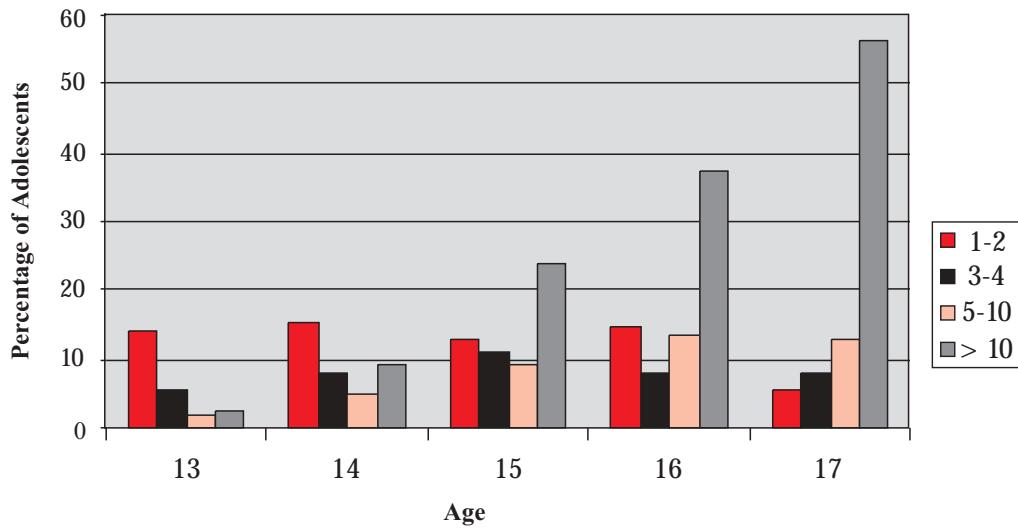
Figure 15 illustrates the number of times that respondents reported feeling drunk. As shown, 27.2% ( $n = 388$ ) indicated that they had felt drunk more than ten times and, of these, a higher percentage were male (64.2%).

Figure 15 No. of times adolescents consumed enough alcohol so as to feel drunk



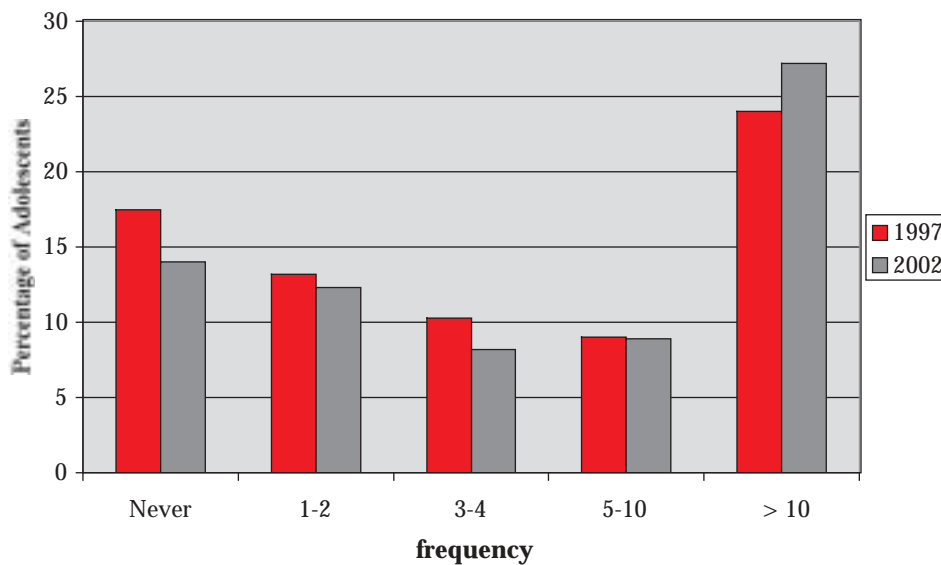
As illustrated in Figure 16, the number of adolescents who reported being drunk more than ten times increased with age from 13 to 17 years, while on the other hand, the number of adolescents who reported being drunk 1-2 times decreased with age. At thirteen years, 13.9% ( $n = 34$ ) reported being drunk 1-2 times while, at 17 years, only 5.7% ( $n = 19$ ) reported that they had been drunk 1-2 times.

Figure 16 Number of times adolescents reported being drunk according to age-group



In the 1997 study, similar figures to the 2002 study were obtained, as illustrated in Figure 17. In the 1997 study, 17.5% (n= 265) of adolescents indicated that they had never drunk enough alcohol so as to feel drunk (14.0% in 2002) and 13.2% (n= 200) reported having felt drunk 1-2 times (12.3% in 2002).

Figure 17 Number of times adolescents reported being drunk according to year of study

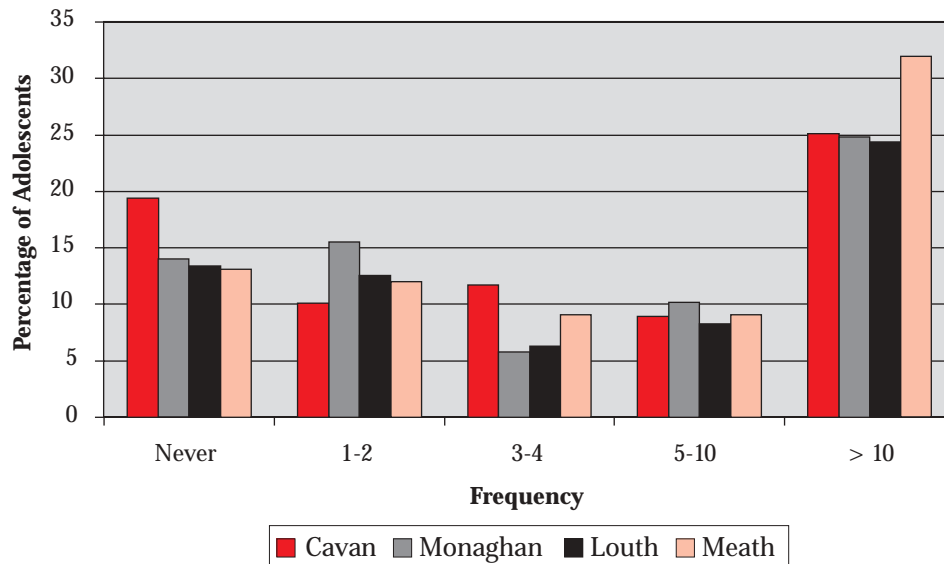


As shown, the greatest difference between the two studies was in relation to feeling drunk more than 10 times, with more adolescents in the 2002 study than in the 1997 study indicating that they had felt drunk more than 10 times (24.0% in 1997 vs. 27.2% in 2002; overall difference = 3.2%; 95% CI: 0.4-6.4).

#### 4.3.4. (a) Reports of Feeling Drunk According to County

Approximately one-quarter of respondents from each county reported that they had felt drunk more than ten times, with almost one-third of respondents from Meath making that report. On the other hand, as shown in Figure 18, less than 15% of respondents from each county indicated that they had never felt drunk, with the exception of Cavan for which 19.4% of respondents reported not having ever felt drunk.

Figure 18 Reports of number of times respondents felt drunk according to county



#### 4.3.5. Type of Drinks Consumed

As illustrated in Figure 19, spirits, bottled cocktail drinks (alco-pops) and beer were reported to be the alcoholic drinks most commonly consumed by adolescents in this study. Of those who have taken an alcoholic drink (n= 1016), 63.1% (n= 641) indicated that they normally drink spirits, such as vodka, gin etc., while 57.1% (n= 580) reported that they normally drink beer and 57.6% (n= 585) normally drink alco-pops such as *Bacardi Breezer* and *Smirnoff Ice*. Shots such as *After-Shock*, *Sambuca* etc. were also a popular option, with 47.9% (n= 487) indicating that they normally have these to drink.

Figure 19 Type of drinks consumed by adolescents

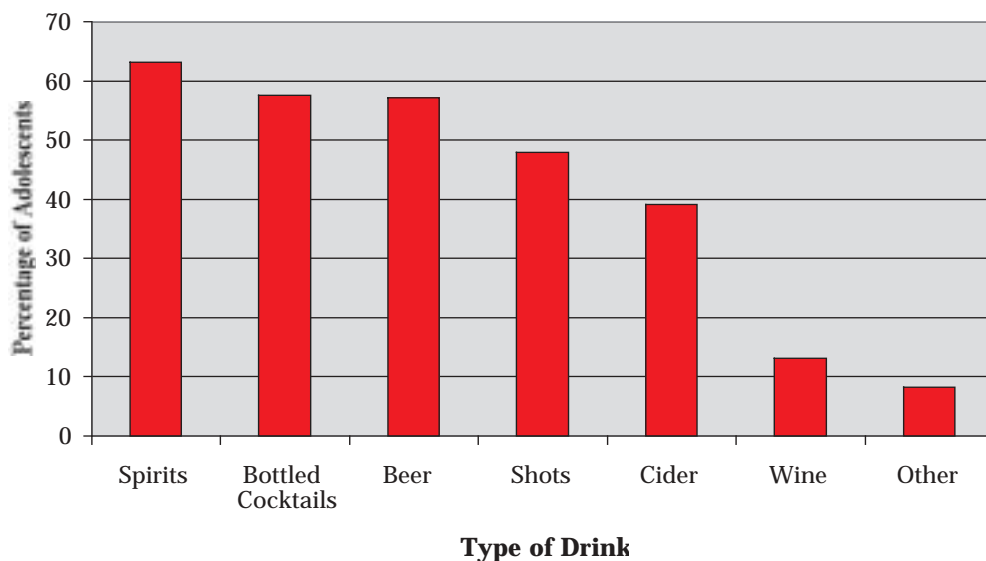




Figure 20 Distribution of drinks normally consumed according to gender

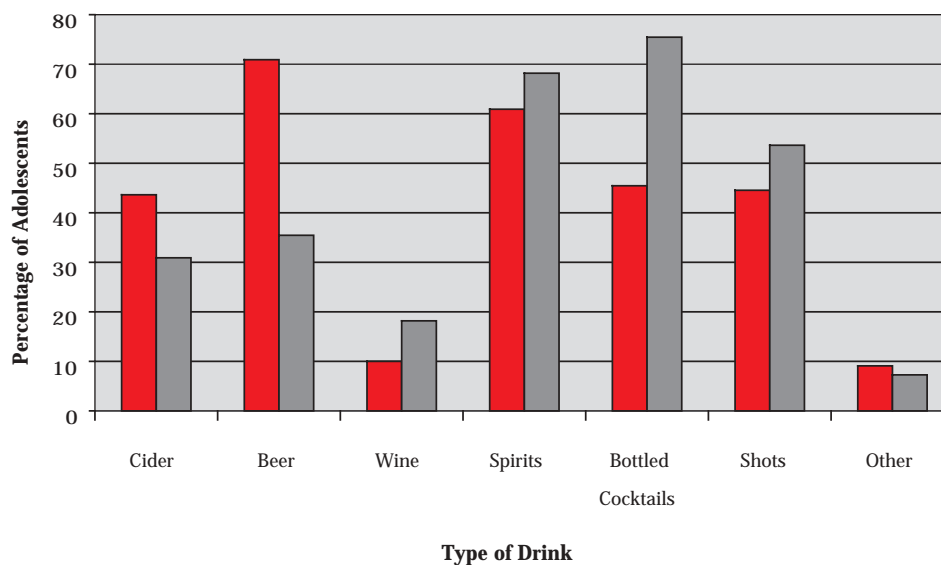


Figure 20 illustrates the type of drinks consumed by males and females in this study. As shown, more males than females reported drinking cider and beer.

In particular, 71.1% (n= 428) of males and 35.8% (n= 144) of females indicated that they normally drink beer. On the other hand, more females than males indicated that they normally drink wine, spirits, alco-pops and shots. In particular, a large difference was evident in relation to alco-pops, which were reported as being regularly drank by 75.4% (n= 303) of females and 45.9% (n= 276) of males.

Some age-differences were apparent in relation to the type of drink normally consumed. The main difference between respondents aged younger than 16 and those aged 16 and older was in relation to the consumption of shots ( $p < 0.001$ ). Within the younger group, 31.1% (n= 146) indicated that they normally drink shots, while this was the case for 62.5% (n= 341) of the older adolescents.

Among girls, alco-pops were a popular option at all age-groups, but spirits and shots did not feature as often among younger girls (less than 16 years) as among their older counterparts (16+ years). For instance, 57.5% (n= 104) of younger girls indicated that they normally drink spirits but this was the case for 76.7% (n= 168) of older girls. On the other hand, 74.0% (n= 134) of younger girls and 76.7% (n= 168) of older girls indicated that they normally drink alco-pops. The choice of drink among boys remained relatively consistent between older and younger boys, with the exception of shots, which featured much more prominently among older than younger boys (59.2% vs. 28.8%).

There was one difference in the list of drinks included in the questionnaire in the 1997 study to that in the present study and that was that 'shots' was not listed as an option in the 1997 study. As presented in Table 9, results similar to the present study were obtained in 1997, with beer, spirits and alco-pops being the most popular drinks in both studies. When the data was analysed according to gender, it was found that the drinking patterns of males and females in 1997 and 2002 were similar, with males more commonly reporting that they drank beer and cider, while more females than males reported drinking spirits, wine and alco-pops.

Table 9

A comparison of the drinks consumed by adolescents in 1997 and 2002

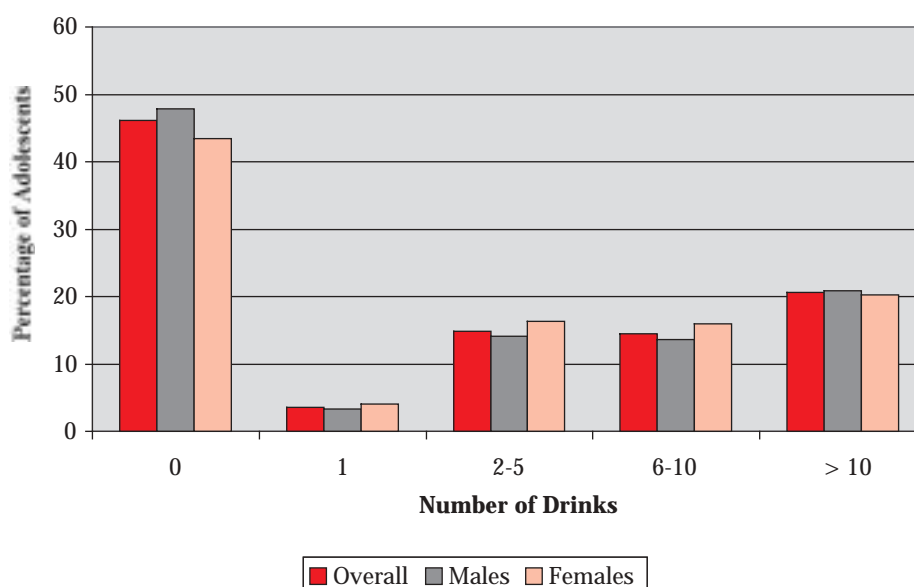
Drink	2002 Study (%)	1997 Study (%)
Cider	39.1	49.3
Beer	57.1	71.6
Wine	13.2	20.8
Spirits	63.1	66.5
Alco-pops	57.6	61.9
Shots	47.9	-
Other Drinks	8.3	39.4

#### 4.3.6. Number of Drinks Consumed

Figure 21 depicts the overall number of alcoholic drinks consumed by all respondents per week. As shown, just over 20% (20.6%, n= 294) indicated that they drink more than ten drinks per week (20.8% among males, 20.2% among females). In 1997, 18.3% (n= 278) of all respondents reported that they have more than ten drinks per week (19.6% among males; 16.4% among females).

Mid-week alcohol consumption was quite rare. The most that was reportedly drunk mid-week was 2-5 drinks on a Thursday night, which was reported by 2.3% (n= 33) of all respondents. Moreover, over 90% of respondents indicated that they did not have any drink from Monday to Thursday or did not respond to this item.

Figure 21 Overall number of drinks consumed per week according to gender

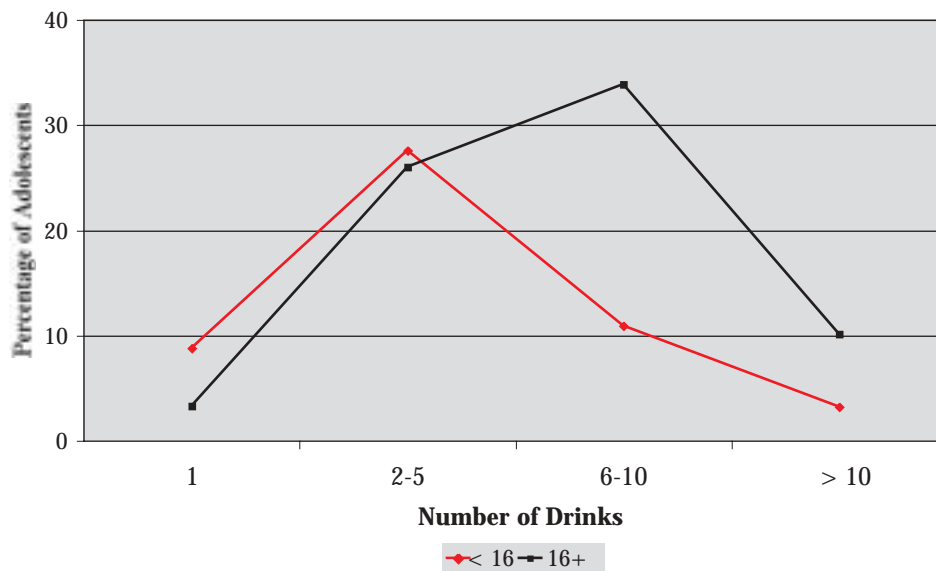


Most adolescents who drank (n= 1016), did so at weekends. On a Friday night, 26.8% (n= 272) reported that they drink 2-5 alcoholic drinks and a further 17.4% (n= 177) indicated that they have 6-10 drinks. On a Saturday night, 23.2% (n= 235) reported drinking 6-10 drinks, while 6.9% (n= 70) indicated having more

than 10 drinks. Among those who have six or more drinks on a Saturday night (n= 305), 79.7% (n= 243) indicated that they drink spirits and 77.1% (n= 235) reported that they drink shots. This is in contrast to the overall findings that show that only 63.1% (n= 641) of those who have taken an alcoholic drink normally drink spirits and only 47.9% (n= 487) normally drink shots.

Overall, 62.5% (n= 635) of all those who indicated that they ever have had an alcoholic drink reported that they have at least one drink on a Saturday night. Conversely, Sunday drinking was substantially less popular, with 20.1% (n= 204) indicating that they have at least one drink on a Sunday night. Across all ages, the greatest amount of drinking was conducted on a Saturday night. As shown in Figure 22, similar percentages of those aged less than 16 years and those aged 16 years and older indicated that they drink 2-5 drinks on a Saturday night (27.6% of younger adolescents and 26% among the older group). A much larger percentage of the older adolescents, however, indicated that they have 6-10 drinks (33.9% vs. 10.9%).

Figure 22 Number of drinks consumed on a Saturday night by adolescents aged younger & older than 16 years



Results from the 1997 yielded comparable findings, whereby most drinking was conducted at weekends. A higher percentage of drinkers in 2002 than in 1997, however, indicated they have more than five drinks on a Saturday night (30.0% vs. 27.1%) and this was evident both among those aged younger than sixteen years (13.8% vs. 11.7%) as well as those aged 16 years and older (44.1% vs. 39.7%). Furthermore, drinkers in 2002 also more frequently reported having more than ten drinks on a Saturday night than in 1997 (6.9% vs. 3.5%), (overall difference = 3.4% 95%:CI; 1.5 - 5.3).

#### 4.3.6 (a) Number of Drinks Consumed and Social Class

As presented in Table 10, there were no significant differences in the amount of alcohol consumed per week in terms of social class.

Table 10 Number of drinks consumed per week according to social class of parents

No. Drinks p/w	Social Class				
	SC 1-2 (%)	SC 3-4 (%)	SC 5-6 (%)	SC 7 (%)	Unknown (%)
None	23.8	24.7	20.5	22.9	29.2
1 Drink	3.8	6.1	4.5	6.0	4.5
> 1 Drinks ≤5	22.9	20.2	20.5	26.5	15.6
> 5 Drinks ≤10	24.1	18.6	23.9	14.5	17.5
> 10 Drinks	24.8	30.3	29.5	30.0	33.1
Non-Response	0.6	0.0	1.1	0.0	0.0

#### 4.3.7. Where Alcohol is Bought

As shown in Table 23, the pub is the most commonly reported place where young people indicated that they buy alcohol (55.5%, n= 564). The second most common venue was an off-licence (42.2%, n= 429), while 16.4% (n= 167) indicated that they get alcohol from home without their parents' knowledge. In addition, 21.4% (n= 217) of respondents indicated that they get alcohol from another source and 'friends' were the most commonly noted other source given by respondents (5.8%, n= 59). It was also reported that alcohol was bought at 'night-clubs'/'discos' (4.5%, n= 46) or parents gave them alcohol or they got alcohol from home *with* their parents' knowledge (4.5%, n= 46).

Figure 23 Respondents reports as to where they get alcohol

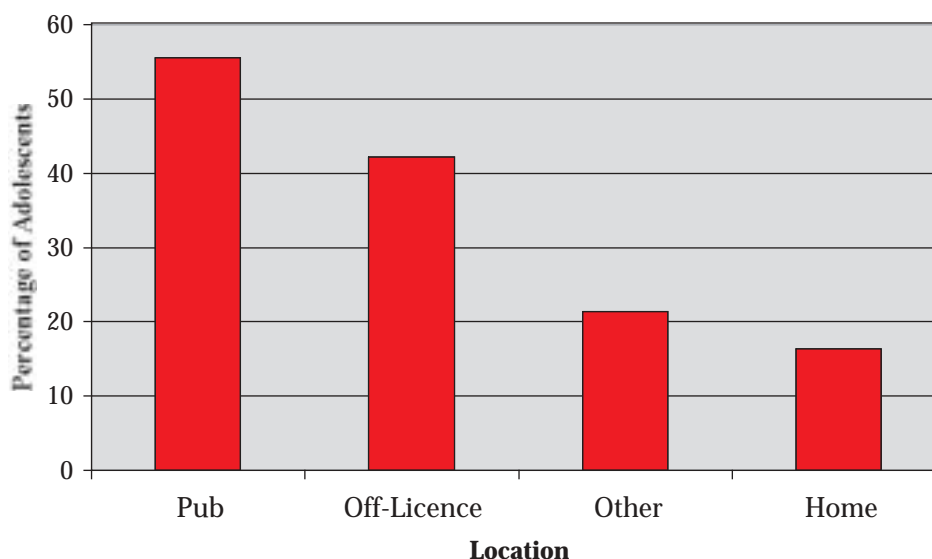
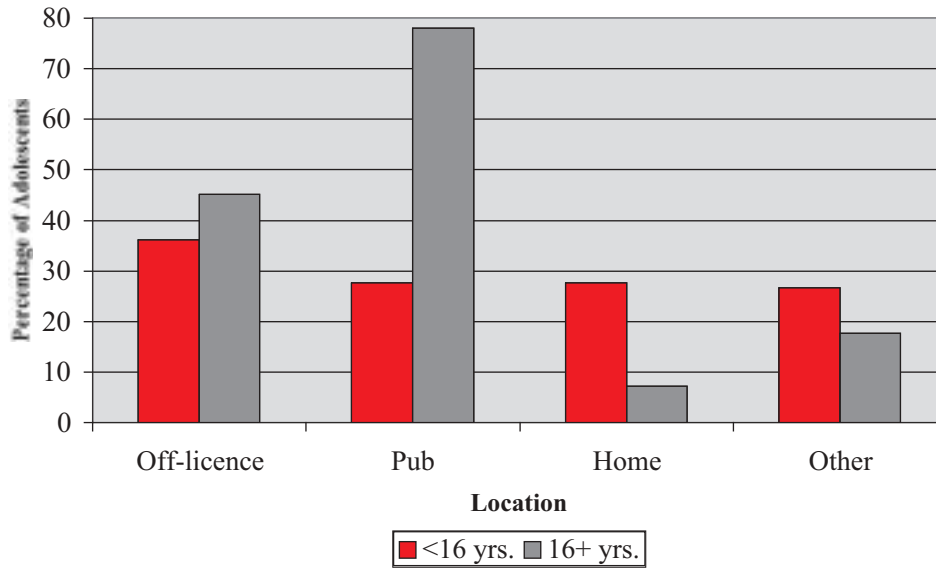


Figure 24 depicts the results relating to where respondents indicated that they get alcohol according to their age status. It was found that for those aged less than 16 years (N= 470), 36.2% (n= 170) get alcohol in an off-licence and 27.7% (n= 130) reported that they get alcohol in a pub. On the other hand, 78.1% (n= 357) of adolescents aged between 16 and 18 years (N= 457) reported that they get alcohol in a pub. No comparable data was available from the 1997 study.

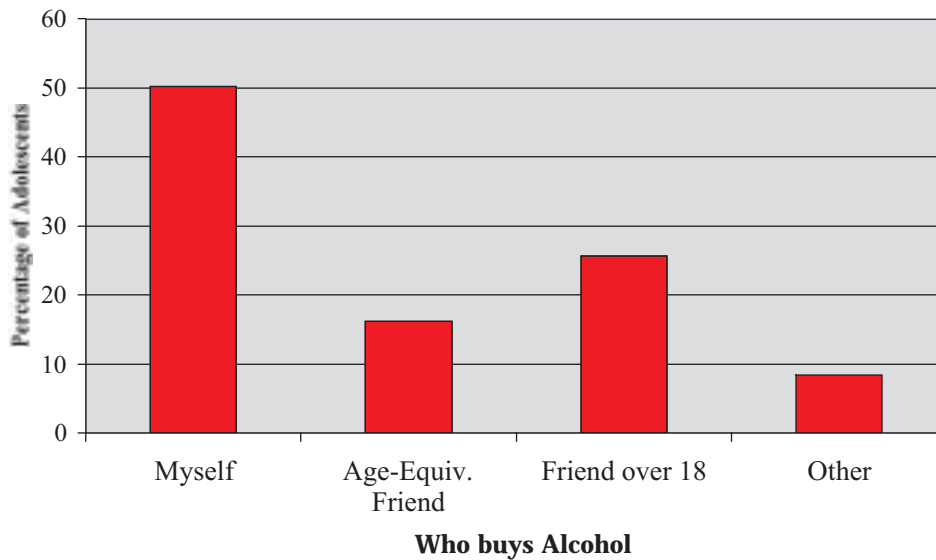
Figure 24 Where respondents indicated that they get alcohol according to age-status



4.3.8. Who Buys the Alcohol?

As illustrated in Figure 25, half of the respondents indicated that they buy alcohol themselves (50.2%, n= 510) while just over one-quarter reported that a person they know who is over 18 years of age gets it for them (25.6%, n= 260).

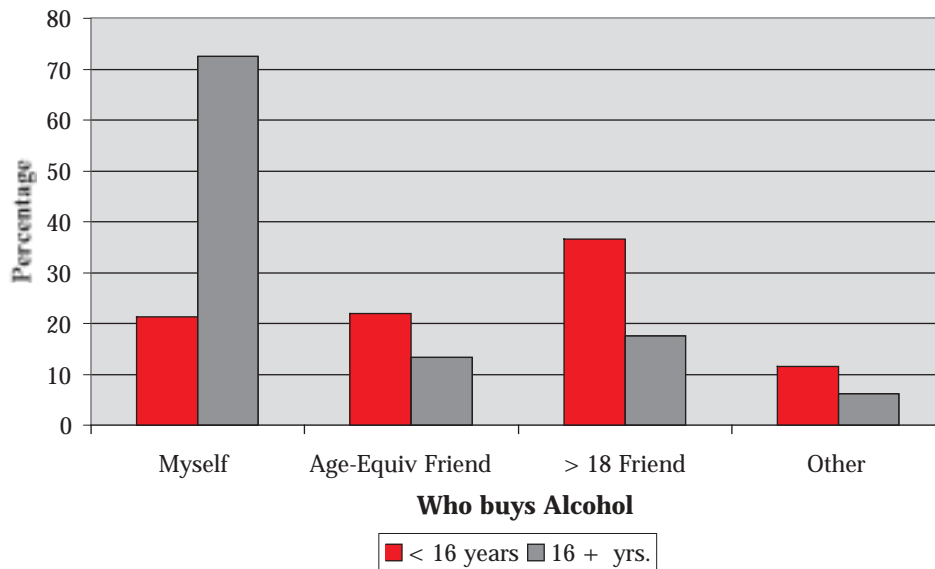
Figure 25 Respondents reports as to who buys alcohol for them



Interestingly, 16.2% (n= 165) indicated that a friend their own age buys the alcohol for them. In addition, 8.4% (n= 85) reported that their alcohol is bought elsewhere and the majority of these indicated that their parents bought the alcohol or that they took alcohol from home without their parent’s knowledge (5.3%, n= 54).

As shown in Figure 26, the majority of respondents aged between 16 and 18 years indicated that they buy alcohol themselves (72.6%, n= 332) whereas this was reported by just over 20% (21.3%, n= 100) of respondents aged less than 16 years. Of those aged younger than 16 years, 36.6% (n= 172) reported that a person they know over 18 years of age buys alcohol for them, while this was the case for only 17.5% (n= 80) of those aged between 16 and 18 years. Again, no data was available from the 1997 study.

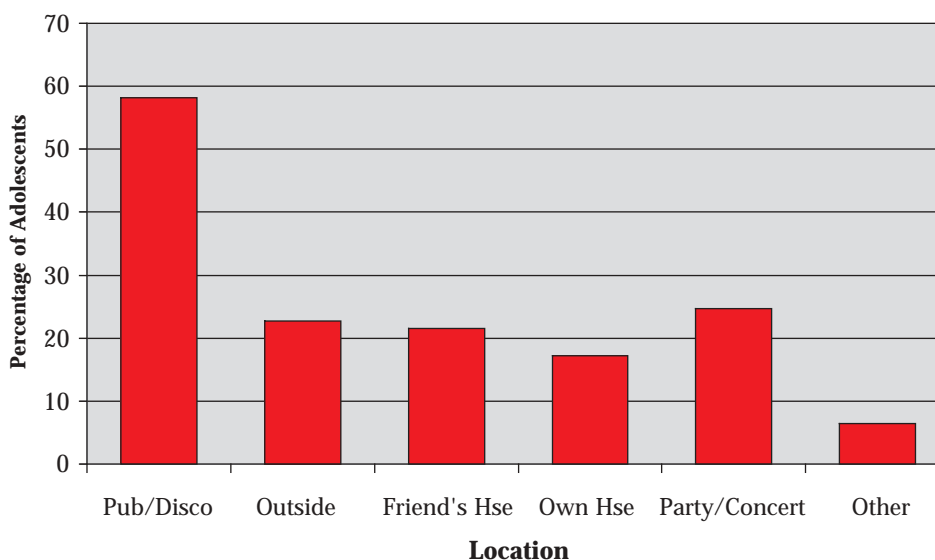
Figure 26 Reports as to who buys alcohol according to age-status



4.3.9. Where is Alcohol Consumed?

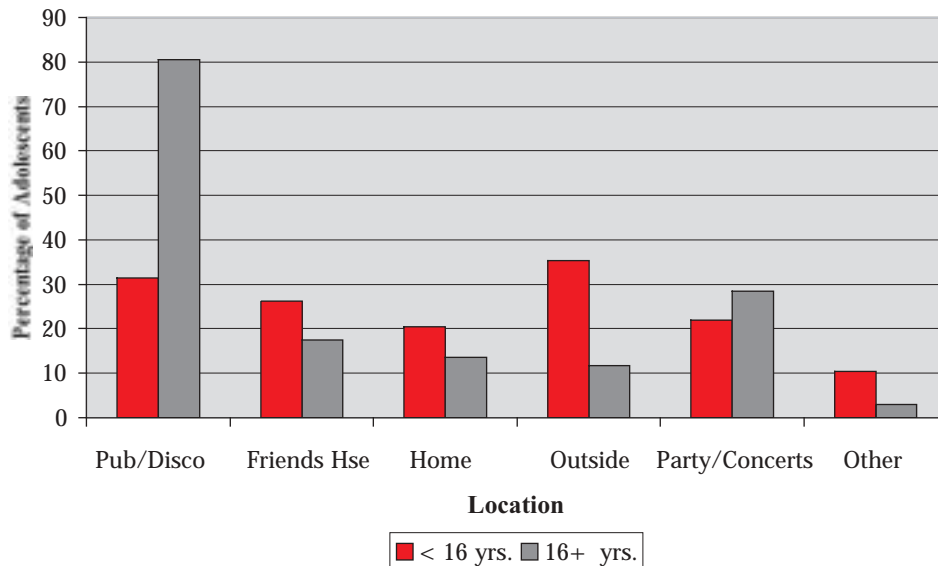
Figure 27 depicts where respondents indicated that they mostly drink. The pub or disco was by far the most popular venue with almost 60% (58.2%, n= 591) of respondents indicating that they do most of their drinking there. The second most commonly reported venue for drinking was at parties or concerts, where 24.7% (n= 251) of respondents indicated that they do most of their drinking.

Figure 27 Locations where alcohol is consumed



As illustrated in Figure 28, age differences were apparent. Of respondents aged older than 16 and less than 18, 80.5% (n= 368) indicated that they mostly drink in a pub/disco whereas, among respondents aged 16 or younger, the greatest percentage indicated that they mostly drink outside (35.3%, n= 166). Furthermore, a higher percentage of adolescents aged younger than 16 years indicated that they frequently drink outside (35.3% vs. 11.8%) or in their own homes, (20.4% vs. 13.6%) than did adolescents aged older than 16 years. Data from the 1997 study was not available for comparison.

Figure 28 Location of alcohol consumption according to age-group



#### 4.4. Use of Illicit Drugs

In this section, findings related to patterns of illicit drug use and experiences with illicit drugs will be explored.

##### 4.4.1. Lifetime Prevalence

Overall, 41.2% (n= 588) of respondents indicated that they had taken an illicit drug at least once in their lives (i.e., lifetime prevalence). Among males, the lifetime prevalence was 40.8% (n= 347) and among females the rate was 41.8% (n= 234), thereby resulting in a non-significant gender difference. As illustrated in Figure 29, lifetime prevalence shows increases with age, such that at 13 years, the lifetime prevalence for drug use was 24.5% (n= 60), while at 17 years, it was found to be 51.5% (n= 173).

Figure 29 Percentage who had taken an illicit drug according to age & gender

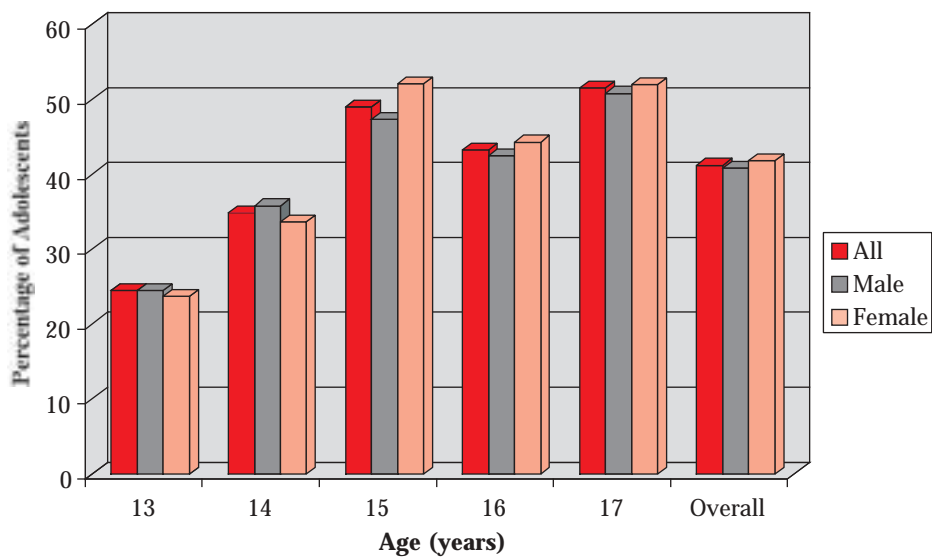


Table 8 presents the type of drug taken by those who indicated that they had taken an illicit drug at least once in their lives (n= 588). As shown, the most commonly taken drug was reported to be cannabis, which was taken by 75.3% (n= 442) of those who had ever taken a drug. The second most commonly reported drug ever taken was solvents or glue, which was indicated by 53.1% (n= 312) of those who had ever taken an illicit drug. Among those who had taken at least one drug (n= 588), 52.8% (n= 310) indicated that they had taken just one drug, 24.2% (n= 142) reported taking two drugs and 10.9% (n= 142) reported having taken three drugs. Finally, 12.0% (n= 71) indicated that they had taken four or more drugs from the given list.

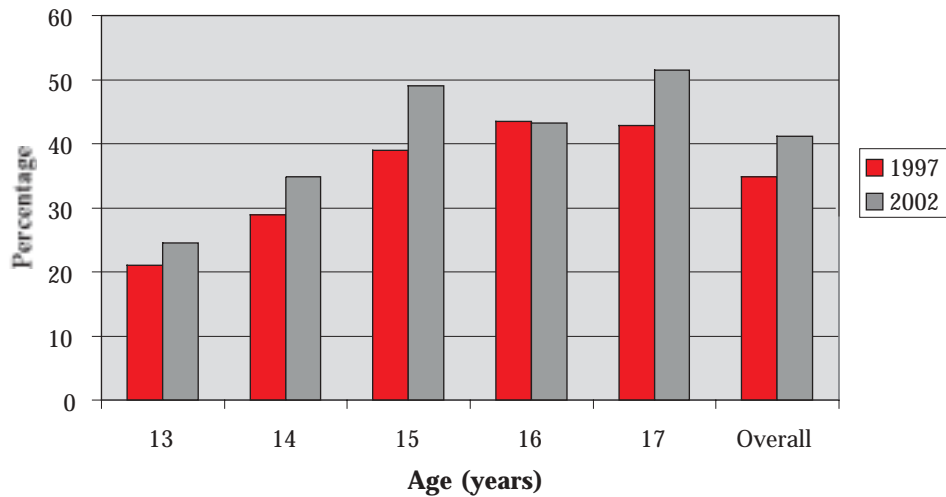
Table 8 Type of drug taken by those who indicated ever taking  $\geq 1$  drug (n= 588)

Type of Drug	N	%
Cannabis	442	75.3
Glue / Solvents	312	53.1
Ecstasy	76	12.9
Speed	67	11.4
Psilocybin	63	10.7
Cough Syrup	55	9.4
Cocaine	33	5.6
LSD	27	4.6
Heroin (smoked)	20	3.4
Barbiturates	7	1.2
Heroin (needle)	5	0.9



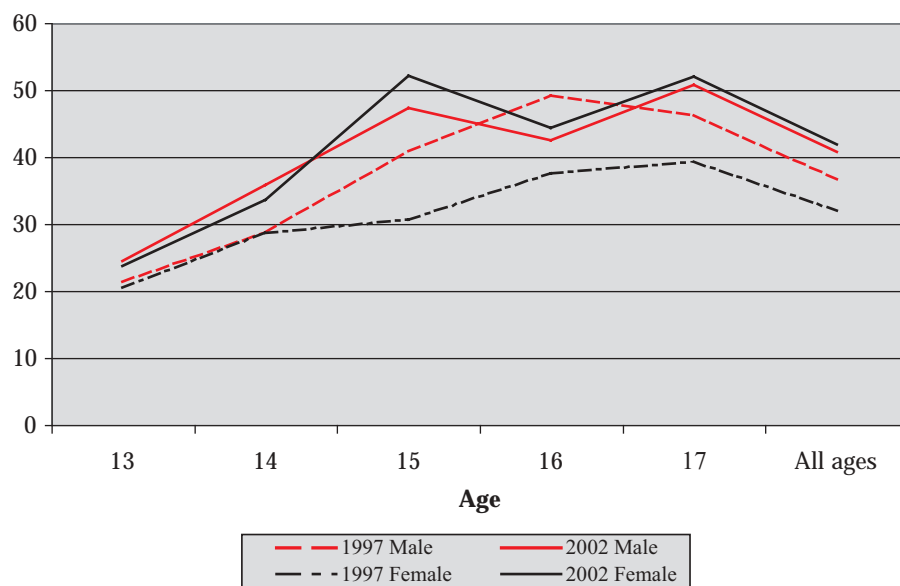
In 1997, the lifetime prevalence rate for illicit drug usage was 34.9% (n= 529), corresponding to 36.7% (n= 325) among males and 32.0% (n= 199) among females. Figure 30 illustrates the lifetime prevalence rates overall and according to each age group, for both the 1997 and 2002 studies. Overall, the lifetime prevalence rate was a statistically significant 6.3% higher in 2002 than in 1997 (95% CI: 2.8 - 9.8).

Figure 30 Lifetime prevalence rates for illicit drug use according to 1997 and 2002 studies



Change was also evident from the 1997 study with regards to gender. As presented in Figure 31, this was particularly so in relation to females. The lifetime prevalence rate for females in 1997 was 32.0% (n= 199) and this increased to 41.8% (n= 234) in 2002. This represents a 31% increase in 2002 from the rate in 1997 among females. Among males, the figure for 2002 (40.8%) represents an 11% increase from that in 1997 (36.7%).

Figure 31 Lifetime prevalence rates for 1997 and 2002 according to gender



Among those in the 1997 study who had used at least one drug, cannabis was also the most commonly reported drug used, as shown in Table 9. Overall, 70.3% (n= 372) of all those who had used at least one drug in 1997 indicated that they had used cannabis (75.3% in 2002).

Table 9 Type of drug taken by those who indicated ever taking  $\geq 1$  drug by study

Type of Drug	1997	2002
Cannabis	70.3	75.3
Glue / Solvents	54.3	53.1
Ecstasy	14.9	12.9
Speed	16.1	11.4
Psilocybin	21.0	10.7
Cough Syrup	12.9	9.4
Cocaine	4.3	5.6
LSD	16.1	4.6
Heroin (smoked/needle)	5.1	4.3
Barbiturates	3.4	1.2

Table 10 presents the overall lifetime prevalence in 2002 and 1997 for each of the given drugs. As shown, the highest lifetime prevalence rates in 2002 were for cannabis (31%) and glue/solvents (21.8%) and these represent higher rates than those obtained in the 1997 study.

Table 10 Overall lifetime prevalence for each drug

Type of Drug	1997	2002
Cannabis	24.6	31.0
Glue / Solvents	18.9	21.8
Ecstasy	5.3	5.3
Speed	5.6	4.7
Psilocybin	7.3	4.5
Cough Syrup	4.5	3.9
Cocaine	1.6	2.3
LSD	5.7	1.9
Heroin (smoked/needle)	2.1	1.8
Barbiturates	1.2	0.5
Other drugs	2.8	2.7
Any drug	34.9	41.2

For most other drugs, the lifetime prevalence rate in 2002 fell from the 1997 figures. While the rate for ecstasy remained the same, cocaine showed a slight increase in 2002 from 1997, however, the lifetime prevalence rate for cocaine still remains low (1.6% to 2.3%).

#### 4.4.2. Frequency of Drug Use

Table 11 presents the percentage of illicit drug use for each user category. For the purposes of this study, the use of illicit drug is categorised as:

- I. Never:** those who had never taken any illicit drug listed.
- II. Once:** those who had taken an illicit drug only once in their lives
- III. Sporadic:** those who had taken an illicit drug more than once but not regularly.
- IV. Regular:** those who had taken an illicit drug once/twice in the last month or at least once a week in the last month.

Overall, 15.1% (n= 215) of all respondents indicated that they regularly used one or more drugs. Among females, 13.4% (n= 75) were regular drug users while, among males, 16.2% (n= 138) reported that they regularly used drugs, thereby resulting in a non-significant gender difference. As shown in Table 11, cannabis was the most frequently used drug, with 12.8% (n= 183) of all respondents reporting that they were regular users of cannabis.

Table 11 Percentage illicit drug use across all ages for each user category in 2002

	Never	Once	Sporadic	Regular	No Response
Cannabis	65.4	6.4	11.8	12.8	3.6
Glue/Solvents	72.8	7.6	11.7	2.5	5.3
Ecstasy	88.9	2.5	1.5	1.3	5.8
Speed	88.7	2.7	1.7	0.3	6.6
Psilocybin	89.2	2.7	1.4	0.4	6.4
Cough Syrup	89.3	2.1	1.2	0.6	6.9
Cocaine	91.3	1.3	0.9	0.1	6.4
LSD	91.4	0.9	0.8	0.2	6.7
Heroin (smoked)	91.7	0.9	0.3	0.2	6.9
Heroin (needle)	92.8	0.3	0.0	0.1	6.9
Barbiturates	92.3	0.3	0.1	0.1	7.2
Other	54.0	1.0	1.1	0.7	43.3

The use of ecstasy, LSD, speed or psilocybin was inclined to be once or sporadic with very low rates of regular usage (less than 1.5%). The use of harder drugs such as heroin, cocaine or barbiturates was less than 1.5% across the different user categories. Cough syrup was used once or sporadically by 3.3% (n= 47) of respondents while 0.6% (n= 9) indicated that they regularly use cough syrup to get high. The use of other drugs was reported by 2.8% (n= 40) of respondents in total.

In 1997, 11.9% (n= 181) of respondents indicated that they regularly used drugs corresponding to 10.5% (n= 65) among females and 12.8% (n= 113) among males. This represents a statistically significant difference of 3.1% from 2002 (95% CI: 0.5-6.6). Results from 1997 also found that cannabis was the most commonly used drug. As shown in Table 12, 9.4% (n= 143) reported that they used cannabis regularly. Overall, there was a statistically significant increase in cannabis usage between 1997 and 2002 of 3.4% (95% CI: 1.1 - 5.7). The figures for the use of glue or solvents are also slightly higher in 2002 than in 1997. For all other drugs, the percentage of respondents who reported regular usage was lower in 2002 than in 1997.

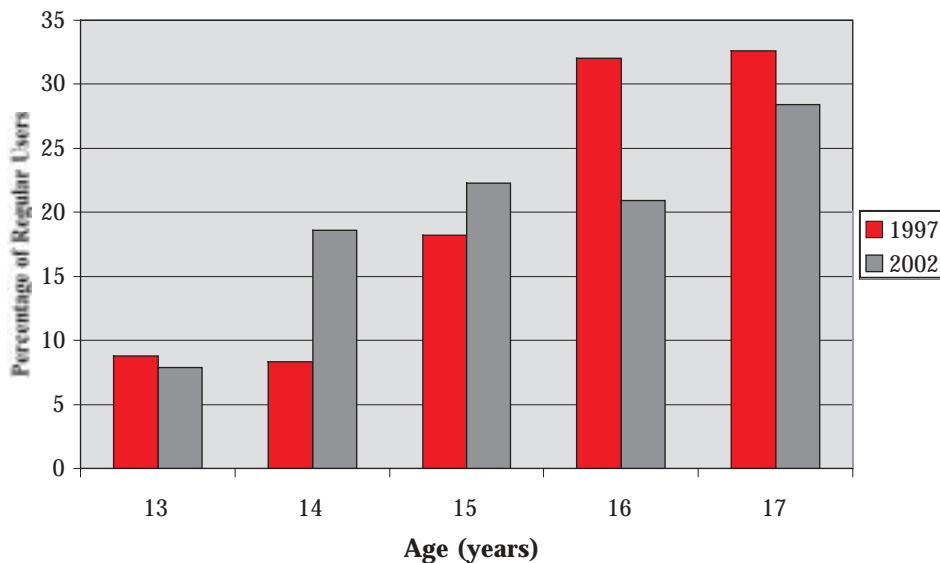
Table 12 Percentage illicit drug use across all ages for each user category in 1997

	Never	Once	Sporadic	Regular	No Response
Cannabis	74.1	5.2	10.0	9.4	1.4
Glue/Solvents	79.2	7.5	9.4	2.0	1.9
Ecstasy	92.2	2.4	1.3	1.6	2.6
Speed	91.4	2.3	1.9	1.4	3.0
Psilocybin	90.1	2.8	3.7	0.8	2.6
Cough Syrup	92.5	1.9	1.9	0.7	3.0
Cocaine	95.3	0.9	0.3	0.4	3.2
LSD	92.0	2.8	2.1	0.8	2.4
Heroin (smoked)	95.1	1.1	0.4	0.3	3.0
Heroin (needle)	96.7	0.2	0.0	0.1	3.0
Barbiturates	95.2	0.5	0.4	0.3	3.6
Other	71.0	0.7	1.6	0.5	26.1

#### 4.4.2. (a) Age Distribution of Regular Drug Users

As illustrated in Figure 32, almost 30% (28.4%, n= 61) of regular drug users in 2002 were aged 17 years, but regular drug use was also frequently reported among 14-16 year olds. In 1997, a higher percentage of 16 and 17-year-olds indicated that they were regular drug users than in 2002, however, regular drug use among younger respondents was less frequently reported in 1997 than in 2002.

Figure 32 Age distribution of regular drug users in 2002 and 1997



4.4.2. (b) Regular Drug Usage & Social Class

Table 13 presents the distribution of regular drug use according to social class. As shown, similar percentages of respondents from each social class indicated that they were regular drug users, with the largest percentage of respondents from social class 3-4 and social class 7 reporting that they regularly use drugs.

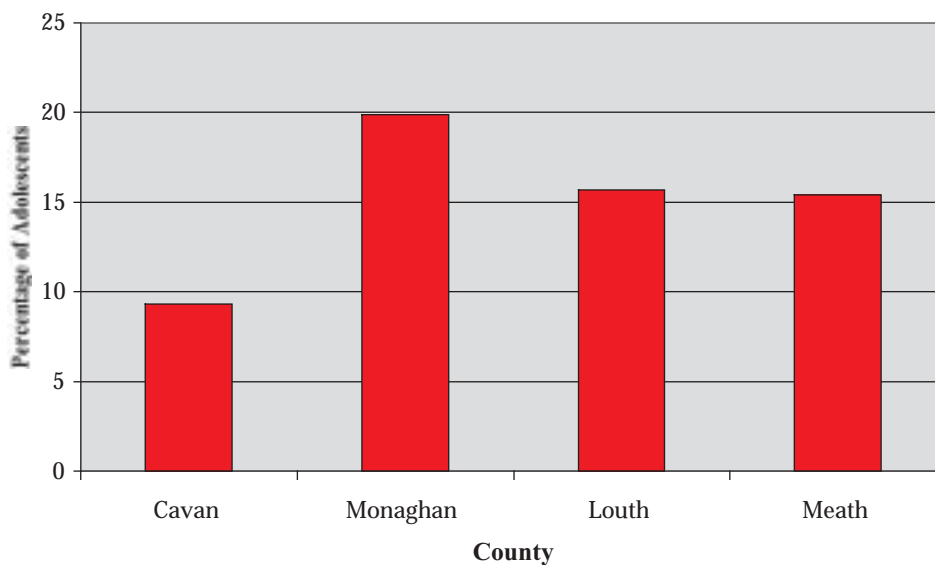
Table 13 Regular drug usage according to social class

	Social Class 1-2	Social Class 3-4	Social Class 5-6	Social Class 7	Not Stated
%	13.5	16.1	10.8	15.7	18.8
N	61	81	16	81	39

4.4.2. (c) Regular Drug Use According to County

Figure 33 illustrates the percentage of respondents attending schools in each of the four counties of the NEHB who reported regularly taking drugs. As shown, almost 20% (19.9%, n= 41) of the respondents from Monaghan reported that they regularly take drugs, a rate that is higher than the overall rate of 15.1%. Cavan demonstrated the smallest percentage of respondents who indicated regular drug usage (9.3%, n= 23), while Louth (15.7%, n= 70) and Meath (15.4%, n= 81) demonstrated similar rates of regular drug usage to the overall rate. Overall, the differences between the counties were not shown to be statistically significant.

Figure 33 Distribution of regular drug users according to county



4.4.3. Number of Drugs Taken

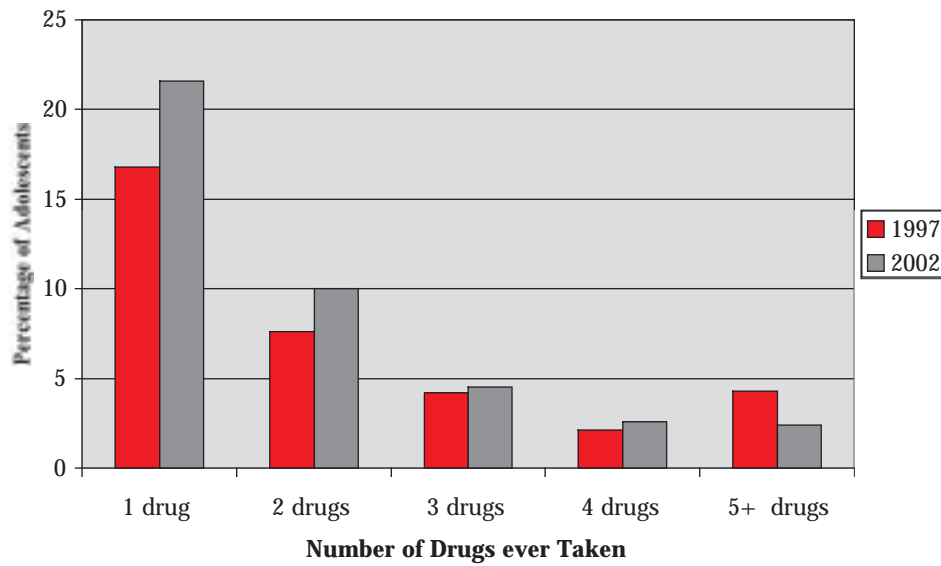
As shown in Table 14, 21.8% (n= 311) of all respondents in this study indicated that they had consumed one drug and an additional 10.0% (n= 142) reported having ever consumed two drugs. There was no gender difference in respect of the number of drugs ever taken.

Table 14 Number of drugs taken by all respondents and according to gender in 2002

No. Drugs						
	None (%)	1 (%)	2 (%)	3 (%)	4 (%)	5+ (%)
<b>Overall</b>	58.8	21.8	10.0	4.5	2.6	2.4
<b>Males</b>	59.2	21.9	9.5	4.5	2.5	2.4
<b>Females</b>	58.3	21.5	10.4	4.7	2.9	2.4

As depicted in Figure 34, a greater percentage of respondents in 2002 than in 1997 indicated that they had taken one, two, three and four drugs. On the other hand, a higher percentage of respondents in 1997 reported having taken five or more drugs than in 2002 (4.3% vs. 2.4%).

Figure 34 Reports of the number of drugs ever taken by respondents in 1997 and 2001



With regards to regular drug users, 12.1% (n= 172) of all respondents in 2002 indicated that they were regularly using one drug while 2.2% (n= 32) indicated that they regularly used two illicit drugs, as shown in Table 15. There was no statistically significant gender difference in respect of the number of drugs regularly taken.

Table 15 No. of drugs regularly taken by all adolescents & according to gender in 2002

No. Drugs				
	None (%)	1 (%)	2 (%)	3+ (%)
<b>Overall</b>	84.9	12.1	2.2	0.8
<b>Males</b>	83.8	12.9	2.6	0.7
<b>Females</b>	86.6	10.7	1.8	0.9

In 1997, 8.4% (n= 128) of all respondents indicated that they regularly took one drug, and 1.8% (n= 27) indicated that they regularly took two drugs. Thus, a higher percentage of respondents in 2002 indicated that they regularly used one or two drugs.

#### 4.4.4. Factors Affecting Regular Drug Use

When multivariate analysis was conducted on the data, the following factors were identified as independent predictors of regular drug use: increasing age (OR 1.23, p< 0.006) and one parent not living at home (OR 1.50, p< 0.006). No significant relationship was found between regular drug use and gender, social class or income.

#### 4.4.5. Reports of Seeing Drugs

Table 16 presents the percentage of adolescents who indicated that they had actually seen the given types of drugs in real life. Respondents were asked to exclude drugs that they had seen on television or that were shown to them via Garda demonstrations at school.

Table 16 Type of drugs seen by respondents overall & according to age category in 2002

Type of Drug Seen	All Ages %	< 16 yrs %	16+ yrs %
Cannabis	61.9	51.3	77.8
Glue or Solvents being sniffed	44.3	41.9	48.8
Ecstasy	28.3	20.8	38.9
Speed	16.9	11.9	24.1
Psilocybin	16.5	12.8	21.8
Cocaine	15.9	13.7	19.1
Heroin	9.6	10.2	9.1
LSD	8.9	6.1	12.9
Barbiturates	2.0	1.5	2.8
Other drugs	3.9	3.9	4.0

As depicted, overall 61.9% (n= 883) of respondents indicated that they had seen cannabis in real life. Furthermore, over half of the adolescents aged less than 16 years indicated that they had seen cannabis (51.3%, n= 411) and 77.8% (n= 472) of those aged 16+ reported having seen it.

As shown in Table 17, a higher percentage of respondents in 1997 indicated that they had seen ecstasy, LSD, speed, psilocybin, barbiturates and other drugs than did respondents in 2002. On the other hand, a greater percentage of respondents in the 2002 study than in 1997 reported having seen cannabis (61.9% vs. 48.2%) and cocaine (15.9% vs. 9.6%) in real life. Of note, however, was that in 1997, some respondents might have reported seeing some of these drugs in drugs awareness classes given by Gardaí or other agencies.



Table 17 Percentage of respondents who reported having seen drugs in real life according to 1997 and 2002 studies

Type of Drug Seen	1997 (%)	2002 (%)
Glue/solvents	42.0	44.3
Cannabis	48.2	61.9
Ecstasy	29.0	28.3
LSD	18.9	8.9
Speed	17.9	16.9
Psilocybin	24.1	16.5
Heroin	9.0	9.6
Cocaine	9.6	15.9
Barbiturates	3.5	2.0
Other	6.7	3.9

#### 4.4.6. Reports of Knowing People who Take Drugs

When asked if they personally knew people who take any of the drugs listed, the most commonly reported drug used by someone known to the respondent was cannabis. As shown in Table 18, 68.9% (n= 983) of respondents indicated that they personally knew someone who took cannabis. The second most commonly reported drug taken by someone respondents knew was ecstasy. Half of all those aged 16 years or more indicated that they personally knew someone who took ecstasy (50.2%, n= 313).

Table 18 Reports of knowing people who take drugs

Type of Drug Seen	All Ages %	< 16 yrs %	16+ yrs %
Cannabis	68.9	57.9	85.5
Ecstasy	35.4	23.9	51.6
Glue or Solvents being sniffed	28.9	30.3	27.8
Speed	20.1	13.8	29.0
Cocaine	16.1	12.6	21.1
Psilocybin	15.9	12.8	20.5
LSD	10.7	6.4	16.7
Heroin	9.7	9.0	10.9
Barbiturates	2.3	2.0	2.7
Others	2.8	3.0	2.7

#### 4.4.7. Knowledge of where Drugs could be Bought

The majority of respondents indicated that they knew somebody from whom they could buy drugs and the most commonly indicated person was someone who deals drugs but was not really a friend (43.1%, n= 374), followed by someone who their friends knew (35.5%, n= 308).

#### 4.4.8. Reports of Being Offered Drugs

Respondents were asked to indicate if they had been offered any of the drugs listed and it was noted on the questionnaire that respondents did not necessarily have to have taken these drugs. In total, 56.7% (n= 809) of all respondents indicated that they had been offered at least one drug. Furthermore, 59.9% (n= 510) of males and 51.6% (n= 289) of females indicated that they had been offered one or more drugs and this constituted a statistically significant gender difference ( $p < 0.01$ ). Among those aged less than 16 years, 48.0% (n= 385) had been offered at least one drug, while this was the case for 67.9% (n= 412) of those aged 16 years or older, resulting in a statistically significant difference, ( $p < 0.001$ ).

As depicted in Table 18A, cannabis featured strongly, with 51.9% (n= 740) of respondents indicating that they had been offered cannabis.

Table 18A Reports of type of drug offered overall and according to age group in 2002

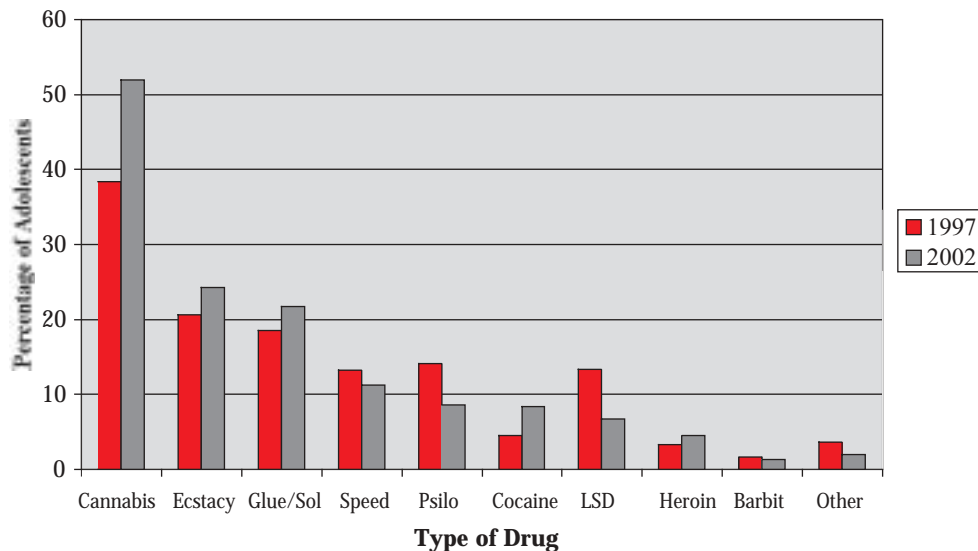
Type of Drug Seen	All Ages %	< 16 yrs %	16+ yrs %
Cannabis	51.9	41.7	64.9
Ecstasy	24.3	15.0	36.4
Glue or Solvents	21.7	22.6	20.8
Speed	11.2	6.4	17.0
Psilocybin	8.6	6.0	11.4
Cocaine	8.4	6.2	10.5
LSD	6.7	2.9	11.7
Heroin	4.5	4.0	4.6
Barbiturates	1.3	1.1	1.5
Other	2.0	2.1	1.8

Among those who reported that they had been offered at least one drug (n= 809), the mean age at which they indicated they were first offered drugs was found to be 14.2 years (s.d.= 1.5). In all, 29.3% (n= 237) of all those who had been offered drugs indicated that they were first offered at 13 years or younger, while 45.4% (n= 367) reported that they were aged between 14 and 15 years of age.

According to the results obtained in the 1997 study, 46.4% (n= 703) of all respondents indicated that they had been offered at least one drug, which is a significantly smaller proportion of respondents than in 2002 (56.7%) (difference= 10.4%, 95% CI: 6.7%-14.0%). Cannabis was also the drug most commonly reported as being offered, with 38.4% (n= 582) of respondents indicating that they were offered cannabis.

Figure 35 illustrates the percentage of respondents in 1997 and 2002 who indicated that they were offered drugs and, as shown, there were more adolescents offered all categories of drugs other than speed, psilocybin, LSD and other drugs in 2002 than in 1997. A greater percentage of adolescents in 2002 reported that they were offered at least one drug than did their counterparts in 1997 and this difference is particularly evident in the younger age group (< 16 years of age). In 1997, 33.7% (n= 283) of respondents aged less than 16 years indicated that they were offered at least one drug, whereas in 2002, this figure corresponds to 48.0% (n= 385). Similar to 2002, however, the mean age at which respondents indicated that they were first offered drugs was 14.2 years (s.d.= 1.7).

Figure 35 Percentage of respondents in 1997 and 2002 who reported having been offered drugs



#### 4.4.9. Where Drugs were Offered

Table 19 presents the locations of where young people reported being offered drugs. As shown, overall, discos (46.0%, n= 372) and the street (45.9%, n= 371) were the most commonly reported places where drugs were offered. The mostly frequently noted locations where drugs were offered that were not contained in the given list include “friend’s house” (2.4%, n= 19), “holidays” (1.5%, n= 12), “The Gaeltacht”, (0.7%, n= 6).

Table 19 Location of where drugs were offered

Location	All Ages %	< 16 yrs %	16+ yrs %
Disco	46.0	33.0	59.2
On the Street	45.9	49.9	43.4
House Party	31.0	22.1	40.3
At School	28.1	25.7	31.1
Concerts	19.8	11.4	28.2
Pub	15.3	7.0	23.5
Shopping Centre	5.1	6.0	4.4
Youth Club	3.0	3.6	2.4
Other place	13.7	16.4	11.7

#### 4.4.10. Who Offered the Drugs?

As shown in Table 20, the most commonly reported person who offered drugs to respondents was someone that their friends knew (36.3%, n= 294), followed by their best or very good friend (32.9%, n= 266).

Table 20 Reports of who offered drugs to respondents

	All Ages %	< 16 yrs %	16+ yrs %
Someone friends know	36.3	32.0	41.5
Best / Very Good Friend	32.9	32.2	34.5
Dealer	25.1	20.0	30.3
Stranger	23.5	21.0	26.5
Other Person	11.3	13.8	9.2

#### 4.4.11. Social Class & Reports of Being Offered Drugs

Table 21 presents the percentage of respondents from each social class who reported that they were offered drugs and, as shown, similar percentages of respondents from each of the social classes indicated that they were offered at least one drug with the highest percentage reported among respondents who did not specify their parents' occupations.

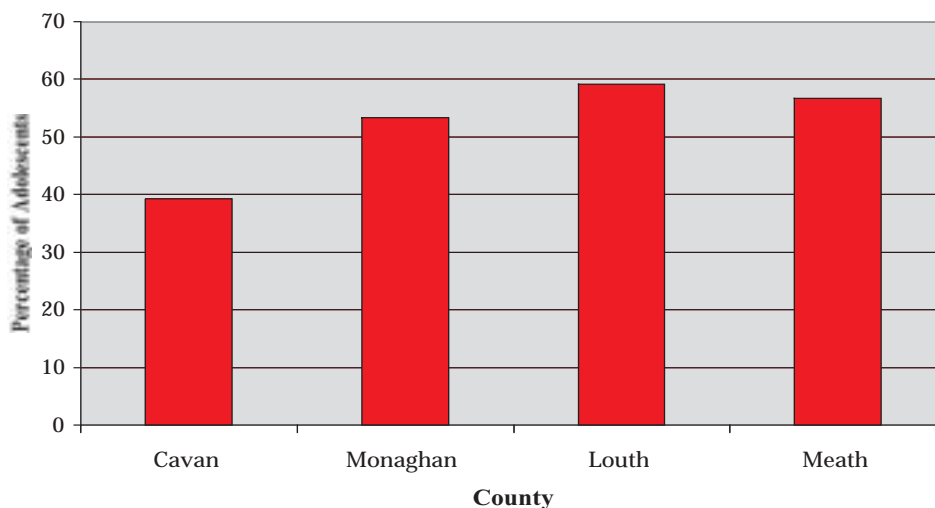
Table 21 Reports of being offered drugs according to social class

	Social Class 1-2	Social Class 3-4	Socual Class 5-6	Social Class 7	Not Stated
%	54.4	58.8	47.7	58.4	62.5
N	252	276	51	170	60

#### 4.4.12. Reports of Being Offered Drugs According to County

Figure 35 illustrates the percentage of respondents from each county who reported that they had been offered drugs. As shown, with the exception of Cavan, over half of the respondents from each county reported that they had been offered at least one drug.

Figure 35 Reports of being offered drugs according to county



## 4.5 Relationships between Smoking, Alcohol & Drug Usage

In this section, findings with regard to the inter-relationships between smoking, alcohol and drug usage are presented.

### 4.5.1. Regular Smoking & Regular Drinking

Statistically significant differences were found with regard to the relationship between regular smoking and regular drinking ( $p < 0.001$ ). Among the regular smokers ( $n = 260$ ), 86.2% ( $n = 224$ ) indicated that they also regularly consumed alcohol, whereas on the other hand, among the non-smokers ( $n = 1166$ ), 46.5% ( $n = 542$ ) were regular drinkers. Among regular drinkers ( $n = 766$ ), 29.2% ( $n = 224$ ) were regular smokers, whereas among non-drinkers ( $n = 660$ ), 5.5% ( $n = 36$ ) indicated that they regularly smoked.

### 4.5.2. Smoking Status & Reports of Being Offered Drugs

Table 22 presents the percentage of regular smokers and non-smokers who reported that they were offered at least one illicit drug. Overall, 91.2% ( $n = 237$ ) of all regular smokers ( $N = 260$ ) indicated that they were offered at least one drug in their lives, whereas only half of the non-smokers ( $N = 1166$ ) indicated that they were ever offered a drug (49.1%,  $n = 572$ ), resulting in a statistically significant difference ( $p < 0.001$ ). As shown, of the regular smokers, 86.9% ( $n = 226$ ) reported that they were offered cannabis compared to 44.1% ( $n = 514$ ) of the non-smokers.

Table 22 Percentage of regular & non-smokers who reported being offered drugs

Drug Offered	Regular Smoker (%)	Non-Smoker (%)
Cannabis	86.9	44.1
Ecstasy	56.5	17.1
Glue/Solvents	40.0	17.7
Speed	32.3	6.4
Psilocybin	24.6	5.0
Cocaine	21.5	5.5
LSD	18.5	4.1
Heroin	9.6	3.3
Other	4.2	1.5
Barbiturates	3.9	0.7
≥1 drug	91.2	49.1

### 4.5.3. Smoking Status & Lifetime Prevalence for Drug Usage

Table 23 presents the percentage of regular smokers and non-smokers who indicated that they had taken drugs.

Table 23 Percentage of regular- and non-smokers who reported having ever taken drugs

Drug Taken	Regular Smoker (%)	Non-Smoker (%)
Glue/Solvents	41.2	17.6
Cannabis	75.0	21.2
Ecstasy	20.4	2.0
LSD	6.9	0.8
Speed	17.3	1.9
Psilocybin	14.6	2.1
Heroin (smoked)	3.5	0.9
Heroin (needle)	1.2	0.2
Cocaine	7.3	1.2
Barbiturates	1.5	0.3
Cough Syrup	7.3	3.1
Other	5.0	2.2
Taken ≥1 drugs	81.5	32.3

A statistically significant difference was evident, such that 81.5% (n= 212) of the regular smokers reported that they had taken at least one drug in their lives whereas this was reported by 32.3% (n= 376) of non-smokers (p< 0.001). Table 23 also highlights that three-quarters (75%) of all regular smokers had taken cannabis at least once as opposed to less than one-quarter (21.2%) of all non-smokers.

#### 4.5.4. Smoking Status & Regular Drug Usage

A statistically significant difference was evident in relation to regular drug use and smoking status (p< 0.001). As shown in Table 24, 48.5% (n= 126) of regular smokers indicated that they regularly use at least one drug, whereas this was indicated by 7.6% (n= 89) of non-smokers.

Table 24 Percentage of regular- and non-smokers who reported regular drug use

Drug Taken	Regular Smoker (%)	Non-Smoker (%)
Glue/Solvents	6.5	1.6
Cannabis	44.2	5.8
Ecstasy	6.5	0.2
LSD	1.2	0.0
Speed	1.2	0.09
Psilocybin	1.5	0.09
Heroin (smoked)	0.0	0.3
Heroin (needle)	0.0	0.09
Cocaine	0.8	0.0
Barbiturates	0.4	0.0
Cough Syrup	1.9	0.3
Other	1.2	0.6
≥1 drug regularly	48.5	7.6

#### 4.5.5. Regular Drinking & Reports of Being Offered Drugs

As depicted in Table 25, 79% (n= 605) of regular drinkers reported that they were offered at least one drug, whereas this was reported by 30.9% (n= 204) of non-regular drinkers ( $p < 0.001$ ).

Table 25 Percentage of regular and non-regular drinkers who were offered drugs

Drug Offered	Regular Smoker (%)	Non-Smoker (%)
Cannabis	74.3	25.9
Ecstasy	38.1	8.2
Glue/Solvents	29.9	12.3
Speed	18.5	2.6
Psilocybin	14.4	1.8
Cocaine	13.3	2.7
LSD	11.2	1.5
Heroin	6.5	2.1
Other	2.7	1.1
Barbiturates	2.4	0.0
Taken $\geq 1$ drugs	79.0	30.9

#### 4.5.6. Regular Drinking & Lifetime Prevalence for Drug Usage

Table 26 presents the percentage of regular and non-regular drinkers who indicated that they had ever taken an illicit drug. As shown, 60.2% (n= 461) of regular drinkers and 19.2% (n= 127) of non-regular drinkers reported that they had ever taken a drug ( $p < 0.001$ ).

Table 26 Percentage of regular and non-regular drinkers who had taken a drug

Drug Taken	Regular Smoker (%)	Non-Smoker (%)
Cannabis	49.5	9.6
Glue/Solvents	30.4	12.0
Ecstasy	8.9	1.2
Speed	8.0	0.9
Psilocybin	7.3	1.1
Cough Syrup	5.9	1.5
Other	3.7	1.7
Cocaine	3.5	0.9
LSD	3.3	0.3
Heroin	2.4	1.1
Barbiturates	0.8	0.2
Taken $\geq 1$ drug	60.2	19.2

#### 4.5.6. Regular Drinking & Regular Drug Usage

As shown in Table 27, 24.7% (n= 189) of regular drinkers and 3.9% (n= 26) of non-regular drinkers reported that they regularly use at least one drug and this difference was statistically significant (p< 0.001).

Table 27 Percentage of regular & non-regular drinkers who regularly take drugs

Drug Regularly Taken	Regular Smoker (%)	Non-Smoker (%)
Cannabis	21.5	2.7
Glue/Solvents	3.5	1.4
Ecstasy	2.2	0.3
Other	1.2	0.2
Cough Syrup	0.9	0.2
Psilocybin	0.7	0.0
Speed	0.5	0.0
LSD	0.4	0.0
Cocaine	0.3	0.0
Heroin (smoked)	0.1	0.3
Barbiturates	0.1	0.0
Heroin (needle)	0.0	0.2
≥1 drug regularly	24.7	3.9

## 4.6. Opinions About Smoking, Alcohol & Drugs

In this section, respondents were asked for their opinions in relation to aspects of smoking, alcohol and drug consumption.

(a) *“Do you consider a drug addict more as a criminal or as a patient?”*

Respondents were asked to indicate their opinion of this statement from a list of five given options: (1) more as a criminal; (2) more as a patient; (3) neither; (4) both; (5) don't know. Table 28 presents the distribution of responses and, as shown, almost 30% (29.9%, n= 426) of all respondents reported that they considered a drug addict more as a patient than as a criminal.

Table 28 Respondent opinion of a drug addict

	All Ages %	< 16 yrs %	16+ yrs%
More as a Patient	29.9	28.8	32.1
Both	22.7	24.2	21.3
Don't know	18.0	20.3	15.5
More as a Criminal	16.0	15.1	17.6
Neither	11.9	10.4	14.3
Non-response	1.5	1.3	2.0



(b) *“People should be allowed to take cannabis/marijuana”*

Respondents were asked to indicate the extent to which they agreed or disagreed with the above statement. As shown in Table 29, respondents were undecided in this regard with 29.7% (n= 423) indicating that they neither agreed nor disagreed with the statement. Nonetheless, 40.3% (n= 574) expressed disagreement, while 27.6% (n= 394) indicated that people should be allowed to take cannabis.

Table 29 Respondent opinion of whether people should be allowed to take cannabis

	All Ages %	< 16 yrs %	16+ yrs%
Fully Agree	14.0	10.7	18.1
Largely Agree	13.7	11.1	17.0
Neither Agree or Disagree	29.7	30.1	28.8
Largely Disagree	13.4	14.6	12.2
Fully Disagree	26.9	30.7	22.4
Non-response	1.6	1.7	0.8

Twelve respondents (0.8%) stated that they felt that people should be allowed to take cannabis/marijuana for medical reasons. A significantly greater percentage of older adolescents than younger adolescents indicated that people should be allowed to take cannabis (35.1% vs. 21.8%,  $p < 0.001$ ). Furthermore, those who were regular users of cannabis were significantly more likely to express agreement than were non-users (81.4% vs. 19.8%,  $p < 0.001$ ).

(c) *Approval/Disapproval of Trying Ecstasy*

Respondents were also asked to indicate their approval or disapproval of four given behaviours. Firstly, they were asked for their opinion with regard to trying ecstasy once or twice. As depicted in Table 30, almost three-quarters of respondents indicated that they disapproved of trying ecstasy once or twice (74.3%, n= 1060) and this was approximately the case for both older and younger respondents.

Table 30 Respondent opinion of trying ecstasy once or twice

	All Ages %	< 16 yrs %	16+ yrs%
Do not Disapprove	13.5	13.1	13.8
Disapprove	28.4	29.9	26.5
Strongly Disapprove	45.9	42.0	52.1
Don't Know	10.7	13.3	6.8
Non-Response	1.4	1.6	0.8

(d) *Approval / Disapproval of Smoking*

When asked for their opinion of smoking ten or more cigarettes per day, a total of 62.3% (n= 888) expressed disapproval, with 29.9% of this group expressing strong disapproval as shown in Table 31.

Table 31 Respondent opinion of smoking ten or more cigarettes per day

	All Ages %	< 16 yrs %	16+ yrs%
Do not Disapprove	30.0	27.6	33.4
Disapprove	32.3	31.7	33.4
Strongly Disapprove	29.9	32.4	27.0
Don't Know	6.5	7.0	5.3
Non-Response	1.4	1.4	0.8

A statistically significant difference was found between younger and older respondents, with a greater percentage of older people indicating that they did not disapprove of smoking ten or more cigarettes daily ( $p < 0.05$ ). Furthermore, when analysed according to smoking status, regular smokers were more likely to report that they do not disapprove of smoking ten or more cigarettes per day than were non-smokers (73.1% vs. 20.4%,  $p < 0.001$ ).

(e) *Approval / Disapproval of Drinking*

As depicted in Table 32, respondents were more tolerant of people having one or two drinks several times per week than they were of people smoking. Over half of all respondents indicated that they do not disapprove of people having 1-2 drinks several times per week (52.5%, n= 749). A statistically significant age difference was evident, with a greater percentage of older than younger adolescents indicating that they do not disapprove of this behaviour (59% vs. 48.2%,  $p < 0.001$ ). Furthermore, regular drinkers were significantly more likely not to disapprove than were non-drinkers ( $p < 0.001$ ).

Table 32 Respondent opinions of having 1-2 drinks several times per week

	All Ages %	< 16 yrs %	16+ yrs%
Do not Disapprove	52.5	48.1	59.0
Disapprove	25.7	27.2	23.7
Strongly Disapprove	9.9	11.6	7.9
Don't Know	11.0	12.3	8.7
Non-Response	0.9	0.8	0.7

(f) *Smoking Cannabis / Marijuana Occasionally*

Overall, one-third of respondents indicated that they do not disapprove of people smoking cannabis/marijuana occasionally (33.1%, n= 472), as shown in Table 33. A significantly greater percentage of older adolescents than younger adolescents indicated that they do not disapprove of this behaviour (42.3% vs. 25.7%,  $p < 0.001$ ). Lack of disapproval was significantly greater both among those who reported regular cannabis use and among those who had ever taken cannabis. In total, 57.5% (n= 820) of respondents disapproved of this behaviour, with 64.4% (n= 517) of younger adolescents and 49.8% (n= 302) of older respondents conveying disapproval ( $p < 0.001$ ).

Table 33 Respondent opinion of smoking cannabis/marijuana occasionally

	All Ages %	< 16 yrs %	16+ yrs%
Do not Disapprove	33.1	25.7	42.3
Disapprove	25.7	26.6	25.2
Strongly Disapprove	31.8	37.9	24.6
Don't Know	8.1	8.6	7.1
Non-Response	1.3	1.1	0.8

(g) *Reasons for Taking Drugs*

Finally, respondents were asked for their opinion as to why young people take drugs. As presented in Table 34, the most commonly indicated reasons were that young people take drugs because “the people they hang around with do it” (58.6%, n= 836). Moreover, a higher percentage of younger than older respondents reported that people take drugs for that reason (61.2% vs. 55.5%,  $p < 0.05$ ).

Table 34 Respondents’ reasons regarding why young people take drugs

	All Ages %	< 16 yrs %	16+ yrs%
The people they hang around with do it	58.6	61.2	55.5
Just to try it out	52.4	50.3	55.0
They make them feel great	46.0	45.3	46.3
It’s exciting to take risks	35.0	33.0	37.7
To help them cope with life	30.1	29.6	30.5
It’s the thing to do	24.1	23.2	25.2
Something parents wouldn’t like	11.2	12.7	8.6
Some other reason	18.6	17.6	20.3

In total, 18.6% (n= 265) of respondents noted an additional reason to those in the given list and the most commonly given reasons are presented in Table 35. As shown, the most frequently noted ‘other’ reason why people take drugs was their perception that it is “cool” or “hard” or they are “trying to be cool” (3.9%, n= 56). Secondly, respondents remarked that people take drugs because “there is nothing else to do” or because they are “bored” (3.0%, n= 43).

Table 35 Additional reasons given as to why people take drugs

Additional Reasons	N	%
Perception of “coolness”	56	3.9
Nothing else to do / Boredom	43	3.0
Peer Pressure	40	2.8
Enjoyment / Relaxation	26	1.8
The “buzz” / To get High	15	1.1
To be part of a gang	11	0.8
Escape reality / problems	9	0.6

#### 4.7. Smoking, Drinking, Illicit Drugs and “Spending Power”

Respondents were asked to indicate if they received money and, if so, how much they received. Furthermore, they were also asked to state if they had a part-time job and how much they earned. In total, 58.3% (n= 832) of all respondents indicated that they got pocket money and 44.7% (n= 638) indicated that they had a part-time job. Overall, 18.7% (n= 266) reported that they did not receive pocket money or have a part-time job. On the other hand, 21.7% (n= 310) stated that they both worked part-time and received pocket money. As shown in Table 36, almost 30% of 13-year-olds reported having a part-time job.

Table 36 Reports of having a part-time job according to age-group

Age-Group	N	%
13 years	71	29.0
14 years	118	39.6
15 years	117	45.2
16 years	159	58.7
17 years	171	50.9

The total income of respondents was calculated from their earnings from part-time work and the pocket money they received. As shown in Table 37, just over 30% (30.4%, n= 433) of all respondents indicated that they had a total income of more than €40 per week. Furthermore, income was positively associated with age up to sixteen years ( $p < 0.001$ ). As noted in Table 36, there was a decrease in the percentage of 17-year-olds who reported having a part-time job, possibly reflecting school and examination commitments within that age-group.

Table 37 Total income per week of respondents

	%	N
< €20	30.8	439
< €40	16.8	239
> €40	30.4	433
No Response	22.1	315

Total income was found to be independently and positively related to regular smoking, even after controlling for age ( $p < 0.0001$ ). Likewise, a strong positive relationship was also observed with regards to regular drinking when controlled for age ( $p < 0.001$ ). No relationship was found, however, between total income and regular drug use.

Thus, the income of respondents in this study, earned by part-time work and/or received as pocket money, appears to be related to regular smoking and drinking but not to regular use of illicit drugs.

## Chapter 5

### *Discussion*

This study presents the rates for smoking, alcohol and illicit drug use among young people attending post-primary schools in the north-eastern region. In total, 1426 pupils responded to the survey, which was conducted in 24 schools throughout the counties of Cavan, Monaghan, Louth and Meath. In this section, a brief summary of the findings, as well as results from comparative studies, will be outlined. It is important to bear in mind that these studies are not homogeneous, rather they vary in terms of methodology, sample size, geographical location as well as the specific age-groups surveyed. Nonetheless, it is useful to examine the findings in light of what has been found in other studies conducted nationally and across Europe, which have used broadly similar techniques.

#### **5.1. Smoking**

The lifetime prevalence rate for smoking in this study was found to be 50.8%. This represents a decrease from the rate observed in the 1997 study (57.1%) and, in particular, the decline was found to be most substantial among males. This rate was below that found in the 1999 ESPAD report (73%). Of note, however, is that the age-group surveyed in the ESPAD study was 15-16 year-olds. Thus, it would be expected that the lifetime smoking prevalence rate would be lower than in the ESPAD report. Among 15-16 year-olds in the present study, however, the lifetime prevalence rate for smoking was found to be 55.9%, which is still substantially lower than that observed in the ESPAD report. This study also reveals a lower lifetime smoking rate than that found in the Grube & Morgan (1986) study in Dublin (67.1%), the O’Fathaigh study (1990) conducted in Cork (72%) as well as the study conducted by Kiernan (1995) in the Western Health Board (67.3%) and by Cahill (1999) in Kildare and west Wicklow (67%). A comparable rate was obtained in the Mid-Western Health Board (1998) (58%). The recently published HBSC Survey (2003) observed a lower lifetime prevalence rate for smoking within the population they surveyed (41%). Of note, however, was that in the HBSC study, pupils in both primary and post-primary schools were surveyed, thereby incorporating a younger population than that of the present study.

In this study, 18.2% of all respondents regularly smoked. Of considerable interest, this finding represents a substantial decrease from the rate of regular smoking observed in the 1997 study (30.7%). In the 1999 ESPAD report, 25% of 15-16 year-olds regularly smoked, a figure just below the overall average (26%). Indeed, the figure observed in this study is among the lowest observed across all the countries surveyed by ESPAD (1999). Among the 15-16 year-olds in the present study, the rate of regular smoking was calculated as 18.9%. This rate is also substantially lower than that observed by Grube & Morgan (1986) (24.4%), O’Fathaigh (1990) (25%), Kiernan (1995) (27.1%) and the Mid-Western Health Board (1998) (28.6%). In the HBSC Survey, 19% of the 10-17 year-olds surveyed were currently smoking. Thus, the rate of regular smoking among the young people in the NEHB who participated in this study was lower than that observed in several other regional studies as well as a recent national and European study.

Regular smoking was also more prevalent among girls than boys in this study, as was the lifetime prevalence rate. This trend is also evident in the 1997 study as well as in numerous other studies conducted in Ireland as well as internationally (MWHB, 1998; Kiernan, 1995; Ariza-Cardenal & Nebot-Adell, 2002). This suggests that there is a specific need to focus on teenage girls both in terms of understanding their motivations to initiate and maintain smoking and on effective cessation strategies.

No association was found in this study between regular smoking and social class. Regular smokers in 2002 seem to be smoking more cigarettes daily than did regular smokers in 1997. Furthermore, a steady increase with age was observed in 2002 with regard to the percentage of regular smokers smoking up to 20 cigarettes per day. The mean age at which regular smokers had their first cigarette (11.6 years) was significantly younger than that of non-regular smokers (12.5 years). This is noteworthy in light of research indicating that earlier smoking onset predicts substance problems and nicotine dependence in young adulthood (Lewinsohn, Rohde & Brown, 1999). Over 85% of regular smokers reported that they buy cigarettes themselves and, although it is illegal to sell cigarettes to persons under 18 years, 83.6% of regular smokers aged less than 18 years stated that they buy their cigarettes themselves. This finding points to the need for more stringent enforcement of the law in this area. Regular smokers were more likely to live in a home where at least one other person smokes. This finding was also observed in the 1997 study. Conrad, Flay & Hill (1992) found that parental smoking significantly predicted smoking onset among adolescents, while another study found that parental smoking was a predictor in the transition to regular smoking (Flay et al., 1998). Furthermore, Chassin et al., (1996) found that smoking cessation was less likely among young smokers whose parents smoked. This has implications for broader programmes of smoking cessation.

## 5.2 Alcohol

Among young people in the NEHB, the lifetime prevalence for alcohol consumption was 71.3% and the prevalence was similar for males and females. This represents a figure just below that obtained in the 1997 study (72.5%). A higher rate was observed in the 1999 ESPAD report (92%). Other higher rates were obtained by O’Fathaigh, (1990) (78%), the MWHB (1998) (81.5%) and Cahill (1999) (81%). On the other hand, lower rates have been observed in other studies - Grube & Morgan (1986): 65%; Kiernan (1995): 67%. The HBSC Survey revealed that 40% of the young people surveyed had never had an alcoholic drink, suggesting that approximately 60% had consumed a drink at some point in their lives. Thus, there appears to be considerable disparity between the various studies, with lifetime prevalence ranging from 60% to 92%, showing that the findings of our study are within the parameters of what has been found elsewhere.

For all ages, 53.7% of young people were regularly consuming alcohol and, similar to lifetime prevalence, rates were similar for both males and females. The rate of regular drinking was shown to rise incrementally with age, such that at 13 years, 21.6% were regular drinkers, while at 17 years, 79.2% regularly drank. Cavan and Meath demonstrated the highest percentage of respondents who reported that they were regular drinkers and, again, no pattern was discernible with regard to social class and regular drinking. In 1997, a slightly higher percentage of respondents indicated that they were regular drinkers (57.3%). Difficulties exist in making comparisons with other studies, due to differences in the definition of “regular drinking” used. For example, Grube & Morgan (1986) defined regular drinking as those who consumed more than one type of beverage or who had drunk alcohol on more than two occasions, whereas in the present study, regular drinking was defined as consuming one or more drinks per week. Thus, quite variable rates are evident across studies. Grube & Morgan (1986) found that 36.5% were regular drinkers, while O’Fathaigh (1990)

found that 51% of their sample were regular-occasional drinkers. In the MWHB (1998), 67.8% were currently drinking. The HBSC (2003) survey revealed that 25% of respondents had a drink in the last month.

When asked if they had ever had enough alcohol so as to feel drunk, 56.7% responded affirmatively, while over one-quarter of respondents (27.2%) reported that they had been drunk on more than ten occasions. A higher percentage of males than of females indicated that they had been drunk more than ten times (64.2% of males; 35.3% of females). This figure is higher than that obtained in 1997, when 24% indicated that they had been drunk more than 10 times. In the 1999 ESPAD report, 72% of Irish students indicated that they had been drunk at least once and 37% reported that they had been drunk more than ten times. O’Fathaigh found that 51% had been drunk at least once and in the MWHB (1998), 53.8% made this report. The HBSC study reported that 30% had been “really drunk” while 7% of boys and 5% of girls had been so on more than ten occasions. It is likely that both differences in age-groups surveyed and the different language used contributes to the different rate observed here than in the present study. Difficulties arise in making comparisons across studies in relation to this item, mainly due to differences in the terminology used in these studies.

Over 20% of all respondents indicated that they have more than ten alcoholic drinks per week. Most drinking is conducted during weekends, with 23.2% indicating that they drink 6-10 drinks on Saturday night. Results from 1997 also revealed that most of those who drank did so at weekends, however, it seems that drinkers in 2002 were having more to drink on a Saturday night than were drinkers in 1997.

Over half indicated that they buy alcohol in a pub (55.5%) while 42.2% reported buying alcohol in an off-licence. Among those aged younger than 16 years, over one-quarter reported buying their alcohol in a pub (27.7%), while the majority of those aged 16-18 years indicated that their alcohol is bought in a pub (78.1%). Furthermore, over half of all those who have had a drink, reported that they buy their alcohol themselves. In particular, among those aged less than 16 years who have taken a drink, 21.3% stated that they buy alcohol themselves. Thus, despite being under the legal age requirement, it appears that young people in the region have little difficulty sourcing alcohol themselves. Hawkins, Catalano & Miller (1992) note that while availability of substances such as alcohol is dependent to an extent on the laws and norms of a given society, availability may, however, vary and is independently associated with use. Gorsuch & Butler (1976) found that when alcohol is more available, the prevalence of drinking, the amount of alcohol consumed and the heavy use of alcohol all increase. This is an area that certainly requires redress in an Irish context.

### **5.3 Illicit Drug Use**

Of the adolescents in this study, 41.2% indicated that they had taken an illicit drug at least once in their lives and this represents a higher figure than that obtained in the 1997 study (34.9%). In particular, there was an increase in the number of girls in 2002 from 1997 who reported that they had taken an illicit drug. Overall, cannabis had the highest lifetime prevalence, with 31% indicating that they had taken this drug. The second most commonly reported drugs were glue/solvents. While the lifetime prevalence for most drugs decreased or stayed the same from 1997 to 2002, the lifetime prevalence for cannabis and glue/solvents showed an increase. In addition, cocaine showed a small increase from 1.6% in 1997 to 2.3% in 2002. Thus, more young people have taken at least one drug than did their age-equivalents in 1997 and cannabis is the drug they have predominantly taken. While the media is currently focussing on the misuse of cocaine, our



study highlights that only a very small percentage (albeit higher than in 1997) of the young people surveyed indicated that they have taken cocaine.

ESPAD (1999) found that, in Ireland, the lifetime prevalence rate for any illicit drug was 31%, which is lower than that observed in the present study (41.2%). Indeed, the rate found in this study is higher than any rate found in the countries surveyed by ESPAD, where the UK had the highest lifetime prevalence rate of 37%. Cannabis was also found by ESPAD to be the most widely used drug, with a lifetime prevalence rate of 32% in Ireland, which is analogous to the figure observed in the present study (31%). Similarly, the lifetime prevalence rate for glue/solvents was similar to that found for 'inhalants' by ESPAD. In relation to other illicit drugs, comparable lifetime prevalence rates were found. The figures found in the present study are also substantially higher than that found in several studies conducted in Ireland (Grube & Morgan, 1986; O'Fathaigh, 1990; Kiernan, 1995; MWHB, 1998; HBSC, 2002). Cahill (1999) found figures somewhat closer to that observed in this study - they found that 36% had taken an illicit drug and cannabis had been taken by 27.5% of all respondents. Hence, a higher percentage of young people in this study have taken an illicit drug compared to the percentage found in other studies, conducted nationally and across Europe.

Overall, 15.1% of young people in this study indicated that they regularly use one or more drugs and, similar to lifetime prevalence, cannabis was the drug reported as being most regularly used, with 12.8% of all respondents indicating regular usage of cannabis. Regular usage of drugs other than cannabis was infrequently reported. Overall, more young people in this study than in 1997 reported regular drug usage. The results also indicate that while regular drug usage was most common among 17-year-olds in 2002, it occurred more frequently among the younger age-groups than it did in 1997, suggesting that teenagers at younger ages than five years ago are using illicit substances, mainly cannabis, on a regular basis. County Monaghan demonstrated the highest level of regular drug usage, while Cavan demonstrated the lowest rate. Similar percentages of respondents from each social class reported regular usage of drugs, implying that social class and regular drug usage bear no significant relationship in this study.

ESPAD (1999) observed that 15% of Irish 15-16 year-olds used cannabis in the last month, which is slightly higher than that found in the present study. Regular usage of inhalants was reported by 4% in the ESPAD study but, in the present study, this was reported by 2.5%. O'Fathaigh (1990) found that 9% had used cannabis at least once in the previous month and the MWHB (1998) observed that 12.2% were currently using at least one drug and current use of cannabis and inhalants was found to be 8.4% and 2.7%, respectively. Cahill (1999) observed that 12% were current cannabis users and 5.1% were regularly using solvents. Thus, the picture that emerges is that while the lifetime prevalence rate for illicit substances is higher in the north-eastern region than that observed in other regional studies and in a European-wide study, the rate of regular usage of illicit substances is comparable. It appears that cannabis and, to a lesser extent, glue/solvents are the most prevalent drugs reported in this and other studies, while other illicit drugs are to a large extent infrequently used.

Over half (56.7%) of all respondents indicated that they had been offered one or more drugs and more males than females reported this. Reports of being offered drugs was higher than in 1997, when 46.4% indicated that they had been offered one or more drugs. Again, cannabis was the drug most commonly offered (51.9%) and this was followed by reports of being offered ecstasy (24.3%) and glue/solvents (21.7%). The result in relation to ecstasy is noteworthy in light of the finding that only 5.3% reported that they had ever taken ecstasy. Reports of having taken glue/solvents, however, were similar to reports of having been offered them. A higher level of perceived danger associated with taking ecstasy might possibly explain this finding. This

perception of danger may not be evident with regard to glue/solvents, which are freely available and involve no restrictions in terms of acquiring them. Indeed, the NEHB (1997) found that ecstasy was perceived as more dangerous than cannabis because its adverse effects were immediate and life threatening. Furthermore, it was found that the impact of high-profile deaths from ecstasy use served as a deterrent. The MWHB (1998) investigated the extent to which young people in their region had been offered drugs and they found that 33.5% had been offered cannabis, a figure rather lower than in the present study, while 24% were offered inhalants and 20.3% were offered ecstasy. Similarly, a large disparity was observed between the percentage that reported being offered ecstasy and the percentage that had taken this drug (3.3%).

Almost 30% of those offered a drug stated that they were first offered at 13 years or younger. Among the younger age-groups (less than 16 years), offers were more frequently reported in 2002 than they were in 1997, suggesting that younger people are being approached with offers of drugs more so in 2002 than in 1997. In terms of where drugs were offered, discos and the street were the places most commonly stated by respondents and the person who offered these drugs was someone that their friends knew or their best or very good friend. The literature shows that peer use of substances has consistently been found to be among the strongest predictors of substance use among young people (Hawkins, Catalano & Miller, 1992). Brook, Kessler & Cohen (1999) found that young people who associate with peers who use marijuana are at increased risk for marijuana initiation. Thus, the influence of peers cannot be undermined and strategies, which are aimed at facilitating young people to identify and resist social influences to use drugs (social resistance strategies), have demonstrated success in this endeavour.

One of the most notable findings in this study is the relationship that emerged between smoking, alcohol consumption and illicit drug use. Regular smokers were more likely to have been offered drugs and to have taken an illicit drug and they were more than six times more likely to report that they regularly use an illicit drug than were non-smokers. The same pattern was also apparent among regular drinkers, although smokers were more likely to have been offered drugs, to take them or to regularly use them than were regular drinkers. These findings point to the potency of alcohol and especially tobacco, in illicit drug use and serve as support for considering these substances as *gateway* drugs. As noted in the Introduction, gateway drugs do not necessarily cause young people to use harder drugs, but using these substances may set up patterns of behavior that may make it easier to progress to using other drugs or may result in young people frequenting places where they can get or be offered illicit drugs.

#### **5.4 Attitudes towards Tobacco, Alcohol & Illicit Drugs**

The results show that young people in this study were least tolerant of taking ecstasy and of smoking cigarettes, but were more accepting of smoking cannabis and most liberal in their opinions towards alcohol. Furthermore, older respondents (those aged 16 years or older) were least censorious in their opinions. As expected, those who engaged in smoking, drinking and cannabis use were more tolerant of these behaviours than were those who did not use these drugs. Interestingly, they regarded a drug addict more as a patient than as a criminal. This was also found in the Nordic Drug Study (Hakkarainen et al., 1996) and is an important indicator of attitude toward drug abuse, since it suggests that respondents are attributing a greater proportion of responsibility for the individual's situation to extraneous circumstances rather than to factors within their control.

Over half of all respondents did not disapprove of having one or two drinks several times per week and this lack of disapproval was particularly evident among older adolescents and among those who regularly drank

themselves. In relation to smoking ten or more cigarettes per day, however, 30% reported that they did not disapprove, whereas 62% expressed disapproval. Again, more older than younger respondents expressed a tolerance for this behaviour as did more regular smokers than non-smokers. A slightly higher percentage (33.1%) indicated that they did not disapprove of smoking cannabis occasionally. In particular, older respondents were more tolerant of smoking cannabis than were younger respondents, as were those who regularly used cannabis. In addition, over one-quarter of all respondents felt that people should be allowed to take cannabis, with the greatest support emanating from older respondents and from those who used cannabis regularly. Trying ecstasy once or twice was the behaviour that resulted in the lowest level of approval among respondents in this survey, with approximately three-quarters expressing disapproval. As noted earlier, it is likely that respondents perceive a high level of danger associated with ecstasy, thereby preventing them from engaging in ecstasy use themselves and creating a sense of disapproval of the use of this drug. Moreover, younger and older respondents showed considerable concurrence in their opinion in this regard. It thus seems that young people in this survey, especially those aged older than 16 years, were less critical of smoking cannabis than they were of smoking cigarettes. Overall, respondents were most lenient in relation to alcohol consumption and most disapproving of ecstasy use. Interestingly, in the qualitative study conducted by the NEHB in 1997, some participants felt that the risks from taking cannabis were less than consuming alcohol or smoking cigarettes while ecstasy, on the other hand, was perceived as more risky than cannabis or alcohol.

## **5.5. Reasons for Taking Drugs**

Respondents in this study felt that the main reasons young people take drugs were because “the people they hang around with do it” and “just to try it out”. Taking drugs because “they make them feel great” was the third most common response. Thus, overall, young people perceive that drug use occurs via social mechanisms involving peers with whom they affiliate. This, however, does not imply that overt peer pressure is in operation; it is likely that the relationship is more aptly defined in terms of peer empathy or modelling (NEHB, 1997). The Health Promotion Agency for Northern Ireland (1996) found that the most commonly reported reason as to why young people take drugs was that “they make them feel great” followed by wanting to “just try it out” and because “the people they hang around with do it”.

Looking at the responses of those who regularly use drugs, however, it seems that they perceived that young people primarily take drugs because drugs “make them feel great” and because they want “to try it out”. Interestingly, almost 40% indicated that young people take drugs because those with whom they “hang around with do it”, implying that regular drug users themselves were aware at some level of the influence of their peer affiliations on their drug-taking behaviour. The NEHB (1997) found that all users emphasized that they take drugs primarily because they enjoy their effects and the sociability of the behaviour.

## **5.6. Conclusion**

This study of post-primary pupils in the north-eastern region revealed a number of notable findings in terms of smoking, drinking and illicit drug behaviour within this age-group. Firstly, it showed that fewer young people were regularly smoking than five years ago. Furthermore, the rate of regular smoking was lower than that observed in numerous other Irish studies and corresponds to the lower rates observed in the ESPAD (1999) report.

The majority of the young people surveyed indicated that they had taken a full alcoholic drink and over half were consuming at least one drink weekly, while one-quarter indicated that they have more than ten drinks per week. Slightly fewer adolescents in 2002 than in 1997 indicated that they had taken a drink or were regular drinkers, however, among those who do drink, it appears that they drink more than did those in 1997, particularly at weekends. Over one-quarter reported that they had drunk enough alcohol so as to feel drunk on more than ten occasions, which also represents an increase from the figure obtained in 1997. Young people in this study generally buy their alcohol in a pub and, although the vast majority of respondents were younger than eighteen years of age, over half reported that they buy alcohol themselves. These findings reinforce recent media reports of binge drinking in society in general and undoubtedly pose an immense challenge for Irish society as a whole.

In relation to illicit drugs, more young people in this study than in 1997 reported that they had taken an illicit drug and the rate found in this study is among the highest observed by other regional studies and by ESPAD (1999). In terms of regular use of illicit drugs, this study also found a higher overall rate than that observed in the 1997 study. Cannabis was the main drug used, with regular use of other drugs rarely reported. While regular use of cannabis increased from 1997 to 2002, regular use of most other drugs decreased.

Regular smoking was shown to be predicted by parental smoking, increasing age, female gender, increasing income and having only one parent living at home. Regular drinking was predicted by only increasing age and income, while regular drug use appeared to be predicted by increasing age and having only one parent living at home. These findings raise interesting issues in light of recent figures showing an increase in marital breakdown in Ireland (Census 2002). A relationship was also found between smoking and drinking behaviour and reports of being offered, having taken and regularly using an illicit drug. Overall, no relationship was found between social class and smoking, drinking or illicit drug use.

The main reasons cited as to why young people take illicit drugs were that “the people they hang around with do it” and “just to try it out”. Finally, the results show that young people were most censorious of taking ecstasy as well as smoking cigarettes, but expressed greater acceptance of smoking cannabis and were most liberal in their attitude towards alcohol consumption.

This study highlights that while fewer young people appear to be regularly smoking, the rate of regular alcohol consumption remains high. In relation to illicit drugs, lifetime prevalence and regular use seems to be on a modest upward trend with cannabis being the principal drug used.

## **Acknowledgements**

We would like to extend our appreciation to the staff and students of all the schools who participated in this project for their cooperation and enthusiasm.

Many thanks also to the staff at the Department of Public Health NEHB, who gave their time and support to the project, in particular, Ita Hegarty, Una Begley, Helen Keating, Jacque Duignan, Jarlath Conefrey, Mary Tolan, Denise Ryan and Rose Carolan.

# References

- Allgood-Merten, B. Lewinsohn, P.M. & Hops, H. (1990). Sex differences and adolescent depression. *Journal of Abnormal Psychology*, 99, 55-63
- Ariza-Cardenal, C. & Nebot-Adell, M. (2002). Factors associated with smoking progression among Spanish adolescents. *Health Education Research*, 17, 6, 750-760
- Aronson, E., Wilson, T.D. & Akert, R.M. (2002). *Social Psychology (4<sup>th</sup> Ed.)*. New Jersey: Prentice Hall
- Armstrong, T.D. & Costello, E.J. (2002). Community studies on adolescent substance use, abuse or dependence and psychiatric co-morbidity. *Journal of Consulting & Clinical Psychology*, 70, 6, 1224-1239
- ASH Ireland(2001). [http://www.ash.ie/health\\_effects.html](http://www.ash.ie/health_effects.html)
- Beck, A. T. (1967). *Depression: Clinical Experimental and Theoretical Aspects*. New York: Harper & Row
- Blascovich, J. & Tomaka, J. (1993). Measures of Self-Esteem. In J.P. Robinson, P.R. Shaver & L.S. Wrightsman (Eds), *Measures of Personality and Social Psychological Attitudes (3<sup>rd</sup> Ed)*. Ann Arbor: Institute for Social Research
- Botvin, G.J., Malgady, R.G., Griffin, K.W., Scheier, L.M., Epstein, J.A. (1998). Alcohol and marijuana use among rural youth: interaction of social and interpersonal influences. *Addictive Behaviours*, 23, 3, 379-387
- Brasil, E. & Sheehan, J. (2001). *Pilot study of Alcohol-Related Attendance at Accident & Emergency Department*. Mater Hospital Dublin.
- Breslau, N., Kilbey, M.M. & Andreski, P. (1991). Nicotine dependence, major depression and anxiety in young adults. *Archives of General Psychiatry*, 48, 1069-1074
- Brook J.S., Brook, D.W., Whiteman, M., Gordon, A.S. & Cohen, P. (1990). The psychosocial aetiology of adolescent drug use and abuse. *Genet Soc Gen Psychol Monogr* 116, 111-267
- Brook J.S., Whiteman, M., Finch, S.J. & Cohen, P. (1996). Young adult drug use and delinquency: childhood antecedents and adolescent mediators. *Journal of the American Academy of Child & Adolescent Psychiatry*, 35, 1584-1592
- Brook, J.S., Adams, R.E., Balka, E.B. & Johnson, E. (2002). Early adolescent marijuana use: risks for the transition to young adulthood. *Psychological Medicine*, 32, 1, 79-91
- Bryan, A., Moran, R., Farrell, E. & O'Brien, M. (2000). *Drug-related knowledge, attitudes and beliefs in Ireland: Report of a Nation-wide Survey*. Dublin: Drug Misuse Research Division, Health Research Board
- Cahill, R., (1999). Substance-use in school-going teenagers in Co. Kildare & West Wicklow. Dublin: EHB
- Carr, A. (1999). *The Handbook of Child and Adolescent Clinical Psychology – A Contextual Approach*. Routledge

- Central Statistics Office (1998). *Census 96: Principal Socio-economic Results*. Stationary Office, Dublin
- Central Statistics Office (2002). *Census 2002: Principal Demographic Results*. Stationary Office, Dublin
- Chabrol, H., Montovany, A., Chouicha, K. & Duconge, E. (2002). Study of the CES-D on a sample of 1953 adolescent students. *Encephale*, 28, 5, 429-432
- Chassin, L., Presson, C.C., Rose, J.S. & Sherman, S.J. (1996). The natural history of cigarette smoking from adolescence to adulthood: demographic predictors of continuity and change. *Health Psychology*, 15, 6, 478-484
- Coehlo, R., Martins, A. & Barros, H. (2002). Clinical profiles relating gender and depressive symptoms among adolescents ascertained by the Beck Depression Inventory II. *European Psychiatry*, 17, 4, 222-226
- Conrad, K., Flay, B.R. & Hill, D. (1992). Why children start smoking: predictors of onset. *British Journal of Addiction*, 87, 12, 1711-1724
- Daly, A. & Walsh, D. (1999). *Irish Psychiatric Services: Activities 1999*. Health Research Board, Dublin.
- Department of Health & Children (1996). *National Alcohol Policy*. Government Publications, Dublin
- Department of Health & Children (2001). *National Drugs Strategy: Building on Experience 2001-2008*. Government Publications, Dublin
- Department of Health & Children (2001). *Quality and Fairness: A Health System for You*. Government Publications, Dublin
- Department of Health & Children (2002). *Strategic Task Force on Alcohol Interim Report*. Government Publications, Dublin
- Dinges, M.M. & Oetting, E.R. (1993). Similarity in drug use patterns between adolescents and their friends. *Adolescence*, 28, 110, 253-266
- Dumont, M. & Provost, M.A. (1999). Resilience in adolescents: protective role of social support, coping strategies, self-esteem and social activities on experience of stress and depression. *Journal of Youth & Adolescence*, 28, 3, 343-363
- Durkin, K. (1995). *Developmental Social Psychology: From Infancy to Old Age*. Cambridge, Mass: Blackwell Publishers Inc
- Epstein, J. A., Botvin, G. J., Diaz, T., Toth, V., & Schinke, S. P. (1995). Social and Personal Factors in Marijuana Use and Intentions to Use Drugs Among Inner City Minority Youth. *Journal of Developmental Behavioural Pediatrics*, 16(1), 14-20
- European Monitoring Centre for Drugs & Drug Addiction (EMCDDA), (1999). *Final Report: Co-ordination of an Expert Working Group to develop instruments and guidelines to improve quality and comparability of general population surveys on drugs in the EU. Follow-up of EMCDDA project CT.96.EP.08 (CT.97.EP.09)*. Lisbon EMCDDA
- Fagan, J. (1988). *The Social Organisation of Drug Use and Drug Dealing among Urban Gangs*. NY: Jay College of Criminal Justice



- Garrison, C.Z., Schluchter, M.D., Schoenbach, V.J. & Kaplan, B.K. (1989). Epidemiology of depressive symptoms in young adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, 28(3), 343-351
- Grant B.F. & Dawson D.A. (1997). Age at onset of alcohol use and its association with DSM-IV alcohol abuse and dependence: results from the National Longitudinal Alcohol Epidemiologic Survey. *Journal of Substance Abuse*, (9), 103-110
- Grube, J.W. & Morgan, M. (1986). *Smoking, drinking and other drug use among Dublin post-primary pupils*. Dublin: ESRI
- Hakkarainen, P., Laursen, L. & Tigerstedt, C. (Eds) (1996). *Discussing drugs and control policy: Comparative studies on four Nordic countries*. NAD Publication no. 31. Nordic Council for Alcohol and Drug Research (NAD). Helsinki
- Hawkins, J.D., Catalano, R.F. & Miller, J.Y. (1992) Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin*, 112, 64-105
- Helzer J.E. & Burnam, A. (1991), Epidemiology of alcohol addiction: United States. In Miller, N.S, (Ed.) *Comprehensive Handbook of Drug and Alcohol Addiction*, New York: Marcel Dekker, pp 9–38
- Hibell, B., Andersson, B., Ahlstrom, S., Balakireva, O., Bjarnasson, T., Kokkevi, A. & Morgan, M. (2000). *The 1999 ESPAD Report: Alcohol and Other Drug Use among Students in 30 European countries*. The Swedish Council for Information on Alcohol and Other Drugs, The Pompidou Group at the Council of Europe
- Jessor, R. & Jessor, S. (1977). *Problem Behaviour and Psychosocial Development: a Longitudinal Study of Youth*. NY: Academic Press
- Kandel, D. & Andrews, K. (1987). Processes of adolescent socialization by parents and peers. *International Journal of the Addictions*, 22, 319-342
- Kandel, Denise B; Davies, Mark. Progression to regular marijuana involvement: Phenomenology and risk factors for near-daily use. Glantz, M.D & Pickens, R. W. (Eds)(1992). *Vulnerability to Drug Abuse*. (pp. 211-253). xvi, 533pp
- Kandel, D. & Davies, m. (1986). Adult sequelae of adolescent depressive symptoms. *Archives of General Psychiatry*, 43, 255-262
- Kandel, D., & Yamaguchi, K. (1993). From Beer to Crack - Developmental Patterns of Drug Involvement. *American Journal of Public Health*, 83(6), 851-855
- Keene, J., James, D. & Willner, P. (1998). Social influences on individual drug use: three distinct sub-cultures among agency non-attenders. *Addiction*, 6, 1, 43-62
- Kelleher C. NicGabhainn, S. & Friel S. (2003). *National Health and Lifestyle Surveys: Survey of Lifestyle Attitudes and Nutrition (SLAN) and the Irish Health Behaviour in School-aged Children Survey (HBSC)*. Centre for Health Promotion Studies, NUI, Galway.
- Kiernan, R. (1995). *Report on Substance Use among Adolescents in the Western Health Board*. Galway: WHB

- Lewinsohn, P.M., Rohde, P. & Brown, R.A. (1999). Level of current and past adolescent cigarette smoking as predictors of future substance use disorders in young adulthood. *Addiction*, 94, 6, 913-921
- Müller R, Meyer M et al (1997). *Alcohol, Tobacco and Illegal Drugs in Switzerland 1994- 1996*. SFA, Lausanne
- National Household Survey on Drug Abuse (NHSDA) (1995). Office of Applied Studies (OAS), Substance Abuse and Mental Health Services Administration (SAMHSA).
- National Safety Council (2002). *Information on Alcohol-Related Road Fatalities/Injuries*. National Safety Council, Dublin.
- Nolen-Hoeksema, S. & Girgus, J.S. (1994). The emergence of gender differences in depression during adolescence. *Psychological Bulletin*, 115, 3, 424-443
- O'Fathaigh, M. (1990). *Smoking, drinking and other drug use among Cork city post-primary school pupils*. Cork: Cork Youth Federation, UCC Joint Research Project
- Office of Tobacco Control (2000). *Towards a Tobacco Free Society, Ireland – a Smoke-Free Zone*. The Report of the Tobacco Free Policy Review Group. Dublin: Stationary Office
- Radloff, S. (1977). The CES-D scale: a self-report depression scale for research in the general population. *Applied Psychological Measurement*, 1, 385-401
- Roberts, R.E., Andrews, J.A., Lewinsohn, P.M. & Hops, H. (1990). Assessment of depression in adolescents using the Centre for Epidemiologic Studies Depression Scale. *Psychological Assessment*, 2, 122-128
- Rohde, P., Lewinsohn, P.M. & Seeley, J.R. (1996). Psychiatric comorbidity with problematic alcohol use in high school students. *Journal of the American Academy of Child & Adolescent Psychiatry*, 35, 1, 101-109
- Rossow, I., Pernanen, K. & Rehm, J. (2001). Accidents, suicide and violence. In Klingemann & Gmel. (Eds) *Mapping the Social Consequences of Alcohol Consumption*. The Netherlands: Kluwer Academic Press
- Sequeira, L.M. & Brook, J.S. (2003). Tobacco use as a predictor of illicit drug use and drug-related problems in Colombian youth. *Journal of Adolescent Health*, 32, 1, 50-57
- Swadi, H. (1996). Psychiatric symptoms in adolescents who abuse volatile substances. *Addiction Research*, 4, 1, 1-9
- U.S. Department of Health & Human Services (1999). *The relationship between mental health and substance abuse among adolescents*. Office of Applied Studies, US DHHS
- Mid-Western Health Board (1998). *Teenage Smoking, Alcohol and Drug Use in the MWHB*. MWHB: Department of Public Health
- Wills, T.A. & Stoolmiller, M. (2002) The role of self-control in early escalation of substance use: a time-varying analysis. *Journal of Consulting and Clinical Psychology*, 70(4), 986-997
- Winters, N.C., Myers, K., Proud, L. (2002). Ten-year review of rating scales III: scales assessing suicidality, cognitive style and self-esteem. *Journal of the American Academy of Child & Adolescent Psychiatry*, 41, 10, 1150-1181



# Appendix A

## Adolescent Lifestyle Survey

There is a lot of talk today about how young people live their lives: their habits and practices, their likes and dislikes etc. We would like to know what you think about a wide variety of issues that you face everyday. To do this, we are going to ask a series of questions on topics such as diet, smoking, alcohol, exercise and a lot more. To give us an accurate picture of what adolescents think and do, it is very important to us that you answer all questions truthfully. In this survey, we are interested in group averages and not in any one person's individual responses. Your answers will never be shown to your parents, the school or any other person.

**PLEASE DO NOT PUT YOUR NAME ON THIS QUESTIONNAIRE.**

**YOUR PARENTS OR TEACHERS WILL NOT SEE YOUR ANSWERS AND WE WILL NOT KNOW WHO YOU ARE.**

Questions are answered by writing in the appropriate response or by ticking (✓) what you think is the right answer or what applies to you. There are no right or wrong answers in this questionnaire; rather it is your personal thoughts and experiences that matter, so please make sure you answer all questions.

Thank you for helping us.

Edel Flanagan (B.A., M.Sc. (Psych.), Dip. Stats)  
Research Officer

## Sample Questions

Here are some sample questions:

- (a) Have you done your Junior Certificate yet?  
                     Yes                       No
- (b) Do you own any of the following?
- |                    |                              |                             |
|--------------------|------------------------------|-----------------------------|
| Sony Playstation 1 | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Gameboy Advanced   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Personal Computer  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Sony Playstation 2 | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

For some questions, if you answer 'Yes', you will be asked for more information:

- (c) Do you own a mobile phone?    Yes                       No
- If 'Yes', what model of phone is it? \_\_\_\_\_

Lastly, for some questions, you will be asked how many times you have done something in the past:

- (d) How often have you been late for school in the last year?
- Never been late for school
  - Late once
  - Late 2-5 times
  - Late 6-10 times
  - Late more than 10 times

Please tick (✓) your response to the following questions.

How many times have you ...	Never in my life	Only once in my life	2-3 times a year	I go once times a year	2 or more
gone to Europe on holiday?					
been in a car accident?					

**DO NOT TURN THIS PAGE UNTIL YOU ARE TOLD TO DO SO**

Section A.

### Eating Habits & Dental Health

1. How many days per week do you eat the following: (please tick (✓) one box per food type)

	Never	1-2 Days	3-6 Days	7 Days
Fresh Fruit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biscuits/cakes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chicken/Turkey	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burgers/Sausages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other red meat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweets/Bars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Do you eat butter/margarine?

Yes       No  → Go to Q.3

2(a). If 'Yes', please state the name of the brand of butter/margarine that you usually use (e.g., DairyGold; Flora; Kerry Gold)

\_\_\_\_\_

3. When was the last time you visited the dentist? (tick (✓) one box only)

- Less than 1 month ago
- 1-6 months ago
- 6-12 months ago
- 1-2 years ago
- More than 2 years ago

4. How many times per day do you brush your teeth? (tick (✓) one box only)

- 3 or more times per day
- 2 times per day
- Once a day
- I don't wash my teeth everyday

Section B.

### Tobacco Usage

5. Have you ever smoked a whole cigarette?  
Yes       No

5(a). If 'Yes', how old were you when you first smoked a whole cigarette?  
\_\_\_\_\_ yrs.

6. In the **last month**, how many cigarettes, on average, did you smoke?  
 None  
 Only smoked a few, not every day  
 I smoked about 1-2 cigarettes per day  
 I smoked about 3-10 cigarettes per day  
 I smoked 11-20 cigarettes per day  
 I smoked more than 20 per day

7. Do you think that you have smoked more than 100 cigarettes in your lifetime?  
Yes       No

8. Who buys cigarettes for you?  
 I don't smoke  
 Usually, I buy them myself  
 Somebody else usually buys them for me

9. Do your parents know you smoke?  
Yes       No        I don't smoke

10. Does anybody **living** in your house smoke? (You may tick (✓) more than one box)

- Nobody in my house smokes
- Father
- Mother
- Brother
- Sister
- Grandparent
- Other person at home

P.T.O.

Section C

### Exercise Habits

11. How fit would you rate yourself against someone your own age?

(Please place **X** on the point on the line below that most reflects your answer)

Very Unfit \_\_\_\_\_ Very Fit

12. Apart from PE, how often, do you take physical exercise or play sport?

- 3 or more times per week
- Once or more per week
- Once a fortnight
- Never

13. What sports do you play outside of school hours?

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

Section D

### Road Safety

14. How often do you wear a safety belt when you are in the **back** seat of the car?

- Never
- Sometimes
- Most of the time
- Always

15. How often do you wear a safety belt when you are in the **front** seat of the car?

- Never
- Sometimes
- Most of the time
- Always

16. Do you cycle a bike regularly?

- Yes                       No

17. Do you wear a helmet when cycling?

- I do not own a bike
- Never
- Rarely
- Sometimes
- Always

18. How often do you turn on a light on your bike when cycling at night?

- I do not cycle
- Never
- Rarely
- Sometimes
- Always

Please turn over page



Section E

### Alcohol

19. Have you ever had a whole alcohol drink (e.g. one pint or 1/2 pint or one short)?

- Yes       No

**If you answered 'NO' to Q. 19, then go to Section F on the next page and do not answer any more questions in Section E**

20. If you have drank a whole alcoholic drink, how old were you the first time you drank it?

\_\_\_\_\_ yrs

21. How often have you ever had enough alcohol to feel drunk?

- Never  
 1-2 times  
 3-4 times  
 5-10 times  
 more than 10 times

21(a). If you have felt drunk, how old were you the first time you ever felt drunk?

\_\_\_\_\_ yrs

22. Please indicate by ticking (✓) which of the following drinks you normally drink on a night out (you may tick more than one box):

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Cider   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Beer  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <i>(Budweiser, Guinness, Smithwicks etc.)</i> |                              |                             |
| Wine  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Spirits                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <i>(vodka, whiskey, gin etc.)</i>             |                              |                             |
| Low-alcohol drinks                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <i>(Bacardi Breezer, Smirnoff Ice etc</i>     |                              |                             |
| Liquers                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <i>(After-Shock; Sambuca etc.)</i>            |                              |                             |

Other (please specify) \_\_\_\_\_

23. In the last month, how many alcoholic drinks would you have had on a normal ... (write on line for each night)

- Monday night      \_\_\_\_\_ drink/s  
Tuesday night     \_\_\_\_\_ drink/s  
Wednesday night  \_\_\_\_\_ drink/s  
Thursday night    \_\_\_\_\_ drink/s  
Friday night        \_\_\_\_\_ drinks  
Saturday night     \_\_\_\_\_ drink/s  
Sunday night        \_\_\_\_\_ drink/s

24. Where do you buy alcohol? (you may tick more than one box)

- Off-Licence  
 Pub  
 Get it from home without my parents knowing  
 Other \_\_\_\_\_ (please specify)

25. Who buys the drink for you?

- I mostly/always get it myself  
 A friend my age gets it for me  
 A person I know over 18 years old gets it for me  
 Other \_\_\_\_\_ (please specify)

26. Where do you do *most* of your drinking?

- In a pub/disco  
 In a friend's house  
 In my house  
 Outside  
 Party/Concerts  
 Other

27. Have you been regularly drinking alcohol for at least one year?

- Yes       No

P.T.O.



Section F

## Drugs

Street names for drugs will appear in brackets next to drug names. e.g., cannabis (hash)

28. Please tick (✓) which of these drugs you have actually seen in real life. You do not have to have taken them. Tick (✓) one box per drug type. (Exclude Garda demonstrations at school or drugs you have seen on TV)

**Glue or Solvents**

- |                         |                              |                             |
|-------------------------|------------------------------|-----------------------------|
| being sniffed           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cannabis (hash, dope)   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ecstasy (e-tabs; pills) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| LSD (acid)              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Norenol (buzz)          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Speed (uppers)          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Psilocybin</b>       |                              |                             |
| (magic mushrooms)       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heroin (smack)          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cocaine (coke)          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Barbiturates (downers)  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please specify \_\_\_\_\_

29. Do you personally know people who take the following (you may tick (✓) more than one box):

- |                         |                              |                             |
|-------------------------|------------------------------|-----------------------------|
| Glue or Solvents        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cannabis (hash, dope)   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ecstasy (e-tabs; pills) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| LSD (acid)              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Norenol (buzz)          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Speed (uppers)          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Psilocybin</b>       |                              |                             |
| (magic mushrooms)       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heroin (smack)          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cocaine (coke)          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Barbiturates (downers)  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please specify \_\_\_\_\_

30. Have you ever been **OFFERED** any of these drugs? You do not have to have taken them.

Tick (✓) at least one box per drug type.

**Glue or Solvents**

- |                         |                              |                             |
|-------------------------|------------------------------|-----------------------------|
| being sniffed           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cannabis (hash, dope)   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ecstasy (e-tabs; pills) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| LSD (acid)              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Norenol (buzz)          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Speed (uppers)          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Psilocybin</b>       |                              |                             |
| (magic mushrooms)       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heroin (smack)          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cocaine (coke)          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Barbiturates (downers)  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please specify \_\_\_\_\_

30(a). If you have been offered drugs, what age were you when you were *first* offered drugs?

\_\_\_\_\_ years old

30(b). If you have been offered any of these drugs, where were you offered? (you may tick (✓) more than one box):

- I have never been offered drugs
  - Pub
  - Disco
  - House Party
  - Concerts
  - On the Street
  - At School
  - Youth Club
  - Shopping Centres
  - Other \_\_\_\_\_
- (please specify)

Please turn over page



30(c). Who offered these drugs to you?

- I have never been offered drugs
- Best or very good friend
- Someone my friends know
- Someone I or my friends did not know (stranger)
- Someone who deals drugs but is not really my friend
- Other \_\_\_\_\_ (please specify)

31. Do you know somebody from whom you could buy drugs?

- Yes
- No

31(a). If 'Yes', is that person:

- Best or very good friend
- Someone my friends know
- Someone who deals drugs but is not really a friend
- Other \_\_\_\_\_ (please specify)

Section G

### Your Opinions About Smoking, Alcohol & Drugs

32. Do you consider a drug addict more as a criminal or as a patient?

- More as a criminal
- More as a patient
- Neither a criminal nor a patient
- Both a criminal and a patient
- Don't know, cannot decide

33. To what extent do you agree or disagree with the following statement: "people should be allowed to take cannabis/marijuana"?

- Fully agree
- Largely agree
- Neither agree nor disagree
- Largely disagree
- Fully disagree

34. Please indicate if you strongly disapprove, disapprove or do not disapprove when people do any of the following things?

(a) Trying ecstasy once or twice

- Do not disapprove
- Disapprove
- Strongly disapprove
- Don't know

(b) Smoking 10 or more cigarettes per day

- Do not disapprove
- Disapprove
- Strongly disapprove
- Don't know

(c) Having one or two drinks several times per week

- Do not disapprove
- Disapprove
- Strongly disapprove
- Don't know

(d) Smoking cannabis/marijuana occasionally

- Do not disapprove
- Disapprove
- Strongly disapprove
- Don't know

35. Why do you think young people take drugs? (you may tick (✓) as many boxes as you like)

- It's the thing to do
- They make them feel great
- The people they hang around with do it
- Just to try it out
- To help them cope with life
- Something parents wouldn't like
- It's exciting to take risks
- Some other reason

\_\_\_\_\_ (please specify the other reason)

P.T.O.



## Substance Use

Please tick (✓) which of these drugs you have taken **to get high** and which you have not taken. For the drug/s you have taken, please indicate how many times you have taken the drug/s. If there are any other drug/s, which you have taken which are not on the list, please write in the name/s at the end and tick how often you have taken the drug/s.

**Make sure you tick one of the boxes for each drug type**

<b>Have you ever taken ...</b>	<i>Never</i>	<i>Only once in my life</i>	<i>Only a couple of times in my life</i>	<i>Once or twice in the last month</i>	<i>At least once week in the last month</i>
Glue or solvents (Tipp-Ex, Lighter Fluid)					
Cannabis (hash, dope)					
Ecstasy (e-tabs, pills)					
LSD (acid)					
Norenol (buzz)					
Speed (uppers)					
Psilocybin (magic mushrooms)					
Heroin (smack) - smoked					
Heroin (smack) - taken by needle					
Cocaine (coke)					
Barbiturates (downers)					
Cough syrup to get high (Benylin etc)					
Other (please write in name of the drug/s):					

***Please turn over page***





**How I Feel About Myself**

Here is a list of statements dealing with your general feelings about yourself. If you **agree** with the statement, circle A. If you **strongly agree**, circle SA. If you **disagree**, circle D. If you **strongly disagree**, circle SD.

	<b>Strongly Agree</b>	<b>Agree</b>	<b>Disagree</b>	<b>Strongly Disagree</b>
1. On the whole, I am satisfied with myself.	SA	A	D	SD
2. At times, I think I am no good at all.	SA	A	D	SD
3. I feel that I have a number of good qualities.	SA	A	D	SD
4. I am able to do things as well as most other people.	SA	A	D	SD
5. I feel I do not have much to be proud of.	SA	A	D	SD
6. I certainly feel useless at times.	SA	A	D	SD
7. I feel that I'm a person of worth, at least on an equal plane with others.	SA	A	D	SD
8. I wish I could have more respect for myself.	SA	A	D	SD
9. All in all, I am inclined to feel that I am a failure.	SA	A	D	SD
10. I take a positive attitude toward myself.	SA	A	D	SD

Please turn over page



**Circle** the number for each statement, which best describes how often you felt or behaved this way **during the past week**.

	<b>Rarely or none of the time (less than day)</b>	<b>Some or a little of the time (1-2 days)</b>	<b>Occasionally or a moderate amount of time (3-4 days)</b>	<b>Most or all of the time (5-7 days) 1</b>
<b>During the past week ....</b>				
1. I was bothered by things that don't usually bother me.	0	1	2	3
2. I did not feel like eating; my appetite was poor	0	1	2	3
3. I felt that I could not shake off the blues even with help from my family or friends.	0	1	2	3
4. I felt that I was just as good as other people.	0	1	2	3
5. I had trouble keeping my mind on what I was doing.	0	1	2	3
6. I felt depressed.	0	1	2	3
7. I felt that everything I did was an effort.	0	1	2	3
8. I felt hopeful about the future.	0	1	2	3
9. I thought my life had been a failure.	0	1	2	3
10. I felt tearful.	0	1	2	3
11. My sleep was restless.	0	1	2	3
12. I was happy.	0	1	2	3
13. I talked less than usual.	0	1	2	3
14. I felt lonely.	0	1	2	3
15. People were unfriendly.	0	1	2	3
16. I enjoyed life.	0	1	2	3
17. I had crying spells.	0	1	2	3
18. I felt sad.	0	1	2	3
19. I felt that people disliked me.	0	1	2	3
20. I could not 'get going'.	0	1	2	3

*P.T.O.*



Section J

**Questions About You  
For Statistical Purposes Only**

36. What age were you on your last birthday?  
\_\_\_\_\_ years old

37. Gender:  Male  Female

38. Who currently **lives** in your house?  
(excluding brothers/sisters/others who  
only come at weekends)

• Mother  Yes  No

• Father  Yes  No

• Brothers  Yes  No

IF Yes, please state how many \_\_\_\_\_

• Sisters  Yes  No

IF Yes, please state how many \_\_\_\_\_

• Grandparents  Yes  No

IF Yes, please state how many \_\_\_\_\_

• Other/s \_\_\_\_\_ (please specify)

39 (a). At the moment, is your mother:  
(you may tick (✓) more than one box)

in full-time employment?

in regular part-time employment?

in casual part-time employment?

working in the home (full-time)?

unemployed?

student?

Other? \_\_\_\_\_ please specify

39 (b). If your mother works outside the  
home, what does she do (if she is  
deceased or out of work, what did she do  
when she had a job)?

\_\_\_\_\_

39(c). At the moment, is your father:  
(you may tick (✓) more than one box)

in full-time employment?

in regular part-time employment?

in casual part-time employment?

working in the home?

unemployed?

student?

Other? \_\_\_\_\_ please specify

39(d). If your father works outside the  
home, what does he do (if he is deceased  
or out of work, what did he do when he  
had a job)?

\_\_\_\_\_

40. If your parents own a farm, what size is it?

Less than 30 acres

30-49 acres

50-99 acres

100-199 acres

200+ acres

Don't know

41. Do you get pocket money?

Yes

No

40 (a). If Yes, how much do you get?

\_\_\_\_\_

42. Do you have a part-time job in the  
evenings or at weekends?

Yes

No

42(b) If Yes, how much do you earn?

£5-10 per week

£11-20 per week

£21-30 per week

more than £30 per week

43. What is your:

Height \_\_\_\_\_ Weight \_\_\_\_\_

44. Has your doctor ever diagnosed or told  
you that you had:

Diabetes  Yes  No

Asthma  Yes  No

# Appendix B

In *Census 1996*, the entire population was classified into one of the social class groups listed in the Table below. This classification was defined on the basis of occupation. The occupations included in each of these groups were selected in such a way as to bring together people with similar levels of occupational skill. In determining social class, no account is taken of the differences between individuals on the basis of other characteristics, such as education. Accordingly, social class ranks occupations by the level of skill required on a social class scale ranging from 1 (highest) to 7 (lowest). The category “all others gainfully occupied and unknown” is used where no precise allocation is possible.

Group	Social Class
Professional	1
Managerial/Technical	2
Non-Manual	3
Skilled Manual	4
Semi-Skilled	5
Unskilled	6
All others gainfully employed & unknown	7

Farmers are divided into five groups on the basis of farm size:

- Farmers owning 200 acres or more - Social Class 1
- Farmers owning 100-199 acres - Social Class 2
- Farmers owning 50-99 acres - Social Class 3
- Farmers owning 30-49 acres - Social Class 4
- Farmers owning less than 30 acres - Social Class 5

