

Research Report No. 3/96

**SURVEY OF TIPPERARY POST-PRIMARY STUDENTS' VIEWS AND
EXPERIENCES OF ILLEGAL DRUGS, 1995-6**

SARAH HEYWOOD

Confidential

For further information, contact:
Garda Research Unit,
Garda Siochana College,
Co, Tipperary.
Tel: (0504)31522
Fax:(0504)31080

TABLE OF CONTENTS

	Page
List of Tables	i
List of Figures	iii
Acknowledgements	iv
Preface	v
Executive Summary	vi
<i>Chapter 1: Introduction</i>	<i>1</i>
1.1 Definition of drug use	1
1.2 Risk factors	2
1.3 Protective factors	5
1.4 Trends in drug abuse among teenagers	5
1.5 The present study	6
<i>Chapter 2: Methodology</i>	<i>7</i>
2.1 Sampling	8
2.2 An overview of the questionnaire	12
2.2.1 Questionnaire administration	14
2.3 Reliability and validity	14
2.4 The sample obtained from the questionnaire (Entire group n = 617)	16
2.4.1 Age and sex	16
2.4.2 Educational level and sex	16
2.4.3 Parental presence and sex	17
2.4.4 Parental presence and home location	17
2.4.5 Parental presence and maternal employment	17
2.4.6 Parental presence and paternal employment	18
2.4.7 Parental occupation (Socio-economic background)	18
2.5 The sample obtained from the questionnaire (Selected group n = 470)	19
2.5.1 Age and sex	19
2.5.2 Educational level and sex	19
2.5.3 Parental presence and sex	20
2.5.4 Parental presence and home location	20
2.5.5 Parental presence and maternal and paternal employment	21

	Page
Chapter 3: <i>Results (Entire survey sample)</i>	22
3.1 Measures employed in the survey questionnaire	23
3.2 Correlational analysis on the questionnaire scales	25
3.3 Schools and drugs	27
3.3.1 Lessons/classes on illegal drug use provided by schools	27
3.3.2 The participating schools	29
3.4 Knowledge and experiences of smoking	31
3.4.1 Perceived accessibility	31
3.4.2 Prevalence rates	32
3.4.3 Age and smoking	32
3.4.4 Sex and smoking	33
3.4.5 Home location and smoking behaviours	33
3.4.6 Parental presence within the family home and smoking	33
3.4.7 Parental employment and smoking behaviours	34
3.5 Knowledge and experiences of alcohol	34
3.5.1 Perceived accessibility	34
3.5.2 Prevalence rates	35
3.5.3 Drinking behaviours	37
3.5.4 Age and drinking	39
3.5.5 Sex and drinking	40
3.5.6 Home location and drinking behaviours	42
3.5.7 Parental presence within the family home and drinking	42
3.5.8 Parental employment and alcohol consumption	43
3.6 Knowledge and experiences of illegal drugs	43
3.6.1 Perceived accessibility	43
3.6.2 Prevalence rates	45
3.6.3 Drug taking behaviours	46
3.6.4 Knowledge of illegal drugs	46
3.6.4.1 Drug effects	49
3.6.4.2 Drug costs	52
3.6.5 Age and illegal drug taking	54
3.6.6 Sex and illegal drug taking	54
3.6.7 Home location and illegal drug usage	54
3.6.8 Parental presence within the family home and illegal drug use	55
3.6.9 Parental employment and illegal drugs	55

	Page
<i>Chapter 4: Results (Modified sample)</i>	56
4.1 Schools and drugs	57
4.2 Knowledge and experiences of smoking	59
4.2.1 Perceived accessibility	59
4.2.2 Prevalence rates	59
4.2.3 Age and smoking	59
4.2.4 Sex and smoking	60
4.2.5 Home location and smoking behaviours	61
4.2.6 Parental presence within the family home and smoking	61
4.2.7 Parental employment and smoking behaviours	61
4.3 Knowledge and experiences of alcohol	62
4.3.1 Perceived accessibility	62
4.3.2 Prevalence rates	62
4.3.3 Drinking behaviours	64
4.3.4 Age and drinking	64
4.3.5 Sex and drinking	66
4.3.6 Home location and drinking	66
4.3.7 Parental presence within the family home and drinking	67
4.3.8 Parental employment and alcohol consumption	67
4.4 Knowledge and experiences of illegal drugs	68
4.4.1 Perceived accessibility	68
4.4.2 Prevalence rates	68
4.4.3 Drug taking behaviours	70
4.4.4 Age and illegal drug taking	73
4.4.5 Sex and illegal drug taking	73
4.4.6 Home location and illegal drug taking	74
4.4.7 Parental presence within the family home and illegal drug taking	74
4.4.8 Parental employment and illegal drug taking	74

	Page
<i>Chapter 5: Conclusions and recommendations</i>	75
5.1 Introduction	76
5.2 Schools and drug misuse	76
5.3 Smoking behaviours	77
5.4 Drinking behaviours	77
5.5 Knowledge and experiences of illegal drugs	79
5.6 Conclusions and recommendations	81
<i>Chapter 6: References</i>	84
<i>Chapter 7: Appendices</i>	86
7.1 The Questionnaire: Survey of Post-Primary Students' Views and Experiences of illegal Drugs	87
7.2 Table of participating schools	101
7.3 Socio-economic Group codes	102
7.4 List of lessons/classes employed to teach drugs education	103
7.5 List of drinking locations: current and first drink	104
List of persons with whom respondents normally drink	106
7.6 Tables of young people drinking beer, cider, wine, wine coolers and spirits	107
7.7 List of locations where respondents have been offered drugs	110
7.8 List of possible actions subjects might take if they were offered an illegal drug	112
7.9 Effects of illegal drugs	113
7.10 Qualitative data for the effects of drugs	119

LIST OF TABLES

	Page
 CHAPTER 2	
Table 2.1.1 Total number of pupils doing each programme in school in year 1994/1995 in County Tipperary	8
Table 2.1.2 School classification and numbers within Co. Tipperary and the survey sample	9
Table 2.1.3 Number of pupils undertaking each school programme in the survey sample	9
Table 2.1.4 Geographical location and numbers of secondary schools within Co. Tipperary and the survey sample	10
Table 2.4.1 Age and sex distribution of sample	16
Table 2.4.2 Educational level and sex distribution	17
Table 2.4.3 Parental presence and maternal employment	18
Table 2.4.4 Parental presence and paternal employment	18
Table 2.5.1 Age and sex distribution	19
Table 2.5.2 Educational level and sex	20
Table 2-5.3 Parental presence and sex	20
Table 2.5.4 Parental presence and maternal employment	21
Table 2.5.5 Parental presence and paternal employment	21
 CHAPTER 3	
Table 3.2.1 Intercorrelatory matrix between attitudes to drink, drugs and perceived danger scales	25
Table 3-2-2 Example of Chi-square statistic	27
Table 3.3.1 Perceived usefulness of lessons/classes on illegal drugs	27
Table 3.3.2 Perceptions of illegal drug-related information	28
Table 3.4.1 Amount of cigarettes smoked in the past 12 months and age of respondent	32
Table 3.4.2 Parental presence and smoking life-time prevalence rate	34
Table 3.5,1 Age and ease of acquiring beer	35
Table 3.5.2 Age and ease of acquiring cider	35
Table 3.5.3 Sex and reported drinking behaviours	37
Table 3-5.4 Age and illegal drinking behaviours of male respondents	38
Table 3.5.5 Age and illegal drinking behaviours of female respondents	38

CHAPTER 3	Page
Table 3.5.6 Sources of alcohol	39
Table 3.5.7 Sex and regularity of drinking behaviours in the past 12 months	41
Table 3.5.8 Sex and quantities of alcohol consumed on a given occasion	41
Table 3.6.1 Ease of acquiring drugs (percentages of total sample population)	44
Table 3.6.2 Frequency distribution and percentages of respondents maintaining to use illicit drugs	46
Table 3.6.3 Frequencies and percentages of respondents who had taken any of the drugs listed and drug-taking behaviours in the past 12 months	47
Table 3.6.4 Rationale for drug taking	49
Table 3.6.5 Numbers of missing observations and “don’t knows” for drug taking effects	51
Table 3.6.6 Percentages of self-reported using population with definite incorrect or “don’t know” responses	52
Table 3.6.7 Costs of illegal drugs	53
 CHAPTER 4	
Table 4.2.1 Amount of cigarettes smoked in the past 12 months and age of Respondent	60
Table 4.2.2 Age and life-time prevalence rate	60
Table 4.2.3 Parental presence and smoking lifetime prevalence rate	61
Table 4.3.1 Ease of access of acquiring alcohol	62
Table 4.3.2 Age and amount consumed in the past 12 months	64
Table 4.3.3 Chi-squares for place of purchasing alcohol and age	66
Table 4.3.4 Chi-squares for parental presence and locations for getting alcohol	67
Table 4.4.1 Ease of acquiring drugs (valid percentages of selected sample population)	68
Table 4.4.2 Frequency distribution and percentages of respondents maintaining use of illicit drugs	69
Table 4.4.3 Frequencies of respondents (and percentages of total selected sample) who had taken any of the drugs listed and drug-taking behaviours in the past 12 months	71
Table 4.4.4 Rationale for drug taking	72

LIST OF FIGURES**CHAPTER 2**

Figure 2.1	Formula for establishing sample size	11
------------	--------------------------------------	----

CHAPTER 3

Figure 3.5.1	Percentage distribution of alcohol intake	36
Figure 3.6.1	Numbers of different drug-types taken and numbers of subjects within the sample population	45
Figure 3.6.2	Sources of illegal drugs	48
Figure 3.6.3	Effects of various drugs: negative and partially negative responses	51

CHAPTER 4

Figure 4.3.1	Percentage distribution of alcohol intake	63
Figure 4.4.1	Numbers of different drug-types taken and numbers of subjects within the sample population	69
Figure 4.4.2	Sources of illegal drugs	73

Acknowledgements

Sincere appreciation is extended to the principals, teachers and pupils of the participating schools who gave up their valuable time to facilitate or participate in this research.

I am particularly indebted to Carmel Lynagh who assisted me with the field work. Finally, I am most grateful to the following for supplying me with valuable information: members of the Garda Drugs Squad, Harcourt Square, especially Garda C. McEnerney; Mr C. Murphy (Pharmacist, Templemore) and Dr. T. Quillinan (General Practitioner, Templemore).

Sarah Heywood

Preface

This research was requested by Chief Superintendent Liam Harris to provide empirical analysis of the drugs situation in County Tipperary.

The report is structured in seven chapters. The introduction defines key terms for the reader and discusses briefly some of the issues associated with adolescent substance misuse which are relevant to the report. The methodologies utilised are provided in Chapter 2. The analysis was undertaken using two samples and the results are presented in Chapters 3 and 4. The conclusions and recommendations are outlined in Chapter 5. This Chapter combines the results from the main and the modified samples. The final chapters contain references (Chapter 6) and appendices (Chapter 7).

Although the reader may be tempted to select particular sections of this report to read, a thorough study in the order presented is strongly advised. A complete picture and understanding of the drugs situation in Tipperary may only be found in the entire document.

EXECUTIVE SUMMARY

The absolute number of young people using drugs (both legal and illegal) in County Tipperary can never be determined. However, this study provides a relative gauge of the current situation. An extensive questionnaire survey of post-primary school pupils between the ages of 15 and 19 years was conducted. More than six hundred questionnaires were completed. The schools and classes were selected in a random and representative manner. The results were analysed using a computerised statistical package (SPSS).

This report includes two sets of analyses: (i) analyses of questionnaires completed by the entire survey sample (n = 617); and (ii) analyses of questionnaires of a sub-section of the total population. This latter group excluded those who were deemed “over-reporters” (n = 470).

The investigation revealed objective evidence of the extensive use of alcohol and cigarettes by teenagers in County Tipperary. Among the smaller sample, 66.4% had ever smoked a whole cigarette and 50.9% had smoked in the previous 12 months. The average age for first cigarette was 12 years, and as might be expected, experimentation increased with age. The respondent's sex or home location (urban versus rural) did not appear to impact on smoking behaviours, although family circumstances may have had a small effect. As regards alcohol, 63.8% of respondents claimed to have consumed a whole alcoholic drink at some stage in their life, 60.6% within the previous 12 months. Some 30.2% claim to have consumed a whole alcoholic drink 2-3 times a month or more frequently. Of these 5.1% reported drinking several times a week or everyday. The average age for consumption of first alcoholic drink was 14 years. Males tended to drink more than females, and beer in particular. Further differences were noted between urban and rural dwellers and family background.

Illegal drugs had been offered to and used by a minority of respondents. Among the smaller sample, 22% reported ever having taken one or more illegal drugs. This included those who had ever inhaled glue, paint and other inhalants (12%) and those who had experimented on one occasion only. Apart from inhalants, cannabis is the most common drug used, with 12% stating they had ever used it, followed by hallucinogens (7%) and ecstasy (3%). The number of regular users, defined as those using a drug at least once a month, was substantially smaller. Eleven students (2.4%) claimed to be regular users of cannabis. Percentages were less than 1% for other drugs, including inhalants. As regards access to drugs, 42% said it would be easy to get hallucinogens or ecstasy and 22% cannabis. Poly-drug use is not the norm, with 11% of respondents claiming to have ever used two or more drugs, including inhalants. Use of drugs appears to be fairly evenly spread among schools, with all schools/classes having at least one self-reported user. Friends are the most usual suppliers of drugs (for 75% of user-respondents) or dealer/supplier (19%). Over half (55%) said they sometimes or always paid for their drugs which they finance through either one or a combination of the following: pocket money; earnings or savings. The most frequently quoted reasons for taking drugs were “curiosity” (68%) and “fun” (58%).

Most students in County Tipperary did not view the consumption of illegal drugs in a favourable light. Illegal drugs perceived as most dangerous were those used the least, such as heroin. Only 3.5% of respondents considered experimentation with ecstasy as “not dangerous”. The average age for taking first illicit drug was 14/15 years regardless of the type of drug. The locations where young people are most likely to be offered drugs include discos, pubs, night-clubs, raves, concerts (including Féile) and public places. Drugs considered to be the most available were:(inhalants, ecstasy, hallucinogens and cannabis. The research revealed a lack of sufficient drugs-related education. Half of respondents reported getting no lesson about illegal drugs. Of those that did, 35% did not find it of value. The survey findings suggest that gardai and teachers work together to yield the greatest benefit.

1. INTRODUCTION

The recent surge of media interest in adolescent substance abuse has provoked a wave of concern within Irish society. The general public has been bombarded by the local, national and international press with frightening statistics of extensive misuse of illegal substances among teenagers. However, there is a paucity of research about the drugs situation, in Ireland in particular, from which journalists can support their claims. Through the use of empirical research techniques this study provides an objective and realistic account of the drugs situation in County Tipperary. The collection of baseline statistics will facilitate interested parties in the development of strategies to deal with this issue. This chapter is not a critique of research related to adolescent drug misuse, but rather, briefly introduces some of the relevant issues.

1.1 DEFINITION OF DRUG USE

For the purposes of this project, the definition of drug abuse employed by Corrigan (1994) has been adopted. Therefore, drug abuse is defined as:

“the use of any drug, legal or illegal, which damages some aspect of the user’s life -•whether it is their mental or physical health, their relationship with their family, friends or society in general or their vocational functioning as students or as workers both inside and outside the home “.

(Corrigan, 1994: Facts about Drug Abuse in Ireland, Health Promotion Unit, p. 2)

Thus, the misuse of legal drugs such as tobacco, alcohol and prescribed medicines are incorporated into this definition. Indeed, legal drugs are not necessarily less harmful or damaging than illegal ones. Since it is illegal in the Republic of Ireland for those under the age of 16 years to smoke and under 18 years to drink in a

public place, minors who break the law in this regard are considered to be abusing drugs in this study¹.

Most illicit drugs are mood or mind altering (psychoactive) substances. In addition, they can have significant physical effects. The effects of various illegal drugs are recorded in Appendix 7.9. However, these effects exclude the many social and interpersonal consequences of drug taking such as, *inter alia*, possible acquisition of a criminal record, deterioration in academic performance, and disruption/violence within the family home.

1.2 RISK FACTORS

It is widely considered by researchers, commentators and health practitioners that understanding the *risk factors* associated with the abuse of drugs, cigarettes and alcohol by young people is the most effective means of prevention. In addition, certain “*protective factors*” can help moderate the effects of exposure to risk. The risk and protective factors to adolescent drug and alcohol abuse have been extensively analysed.

Research testifies that age is a crucial factor in drug usage, particularly between 12 and 15 years. (Coombs, Fawzy and Gerber, 1986). The period of greatest risk of initiation into drug use is considered to be over by the age of 20 or 21 (Robbins. 1992). Over recent years, the age at which individuals start drinking alcohol has been declining. According to the European Omnibus Survey, 25% of respondents aged 11-15 took their first whole alcoholic drink (more than a sip or taste) before the age of 11. Ireland compared favourably with other European countries in that 10% of very young people were found to drink while 30% or more drank in Denmark, Greece, Italy and the U.K (Commission of the European Communities, 1991).

¹However, the use of the actual term “drugs” in this report is not inclusive of cigarettes and alcohol.

A questionnaire survey of post-primary students in Cork city discerned the average age for onset of smoking to be 14 years, and between ages 12 and 16 was the timeframe when young people were most likely to take their first alcoholic drink (O’Fathaigh, 1990). Morgan and Grube (1994) observed that a mere 7% of 17 year olds abstained from alcohol in their study of pupils attending second-level schools in Dublin and California. The findings of a project conducted in Galway by Alcohol Concern² would concur with the above and observed the average age for consumption of first alcoholic drink to be 12 years.

Young males have been found to use more alcohol and other drugs than females (Johnston, O’Malley, and Bachman 1988; Pacale, Trucksis, and Sylvester, 1985; and Johnston, Bachman, and O’Malley, 1986). Silbereisen, Robins and Rutter (1995) commented that boys consume more of all substances, excluding tobacco, and use them more heavily than girls (see Plant and Plant, 1992; Robbins, 1992). However, Coombs et al. (1986) failed to note a significant difference between the sexes. The numbers of boys and girls experimenting with alcohol was found to be similar in the Grube and Morgan (1994) survey, although boys drank more heavily.

An association between socio-economic status and the use or abuse of illicit substances has not been determined (Morgan and Grube, 1994, Hawkins, Catalano, and Miller, 1992; Plant and Plant, 1992; Robbins, 1992, and Coombs et al., 1986), although different social subgroups are thought to have distinctive ‘fashions’ in drug usage (Rainer et al., 1995).

Peer influence is considered an important predictor of drug use (Robbins, 1992; O’Fathaigh, 1990; Ong, 1989; Reid, 1989). Nevertheless, the Morgan and Grube (1994) investigation implied that much of the apparent influence of peers is due to selective friendships, rather than direct influence. Thus, the friends, and not necessarily peers because they could be younger or older, who were “psychologically closer” to the individual appeared to have the greatest influence on their behaviour. In addition, behaviour of friends (i.e. actual drug use) proved to be more important than

²No reference available. Summary supplied by the Health Promotion Unit.

approval. While older siblings are frequently cited as a source of drugs, friends remain the primary suppliers (Needle, McCubbin, Wilson, Reineck, Lazar and Mederer, 1986).

Young people whose parents drink heavily are more likely to drink and use illicit drugs themselves (Hawkins et al., 1992). Abuse of drugs (including alcohol) is more common among children whose family background is characterised by discord, erratic discipline, inadequate parenting and supervision. There is both genetic and environmental transmission (e.g. Hodgkinson, Mullan and Murray, 1991).

Attitudes towards drugs and delinquency impact on behaviour such that youngsters who condone the taking of drugs are more inclined to consume them (e.g. Dembo, Alien, Farrow, Schmeidler and Burgos, 1985). Individual characteristics indicative of substance abuse include early conduct problems (Robbins, 1992); poor school achievement; truancy and school-drop out. Personality traits shown to effect alcoholism include: disinhibition; novelty-seeking; risk-taking; harm-avoidance; hyperactivity and emotional liability (see Berman and Noble, 1993).

Antecedents to adolescent drug abuse identified by Hawkins, Catalano, and Miller (1992) through meta-analysis include:

“laws and norms favourable toward drug use; availability of drugs; extreme economic deprivation; neighbourhood disorganisation; certain physiological characteristics; early and persistent behaviour problems including aggressive behaviour in boys, other conduct problems, and hyperactivity in childhood and adolescence; poor family management practices; family conflict; low bonding to family; academic failure; lack of commitment to school; early peer rejection; social influences to use drugs; alienation and rebelliousness; attitudes favourable to drug use; and the early initiation of drug use. There is some evidence that certain factors including personal attributes and a social bond to conventional society may protect against drug abuse, though more research is needed to determine the relationships between risk and protective factors as related to adolescent drug abuse.” (p.97)

Whether there is a gradual progression from smoking and drinking to illegal drugs is still under debate. In respect of illegal drugs, it would seem that for individuals whose drug use is heavy and initiated at an early age, there is a development from single to polydrug usage rather than a specific order of particular drugs (Kandel, Tamaguchi and Chen, 1992). Moreover, those who use the most substances most often are the least inclined to cease (Hammersley, Lavelle and Forsyth, 1992).

1.3 PROTECTIVE FACTORS

Many young people do not abuse drugs and/or alcohol despite exposure to risk factors. Conditions or personal qualities (protective factors) are thought to moderate the effects of exposure to risk. There is evidence to suggest that young people who are strongly bonded to parents, to school, to non-drug using peers, and to their communities are less likely to partake in behaviours disapproved by these groups since these bonds would be threatened in doing so (Hawkins, Catalano and associates, 1992)

1.4 TRENDS IN DRUG USE AMONG TEENAGERS

Research on the type of drugs consumed by teenagers reveal a number of important trends. A U.K. survey implied that amphetamines, hallucinogens, solvents and MSDM have all probably been used by approximately 5-10% of young adults (Silbereisen et al., 1995). Cannabis was the most pervasively abused substance, followed by amphetamines, MDMA and nitrates as part of a “rave” dance and party culture. Furthermore, surveys of young adults have shown relatively high rates of LSD usage: 4-10% in surveys between 1985-1992 (Institute for Drugs Dependence, 1992

Young teenagers, as opposed to young adults and older adolescents, tend to admit misuse of solvents. Substantial increases in the percentages of teenagers (15 to

29%) reporting drug use (particularly MDMA and LSD) have been revealed by a British National Survey conducted by Gallup in 1989 and 1992.

The rationale for drug taking given by adolescents includes: curiosity, relaxation and recreation; insight and loneliness (Pascale and Evans, 1993).

1.5 THE PRESENT STUDY

The present study presents information in respect of drug usage by adolescents in County Tipperary. It is recognised that trends in drug use are culture and time specific. Thus, the information yielded by some of the aforementioned projects, while of obvious value, can not explicitly define the drug situation in Tipperary in 1995/6 and hence this survey.

2. METHODOLOGY

2. Methodology

2.1 Sampling

2.2 An overview of the questionnaire

2.2.1 Questionnaire administration

2.3 Reliability and validity

2.4 The sample obtained from the questionnaire (Entire group n = 617)

2.4.1 Age and sex

2.4.2 Educational level and sex

2.4.3 Parental presence and sex

2.4.4 Parental presence and home location

2.4.5 Parental presence and maternal employment

2.4.6 Parental presence and paternal employment

2.4.7 Parental occupation (Socio-economic background)

2.5 The sample obtained from the questionnaire (Selected group n = 470)

2.5.1 Age and sex

2.5.2 Educational level and sex

2.5.3 Parental presence and sex

2.5.4 Parental presence and home location

2.5.5 Parental presence and maternal and paternal employment

2.1 SAMPLING

Systematic research necessitates that a sub-section of the total population under investigation (i.e. all school-attending pupils in County Tipperary between the ages of 15-18+) should be selected to represent the entire group. To generalise from the sample to the population as a whole requires that the sample is truly representative. In other words, the sample must display a similar distribution of characteristics as the population from which it was chosen. For example, if 30% of a population are female, then a representative sample of 100 comprises approximately 30 females. Representativeness is undermined if a section of the survey sample is either overrepresented or underrepresented due to selection bias, or when recipients fail to complete a survey questionnaire (response bias). Response bias can be reduced through increasing the number of returned questionnaires. Consequently, ensuring a high return rate is fundamental to survey research.

A stratified random sampling approach was adopted for this survey. In this procedure, the sample was divided into subpopulations called strata. The strata employed were: educational level (e.g. leaving certificate - 5th and 6th years, senior certificate etc.), sex, type of school (i.e. secondary - inclusive of convents and Christian Brothers schools, vocational and community) and geographical location. The strata were chosen through proportional allocation. From a total of 40 schools, 23 were represented.

Table 2.1.1 Total Number of pupils undertaking each programme in school year 1994/1995 County Tipperary

PROGRAMME	Programme Year	Boys	Girls	Total
Repeat Leaving Certificate	1	173	174	347
Leaving Certificate	1	1049	1130	2179
	2	1018	1338	2356
Senior Certificate	1	15	11	26
	2	14	9	23
Leaving Certificate Vocational Programme	1	264	47	311
	2	222	4	226
Transition Year	1	307	535	842
Total		3062	3248	
% of Total		48.5	51.5	

(Statistics provided by the Department of Education, 1995)

The survey sample comprises 311 males (50.7%) and 302 females (49.3%) which matches the total population researched. The number of subjects for each type of school and programme year approximate those of the overall population and were as follows:

Table 2.1.2 School Classification and numbers within Co. Tipperary and the survey sample

School Classification	Tipperary County	Survey Sample
Secondary (CBS and Covent Schools)	23	17
Community	1	1
Vocational	12	5
Total	36	23

Table 2.1.3 Number of pupils undertaking each school programme in the survey sample

Programme	Programme Year	f(x)	% of total
Repeat Leaving Certificate	1	16	2.6
Leaving Certificate	1	267	75.5
	2	199	
Senior Certificate	1&2	1	.2
Leaving Certificate Vocational Programme	1&2	1	.2
Transition Year	1	129	21.0
Total		613	

(4 missing values)

Table 2.1.4 Geographical location and numbers of secondary schools within Co. Tipperary and the survey sample

Geographical location	No. schools in Tipperary	No. schools in sample
Newport	2	0
Nenagh	3	2
Borrisokane	1	0
Roscrea	4	3
Templemore	2	1
Borrisoleigh	1	1
Thurles	4	4
Killenaule	1	0
Ballingarry (South)	1	1
Cashel	2	1
Cahir	3	3
Tipperary	3	3
Cappawhite	1	0
Clonmel	4	3
Fethard	1	0
Carrick-on-Suir	3	1
Total	36	23

There was no response bias due to the nature of questionnaire administration, i.e. all respondents were required to complete the survey during a class period, while the researcher was present.

The size of the sample is a crucial factor in establishing the representativeness of a given subpopulation. The basic belief is that as the sample size increases, the chance of sampling error decreases, and the greater the level of confidence in the interval estimate. Confidence intervals specify a range of values within which we can have a certain degree of confidence that the population mean is included. Furthermore, the sample size is affected by the homogeneity of the group i.e. the less variable the scores in the population, the better chance that the estimate of the population mean will be accurate. A formula (see fig.2.1) employing a 98% confidence coefficient and an estimate of the population proportion to be within +/-5% will yield a sample of 540. The same formula using a 95% confidence coefficient produces a sample of 384. Thus, both samples ($n = 617$ and $n = 470$) employed in this research may be considered representative.

Fig. 2.1 **Formula for establishing sample size**

$$n = \frac{Z^2 pq}{e^2}$$

Where p = probability, q = 1- p, e = estimate of population proportion
n = number and Z = Z value of 2.33 for 98% confidence

A list of the participating schools can be found in Appendix 7.2

2.2 AN OVERVIEW OF THE QUESTIONNAIRE (Appendix 7.1)

The questionnaire design incorporated both standardised measures and items/scales tailored specifically to the requirements of this project. It comprised the following 3 sections:

- * **Demographic information**
- * **Your school and drugs**
- * **Your knowledge and experiences of alcohol, smoking and illegal drugs**

Background information such as gender, age, educational level and family background was sought in the first section of the questionnaire. The collection of background material permits the analysis of potential risk factors for adolescent drug abuse. In addition, comparative statistics may be conducted between groups on various dimensions such as smoking and drinking behaviours.

Perceptions of the nature, amount and quality of drugs education in schools within the County Tipperary were measured in the section entitled **Your school and drugs**.

The respondents' **knowledge and experiences of alcohol, smoking and illegal drugs** were assessed in the final section of the questionnaire. A range of questions pertaining to information sources, perceived availability, behaviours, attitudes and beliefs were included in this section.

The scale concerning "*perceived access*" comprised a list of substances, presented in a likert-type format, ranging from "very easy" to "very difficult"/"never heard of it". This scale was based on Morgan and Grube's 1994 scale with the addition of "ecstasy" to the list.

Prevalence rates were acquired for smoking, drinking and drug-taking behaviours. "*Lifetime prevalence rate*" identified the number of young people who had *ever* had an alcoholic drink, smoked a cigarette, or taken an illegal drug. This

rather unsophisticated measure is widely considered one of the best indicators of trends for substance abuse (Johnston, O'Malley and Bachman, 1990; Morgan and Grube, 1994).

“Current prevalence rate” refers to the numbers of young people who have had a cigarette, drink or drug within a specified timeframe (Morgan and Grube, 1994). In this survey the current prevalence rates for smoking and drinking were one month and twelve months. The likert-type scale for illegal drugs ranged from “not at all” to “every day”.

The age at which young people have their first drink, cigarette and illegal drug(s) was sought as a useful gauge for prevalence of abuse within County Tipperary.

In regard to alcohol, respondents were asked for the average quantities of drink consumed at any one time, where they took their first alcoholic drink, where they drink currently, where they purchase alcohol and with whom they normally drink.

Attitudes to drinking alcohol and drug taking were measured on (likert) scales, 7 and 13 items respectively, ranging from “strongly agree” to “strongly disagree”.

A scale developed by Crundall (1992) was employed to determine how much danger respondents associated with varying degrees of prescribed drug use. Subjects were required to respond to one of the following categories; “Not dangerous”, “A little dangerous”, “Very dangerous” and “Don't know”.

To ascertain pupils' “actual” knowledge about drugs, open-ended questions were included with respect to the effects and costs of various drugs. Respondents were asked whether they had been offered an illegal drug and if so, where they were, in order to gain some insight into the nature of the Tipperary drug situation. Finally, a question concerning what the subject might do if he/she was offered an illegal drug was posed.

2.2.1 Questionnaire Administration

For research purposes the questionnaire was administered to one class group in the form of a pilot survey. The pilot group were asked to comment on the various statements and questions within the questionnaire to ascertain any difficulties which were then noted and acted upon where necessary. Upon completion of the sampling frame (see Section 2.1) school principals were requested to volunteer a class to participate in the survey¹. All the schools approached were willing to take part and were exceedingly facilitative in the administration of the questionnaire.

The questionnaire was distributed to students during one class period. The researcher explained the purpose of the study and reassured the pupils that their answers would be treated in the strictest confidence and were entirely anonymous. Subjects were asked to skip a question and move on to the next one if they felt they could not be honest in answering it, rather than not telling the truth. Confidentiality was reinforced by placing the completed questionnaires into an envelope. Respondents were asked not to discuss the questionnaire with anyone else as it was their personal opinions that were being sought. Indeed, the questionnaire was completed in “exam-like” conditions in the majority of cases.

The researcher was available throughout the session to help any subject who had difficulty understanding instructions or the phraseology of any of the items. Subjects returned their completed questionnaire to the researcher. The field work took approximately 2/3 weeks and took place in October/November 1995.

2.3 RELIABILITY AND VALIDITY

The reliability and validity of data is a major concern for all survey research. Reliability concerns the extent to which the survey measures might be affected by

¹ This had the potential to produce bias through the selection of a “good” or “bad” class. However, the researcher was satisfied that this did not occur. Classes were selected on the basis of availability on their timetable.

unsystematic or random error. Reliability can be determined through (i) the extent of internal consistency of questionnaire items and (ii) test-retest analysis which gauges the level of consistency of a subject's responses overtime.

In terms of validity, Grube and Morgan (1986) noted that while some over-and under-reporting may occur, under conditions of confidentiality and anonymity reports for adolescent substance use seem to have good validity.

A number of mechanisms were embedded within the questionnaire design to specifically address the issue of over-reporting. Firstly, a "dummy" drug (namely "relexin") was placed in the scale measuring perceived availability; respondents who reported that this drug was either "easy" or "very easy" to get were considered to be over-reporting. Secondly, a subject was deemed to be an over-reporter if he/she claimed to have taken a particular drug, to "always" pay for his/her supply, but not to know the cost of the drug.

Thus, analysis of the survey was undertaken using two samples. The first constitutes the entire group to whom a questionnaire was administered ($n = 617$) and the second excludes those who were considered to be over-reporting ($n = 470$; 76% of the entire group).

2.4 THE SAMPLE OBTAINED FROM THE QUESTIONNAIRE (Entire group)

2.4.1 Age and sex

Six hundred and seventeen questionnaires were completed by pupils in Count Tipperary with an age/sex distribution as shown in Table 2.4.1 below.

Table 2.4.1 Age and sex distribution of sample

	Male	Female	Row Total
15 years	81	95	176
16 years	127	86	213
17 years	79	81	160
18+ years	23	40	63
Column Total	310	302	612

(5 missing observations)

Males and females were equally represented. The largest sub-section of the population comprised 16 year-old males (20.6%). Males “18 years and over” constituted the smallest group (3.7%).

2.4.2 Educational level and sex

Crosstabulation analyses revealed the largest proportion of the sample to be males in 5th year leaving certificate classes (25.4%). Females undertaking their leaving certificate examinations in 1996 (i.e. 6th year) formed the second largest group (18.8%). Since leaving certificate students formed the greatest proportion within the sampling frame (see Section 2.1) these results are not surprising.

Table 2.4.2 Educational level and sex distribution

	MALE	Female	Row Total
Repeat Leaving Certificate	12	4	16
Leaving Certificate - 5th year	157	109	266
Leaving Certificate - 6th year	83	116	199
Senior Certificate	1		1
Leaving Certificate Vocational Programme	1		1
Transition Year	56	73	129
Column Total	310	302	612

(5 Missing Observations)

2.4.3 parental presence and sex (i.e. Single versus dual parent families)

A significant minority of respondents came from single-parent families (10.3%). There were slightly more females ($n = 35$) than males ($n = 29$) in this category.

2.4.4 Parental presence and home location

Individuals living with both parents in a rural setting constituted the largest group (58%) of respondents. Single-parent families were more likely to be located in a town environment but not significantly so.

2.4.5 Parental presence and maternal employment

The sample population was divided equally into those whose mother worked outside of the family home and those whose mother did not (see Table 2.4.3). This distribution was consistent across single - and dual-parent families.

Table 2.4.3 Parental presence and maternal employment

	Works outside family home	Works within family home	Retired	Row Total
Dual-parent family	253	255	2	510
Single-parent family	28	28		56
Column Total	281	283	2	566

(51 Missing observations)

2.4.6 Parental presence and paternal employment

As Table 2.4.4. indicates, for the greatest percentage of respondents (72.6%), their father was currently in employment. This finding was not affected by the presence of only one parent in the family home.

Table 2.4.4 Parental presence and paternal employment

	Works outside family home	Works within family home	Retired	Row Total
Dual-parent family	448	83	11	542
Single-parent family	34	10		44
Column Total	482	93	11	586

(31 Missing observations)

2.4.7 Parental occupation (Socio-economic background)

The occupational status of parents is a useful guide to socio-economic background. According to the Central Statistics Office (Ireland) “the socio-economic group (SEG) of persons aged 15 years or over who are at work is determined by their occupation or in some cases by a combination of occupation and employment status. Unemployed or retired persons are classified by socio-economic group according to their former occupation. All other persons are classified according to the SEG of the person on whom they are deemed dependent.” (The Central Statistics Office, Dublin; The socio-economic background of respondents is presented with the codes in Appendix 7.3.

2.5 THE SAMPLE OBTAINED FROM THE QUESTIONNAIRE (Selected group)

As previously stated, this group excluded those individuals deemed to be over-reporting in their responses to certain items on the questionnaire (Page 9).

2.5.1 Age and sex

The selected group constituted 76.2% (n = 470) of the sample surveyed. Although there were slightly more females than males within this group, the difference was insignificant. The proportional allocation of females to males within the general population (i.e. all Tipperary school attending pupils between the ages of 15-18+) was reflected in this sample.

Table 2.5.1 Age and sex distribution

	Male	Female	Row Total
15 years	62	75	137
16 years	94	75	169
17 years	56	62	118
18+years	16	28	44
Column Total	228	240	468

(2 Missing Observations)

2.5.2 Educational level and sex

Table 2.5.2 lists the educational level of males and females within the selected group. The results parallel those of the entire and general population samples with 5th year males forming the largest group (23.4%).

Table 2.5.2 Educational level and sex

	Male	Female	Row Total
Repeat Leaving Certificate	7	2	9
Leaving Certificate - 5th year	110	93	203
Leaving Certificate - 6th year	62	87	149
Senior Certificate	0	0	0
Leaving Certificate Vocational Programme	1	0	1
Transition Year	47	58	105
Column Total	227	240	467

(3 Missing Observations)

2.5.3 Parental presence and sex

In this sample there was a larger number of females living in single-parent ' homes: 6.2% compared to 3.8% of males. There were matched numbers of boys and girls in dual-parent households.

Table 2.5.3 Parental presence and sex

	Male	Female	Row Total
Dual-parent	210	211	421
Single-parent family	18	29	47
Column Total	228	240	468

(2 Missing observations)

2.5.4 Parental presence and home location

The figures for parental presence and home location correspond with those of the main population: 60% of respondents live in a rural area with both of their parents.

2.5.5 Parental presence and maternal and paternal employment

As with the previous statistics the distribution of single- and dual-parent families with mothers and/fathers working in the home mirror those of the entire survey sample (Tables 2.5.4 and 2.5.5 respectively).

Table 2.5.4 Parental presence and maternal employment

	Works outside family home	Works within family home	Retired	Row Total
Dual-parent family	204	188	1	393
Single-parent family	22	20		42
Column Total	226	208	1	435

(35 Missing observations)

Table 2.5 Parental presence and paternal employment

	Works outside family home	Works within family home	Retired	Row Total
Dual-parent family	350	59	9	418
Single-parent family	22	7		29
Column Total	372	66	9	447

(23 Missing observations)

3. RESULTS (Entire Survey Sample N = 617)

- 3.1 Measures employed in the survey questionnaire
- 3.2 Analysis on the questionnaire scales
- 3.3 Schools and drugs
 - 3.3.1 Lessons/classes on illegal drug use provided by schools
 - 3.3.2 The participating schools
- 3.4 Knowledge and experiences of smoking
 - 3.4.1 Perceived accessibility
 - 3.4.2 Prevalence rates
 - 3.4.3 Age and smoking
 - 3.4.4 Sex and smoking
 - 3.4.5 Home location and smoking behaviours
 - 3.4.6 Parental presence within the family home and smoking (i.e. single- versus dual-parent families)
 - 3.4.7 Parental employment and smoking behaviours
- 3.5 Knowledge and experiences of alcohol
 - 3.5.1 Perceived accessibility
 - 3.5.2 Prevalence rates
 - 3.5.3 Drinking behaviours
 - 3.5.4 Age and drinking
 - 3.5.5 Sex and drinking
 - 3.5.6 Home location and drinking behaviours
 - 3.5.7 Parental presence within the family home and alcohol use
 - 3.5.8 Parental employment and alcohol consumption
- 3.6 Knowledge and experiences of illegal drugs
 - 3.6.1 Perceived accessibility
 - 3.6.2 Prevalence rates
 - 3.6.3 Drug taking behaviours
 - 3.6.4 Knowledge of illegal drugs
 - 3.6.4.1 Drug effects
 - 3.6.4.2 Drug costs
 - 3.6.5 Age and illegal drug taking
 - 3.6.6 Sex and illegal drug taking
 - 3.6.7 Home location and illegal drug usage
 - 3.6.8 Parental presence within the family home and illegal drug use
 - 3.6.9 Parental employment and illegal drugs

3.1 MEASURES EMPLOYED IN THE SURVEY QUESTIONNAIRE

Prior to analysing the survey findings it is important to synopsise the measures used to estimate levels of substance abuse among Tipperary adolescents.

As stated previously prevalence rates were employed as a useful guide to illicit drug use behaviours (Pages 12 and 13). Questions 21, 23 and 24 concerned cigarette smoking. In respect of alcohol consumption, questions 25, 27 and 28 sought prevalence rate information. Prevalence rates for illegal drug abuse were acquired through 2 scales that correspond to questions 34 and 36 on the questionnaire.

Age levels for cigarette, alcohol and drug behaviours were ascertained through questions 22, 26 and 35 respectively.

The scale measuring attitudes towards drinking alcohol formed question 33 on the survey form. The range for this scale was 7-35 and the midpoint value 21 with a higher score indicating positive attitudes. Since the mean ($X = 16,73$) is below the midpoint it can be suggested that students tend to score on the negative end of this scale (i.e. they are more likely to see the negative consequences of taking alcohol).

The midpoint value for the scale measuring attitudes towards illegal drugs (Question 41 of the questionnaire) was 39 with a scoring range of 13-65. Pupils in this survey were more disposed to negative attitudes towards drug taking ($X = 44,47$), that is, they perceive the taking of drugs in a negative light.

The scale assessing how much danger respondents associate with varying degrees of prescribed drug use corresponds to Question 42 of the survey instrument. The midpoint value for the scale was 34 and the scoring range was 17-51 whereby higher scores suggested greater perceptions of danger. The mean for this scale ($X = 38,76$) was above the midpoint value and indicated that subjects tended to perceive the dangers of drinking alcohol, smoking and taking illegal drugs.

“Actual” knowledge of drugs in terms of costs and effects was measured in questions 43 and 46.

Unfortunately, due to technical difficulties it was not possible to compute the alpha reliability coefficients for these scales at the time of writing this report. Consequently very little between-scale analysis has been conducted.

3.2 ANALYSIS OF QUESTIONNAIRE SCALES

Correlational analysis determines the direction and strength of relationship between two variables. A positive correlation indicates that as values on one variable increase, values on another variable also increase. A negative correlation occurs when values on one variable increase as values on another variable decrease. Correlation coefficients vary from +1 (strong and positive) to -1 (strong and negative), and 0 indicates no relationship. Correlational analysis was used to establish the strength and direction of relationships between the various scales within the questionnaire. The type of correlation employed is known as a Pearson correlation.

An intercorrelatory matrix between the attitude scales is presented in Table 3.2.1. Attitudes towards alcohol were significantly associated with attitudes towards taking illegal drugs. That is, as scores increase on one scale they also significantly increase on the other scale. The perceived danger scale was related significantly with attitudes towards taking drugs but not with attitudes towards drinking alcohol. Students who were unfavourable towards taking drugs were significantly more likely to perceive the dangers of drug-taking habits.

Table 3.2.1 Intercorrelatory matrix between attitudes to drink, drugs and perceived danger scales

	Attitudes towards drugs	Perceived danger of smoking, drinking and taking drugs
Attitudes towards alcohol	.3851**	.0498
Attitudes towards drugs		.2447**

** significant at 0.01 level (1-tailed test)

The remaining analyses comprise percentages, frequencies and correlations in the form of chi-squares. Chi-square statistics are used to determine relationships between items such as sex and drinking beer, rather than questionnaire scales. The

observed value, an expected value and a standardised residual are used to assess the significance of the Chi-square. The observed value is the actual number of subjects within the cell. The expected value refers to the number of subjects that would be statistically anticipated to be in that cell. Finally the standardised residual determines the major contributors) to a significant relationship. Only when a standardised residual for a category is greater than ± 2.00 (in absolute value), can a researcher conclude that it is a major contributor to the significant value of Chi. Thus, in Table 3.2.2. there were 240 males in the sample who reported ever having drunk beer which was more than expected (statistically) i.e. 212.8, However, since the residual value is less than ± 2 , we can not conclude that the difference is significant or that males were more likely than expected to say that they had drunk beer. There were 61 males who reported never having drunk beer, which was less than expected (statistically) i.e. 88.2. Since the standardised residual is greater than ± 2 we can conclude that this -factor was a significant contributor to the Chi-square statistic.

A significant relationship may be observed between 2 variables where there are no standardised residuals greater than ± 2.00 in the cell boxes. When this occurs it is not possible to describe the nature of the relationship, merely that one exists. A significant chi-square may be determined when there are less than five subjects within one or more cells. In this case one can not state a statistically significant relationship.

Table 3.2.2. Example of Chi-Square Statistic**Sex and drinking beer**

Count Exp Val Std Res	“Yes”	“No”	Row Total
Male	240 212.8 1.9	61 88.2 -2.9	301 52.2%
Female	168 195.2 -1.9	108 80.8 3.0	276 47.8%
Column Total	408 70.7%	169 29.3%	577 100.0%

(40 missing observations)

(Chi-square = 24.74; df = 1; P<.01)

3.3 SCHOOLS AND DRUGS**3.3.1 Lessons/classes on illegal drug use provided by schools**

The percentage of respondents who reported receiving lessons/classes on illegal drugs was 50.5. Of these, 65.4% found them to be of some value (Table 3.3.1). The implication is that, at the time of the survey, approximately two-thirds of the entire sample were receiving insufficient drug(s)-related education.

Table 3.3.1 Perceived usefulness of lessons/classes on illegal drugs

	f(x)	%	Cumulative f(x)	Cumulative%
Very useful	57	9.2	57	18,6
Fairly useful	143	23.2	200	65.4
Not very useful	65	10.5	265	86.6
Not at all useful	18	2.9	283	92.5
Don't know	23	3.7	306	100.0

(note: 297 were not required to answer this question and there were 14 Missing observations)

Transition year students were more likely than any other group to have partaken in drugs education (62%). For 5th and 6th year leaving certificate programmes the percentages were 44.5% and 51% respectively.

Religious Education was the predominant class used to impart information on drugs (n = 189). Other classes predominantly used were social and/or health studies and science- Some subjects reported receiving drugs education through a combination of different lessons or outside of a scheduled class (77% of those who received the latter thought the class was either “very useful” or “fairly useful”). (See Appendix 7.4 for full list of classes).

Classes on illegal drugs are relayed by teachers, gardai, health authority representatives, priests or a combination of these. Analyses revealed that lessons taught by both gardai and teachers were appraised as most useful. Classes instructed by gardai on their own were considered to be marginally more beneficial (62.5%) than teachers (60.4%). Priests appeared to have the least to offer in this regard.

Leaflets, books, pamphlets and handouts constituted the largest alternative source of information about illegal drugs provided by school authorities within County Tipperary (17.9%). However, 70% of the total population claimed that they had not been offered any such information.

Table 3.3.2 reveals that a mere 6.2% of the population felt that their school provided enough information about illegal drugs,

Table 3.3.2 Perceptions of illegal drug-related information

	f(x)	Valid %
Enough information is given	37	6.2
A little more is needed	131	21.8
A lot more is needed	382	63.6
Don't Know	51	8.5

(16 Missing observations)

3.3.2 The participating schools (see Appendix 7.2)

Although the programme level (i.e. transition year, leaving certificate, etc.) varied across schools, it is still worth noting some of the global similarities between them.

There was no class participating in this survey that did not have at least one student who claimed to have taken an illicit drug(s) in his/her lifetime. Three schools had no pupils who had not consumed a whole alcoholic drink (i.e. life-time prevalence rate, see page 12), and those who had ever smoked a whole cigarette were in the majority in all but two classes.

Specifically, cannabis had been consumed by subjects from 21 of the 23 schools examined. The two classes with no self-reported cannabis users were both composed of transition year pupils.

Ecstasy had been used by individuals from 65,2% of the schools studied, although the numbers within each class were small, with no group exceeding $n = 5$. One school alone had no pupils professing to have abused inhalants: this was a 6th year leaving certificate class within a secondary school.

Six of the twenty-three schools had one or two teenagers who maintained that they had used cocaine. This statistic must be considered with a degree of caution in the light of subsequent statistics (see Chapter 4), and the scarcity of this drug in the county, and indeed in the country as a whole (An Garda Síochána, 1996¹).

Two instances of two individuals from the same school claiming to have taken tranquillisers were observed in the survey sample. The remainder ($n = 9$) reported their abuse in isolation from other class members (i.e. there was only one from each school).

¹Information supplied by members of the Drugs Squad, Harcourt Square, Dublin

Use of hallucinogens was evident in 73.9% of schools taking part in the research.

Three of the nine self-disclosed barbiturate users came from the same school. Others were divided between six schools with individuals answering separately from their peers (Le. $n = 1$). Interestingly, the aforementioned school accounted for 4 of the heroin users, although at least two of these subjects did not use both drugs. Five of the seven schools with a possible heroin user had no subjects claiming to use barbiturates.

More than half of the subjects who declared that they had taken amphetamines did so without then- school friends. Fifteen schools were involved. Finally, it was suggested that PCP was evident in 3 schools.

Examination of school classification (i.e. secondary, community or vocational) produced some associations with types of drink and drugs consumed. Substances that had a higher occurrence in some school types than others included: (i) inhalants; (ii) hallucinogens; (iii) heroin or other narcotics and (iv) all alcoholic drinks (i.e. beer, cider, wine, wine coolers and spirits).

Analysis within each school category shows that the number of inhalant users was higher than expected amongst vocational school students ($n = 36$). Four pupils attending the community school claimed to have abused inhalants at some stage² and 60 secondary school pupils. The percentages out of each school type were 23.2%, 18.2% and 14% respectively.

Although a significant relationship between hallucinogen abuse and the nature of the school was ascertained, the major contributors to this relationship cannot be determined. Whilst the number of students reporting hallucinogen abuse was highest

² Since there were only four subjects within this cell, the statistics cannot be considered conclusive despite the significance of the Chi-square (Chi-square = 7.10; $df = 2$; $P < .05$).

for secondary schools ($n = 40$) this was lower than the expected value for this group. The numbers of users exceeded the expected values for both vocational schools and the community school but not significantly so.

In respect of heroin, vocational schools contained the greatest percentage. There were no reported cases of young people within the community school group taking heroin.

Within vocational schools, significantly fewer pupils than expected said they had never drunk beer, cider or wine (Chi-square = 13.53; $df = 2$; $P < .01$, Chi-square = 23.7; $df = 2$; $P < .01$ and Chi-square = 13.21; $df = 2$; $P < .01$). Moreover, vocational school pupils, in direct contrast to students attending secondary schools, were significantly more likely to report consumption of at least one whole drink of cider.

3.4 KNOWLEDGE AND EXPERIENCES OF SMOKING

3.4.1 Perceived accessibility

The results show that 91.3% of young people in this survey regard cigarettes as “very easy” to get. A further 6.1% believe that cigarettes are “easy” to procure. These findings are not surprising since the majority of respondents are above the legal age limit for purchasing cigarettes. Nevertheless, for the subjects who are beneath the age of 16 (28.7% of the sample population) an overwhelming 95.4% maintained that cigarettes are either “very easy” or “easy” to obtain. Perceived accessibility did not differ significantly as a function of smoking behaviours, i.e. 92% of non-smokers compared with 98.9% of smokers believed they would have no difficulty getting cigarettes. However, this similarity was not sustained to such a great extent for the under 16s (99.1% of the smokers compared with 86.9% of non-smokers indicated that cigarettes were easy to acquire),

3.4.2 Prevalence rates

A significant number (n = 422; 68.7% of the sample population) of Tipperary adolescents had smoked a whole cigarette. Of those who had experimented with cigarettes, 77.3% (n = 326) alleged that they had smoked a cigarette within the last 12 months. “Regular” smokers (1-2 each week and more, Q.24) accounted for 34.9% of the total population and 66.3% of the sample who reported smoking within the past year.

3.4.3 Age and smoking

The average age for onset of smoking behaviour amongst those who had ever tried a whole cigarette was 12.4 (SD = 2.2; range = 5-18 years). The number of 15 year- old respondents smoking unlawfully was 115 (65.3% of 15 year olds). There was no relationship ascertained between smoking behaviour and age (Chi-square = 3.50;df = 3;P>.05).

Table 3.4.1 Amount of cigarettes smoked in the past 12 months and age of respondent

	None/only a	1-5 each week	1-10 each day	11+ each day	Total
15	55	19	26	15	115
16	76	11	46	12	145
17	54	9	42	15	120
18+	21	1	11	9	42
Total	206	40	125	51	422

(195 Missing observations including non-smokers)

Heavy smokers (11+ each day) were least likely to be discerned amidst those aged 16 years. However, the highest percentage of individuals who had tried a whole cigarette but were not regular smokers was also in this age category.

3.4.4 Sex and smoking

Chi-square analysis suggested that there was no relationship between sex and lifetime prevalence rate (Chi-square = 1.06; df = 1; $P > .05$), age of first cigarette (Chi-square = 25.74; df = 14; $P > .05$)³, and whether the subject had smoked in the past year (Chi-square = 3.51; df = 2; $P > .05$). Although a significant association was observed between sex and current smoking behaviours (Chi-square = 18.86; df = 10; $P < .05$) some of the cells contained numbers of less than 5 subjects and consequently the analysis cannot be conclusive. Moreover, the relationship was not maintained when the categories were collapsed (from 10 into 4) in order to increase the numbers within each cell (Chi-square = 1.36; df = 3; $P > .05$).

3.4.5 Home location and smoking behaviours

Those subjects living in an urban area within the county were no more likely to have ever smoked at least one whole cigarette than those based in rural locations (Chi-square = 0.17; df = 1; $P > .05$). Furthermore, the age at which an individual began-smoking (Chi-square = 8.64; df = 14; $P > .05$)⁴, present smoking habits (Chi-square = 1.64; df = 2; $P > .05$)⁵, and smoking behaviour in the past 12 months (Chi-square = 1.64; df = 2; $P > .05$) were unaffected by home location.

3.4.6 Parental presence within the family home and smoking (i.e. single-versus dual-parent families)

The results infer a significant relationship between the presence of one or both parents within the family home and yearly prevalence rate, but the precise nature of this association cannot be specified (Chi-square = 8.36; df = 2; $P < .05$). Table 3.4.2 gives the numbers for each group on these dimensions. The percentage of pupils who

³ Some cells contained insufficient numbers i.e. <5

⁴ Some cells contained insufficient numbers i.e. <5

⁵ Some cells contained insufficient numbers i.e. <5

have ever smoked is marginally higher amongst the disadvantaged group (78.1% compared with 67.7%).

Table 3.4.2 Parental presence and smoking life-time prevalence rate

	Dual-parent family	Single-parent family	Row Total
No response required⁶	176	14	190
Yes	281	45	326
No	88	5	93
Column Total	545	64	609

(8 Missing Observations)

3.4.7 Parental employment and smoking behaviours

Chi-square analysis failed to determine any relationships between any aspects of smoking behaviours and parental employment⁷. Exclusion of children with retired parents failed to affect the findings except for paternal employment and amount of cigarettes smoked in the past month. Teenagers whose father was unemployed were more likely than statistically expected to state that they smoked between 1 and 10 cigarettes each day.

3.5 KNOWLEDGE AND EXPERIENCES OF ALCOHOL

3.5.1 Perceived accessibility

Complete abstainers (i.e. those who had never taken a whole alcoholic beverage) accounted for a mere 16.5% (20.2% when adjusted for missing cases) of the total sample. Ease of access to alcohol was measured over 5 questions to account for different alcoholic drinks (i.e. beer, cider, wine, wine coolers and spirits). Perhaps not surprisingly only 42.8% of survey participants perceived “wine coolers” as easily obtainable. A significant percentage was unsure exactly what “wine coolers” were and this was evident during questionnaire administration. In respect of under age drinking, beer and cider were considered the most accessible (see Tables 3.5.1 and

⁶i.e. subjects who have never smoked a whole cigarette were not required to answer this question

⁷Some cells contained insufficient numbers i.e.<5

3.5.2 below). For wine and spirits the percentages were 60.7 and 66.4 respectively in terms of easiness to procure. The sex or home location of the respondent did not affect the findings significantly.

Table 3.5.1 Age and ease of acquiring beer

	Easy	Row%	Unsure/never heard of it	Difficult	Row Total
15	129	73.7	22	24	175
16	176	83.8	17	17	210
17	143	89.4	9	8	160
Column Total	448	82.2	48	49	545

(5 Missing Observations)

Table 3.5.2 Age and ease of acquiring cider

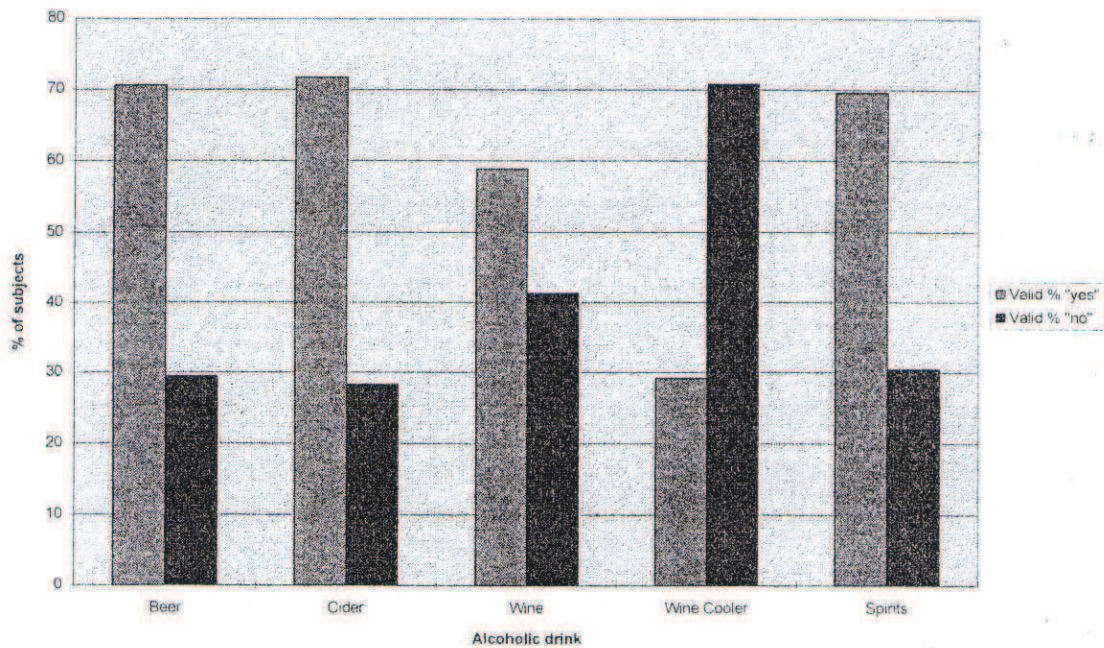
	Easy	Row%	Unsure/never heard of it	Difficult	Row Total
15	129	74.1	22	23	174
16	175	83.7	19	15	209
17	139	88	10	9	158
Column Total	443	81.9	51	47	541

(9 Missing Observations)

3.5.2 Prevalence rates

A minimum of 65.5% of the sample had taken a whole alcoholic drink at the time of the survey. Figure 3.5.1 displays the percentages for each drink listed.

Figure 3.5.1 Percentage distribution of alcohol intake



The heaviest drinkers (defined as drinking “several times a week” or “everyday”) and those drinking 2-3 times a week (i.e. at weekends) were amongst the 17 and 18 year olds, as would be anticipated. These subjects accounted for 21.1% of the total population. Of the entire sample, 20.6% had drunk less than once or twice in the past 12 months. There were significantly more boys reporting heavy drinking⁸ (Chi-square - 15.34 df = 5; P<.01).

⁸ Where the observed value significantly exceeded the expected value for males but the reverse was held for females

Table 3.5.3 Sex and reported drinking behaviours

COUNT	Not at all	1-5 times	6-10 times and about once a month	2-3 times a month /weekends	Several times a week/ everyday	Total
Row pet						
Col pet						
Tot pet⁹						
Males	11 4.1 40.7 2.2	66 24.7 50.4 13.1	68 25.5 50.7 13.5	84 31.5 52.2 16.6	38 14.2 73.1 7.5	267 52.9
Females	16 6.7 59.3 3.2	65 27.3 49.6 12.9	66 27.7 49.3 13.1	77 32.4 47.8 15.2	14 5.9 26.9 2.8	238 47.1
Total	27 5.3	131 25.9	134 26.5	161 31.9	52 10.3	505 100

3.5.3 Drinking behaviours

Those pupils who stated that they had drunk a whole drink in the past 12 months were asked a series of questions on their drinking behaviours. Firstly, information on the approximate amount consumed on each occasion was sought (Q.28). Predictably, in comparison to their female counterparts, male subjects were significantly more inclined to maintain that they drank six or more drinks on a given occasion (Chi-square = 24.68; df = 3; P<.01). Females specified 2-3 alcoholic beverages as their usual consumption rate. In addition, age was a significant factor (Chi-square = 28.71; df = 9; P<.01). For 17 year olds, the observed value was less than expected with regards to drinking less than one drink and more than expected for drinking 4 or 5 drinks.

The locations of teenagers when they took their first alcoholic drink and drink currently were requested.¹⁰ A full list of locations is provided in Appendix 7.5. Tables 3.5.4 and 3.5.5 reveal the high percentages of boys and girls drinking illegally.

⁹ Frequency, row percentage, column percentage and total percentage displayed within each cell

¹⁰ The legal age for drinking alcohol in the Irish Republic is 18 years. Persons below that age are not permitted to drink in any public place.

Table 3.5.4 Age and illegal drinking behaviours of male respondents

Count Row Pet Col Pet Tot Pet	No response required	Legal drinking locations¹¹	Illegal drinking locations¹²	Row Total
15	18 26.1 40.9 6.9	19 27.5 29.2 7.3	32 46.4 21.2 12.3	69 26.5
16	20 17.4 45.5 7.7	31 27.0 47.7 11.9	64 55.7 42.4 24.6	115 44.2
17	6 7.9 13.6 2.3	15 19.7 23.1 5.8	55 72.4 36.4 21.2	76 29.2
Column Total	44 16.9	65 25.0	151 58.1	260 100.0

(27 Missing observations)

Table 3.5.5 Age and illegal drinking behaviours of female respondents

Count Row Pct Col Pct Tot Pct	No response required	Legal drinking locations¹³	Illegal drinking locations¹⁴	Row Total
15	36 40.0 56.3 14.5	20 22.2 35.1 8.0	34 37.8 26.6 13.7	90 36.1
16	17 21.3 26.6 6.8	26 32.5 45.6 10.4	37 46.3 28.9 14.9	80 32.1
17	11 13.9 17.2 4.4	11 13.9 19.3 4.4	57 72.2 44.5 22.9	79 31.7
Column Total	64 25.7	57 22.9	128 51.4	249 100.0

(13 Missing observations)

Fourthly, the question pertaining to where alcohol is obtained divulged the following data:

¹¹ e.g. family or friend's home

¹² e.g. pubs, discos, public parks etc

¹³ e.g. family or friends home

¹⁴ e.g. pubs, discos, public parks etc

Table 3.5.6 Sources of alcohol

	f(x) answering “yes”	% of total “drinking” population
Supermarket	65	10.9
Pub	309	52.0
Disco	198	33.3
Home	74	12.5
From friends	112	18.9
Off-licence	137	23.1

(23 Missing observations)

Other places referred to encompassed: *inter alia*, parties; special functions (e.g. weddings); night-clubs; and duty free. Finally, the majority of young people drink with their friends, followed by a combination of parents and other relatives.

3.5.4 Age and drinking

The numbers and percentages of young people drinking each of the alcoholic drinks listed are provided in Appendix 7.6. Chi-square analysis revealed significant relationships between drinking and age, regardless of the type of drink consumed. No particular age group(s) accounted for the significant association between age and wine drinking (Chi-square = 8.48; df = 3; P<.05). Those respondents aged 15 were less inclined to report ever having taken a whole drink of beer, cider or wine cooler than statistically anticipated. In addition, more 15 year old subjects than expected stated that they had never had spirits (i.e. the observed value exceeded the expected value for a “no” response). The probability of pupils aged 17 years providing a “no” response to taking beer and cider was higher than the observed numbers. Finally, for the legal drinkers (18 year olds), fewer were found to report non-consumption of cider than statistically assumed and more were likely to have drunk wine coolers. The Chi-square tests for beer, cider, wine coolers and spirits were as follows: Chi-square = 27.98; df = 3; P<.01, Chi-square = 30.01; df = 3; P<.01, Chi-square = 19.37; df = 3; P<.01 and Chi-square = 12.25; df = 3; P<.01.

As previously noted, a sizeable proportion of the sample comprises individuals illegally drinking. Analysis of age groups and the regularity and quantity of alcohol consumption has already been commented on in this chapter.

The respondent's current age was associated with the place of purchasing alcohol. Whereas pubs and discos were the most likely places for 17 and 18 year olds to procure alcohol, they were the least likely locations for the youngest set of respondents (15 year olds). In addition, 16 year olds were unlikely to secure alcohol in pubs. Statistics on the variable suggesting friends as sources of alcohol revealed a cell of less than 5 people and are therefore inconclusive. However, the trend implies that 16 year olds acquire drinks from their friends, but statistically this was not the case for 18 year olds. Finally, 15 year olds were less likely than expected to state that they did not get alcohol from home. It is worth mentioning that some subjects commented on their questionnaires that they requested older people to buy alcohol for them and this may well be the case for others even if they did not explicitly say so.

3.5.5 Sex and drinking

There was a greater percentage of males reporting alcohol consumption than females. A greater than expected number of females maintained that they had never drunk beer and cider (Chi-square = 24.74; df = 1; $P < .01$ and Chi-square = 10.64; df = 1; $P < .01$). Perhaps stereotypically, females consumed significantly less beer than their male counterparts and did not report routinely drinking large quantities of alcohol (6 or more drinks). The frequency of drinking in the past 12 months differed between males and females in that males drank more regularly (Chi-square = 10.71; df = 4; $P < .05$) (Table 2.5.8).

Table 3.5.7 Sex and regularity of drinking behaviour in the past 12 months¹⁵

Count Row Pct Col Pct Tot Pct	Not at all	1-5 times	6-10 times and about once a month	2-3 times a month/ weekends	Several times a week/ everyday	Row Total
Male	11 4.1 40.7 2.2	66 24.7 50.4 13.1	68 25.5 50.7 13.5	84 31.5 52.2 16.6	38 14.2 73.1 7.5	267 52.9
Female	16 6.7 59.3 3.2	65 27.3 49.6 12.9	66 27.7 49.3 13.1	77 32.4 47.8 15.2	14 5.9 26.9 2.8	238 47.1
Column Total	27 5.3	131 25.9	134 26.5	161 31.9	52 10.3	505 100.0

(112 Missing observations)

Table 3.5.8 Sex and quantities of alcohol consumed on a given occasion

Count Row Pct Col Pct Tot Pct	Less than one	2 or 3	4 or 5	6 or more	Row Total
Male	40 15.6 47.1 8.3	61 23.7 40.7 12.6	86 33.5 57.0 17.8	70 27.2 71.4 14.5	257 53.1
Female	45 19.8 52.9 9.3	89 39.2 59.3 18.4	65 28.6 43.0 13.4	28 12.3 28.6 5.8	227 46.9
Column Total	85 17.6	150 31.0	151 31.2	98 20.2	484 100.0

(133 Missing observations)

Sex affected the locations of alcohol procurement whereby female subjects, unlike their male peers, displayed a tendency to get their alcohol at discos (Chi-square = 31.23; df = 2; P<.05). Alternative sites on the inventory produced significant relationships although their exact nature was indeterminate. Sex

¹⁵ Those respondents who had never taken a whole alcoholic drink are not included

influenced to a certain degree who you drank with but the statistics were ambiguous due to limited numbers within cells.

3.5.6 Home location and drinking

Examination of the data in respect of home location (i.e. rural versus urban) failed to expose associations with the type of alcohol consumed by respondents, how frequently they drank, and the quantity on each occasion. However, home location influenced purchase in supermarkets, off-licences, pubs and discos (Chi-square = 10.50; df = 2; $P < .01$). (Chi-square = 14.09; df = 2; $P < .01$), (Chi-square = 6.02; df = 2; $P < .05$) and (Chi-square = 23.76; df = 2; $P < .01$). The probability of town dwellers citing off-licences and supermarkets as sources of alcohol was greater than statistically expected. Rural-based students relied on discos for alcohol more so than urban-based respondents. The nature of the relationship between home location and alcohol acquisition in pubs cannot be delineated with statistical certainty.

3.5.7 Parental presence within the family home and drinking

The presence of one or both parents within the family home impacted on drinking beer, cider, and wine but not other drinks (Chi-square = 5.77; df = 1; $P < .05$), (Chi-square = 5.23; df = 1; $P < .05$), (Chi-square = 13.44; df = 1; $P < .01$) (Chi-square = .03; df = 1; $P > .05$) and (Chi-square = 2.37; df = 1; $P > .05$). Wine was the only drink in which the direction of the association could be described and was such that individuals from single-parent households were more likely to consume this drink. No definitive conclusions may be drawn from outstanding statistics on parental presence and drinking behaviours.

3.5.8 Parental employment and alcohol consumption

Statistics analysis conducted on the employment status of both parents yielded crosstabulation tables with less than five subjects within each cell¹⁶. When pupils with retired parents were extracted from the analyses some significant associations were noted but for the most part can not be specified. These relationships included: paternal employment and respondent's likelihood of purchasing alcohol at an off-licence (Chi-square = 9.44; df = 2; P<.01); maternal employment and the average amount consumed by their children (Chi-square = 7.82; df = 3; P<.05), consumption of beer (Chi-square = 4.28; df = 1; P<.05), and spirits (Chi-square = 3.75; df = 1; P<.05). Youngsters with fathers currently out of employment were more inclined than statistically expected to say that they do not get their supply of alcohol from pubs (Chi-square = 9.15; df = 2; P<.01).

3.6 KNOWLEDGE AND EXPERIENCES OF ILLEGAL DRUGS

3.6.1 Perceived accessibility

Ease of access to illegal drugs was measured within the same scale as cigarettes and alcohol. Eleven drugs were specified including one "dummy" drug namely "relexin" (see page 15), Inhalants and hallucinogens were considered readily acquirable products by large percentages of respondents. Since a large number of abusable inhalants exist within the family home and local shops/supermarkets, and hallucinogens can be picked in the form of magic mushrooms, these findings are not alarming.

The ease of access to ecstasy, and to a lesser extent cannabis and amphetamines must be noted. However, the 15.7% of respondents who claimed "relexin" was easy to get are also worthy of comment. These individuals were selected out of the main sample (see page 15) and further statistical procedures conducted in order to ascertain the "real" drugs situation in Tipperary (see Chapter 4)

¹⁶ The fact that some subjects had parents who were retired may have influenced these results.

Table 3.6.1 Ease of acquiring drugs (percentages of total sample population)

	Easy	Unsure/never heard of it	Difficult
Cannabis	31.0	40.1	28.9
Inhalants	80.2	13.6	6.2
Cocaine	14.1	41.4	44.4
Tranquillisers	11.3	52.3	36.4
Hallucinogens	49.6	33.7	16.6
Barbiturates	13.1	68.1	14.8
Relexin	15.7	68.0	16.3
Heroin or other narcotics	12.1	41.5	46.4
Amphetamines	23.3	48.1	28.7
PCP	13.7	52.7	33.7
Ecstasy	49.3	29.5	21.2

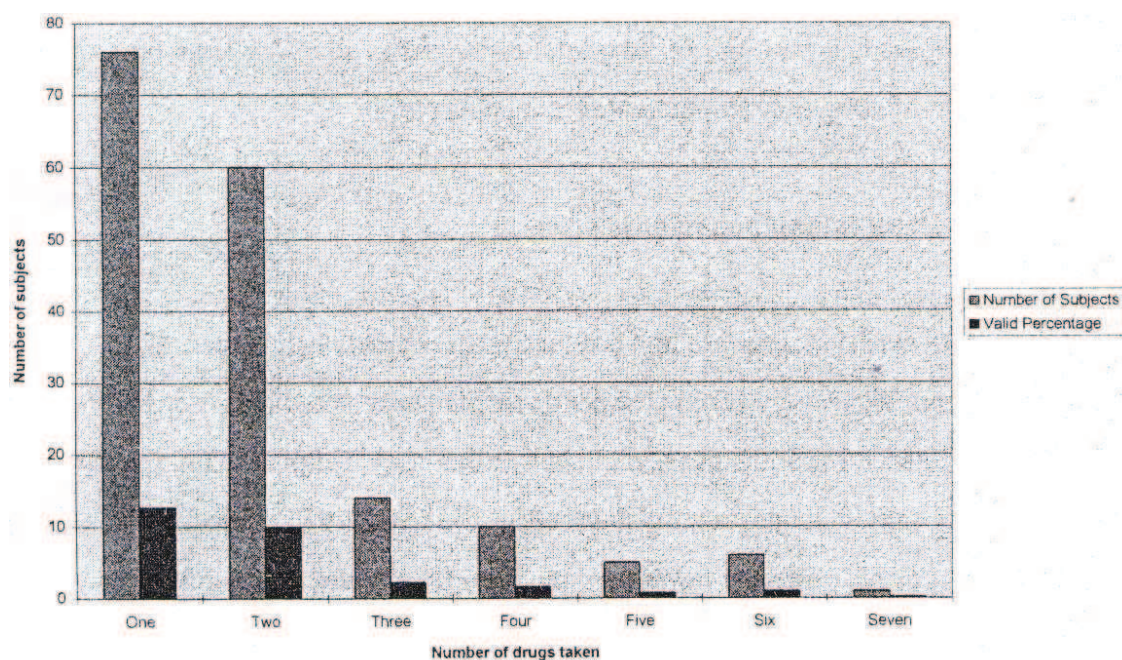
There is widespread concern amongst gardai, parents, teachers and politicians that large numbers of people are being exposed to drugs at an early age. The analysis revealed that 43.1% of the total sample population had been offered drugs, 23.2% said they had never been offered drugs and the remaining 33.7% failed to complete the section of the questionnaire addressing this issue. Of the remaining group who had been confronted with drugs, the greatest percentage (64.3%, n = 171) had been offered them in one or more of the following places; discos, pubs, night-clubs, raves and concerts (including Féile). Public places such as on the street, parks and in town centres were mentioned by 65 subjects. Moreover, 17 respondents reported being offered drugs at school. (A complete list of locations is provided in Appendix 7.7).

It is extremely propitious that the vast majority stated that they would definitely refuse to take an illegal drug if offered (72.3%). A much smaller number of subjects (n = 99,16%) claimed that they would take it and most of these required the satisfaction of a particular condition such as knowledge of the person offering the drug and/or what was in it. Some reported that they would buy the drug but not consume it themselves. Finally, others stated that they would only try “soft” drugs (which they defined as cannabis or magic mushrooms), (see Appendix 7,8 for responses).

3.6.2 Prevalence rates

At least 172 students (27.9%) who took part in this survey claimed to have taken one or more illicit drug(s)¹⁷. However, the largest percentage of this group (44.2%) did not display a tendency towards polydrug abuse (using a variety of substances) as shown in Figure 3.6.1.¹⁸ A small percentage of the total population (5.8%) admitted trying more than two different types,

Figure 3.6.1 Numbers of different drug-types taken and numbers of subjects within the sample population



In respect of the various types of drugs used, inhalants, cannabis and hallucinogens were the most popular (Table 3.6.2).

¹⁷ There were 18 missing observations on this variable. Therefore, the maximum total could be 190.

¹⁸ The proportionately large number of respondents reporting the consumption of two drugs could not be described as multiple drug users in the traditional sense. For the most part, these individuals had not tried “hard drugs”.

Table 3.6.2 Frequency distribution and percentages of respondents claiming to use illicit drugs

	F(x)	% of total sample population
Cannabis	95	15.7
Inhalants	100	16.5
Cocaine	8	1.3
Tranquillisers	13	2.2
Hallucinogens	70	11.6
Barbiturates	9	1.5
Heroin or other narcotics	13	2.2
Amphetamines	25	4.1
PCP	5	0.8
Ecstasy	38	6.3

The average age for onset of drug taking was either 14 or 15 years regardless of the nature of the drug (i.e. amphetamine, cannabis etc.).

3.6.3 Drug taking behaviours

The data revealed a certain level of inconsistency between responses to Questions 34 and 36. A very small number of respondents stated that they had taken a drug within the past 12 months but had not stated that they had ever taken the drug when asked in a previous question. Nevertheless, the majority of subjects were not uniformly using drugs. Regular users (about once a month and more) comprised less than 15% of the total population. For each of the listed drugs the percentages were as set out in Table 3.6.3.

“Friends” were discerned to be the most likely supplier of drugs and this is consistent with the available literature on teenage substance misuse.

Table 3.6.3 Frequencies and percentages of respondents who had taken any of the drugs listed and drug-taking behaviours in the past 12 months¹⁹

Count Row Valid Pct % of drug takers for the category	1	2	3	4	5	6	7	8
Cannabis	80 13.5 9.5	33 5.6 34.7	23 3.9 24.2	10 1.7 10.5	15 2.5 15.8	2 .3 2.2	3 .5 3.2	0 0 0
Inhalants	98 16.6 34	45 7.6 45	12 2.0 12	2 .3 2	5 .8 5	2 .3 3	0 0 0	0 0 0
Cocaine	143 24.7 0	6 1.0 60	1 .2 1	1 .2 1	1 .2 1	0 0 0	0 0 0	1 .2 2 ²⁰
Tranquillisers	141 24.4 15.4	6 1.0 46.2	2 .3 15.4	1 .2 6.7	1 .2 6.7	0 0 0	0 0 0	1 .2 6.7
Hallucinogens	111 18.8 14.3	25 4.2 35.7	15 2.5 21.4	15 2.5 21.4	3 .5 4.3	2 .3 2.9	0 0 0	0 0 0
Barbiturates	142 24.7 22.2	2 .3 22.2	3 .5 33.3	1 .2 11.1	0 0 0	1 .2 11.1	0 0 0	0 0 0
Heroin or other narcotics	141 24.4 15.4	5 .9 38.5	4 .7 30.8	0 0 0	0 0 0	0 0 0	0 0 0	2 .3 15.4
Amphetamines	132 22.9 32	9 1.6 36	4 .7 16	3 .5 12	1 .2 4	0 0 0	0 0 0	0 0 0
PCP	142 24.7 0	1 .2 16.7	1 .2 16.7	1 .2 16.7	1 .2 16.7	1 .2 16.7	0 0 0	1 .2 16.7 ²¹
Ecstasy	130 22.0 7.9	16 2.7 42.1	7 1.2 18.4	6 1.0 15.8	4 .7 10.5	0 0 0	1 .2 2.6	1 .2 2.6

Code:

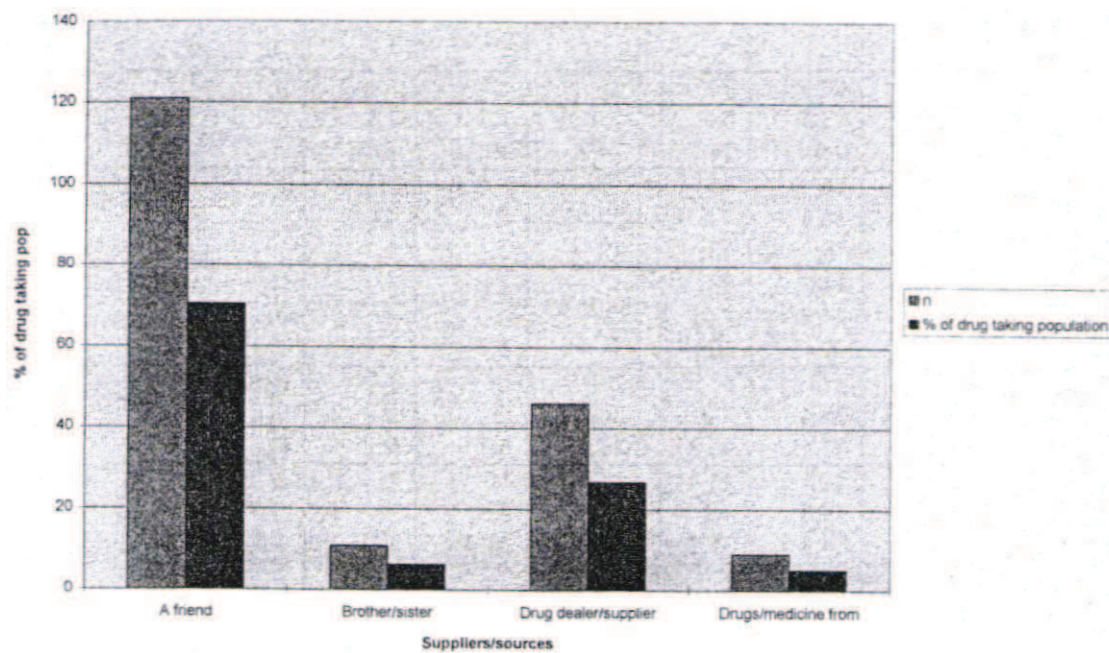
- 1 Not at all**
- 2 1-2 times in the past 12 months**
- 3 3-5 times in the past 12 months**
- 4 about once a month**
- 5 2-3 times a month**
- 6 1-2 times a week**
- 7 several times a week**
- 8 every day**

¹⁹ 427 subjects who said that they had never taken an illegal drug were not required to answer this section of the questionnaire. The number of missing observations was different for each drug. Those responding “not at all” will include those respondents who have never taken that particular substance but will have taken something else at some stage in their lifetime (not necessarily within the last 12 months).

²⁰ N.B. the number of respondents citing use of cocaine on this section of the questionnaire is inconsistent with their answers to Question 34 (see Table 3.6.2).

²¹ N.B. the number of respondents citing use of PCP on this section of the questionnaire exceeds the number on Question 34 (see Table 3.6.2).

Figure 3.6.2 Sources of illegal drugs



Those who either “sometimes” or “always” pay for their drugs (10.5% and 7.8% of drug users, respectively) allege that their habit is/was financed through one or a combination of the following: pocket money (n = 30); earnings (n = 43); and savings (n = 10). A small number (n = 4) professed that they stole in order to pay for their drugs.

Rationale for taking drugs are outlined in Table 3.6.5. Contra-intuitively, peer pressure was not the main reason for drug taking despite the fact that most gain their drugs from friends.

Table 3.6.4 Rationale for drug taking

	f(x) answering “yes”	% of drug-taking population
Boredom	61	35.5
Recreation	30	17.4
Everyone does it	23	13.4
Curiosity	108	62.8
Loneliness	16	9.3
Insight	16	9.3
Relaxation	60	34.9
Rebellion	32	18.6
Medical	6	3.5
My friends do it	35	20.3
Calm nerves	37	21.5
To feel better	64	37.2
Fun	105	61.0
Energy	50	29.1

(Note: Respondents were able to indicate more than one reason)

Some additional motivations for drug taking incorporated “to get high”, “cheaper than alcohol”, “relief from depression”, “to lose weight”, to provide “confidence”, “enjoyment” and to “have a good time”.

3.6.4 Knowledge of illegal drugs

3.6.4.1 Drug effects

To gauge survey participants’ knowledge of illegal substances, open-ended questions pertaining to their effects and costs were incorporated into the questionnaire design. Moreover, these questions enabled the researcher to distinguish some sample members who were overstating their drug(s) usage, i.e. if a subject indicated that they had taken a particular drug and that they either “sometimes” or “always” paid for their supply, then it follows that they should have some appreciation of the costs involved.

The “real” effects of the ten drugs employed are provided in the Appendix together with the qualitative data this survey produced (Appendices 7.9 and 7.10). The lack of insight into the ramifications of using illicit drugs was evident in the survey responses. In most cases, subjects failed to provide a realistic viewpoint

through a combination of positive and negative outcomes. Many students focused on the experience of taking the drug itself to the exclusion of short- and long-term effects or vice-versa.

Frequently, respondents repeated the same response for each drug such as, *inter alia*, “high”, “can kill you”, “addiction”, “feel good”, “relaxed”, “very bad for you” and “energy”. This demonstrated a lack of differentiation between the effects of different drugs and, to a large degree, guesswork. To support this contention, some responses would be correct in some cases and not in others i.e. a “high” may be experienced with cannabis or inhalants but not with tranquillisers.

As the above examples suggest, one-word comments were provided by many subjects. These single word answers (ones that were not necessarily repeated for all drugs) were not always incorrect in the effect (e.g. cannabis can make you “laugh” or “cough”) but they did not illustrate knowledge of the full implications of taking the drug.

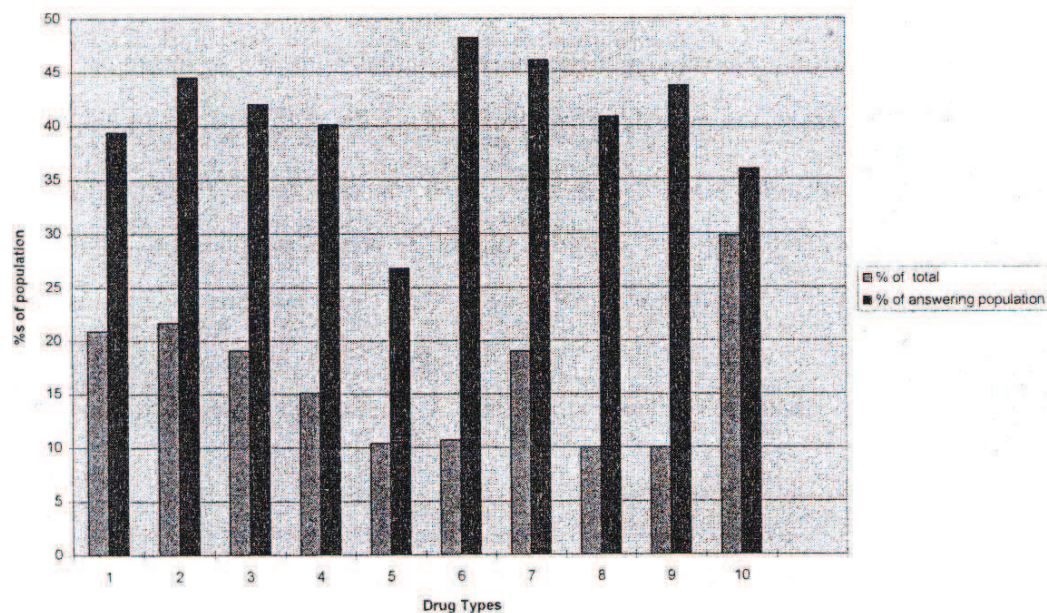
The number of missing observations (i.e. subjects declining to answer a questionnaire item) and individuals admitting their lack of knowledge in respect of the effects of drugs varied for each of the substances listed (Table 3.6.5). Given the extensive media coverage of ecstasy it is not surprising that this drug was commented upon by most subjects. High percentages of students reported openly that they did not have the requisite knowledge in respect of drug effects.

Table 3.6.5 Numbers of missing observations and “don’t knows” for drug effects

	F(x) “don’t know”		F(x) missing observations	Total	% of sample
	Count	Percentage			
Cannabis	150	24.3%	140	290	47.0
Inhalants	163	26.4%	153	316	51.2
Cocaine	173	28.0%	163	336	54.5
Tranquillisers	207	33.5%	178	385	62.4
Hallucinogens	213	34.5%	165	378	61.2
Barbiturates	274	44.4%	206	480	77.8
Heroin or other narcotics	183	29.7%	180	363	58.8
Amphetamines	263	42.6%	202	465	75.4
PCP	266	43.1%	209	475	77.0
Ecstasy	95	15.4%	111	206	33.4

Figure 3.6.3 shows that a negative or partially negative consequence of taking a particular drug was provided by many subjects. The remaining data was either neutral or positive (the accuracy of the response was not controlled for in these analyses).

Figure 3.6.3 Effects of various drugs: negative and partially negative responses



(Drug types 1 through 10 correspond to those listed on the questionnaire: cannabis; inhalants; cocaine; tranquillisers; hallucinogens; barbiturates; heroin or other narcotics; amphetamines; PCP and Ecstasy).

Table 3.6.6 Percentages of self-reported using population with definite incorrect or “don’t know” responses

Drug	% of self-reported users with incorrect or “don’t know” responses	N total of users
Cannabis	9.5	17
Inhalants	19.0	100
Cocaine	37.5	8
Tranquillisers	23.0	13
Hallucinogens	14.3	70
Barbiturates	22.2	9
Heroin or other narcotics	7.7	13
Amphetamines	8.0	25
PCP	20.0	5
Ecstasy	5.3	38

3.6.4.2 DRUG COSTS²²

The following table displays the “real” costs of drugs and the percentage of reasonably accurate answers provided by teenagers within this survey²³. It is impossible to know whether subjects’ responses were the result of conjecture or real knowledge. In all cases, the majority of subjects did not know the costs entailed in purchasing drugs.

²² Some subjects provided a range of costs and for ease of analysis these were not transferred into the data file. Consequently, these statistics must be viewed with a degree of care. Moreover, prices for drugs vary depending on a number of factors (e.g. supplier, amount).

²³ The costs of drugs were supplied by Garda C. Me Enerney, Garda Drugs Squad, Harcourt Square, Dublin 2 and Mr C Murphy (Pharmacist, Templemore)

Table 3.6.7 Costs of illegal drugs

	Real cost	% of reasonably accurate answers
Cannabis	Grass = £50 per oz Resin = £10 per gramme	32.1
Inhalants	£1-2+	13.3
Cocaine	£90-£100 per gramme	9.9
Tranquillisers	Old-brand tranquillisers on prescription = c.£5 per month New-brand tranquillisers on prescription = c.£8/9 per month Prozac = £30 per month	3.6
Hallucinogens	LSD-£3-£5 per tablet (although they can go up to £10) Magic mushrooms can be freely picked in the wild	5.7
Barbiturates	under £2 on prescription	0.16
Heroin or other narcotics	£100-£160 per gramme Can purchase in £20 and £10 bags. ²⁴	12.5
Amphetamines	£25-£30 per gramme	3.7
PCP	Never seized in this country, therefore no price available	
Ecstasy	£12-£15 per tablet (can go up to £20)	28.2

In respect of the self-reported drug users, a significant number stated lack of insight (i.e. “don’t know”) into the costs of drugs. This fact is inconsequential if the respondent did not claim to pay for his/her drugs supply. However, sixteen individuals who said that they “always” paid for their drugs also maintained that they did not know the costs. In addition, among these subjects were some who purported that “relexin” is easily accessible. All these individuals were excluded from the analyses reported in Chapter 4.

²⁴ Naps are a substitute for heroin and their price depends on the strength. Nap 10 = £2-£5, Nap 100-200 = £20-£25.

3.6.5 Age and illegal drug taking

No significant relationships were ascertained between age and taking any of the drugs listed, who supplies them, how they are paid for, reasons for taking them, and amount consumed.²⁵

3.6.6 Sex and illegal drug taking

The sex of the respondent impacted on whether s/he stated usage of ecstasy (Chi-square = 9.93; df = 1; P<.01), hallucinogens (Chi-square = 5.48; df = 1; P<.01), cannabis (Chi-square = 6.70; df = 1; P<.01) and amphetamines (Chi-square = 5.92; df = 1; P<.01). Although boys were more likely than girls to report taking ecstasy, the direction of the association can not be statistically proven for the other drugs mentioned.

Females were less likely than expected to state that their drugs were not either drugs/medicine from others (Chi-square = 12.94; df = 2; P<.05) or provided by a sibling (Chi-square = 15.43; df = 2; P<.01). The precise opposite held true for males (i.e. they were more likely to state that they were not their drugs providers). Furthermore, girls were less likely to state friends as suppliers (chi-square = 10.66; df = 2; P<.01). The major contributors to the association between gender and drug dealer/supplier can not be ascertained (Chi-square = 13.29; df = 2; P<.01)

Males were inclined more than females to “sometimes” pay for their drugs (Chi-square = 19.48; df = 3; P<.01). Significant associations were discerned between” gender and all the reasons for drug taking outlined on the questionnaire. However, the precise nature of the relationships can not be explained.

3.6.7 Home location and illegal drug usage

The home location of the respondent did not effect whether s/he took any of the drugs mentioned on the questionnaire or how they were obtained. Nevertheless, home location did impact on whether the individual paid for his/her drugs (Chi-square

²⁵ Some cells contained insufficient numbers i.e.<5 in some of these analyses

= 9.10; $df = 3$; $P < .05$). The rationale for drug taking influenced by this variable included: to feel better (Chi-square = 6.19; $df = 2$; $P < .05$), everyone does it (Chi-square = 7.22; $df = 2$; $P < .05$), curiosity (Chi-square = 8.77; $df = 2$; $P < .01$), loneliness (Chi-square = 6.4; $df = 2$; $P < .05$), relaxation (Chi-square = 7.63; $df = 2$; $P < .05$), and rebellion (Chi-square = 8.14; $df = 2$; $P < .05$). Urban-based students were more likely to answer “no” when asked if curiosity or rebellion were reasons for taking drugs.

3.6.8 Parental presence within the family home and illegal drug use

Teenagers from single-parent families were significantly more disposed to taking ecstasy (Chi-square = 5.01; $df = 1$; $P < .05$) and hallucinogens (Chi-square = 5.56; $df = 1$; $P < .05$) than expected. Unspecifiable associations were observed with this variable and cannabis usage (Chi-square = 4.88; $df = 1$; $P < .05$), using others’ medicine (Chi-square = 6.41; $df = 2$; $P < .05$), and recreation as a reason for drug taking (Chi-square = 5.84; $df = 2$; $P < .05$).

Chi-square analysis revealed that those subjects with a single parent in the family home were more likely to answer “no” (than statistically assumed) In respect of obtaining drugs from a brother or sister (Chi-square = 6.93; $df = 2$; $P < .05$) and relaxation as an incentive for taking drugs (Chi-square = 8.41; $df = 2$; $P < .01$).

3.6.9 Parental employment and illegal drugs

For maternal and paternal employment the statistics calculated showed no significant relationships and moreover there were cells smaller than 5 in the majority of cases to render the statistics valueless. When the subjects with retired parents were omitted from the calculations in order to elevate cell size, the pattern remained the same. Only one significant, but indeterminate, chi-square emerged from the analyses between maternal employment and use of cannabis (Chi-square = 4.62; $df = 1$; $P < .05$).

4. RESULTS (Selected sample n = 470)

- 4.1 Schools and drugs
- 4.2 Knowledge and experiences of smoking
 - 4.2.1 Perceived accessibility
 - 4.2.2 Prevalence rates
 - 4.2.3 Age and smoking
 - 4.2.4 Sex and smoking
 - 4.2.5 Home location and smoking behaviours
 - 4.2.6 Parental presence within the family home and smoking
 - 4.2.7 Parental employment and smoking behaviours
- 4.3 Knowledge and experiences of drinking
 - 4.3.1 Perceived accessibility
 - 4.3.2 Prevalence rates
 - 4.3.3 Drinking behaviours
 - 4.3.4 Age and drinking
 - 4.3.5 Sex and drinking
 - 4.3.6 Home location and drinking
 - 4.3.7 Parental presence within the family home and drinking
 - 4.3.8 Parental employment and alcohol consumption
- 4.4 Knowledge and experiences of illegal drugs
 - 4.4.1 Perceived accessibility
 - 4.4.2 Prevalence rates
 - 4.4.3 Drug taking behaviours
 - 4.4.4 Age and illegal drug taking
 - 4.4.5 Sex and illegal drug taking
 - 4.4.6 Home location and illegal drug taking
 - 4.4.7 Parental presence within the family home and illegal drug taking
 - 4.4.8 Parental employment and illegal drug taking

Note: Chapter 4 is not an exact replication of Chapter 3. Due to time constraints and other factors, some statistical procedures were not repeated. Statistics omitted from this chapter include, *inter alia*: analyses between scales, analyses of the information provided on drugs by schools, and some statistics that involved qualitative data.¹

The results portrayed in this chapter exclude those subjects who stated that a fictitious drug (“relexin”) was easily accessible to them and subjects who were judged as “over-reporting” their drug taking behaviours. The sample comprised 470 subjects (see Chapter 2).

4.1 SCHOOLS AND DRUGS

The fact that at least one student from each of the participating schools professed to have taken an illegal drug at some stage in his/her lifetime did not change with the modified sample. A certain number of individuals who had totally refrained from drinking alcohol existed in 21 of the 23 schools. Smokers were outnumbered by non-smokers in two schools and one school possessed an equal number of smokers and non-smokers.

There were six classes (four transition year and two sixth year groups) with no self-reported cannabis users. The percentage of schools who had an ecstasy user(s) was reduced from 65% to 39% (i.e. $n = 9$) of schools. However, the number of schools with pupils abusing inhalants did not change, that is only one school had no pupils claiming to have abused inhalants. Only one secondary school had no self-disclosed users of inhalants. Cocaine was reportedly used in four schools by single subjects (i.e. $n = 1$). Use of tranquillisers was cited by youngsters from four schools. There was one case of two individuals from the same school claiming to have taken these drugs and three schools where students were alone in their “yes” responses to this questionnaire item. The percentage of hallucinogen users in Tipperary post-primary schools decreased to 65.2% (from 73.9% in the main sample), while the fact that there

¹ To gain a full understanding of the survey findings, Chapter 3 should have been read prior to this chapter.

were more schools with hallucinogen abusers than those without was sustained with the smaller population. One secondary school had 6 pupils reporting use of hallucinogenic drugs.

There was a dramatic reduction in the number of subjects stating consumption of barbiturates. Two subjects from independent schools maintained that they had taken these drugs (compared with nine in the previous sample). In respect of opiates, there were four schools with self-reported users. As in the case of barbiturates, two of these users were in isolation from classmates (i.e. $n = 1$ in two schools). All of the five subjects in this modified sample who stated that they had taken amphetamines were from separate schools (i.e. $n = 5$ schools). Finally, four pupils from three schools disclosed that they had taken PCP.

Breakdown of the data by school type (i.e. secondary, community or vocational) exposed significant associations with some of the alcoholic drinks consumed but not with drug-taking or smoking behaviours. Vocational school students were less likely than expected to state that they did not drink cider (Chi-square = 13.45; $df = 2$; $P < .01$). Significant associations were determined with wine (Chi-square = 9.36; $df = 2$; $P < .01$) and spirits (Chi-square = 10.63; $df = 2$; $P < .01$) although the precise nature of the relationship cannot be determined.

The same classification systems employed in Chapter 3 to measure the relationships between respondents' demographic background and drug-taking behaviours were used for the selected group. These systems included:

- (i) Sex
- (ii) Age
- (iii) Rural versus urban home location
- (iv) Presence of one or both parents within the family home, and
- (v) Parental employment status

4.2 KNOWLEDGE AND EXPERIENCES OF SMOKING

4.2.1 Perceived accessibility

The high percentages of respondents reporting cigarettes as easy to acquire were upheld for the total adjusted sample population and subjects within this sample who were below the legal age for purchasing cigarettes (96.2% and 93.4% respectively for subjects indicating either “easy” or “very easy”). For the 15 year age category, the percentage depreciated marginally when the smokers were eliminated from the calculations (85.2%). Statistical analysis on the smoking population (all age groups) yielded 99.4% reporting cigarettes as either “easy” or “very easy” to get compared with 91% of the non-smoking sample.

4.2.2 Prevalence rates

The lifetime and yearly prevalence rates of smoking amongst the revised group did not differ significantly from the main sample (66.4% and 76.6% respectively). Approximately forty percent had not smoked at all in the last month and a further 15.1% stated that they had smoked only a few, less than one each week.

4.2.3 Age and smoking

In respect of age and smoking behaviours, the findings were similar to those for the main survey sample. The mean age was 12.45 years (SD = 2.14; range = 6-17). Of the illegal smokers (under 16 year olds), 60.6% reported having smoked a whole cigarette. No significant association was noted between smoking and age at the time of survey administration (Chi-square = 4.55; df = 3; $P > .05$). In other words, there were no significant differences between age groups as regards having smoked a whole cigarette.

Table 4.2.1 Amount of cigarettes smoked in the past 12 months and age of respondent

	None/only a few	1-5 each week	1-10 each day	11+ each day	Total
15 years	46	15	18	5	84
16 years	68	8	31	5	112
17 years	43	7	30	7	87
18+ years	16	1	10	3	30
Total	173	31	89	20	313

(157 Missing observations)

The highest percentage of individuals who had ever tried a whole cigarette was amongst the 18+ group as opposed to the 16 year olds in the larger sample population (Table 4.2.2). Heavy smokers (11+ each day) were least likely to be found in the 16 year age category.

Table 4.2.2 Age and life-time prevalence rate

	Yes	row % for "Yes"	No	Row total
15 years	83	60.6	54	137
16 years	112	66.2	57	169
17 years	87	73	32	119
18+ years	30	68.1	14	44

4.2.4 Sex and smoking

The sex of the respondent was not found to significantly impact on lifetime prevalence rate (Chi-square = .01; df = 1; $P > .05$), yearly prevalence rate (Chi-square = 1.3; df = 2; $P > .05$) and current smoking behaviours (Chi-square = .30; df = 3; $P > .05$). Although significant statistics were observed between sex and age of first cigarette (Chi-square = 24.76; df = 12; $P < .05$) a true relationship cannot be determined due to insufficient numbers in some of the cells. Thus, the gender of the respondent would not appear to affect smoking behaviours.

4.2.5 Home location and smoking behaviours

The position of respondents' family home (either rural or urban) did not significantly impact on smoking behaviours. The following statistics were procured:

- (i) Life-time prevalence rate: Chi-square = .25; df = 1; $P > .05$
- (ii) Age of first cigarette: Chi-square = 7.21; df = 12; $P > .05$ ²
- (iii) Yearly prevalence rate; Chi-square = 4.58; df = 2; $P > .05$
- (iv) Current smoking behaviours (in the last month): Chi-square = 3.49; df = 10; $P > .05$ and Chi-square = 1.32; df = 3; $P > .05$

4.2.6 Parental presence within the family home and smoking

Chi-square analysis suggested that children from single-parent families were less likely than expected to report that they had not smoked a cigarette in the past year (Chi-square = 9.01; df = 2; $P < .01$). A significant, but unspecified, association was noted between current smoking behaviours and presence of one or both parents in the family home (Chi-square = 10.87; df = 3; $P < .01$). Further statistical procedures employed using this variable produced insignificant relationships.

Table 4.2.3 Parental presence and smoking lifetime prevalence rate

	Dual-parent family	Single-parent family	Row Total
Yes	277	145	422
No	35	12	47
Column Total	312	157	469

(1 Missing Observation)

4.2.7 Parental employment and smoking behaviours

The statistics calculated on the reduced sample mirrored those of the main sample for this dimension. Respondents of unemployed fathers were significantly more likely than expected to say that they smoked, on average, between one and ten cigarettes each day in the past month (Chi-square = 9.12; df = 3; $P < .05$). The

² Some cells contained insufficient numbers i.e. <5

employment status of one or both parents did not significantly affect the other variables measuring smoking behaviours³.

4.3 KNOWLEDGE AND EXPERIENCES OF ALCOHOL

4.3.1 Perceived accessibility

The percentage of non-drinking respondents elevated slightly from 16.5% to 18.7% (20.2% and 22.7% respectively, when missing observations were taken into consideration). Table 4.3.1 displays subjects' responses in respect of alcohol accessibility.

Table 4.3.1 Ease of access to alcohol

	Easy	Easy - % for under-age drinkers	Unsure/never heard of it	Difficult
Beer	80.6	78.8	9.4	10.0
Cider	80.9	78.6	9.9	9.2
Wine	58.8	56.7	28.7	12.6
Wine Coolers	39-0	35-8	48.5	12.6
Spirits	63.5	61.2	19.6	16.8

For the legally under-age drinkers (i.e. 17 years and below), the percentages did not change dramatically as shown in the above table. Significant chi-squares were detected between age and the various alcoholic beverages listed although insufficient numbers within some cells rendered these analyses indeterminate.

4.3.2 Prevalence rates

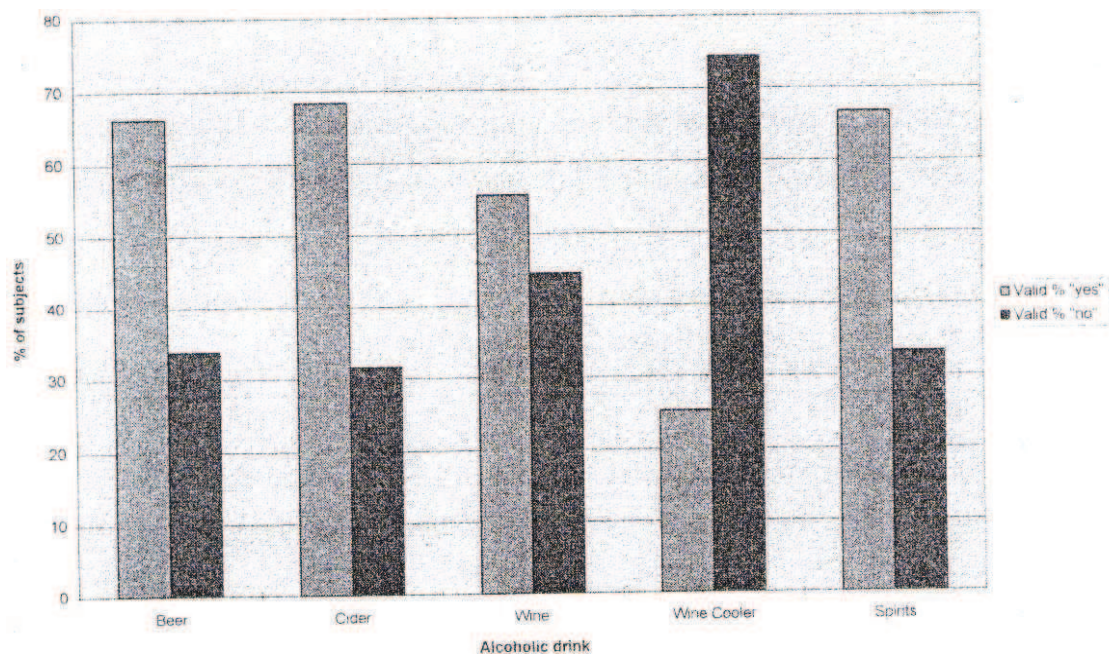
At least 300 (63.8%) respondents⁴ had consumed a whole alcoholic drink in their lifetime.

The percentages for each drink listed are presented in Figure 4.3.1.

³ Two sets of calculations were performed on this variable to take account of children with retired parents. This is the case for alcohol and illegal drug taking as well.

⁴ Not inclusive of missing values on this question

Figure 4.3.1 Percentage distribution of alcohol intake



The age of the drinker was significantly associated with the amount consumed in the past 12 months (Chi-square = 67.08; df = 12; $P < .05$). Fifteen year olds were more likely than expected to allege that they had not taken any alcohol and less likely than expected to recount that they had drunk 2-3 times a month/weekends within this defined time period. In addition, seventeen year olds were less likely than statistically anticipated to report that they had not drunk at all in the past 12 months. Lastly, those subjects aged 18 or above were more likely than expected to say that they drank 2-3 times a month/weekends.

Table 4.3.2 Age and amount consumed in the past 12 months

Count Row pct Col pct Tot pct	Not at all	1-5 times	6-10 times and about once a month	2-3 times a month/week ends	Several times a week/ everyday	Total
15 years	36	12	28	11	4	91
	39.6	13.2	30.8	12.1	4.4	24.1
	39.1	30.0	27.2	9.3	16.7	
	9.5	3.2	7.4	2.9	1.1	
16 years	39	22	40	33	6	140
	27.9	15.7	28.6	23.6	4.3	37.1
	42.4	55.0	38.8	28.0	25.0	
	10.3	5.8	10.6	8.8	1.6	
17 years	11	3	28	52	11	105
	10.5	2.9	26.7	49.5	10.5	27.9
	12.0	7.5	27.2	44.1	45.8	
	2.9	.8	7.4	13.8	2.9	
18 + years	6	3	7	22	3	41
	14.6	7.3	17.1	53.7	7.3	10.9
	6.5	7.5	6.8	18.6	12.5	
	1.6	.8	1.9	5.8	.8	
Column total	92	40	103	118	24	377
	24.4	10.6	27.3	31.3	6.4	100.0

The yearly prevalence rate for drinking was not affected by the sex of the subject (Chi-square - 6.18; df = 4; P>.05).

4.3.3 Drinking behaviours

While the significant relationship between the quantity of alcohol consumed on a usual basis and sex remained with the reduced sample (Chi-square = 17.89; df = 3; P<.01), the precise contributors to this relationship observed in the previous analysis were not retained. The associations with age altered slightly so that 17 year olds were less likely than expected to assert that they consumed 2 or 3 drinks and more likely to state 4 or 5 drinks. Furthermore, the youngest members of the sample who had consumed at least one whole drink (15 year olds) were more likely than expected to maintain that they had taken “less than one” drink in the past 12 months.

4.3.4 Age and drinking

The precise nature of the significant relationship between current age and age of first drink cannot be explained due to lack of numbers within cells (Chi-square =

193.1; $df = 3$; $P < .01$). However, significant relationships between the age of the respondent and the types of alcohol were delineated as follows:

(i) *15 year olds*

Individuals in this age group were more inclined to cite “no” and less likely to state “yes” with regards to drinking beer (Chi-square = 33.32; $df = 3$; $P < .01$) and cider (Chi-square = 34.48; $df = 3$; $P < .01$). In addition, this group were significantly less likely than expected to say “yes” to having drunk wine coolers (Chi-square = 14.73; $df = 3$; $P < .01$).

(ii) *16 year olds*

The sixteen-year-old age category did not significantly contribute to any of the significant Chi-square statistics obtained.

(iii) *17 year olds*

Within this age group, the expected value was greater than the observed value for a “no” response to drinking beer (Chi-squares as above).

(iv) *18 year olds*

The “legal” drinkers were more disposed to consuming wine coolers and less likely to respond with a “no” to cider than statistically expected (Chi-squares as above).

The fact that the youngest age group were significantly more likely to be non-drinkers impacted on the findings between age and the location of acquiring alcohol. However, a number of other factors contributed to the significant relationships. The same age group (i.e. 15 year olds) were less likely than expected to indicate “no” to acquiring alcohol in supermarkets, from friends and from home and “yes” to acquisition at discos and pubs. Sixteen year olds were liable to say that they did not get their alcohol from pubs. Both 17 and 18 year olds were more likely to express a preference for acquiring alcohol in pubs and discos and less given to say that they obtained alcohol from their friends. Moreover, there were fewer 17 year olds than statistically anticipated in the non-drinking category. The Chi-squares for the various locations are presented as follows:

Table 4.3.3 Chi-squares for place of purchasing alcohol and age

Place of purchase	Chi-square
SUPERMARKET	33.11**
Pub	68.08**
Disco	70.25**
Home	34.54**
From Friends	49.17**
Off-licence	33.25**

(df = 6; **P<.01)

4.3.5 Sex and drinking

As with the results noted in Chapter 3, it may be deduced that a significant relationship exists between the sex of the respondent and consumption of beer so that males were more likely than females to have taken a full glass of this drink (Chi-square = 18.86; df = 1; P<.01). Although an additional relationship with cider (Chi-square = 8.75; df = 1; P<.01) was observed, the precise contributors) to this relationship cannot be specified.

The fact that females were more likely than their male counterparts to procure alcohol at discos was sustained for this sample (Chi-square = 32.27; df = 2; P<.01). Moreover, females were less inclined than males to maintain that they purchased alcohol at an off-licence (Chi-square = 26.85; df = 2; P<.01). Significant relationships were ascertained with gender and securing alcohol from home (Chi-square = 8.09; df = 2; P<.05) and from friends (Chi-square = 4.46; df = 2; P<.05).

4.3.6 Home location and drinking

No significant relationships were discerned between the home location of teenagers and the types of alcoholic drinks consumed. Initial experimentation with alcohol was associated with home location but this cannot be considered of note because some cells contained fewer than the required five subjects. Nevertheless, respondents residing in urban environments were more likely to state discos and off-

licences as sources of their alcohol (Chi-square = 15.65; df = 2; P<.05) and (Chi-square = 11.97; df = 2; P<.01).

4.3.7 Parental presence within the family home and drinking

Analysis on dual- and single-parent families failed to impact significantly on the types of drinks consumed, age of first alcoholic drink, the amount taken recently and in the past year. However, those deprived of two parents within the family home were significantly less likely than expected to be in the “no-response required” category (i.e. never having consumed a whole alcoholic drink) on all of the locations for obtaining alcohol.

Table 4.3.4 Chi-squares for parental presence and locations for getting alcohol

Location	CHI-SQUARE
Supermarket	6.25*
Pub	6.44*
Disco	6.26*
Home	11.18**
Friends	6.15-'
Off-licence	6.93*

(df = 2; * P<.05 **P<.01)

4.3.8 Parental employment and alcohol consumption

When the employment status of respondents' parents was measured against drinking behaviours only two associations emerged between father's current employment and ascertaining alcohol from pubs (Chi-square = 12.57; df = 4; P<.05) and off-licences (Chi-square = 7.15; df = 2; P<.05). These relationships required the removal of subjects with retired parents from the analysis. Children whose father was unemployed at the time of the survey were more likely than expected to say that they did not get alcohol from pubs. Maternal employment did not significantly influence their off-springs' drinking behaviours.

4.4 KNOWLEDGE AND EXPERIENCE OF ILLEGAL DRUGS

4.4.1 Perceived accessibility

The percentages of survey respondents maintaining that the various listed substances are either “easy” or “very easy” to acquire were reduced for the modified sample for all drugs. However, the proportionately high percentages for ecstasy, cannabis and amphetamines were retained. The drugs assigned a low percentage in terms of ease of acquisition would not be expected to be pervasive in County Tipperary. Indeed the percentages allocated to drugs such as barbiturates and PCP are comparatively high to the rest of the country.

Table 4.4.1 Ease of acquiring drugs (valid percentages of selected sample population)

	Easy	Unsure/never heard of it	Difficult
Cannabis	22.1	44.0	33.8
Inhalants	79.2	14.0	6.7
Cocaine	9.8	43.6	46.6
Tranquillisers	6.3	54.6	39.2
Hallucinogens	41.9	38.8	19.3
Barbiturates	7.3	71.4	21.2
Relexin	0	80.4	19.5
Heroin or other narcotics	6.8	44.9	48.4
Amphetamines	16.5	52.6	30.9
PCP	9.9	53.5	36.7
Ecstasy	42.3	32.7	24.9

4.4.2 Prevalence rates

The number of self-reported drug-takers was one hundred and three (22.4%)⁴. A large number of those respondents (n = 72, 36.5%) who were omitted from the second set of calculations claimed to have taken at least one illicit drug. Multiple drug usage was not pervasive in the selected sample as shown in Figure 4.4.1.,

⁴ There were 10 missing observations and therefore the maximum number of drug users could be 110.

although the proportionately high number of respondents taking two drugs noted in the original sample remained.

Figure 4.4.1 Numbers of different drug types taken and numbers of subjects within the sample population

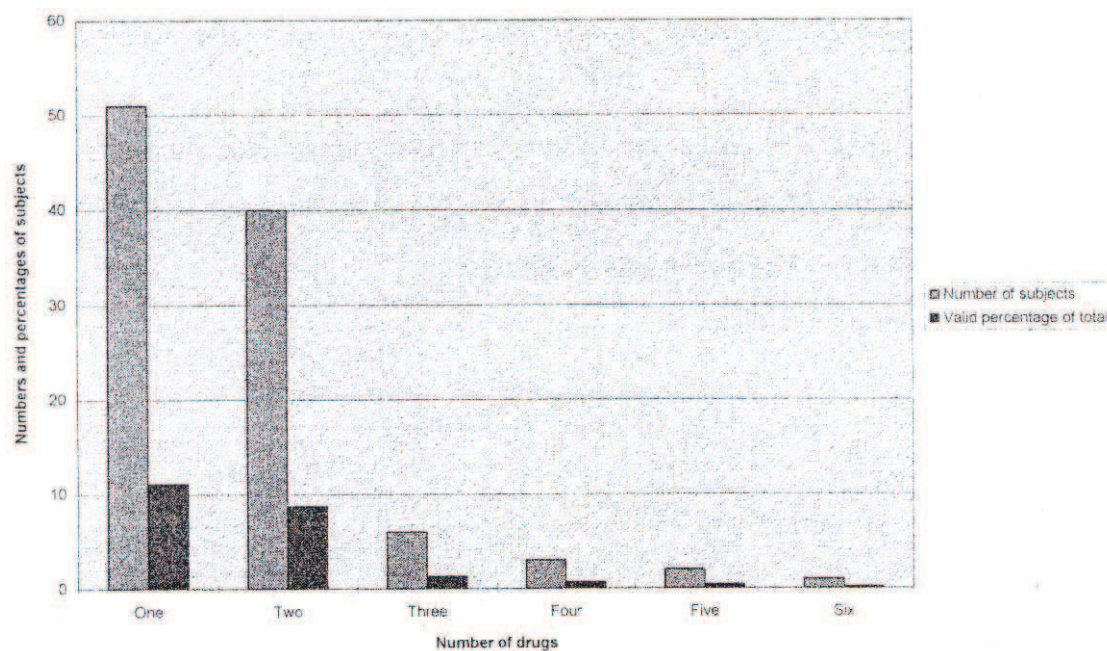


Table 4.4.2 Frequency distribution and percentage of respondents maintaining use of illicit drugs

	F(x)	% of selected sample population
Cannabis	56	11.9
Inhalants	58	12.3
Cocaine	4	0.9
Tranquillisers	5	1.1
Hallucinogens	34	7.2
Barbiturates	2	0.4
Heroin or other narcotics	6	1.3
Amphetamines	5	1.1
PCP	4	0.9
Ecstasy	16	3.4

The number of individuals reporting use of an illegal drug in most cases was almost half of that noted for the original sample. The average age for commencement of substance abuse varied between 14 and 15 years and the youngest age reported was 10 years (for inhalants).

4.4.3 Drug taking behaviours

Regular drug users (about once a month or more) constituted approximately 5% of this population. Indeed, many had refrained from taking drugs or had experimented once or twice in the past 12 months.

Table 4.4.3 Frequencies of respondents (and percentages of total selected sample) who had taken any of the drugs listed and drug-taking behaviours in the past 12 months⁵

Count Row Valid Pct of total selected sample % of drug takers for the category	1	2	3	4	5	6	7	8
Cannabis	49	27	14	4	7			
	10.7	5.9	3.1	.9	1.5			
	7.1	51.9	25	7.1	28			
Inhalants	59	28	6	2	1	1		
	13.0	6.2	1.3	.4	.2	.2		
	34.5	48.3	10.3	3.4	1.7	1.7		
Cocaine	87	5			1			
	19.3	1.1			.2			
	0	83.3			16.7 ^b			
Tranquillisers	88	5						
	19.6	1.1						
	0	100						
Hallucinogens	71	18	5	2		2		
	15.6	4.0	1.1	.4		.4		
	20.6	66.7	14.7	5.9		5.9		
Barbiturates	91	2						
	20.2	.4						
	0	100						
Heroin or other narcotics	88	4	2					
	19.5	.9	.4					
	0	66.7	33.3					
Amphetamines	87	3	1					
	19.4	.7	.2					
	20	60	20					
PCP	88	1		1		1		
	19.6	.2		.2		.2		
	25	25		25		25		
Ecstasy	86	8	2	2	1			
	18.9	1.8	.4	.4	.2			
	18.8	50	12.5	12.5	6.3			

Code:

- 1 Not at all
- 2 1-2 times in the past 12 months
- 3 3-5 times in the past 12 months
- 4 about once a month
- 5 2-3 times a month
- 6 1-2 times a week
- 7 several times a week
- 8 every day

⁵ 427 subjects who said that they had never taken an illegal drug were not required to answer this section of the questionnaire. The number of missing observations was different for each drug. Those responding “not at all” will include those respondents who have never taken that particular substance but will have taken something else at some stage in their lifetime (not necessarily within the last 12 months).

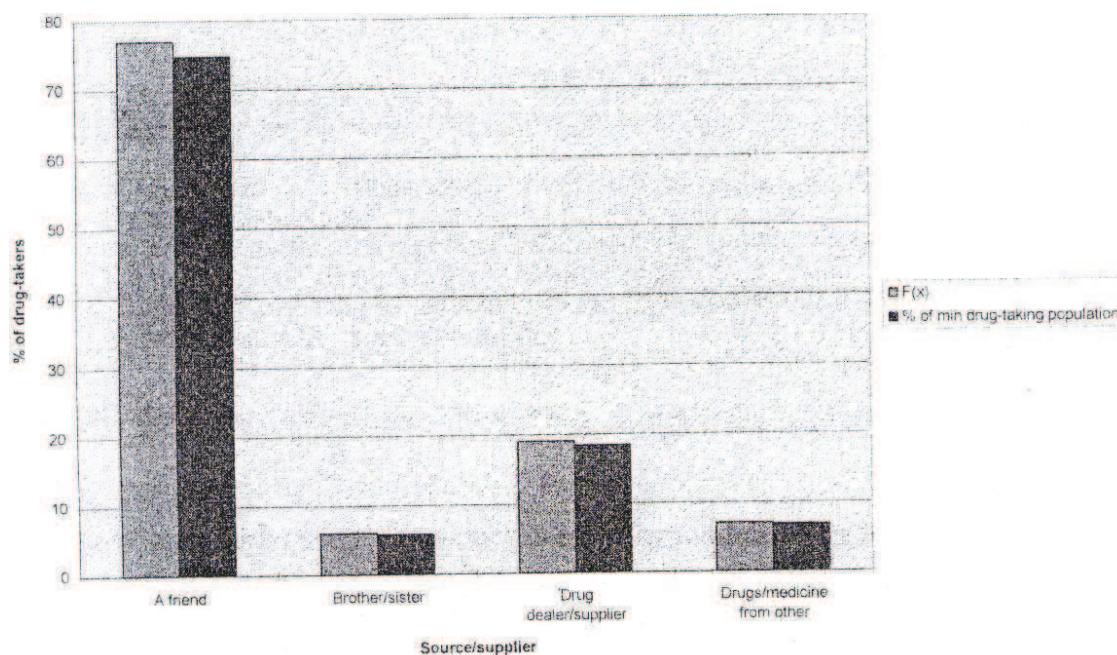
⁶ N.B. the number of subjects claiming to take cocaine exceeds that stated in a prior question (Q.34) see Table 4.4.2

Three-quarters of subjects reported that they secured their drugs from a friend. Therefore, it is surprising that in both samples peer pressure was not among the primary motivators in drug taking. The overriding incentive for taking illicit drugs was curiosity.

Table 4.4.4 Rationale for drug taking

	f(x) answering “yes”	% of drug-taking population
Boredom	30	29.1
Recreation	16	15.5
Everyone does it	12	11.7
Curiosity	70	68
Loneliness	8	7.8
Insight	12	11.7
Relaxation	31	30.1
Rebellion	19	18.4
Medical	1	1
My friends do it	16	15.5
Calm nerves	20	19.4
To feel better	31	30.1
Fun	60	58.3
Energy	26	25.2

Figure 4.4.2 Sources of illegal drugs



The percentages of respondents “sometimes” or “always” paying for their supply increased dramatically from the original sample from 10.5% and 7.8% of drug users to 39.8% and 15.5% respectively. Drug taking was funded through pocket money (n = 16), earnings (n = 23) and savings (n = 2) or a combination of the above (n = 13).

4.4.4 Age and illegal drug taking

The use of hallucinogens was linked to the age of the respondent (Chi-square = 8.9; df = 3; $P < .05$) although the precise relationship can not be identified. No further relationships were ascertained between drug-taking behaviours and the age dimension.

4.4.5 Sex and illegal drug taking

With regards to the sex of the respondent and illegal drug taking, significant but undefinable relationships were realised with acquisition of drugs from a friend (Chi-square = 6.37; df = 2; $P < .05$) or drugs/medicine from others (Chi-square = 8.12;

df = 2; $P < .05$), use of ecstasy (Chi-square = 4.55; df = 1; $P < .05$) and providing “fun” as a reason for drug taking (Chi-square = 7.62; df = 2; $P < .05$).

4.4.6 Home location and illegal drug taking

The results suggested that individuals who live in towns tended to record cannabis usage more than statistically expected (Chi-square = 7.3; df = 1; $P < .01$). Use of other people’s drugs/medicine was associated with home location (Chi-square = 6.69; df = 1; $P < .05$) but the direction of the relationship can not be delineated.

4.4.7 Parental presence within the family home and illegal drug taking

While some significant findings were ascertained between drug usage and the marital status of respondents’ parents, in most cases there were insufficient numbers within the cells of the Chi-square table. As a consequence, these relationships cannot be relayed with any statistical authority. However, individuals from single-parent families were more likely to maintain that they were not motivated to take drugs to “calm their nerves” (Chi-square = 6.87; df = 2; $P < .05$) but more disposed to state “loneliness” as a reason (Chi-square = 15.29; df = 2; $P < .01$). Further associations were identified between this factor and taking barbiturates (Chi-square = 4.38; df = 1; $P < .05$) and the motive for taking drugs “My friends do it” (Chi-square = 5.86; df = 2; $P < .05$) but the exact relationships can not be explained.

4.4.8 Parental employment and illegal drugs

No significant associations were observed between parental employment status and the consumption of illegal drugs. Moreover, for the majority of statistics computed on this variable the numbers within some cells were inadequate.

5. Conclusion and recommendations

- 5.1 Introduction
- 5.2 Schools and drug misuse
- 5.3 Smoking behaviours
- 5.4 Drinking behaviours
- 5.5 Knowledge and experiences of illegal drugs
- 5.6 Conclusions and recommendations

5.1 INTRODUCTION

This chapter combines the information from both survey samples (Chapters 3 and 4) to estimate the prevalence of substance misuse in County Tipperary. A discussion of the results and recommendations is submitted on the basis of the survey findings.

5.2 SCHOOLS AND DRUGS MISUSE

The number of pupils consuming at least one whole cigarette and/or alcoholic drink outweighed the number of abstainers in the vast majority of schools in Tipperary. School type (i.e. secondary, community, and vocational) did not affect illegal drug usage. At least one pupil from each school claimed to have taken an illegal drug in his/her lifetime. The fact that respondents answered in isolation from their classmates on some drugs (i.e. one user for each school), and the 'exam-like*' conditions under which the questionnaires were completed, suggests that these subjects were not necessarily trying to impress their classmates. This would support the contention that it is friends rather than peers that exert the most influence in drug taking.

Post-primary schools in County Tipperary are failing to provide adequate drugs-related education. Research indicates that a programme which combines skills-based learning with information would be of greatest benefit. This programme should be continuous over a period of several years rather than targeted at one particular age group (Hawkins, Catalano and associates, 1992), and address alcohol and cigarette usage as well as illegal substances. To yield the maximum positive effect, gardai and teachers should work together to instruct students on drugs.

5.3 SMOKING BEHAVIOURS

Of the sample surveyed 66.4% have smoked a whole cigarette¹. Cigarettes are considered widely accessible to all age groups regardless of legality. A large percentage of respondents under the legal age (16 years) have smoked. The average age for first cigarette was 12 years, lower than for Cork city in 1990 (14 years). As might be anticipated, experimentation with cigarettes increased with age.

The majority of subjects did not consider cigarettes to be harmful if taken in moderation. Perceived danger of smoking increased with the amount consumed. Thus, occasional smoking was not thought to be harmful.

The respondent's sex or home location (urban versus rural) did not appear to impact on smoking behaviours, although family circumstances may have a small effect. Fewer teenagers (than expected) from single-parent families reported smoking between 1 and 10 cigarettes per day in the past month.

While it is feasible that those under the age of 16 years are acquiring cigarettes from other people (e.g. friends, relatives) and not inevitably purchasing them at a shop, a more stringent enforcement of the law in respect of selling cigarettes might be useful. However, an over-dependence on legal remedies would be ill-advised. Education with respect to the dangers of smoking would be most advantageous.

5.4 DRINKING BEHAVIOURS

The percentage of non-drinking survey participants was particularly small (approximately 19%) given that most subjects were below the legal age for consuming alcohol. However, the majority of subjects perceived the negative consequences of taking too much alcohol.

¹ 68.7% in the larger sample.

Very few young people thought that they would have difficulty obtaining alcohol, especially beer and/or cider. Since many adolescents procure alcohol from locations that are beyond the realm of the law, it would be inappropriate to over-rely on legal solutions to this problem. Research shows that while more stringent enforcement of the law is required, greater educational intervention is needed. Moreover, education should not be confined to minors but extended to parents and shop/public house owners.

The average age for consumption of first alcoholic drink is 14 years and this is similar to figures for Cork (O’Fathaigh, 1990) and Dublin (Grube and Morgan, 1994). Figures for Galway suggested that the onset of drinking alcohol occurs at the age of twelve (Alcohol Concern). Age impacted on drinking behaviours so that seventeen year olds were less likely than expected to state that they had not drunk in the last 12 months and more inclined to be heavier drinkers (4 or 5 drinks on average) and to report drinking beer. As noted in Chapter 1, Grube and Morgan (1994) found a mere 7% of Dublin-based 17 year olds to be abstainers. Perhaps not surprisingly, the youngest members of the sample (fifteen year olds) were more likely to be non-drinkers and less inclined to drink beer and get alcohol from pubs and discos. In contrast, 17 and 18 year olds were more disposed to securing alcohol from pubs and discos. As it is usually difficult to differentiate between a 17 and an 18 year old this is not particularly significant. This project highlights the period between ages 15 and 17 as critical years for intervention because prior to age 17 subjects are not drinking more than would be expected.

Males tended to drink beer more than their female counterparts. There were greater percentages of males reporting alcohol consumption than females (with the exception of wine coolers for the modified sample) reinforcing the stereotype observed in other studies. Discos provided the principal source of alcohol for females and off-licences for males. Both of these places (discos and off-licences) were more commonly used by urban dwellers than rural folk.

The individual's family background impacted on drinking behaviours. Fewer children from single-parent families were found to report non-consumption of alcohol than expected. Those whose father was unemployed at the time of the survey displayed a tendency to say that they did not get alcohol from pubs. Maternal employment did not significantly influence off-springs' drinking behaviours.

5.5 KNOWLEDGE AND EXPERIENCES OF ILLEGAL DRUGS

Most students in County Tipperary do not view the consumption of illegal drugs in a favourable light. Illegal drugs perceived as most dangerous were those used the least, such as heroin. Only 3.5% of respondents considered experimentation with ecstasy as "not dangerous". In comparison, cannabis was considered as "not dangerous" by 16.5% of subjects.

Those drugs assigned a low percentage in terms of ease of access would be (intuitively speaking) difficult to get; it is not possible to be definitive about the availability of illegal substances although Garda authorities and health care professionals can provide a good estimate (for example, number of seizures). Significant percentages of young people in County Tipperary maintain that they would have few problems acquiring ecstasy, inhalants, cannabis and hallucinogens (compared to other drugs). Approximately 22% of respondents claimed to have sampled illicit drugs at some stage in their lifetime. Nevertheless, multiple and frequent drug use is not prevalent. It is interesting to note a significant drop by two-thirds in the percentage of regular users from the main sample to the selected group². The average age for taking first illicit drug was 14/15 years regardless of the type of drug (i.e. amphetamine, cannabis, etc.). Thus, educational intervention must be initiated prior to this and continue throughout the school years.

Less than half of the entire sample population, but nevertheless a significant proportion, had been offered illegal drugs. The locations where young people are

² Analysis on the modified sample excluded those who were deemed to be "over-reporting" and thus would be considered more reliable.

most likely to be offered drugs include discos, pubs, night-clubs, raves, concerts (including Féile) and public places (e.g. on the street, parks and in town centres). A large amount of subjects stated that they were confronted with drugs while abroad or in a location outside of Tipperary, While it is extremely fortunate that the majority of subjects stated that they would definitely refuse to take an illegal drug, the fact that large numbers are being offered them highlights the urgency of initiating educational programmes that provide the skills to reinforce refusal. In accordance with previous research, drugs tended to be supplied by friends. Only a small percentage of users claim to pay for their drugs and this is probably linked to the low percentage of regular users. Despite the fact that most gain their drugs from friends, peer pressure was not one of the principal reasons for taking drugs. The rationale provided by these students would concur with those outlined in Chapter 1, whereby ‘curiosity’ was the most frequently cited reason followed by ‘fun’, ‘to feel better’, ‘boredom’, ‘relaxation’ and ‘energy’ (the proportions were the same for both samples).

The survey revealed insufficient knowledge of the effects and costs of illicit drugs on the part of the respondents. In terms of the effects, subjects did not present an answer that encompassed the short and long-term effects, the experience itself, and the social consequences of taking the drug. Responses tended to be either positive or negative. Often, one-word comments were provided and/or the same response was listed for all drugs. For most drugs, between one half and three-quarters of the sample admitted that they did not know the effects of the drug. Moreover, some self-reported users indicated that they did not know the drug effects. The vast majority of young people did not know the cost of drugs. Prices of cannabis and ecstasy were best known, probably due to media coverage.

In the assessment of risk factors for adolescents in County Tipperary, age was not discerned to be an important predictor in drug use which is contrary to research conducted elsewhere. Significant relationships between the sex of the respondent and “access from a friend”, “drugs/medicine from others”, use of ecstasy and “fun” as a reason for drug taking were noted but indeterminate.

Cannabis use was reported in towns more than statistically expected. An unspecifiable association between home location and drugs/medicine from others was ascertained. Those individuals who lived in a single-parent family were more inclined to state “loneliness” as a reason for taking drugs in comparison to other reasons (8.5%). The other reason that produced a relationship was “my friends do it”. Parental employment was not a significant factor in substance misuse.

5.6 CONCLUSIONS AND RECOMMENDATIONS

There are a number of drawbacks to survey research, discussed in Chapter 2. The fact that the number of respondents reporting drug use in the modified sample was half that of the original sample attests to this. Furthermore, the data revealed inconsistencies between stating drug usage and the amount of use: a small number of respondents reported using a drug in one instance (viz when asked how often they had taken it in the past year), but had not claimed to have used it in the earlier life-time prevalence question. This reflects the difficulties of acquiring truthful/consistent answers from pupils in population surveys. By employing two samples, this problem has been addressed as far as is practicable. It is not possible to state definitively the drug situation in any locale. Records of attendees at treatment centres and Garda statistics are the alternative sources of information. However, not all drug users, even habitual/hardened users, visit rehabilitation clinics and/or come to the attention of Gardai. Moreover, there are no treatment centres in County Tipperary and no statistics available from the Department of Health. Thus, this survey comprises the most comprehensive and reliable data on adolescent substance misuse in the county at this time.

Efforts to prevent drug abuse should begin with early childhood education and family support, parent training, school-based social competence promotion, and school organisational strategies. A sequential programme for the prevention of substance misuse is provided by Hawkins et al., (1992) who suggest the setting-up of a task force composed of senior members of the community to address a drug

problem. A programme such as this would be strongly recommended in Tipperary. It would not have an immediate effect but could be expected to have a considerable impact on the prevention of drugs in the long term. A steering committee could comprise a Garda Chief Superintendent, County managers, representatives of the Departments of Education and Health, and school principals. This committee would design a programme to address the drugs issue to be implemented by teachers, parents and health care workers.

Effective drug and alcohol programmes should be integrated into the school curriculum (not optional), be age-appropriate, address the legal, social and health consequences of drug taking, and, perhaps most importantly, promote social competence. According to Hawkins and associates (1992) social competence promotion programmes concentrate on four key skill areas, namely: (i) self-management; (ii) decision-making and problem-solving; (iii) communication; and (iv) resisting negative and limiting social influences. Techniques should help young people resist pressure from friends and peers to use illicit drugs and alcohol.

A number of strategies for the prevention and management of drug problems have been outlined in the literature. As regards illegal drugs, community action has sometimes taken the form of “neighbourhood drugs watches” similar to crime watches in which local residents and parents work closely with the police to detect and report illegal drug activities (Hawkins and associates, 1992). What is denoted as “responsible beverage service” has been shown to impact significantly on the availability of alcohol to teenagers. This puts the onus of responsibility on those who serve or sell alcohol to minors. In the United States of America (specifically, California) “sting” operations have been put into effect, whereby those individuals found to be selling or serving alcohol to underage teenagers are encouraged to attend special seminars on responsible beverage service. These operations have been proven to reduce sales to minors. Similar operations have been set up for the sales of tobacco products to young people.

The present research findings do not constitute a dramatic surprise. They provide further evidence of the extensive use of alcohol and cigarettes by young people. On the other hand, the illegal drug problem is not a huge one. However, a situation where no drugs exist will never occur. The supply of drugs can not be eliminated as long as demand exists. Stronger law enforcement can not solve the problem. There is widespread recognition that strategies to combat the misuse of drugs must focus on management and prevention. Furthermore, it is recognised that there is no single panacea to the drugs problem and that any efforts to impact on the drugs situation necessitate a multi-agency approach including school principals, the Garda Síochána, local government representatives, parents, and social and health professionals, as propounded by Hawkins and his associates. It is hoped that this report will be of benefit to all of these aforementioned groups.

6. References

- Berman, S.M. and Noble, E.P. (1993). Childhood antecedents of substance misuse. Current Opinion in Psychiatry, 6, 382-387.
- Coombs, R.H., Fawzy, F.I. and Gerber, R.H. (1986). Patterns of cigarette, alcohol, and other drug use among children and adolescents: A longitudinal study. The International Journal of the Addictions, 21 (8), 897-913.
- Commission of the European Communities (eds.) (1991). Young Europeans of 11 to 15 and alcohol conducted in the European Community by the European Omnibus Survey (Facts et Opinions). Luxembourg: Health and Safety Directorate of the Commission of the European Communities.
- Corrigan, D. (1994). Facts about Drug Abuse in Ireland. Dublin: Health Promotion Unit.
- Dembo, R., Alien, N., Farrow, D., Schmeidler, J. and Burgos, W. (1985). A causal analysis of early drug involvement in three inter-city neighbourhood settings. International Journal of Addictions, 20, 1213-1237.
- Hammersley, R., Lavelle, T. & Forsyth, A. (1992). Predicting initiation to and cessation of buprenorphine and tamazepam use amongst adolescents. British Journal of Addiction, 87, 1303-1311.
- Hawkins, J.D., Catalano, R.F., and 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.
- Hawkins, J.D., Catalano, R.F., and Associates (1992). Communities that care: Action for drug abuse prevention. San Francisco: Jossey-Bass Publishers.
- Hodgkinson, S., Mullan, M. and Murray, R.M. (1991). The generic vulnerability to alcoholism. In P. McGuffin and R. Murray (eds.). The new genetics of mental illness, 182-197. Oxford: Butterworth-Heinemann.
- Johnston, L.D., Bachman, J.G., and O'Malley, P.M. (1986). Monitoring the Future: Questionnaire Responses for the Nation's High School Seniors – 1985. Institute for Social Research, Ann Arbor, Michigan.
- Johnston, L.D., P.M. O'Malley, and J.G. Bachman. (1988). Drug Use, Drinking, and Smoking: National Survey Results from High School, College, and Young Adult Populations (1975-1988). U.S. Government Printing Office, Washington, D.C, DHHS Publication No. (ADM) 89-1638.

- Kandel, D.B. (1980). Drug and drinking behaviour among youth. Annual Review of Sociology, 6, pp. 235-285.
- Kandel, D.B., Tamaguchi, K and Chen, K. (1992). Stages of progression in drug involvement from adolescence to adulthood: Further evidence for gateway theory. Journal of Studies on Alcohol, 53, 447-457.
- Morgan, M. and Grube, J.W. (1994). Drinking among post-primary school pupils. Dublin: The Economic and Social Research Institute,
- Needle, R., McCubbin, H., Wilson, M., Reineck, R., Lazar, A., and Mederer, H. (1986). Interpersonal influences in adolescent drug use-The role of older siblings, parents and peers. International Journal of Addiction, 21, 739-766.
- O’Fathaigh, M. (1990). Smoking, drinking and other drug use among Cork city post-primary school pupils, Cork Youth Federation - University College Cork Joint Research Project: Unpublished.
- Ong, T.H. (1989). Peers as perceived by drug abusers in their drug-seeking behaviour. British Journal of Addiction, 84, 631-637.
- Pascale, P.J. & Evans, W.J. (1993). Gender differences and similarities in patterns of drug use and attitudes of high school students. Journal Drug Education, Vol. 23(1), 105-116.
- Plant, M.A. and Plant, M. (1992). Risk-takers. Alcohol, drugs, sex and youth. London/New York: Tavistock/Routledge.
- Reid, L.D. (1989). A path analytic examination of differential social control theory. Journal of Drug Education, 19, 139-156.
- Robbins, L. (1992). Synthesis and Analysis of longitudinal research on substance abuse. A report for the Robert Wood Johnson Foundation, U.S.
- Silbereisen, R.K., Robins, L. and Rutter, M. (1995). Secular trends in Substance use: concepts and data on impact of social change on alcohol and drug use. Psychosocial Disorders in Young People: Time Trends and Their Causes. Edited by Rutter, M. and Smith, D.J. Wiley: Chichester.

- Kandel, D.B. (1980). Drug and drinking behaviour among youth. Annual Review of Sociology, 6, pp. 235-285.
- Kandel, D.B., Tamaguchi, K and Chen, K. (1992). Stages of progression in drug involvement from adolescence to adulthood: Further evidence for gateway theory. Journal of Studies on Alcohol, 53, 447-457.
- Morgan, M. and Grube, J.W. (1994). Drinking among post-primary school pupils. Dublin: The Economic and Social Research Institute,
- Needle, R., McCubbin, H., Wilson, M., Reineck, R., Lazar, A., and Mederer, H. (1986). Interpersonal influences in adolescent drug use-The role of older siblings, parents and peers. International Journal of Addiction, 21, 739-766.
- O’Fathaigh, M. (1990). Smoking, drinking and other drug use among Cork city post-primary school pupils, Cork Youth Federation - University College Cork Joint Research Project: Unpublished.
- Ong, T.H. (1989). Peers as perceived by drug abusers in their drug-seeking behaviour. British Journal of Addiction, 84, 631-637.
- Pascale, P.J. & Evans, W.J. (1993). Gender differences and similarities in patterns of drug use and attitudes of high school students. Journal Drug Education, Vol. 23(1), 105-116.
- Plant, M.A. and Plant, M. (1992). Risk-takers. Alcohol, drugs, sex and youth. London/New York: Tavistock/Routledge.
- Reid, L.D. (1989). A path analytic examination of differential social control theory. Journal of Drug Education, 19, 139-156.
- Robbins, L. (1992). Synthesis and Analysis of longitudinal research on substance abuse. A report for the Robert Wood Johnson Foundation, U.S.
- Silbereisen, R.K., Robins, L. and Rutter, M. (1995). Secular trends in Substance use: concepts and data on impact of social change on alcohol and drug use. Psychosocial Disorders in Young People: Time Trends and Their Causes. Edited by Rutter, M. and Smith, D.J. Wiley: Chichester.

7. Appendix

- 7.1 The Questionnaire: Survey of Post-Primary Students' Views and Experiences of illegal Drugs
- 7.2 Table of participating schools
- 7.3 Socio-economic group codes
- 7.4 List of lessons/classes employed to teach drugs education
- 7.5 List of drinking locations: current and first drink
List of persons with whom respondents normally drink
- 7.6 Tables of young people drinking beer, cider, wine, wine coolers and spirits
- 7.7 List of locations where respondents have been offered drugs
- 7.8 List of possible actions subjects might take if they were offered an illegal drug
- 7.9 Effects of illegal drugs
- 7.10 Qualitative data for the effects of drugs

**7.1 THE QUESTIONNAIRE: SURVEY OF POST-PRIMARY STUDENTS' VIEWS
AND EXPERIENCES OF ILLEGAL DRUGS**

**Survey of Tipperary Post-Primary Students' Views and Experiences
of Illegal Drugs**

(School name and address)

This questionnaire seeks to obtain post-primary students' views and experiences of illegal drugs. The answers will be combined to form a general picture of Tipperary students' views.

Please do not put your name anywhere on this questionnaire. The answers you provide will be anonymous and treated in the strictest confidence. We have no means of matching your name with your questionnaire. Your parents, teachers, or other authorities will not see your answers. The research workers are the only people who will see your questionnaire. We are interested in group averages only and not in any single individual's answers.

Please do not discuss the questionnaire or your answers with anyone else while you are completing the survey; it is your views that are being sought.

For the study to be worthwhile, it is important that you tell us the truth on all of the questions. If you do not want to answer a question, please skip it and go to the next one rather than not telling the truth.

Some questions will ask you about your parents. Please think of the people you live with most of the time when answering these questions. These people may be natural parents, stepparents, grandparents, foster parents, or someone else.

If you want to change an answer once you've marked it, please erase it or draw a slash through it. Then mark your new answer and draw a circle around it like this:

What is your sex? (Please tick one box)

- Male
 Female

When you have completed your questionnaire, seal the booklet in the envelope provided and return it to the researcher.

THANK YOU FOR YOUR COOPERATION

Demographic information

1. What is your sex? (Please tick \surd one box)

Male Female
2. What is your age? (Please tick = one box)

15-16 16-17

17-18 18+
3. What year are you in at school? (Please tick \surd one box)

Repeat Leaving Certificate

Leaving Certificate “ 5th year

Leaving Certificate - 6th year

Senior Certificate

Leaving Certificate Vocational Programme

Transition year
4. How many older brothers do you have?
(If you have none, place a “0”)

How many older sisters do you have?
(If you have none, place a “0”)

How many younger brothers do you have?
(If you have none, place a “0”)

How many younger sisters do you have?
(If you have none, place a “0”)
5. Do you live with both of your parents?
Yes No
6. If you answered “no” to question 5, please give reasons (e.g. parents’ separated, widowed)
7. Where do you live? (Please tick \surd one box)

Rural area Town
8. What is your father’s occupation? _____

9. Is your father currently unemployed?

Yes No

10. What is your mother's occupation? _____

11. Is your mother currently unemployed?

Yes No

Your school and drugs

12. Have you received lessons/classes about illegal drugs at school? (Please tick \surd one box)
- Yes
- No
13. If you answered “no” to Question 12, please go to Question 16, if you answered “yes”, how useful did you find these lessons/classes? (Please tick \surd one box)
- Very useful
- Fairly useful
- Not very useful
- Not at all useful
- Don't know
14. In which subject lesson(s)/class(es) did you receive drugs education? (e.g. biology, science (general), social studies, religious education)
-
-
15. Who taught the lesson(s)/class(es) on drugs?
- Teachers
- Gardai
- Health Authority Representatives
- Other (Please specify) _____
16. Have you received any information (e.g. a leaflet) about illegal drugs from your school authorities?
- Yes
- No
17. If you answered “no” to Question 16 please go to Question 18, if you answered “yes”, what form(s) of information did you receive?
-
-
18. Please indicate whether you think your school provides enough information about illegal drugs. (Please tick \surd one box)
- Enough information is given
- A little more is needed
- A lot more is needed
- Don't know

	Very easy	Easy	Unsure	Difficult	Very Difficult	Never heard of it
Hallucinogens (LSD, acid, magic mushrooms, peyote, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates (sedatives, downers, barbs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relexin (buzz)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines (ice, speed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PCP (angel dust)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

21. Have you ever smoked a whole cigarette (more than just a puff or two)? (Please tick one box)

Yes
N

If you have never smoked a whole cigarette go to Question 25 on page 7.

22. How old were you the first time you ever smoked a whole cigarette? (If you are unsure, make your best guess) _____ years old.

23. Have you smoked at least one cigarette during the last 12 months? (Please tick one box)

Yes
No

24. Overall, about how many cigarettes have you smoked during the past month?

- | | |
|-----------------------------------|--------------------------|
| None | <input type="checkbox"/> |
| Only a few, less than 1 each week | <input type="checkbox"/> |
| 1 -2 each week | <input type="checkbox"/> |
| 3-5 each week | <input type="checkbox"/> |
| 1-2 a day 3-5 a day 6-10 a day | <input type="checkbox"/> |
| 11-15 a day | <input type="checkbox"/> |
| 16-20 a day | <input type="checkbox"/> |
| More than 20 a day | <input type="checkbox"/> |

25. Have you ever had a whole drink (more than a sip or taste) of any of the following alcoholic beverages?

- | | Yes | No |
|--|--------------------------|--------------------------|
| Beer | <input type="checkbox"/> | <input type="checkbox"/> |
| Cider | <input type="checkbox"/> | <input type="checkbox"/> |
| Wine | <input type="checkbox"/> | <input type="checkbox"/> |
| Wine cooler | <input type="checkbox"/> | <input type="checkbox"/> |
| Spirits (vodka, gin, whiskey, etc.
or mixed drinks made with spirits) | <input type="checkbox"/> | <input type="checkbox"/> |

If you have never had a whole drink of beer, cider, wine, wine cooler, or spirits, go to Question 33 on page 9.

26. How old were you the first time you ever had a whole alcoholic drink? _____ years old.

27. On the average, about how often did you have a whole alcoholic drink in the last 12 months? (Please tick = one box)

- | | |
|----------------------------------|--------------------------|
| Not at all | <input type="checkbox"/> |
| 1-2 times in the past 12 months | <input type="checkbox"/> |
| 3-5 times in the past 12 months | <input type="checkbox"/> |
| 6-10 times in the past 12 months | <input type="checkbox"/> |
| About once a month | <input type="checkbox"/> |
| 2-3 times a month | <input type="checkbox"/> |
| Several times a week | <input type="checkbox"/> |
| Every day | <input type="checkbox"/> |

If you have not had a whole alcoholic drink in the past 12 months go to Question 33 on this page.

28. Those times when you drank an alcoholic beverage in the past 12 months, about how much did you usually have at any one time?

- | | |
|---------------|--------------------------|
| Less than one | <input type="checkbox"/> |
| One | <input type="checkbox"/> |
| Two | <input type="checkbox"/> |
| Three | <input type="checkbox"/> |
| Four | <input type="checkbox"/> |
| Five | <input type="checkbox"/> |
| Six or more | <input type="checkbox"/> |

29. Where did you first take your first whole alcoholic drink (e.g. a pub, friend's house)?

30. Where do you drink alcoholic beverages currently (e.g. a pub, disco, friend's house)?

31. Where do you get alcoholic beverages when you drink?

- | | |
|------------------------------|--------------------------|
| Supermarket | <input type="checkbox"/> |
| Pub | <input type="checkbox"/> |
| Disco | <input type="checkbox"/> |
| Home | <input type="checkbox"/> |
| From friends | <input type="checkbox"/> |
| Off-licence | <input type="checkbox"/> |
| Other place (Please specify) | <input type="text"/> |

32. Who would you normally drink alcoholic beverages with (e.g. parents, friends)?

33. Please read each statement and decide on the extent to which you agree or disagree with the statement. (Please tick = one box for each statement)

	Agree a lot	Agree a little	Disagree a lot	Disagree a little	Not sure
It is easy to obtain alcoholic drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A lot of young people drink alcoholic beverages nowadays	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People start drinking alcoholic beverages just to keep up with their friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drinking alcohol can be harmful to my health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drinking alcohol makes you look older	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drinking alcohol makes you feel bad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I will never drink alcohol in my life time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

34. Have you ever used any of the following drugs?

	Yes	No
Cannabis	<input type="checkbox"/>	<input type="checkbox"/>
Inhalants (sniffing, glue, paint, petrol, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine (crack, coke, rock)	<input type="checkbox"/>	<input type="checkbox"/>
Tranquillisers (valium, librium, thorazine, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinogens (LSD, acid, mushrooms, peyote, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates (Sedatives, Downers, Barbs)	<input type="checkbox"/>	<input type="checkbox"/>
Heroin or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines (ice, speed)	<input type="checkbox"/>	<input type="checkbox"/>
PCP (angel dust)	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>

If you have never used any of these drugs, please go to Question 41 on page 11.

35. How old were you the very first time you used each of the following? (Fill in the blank for each with the correct age or tick under "never" if you have never tried it).

	Years old	Never
Cannabis	_____	<input type="checkbox"/>
Inhalants	_____	<input type="checkbox"/>
Tranquillisers	_____	<input type="checkbox"/>
Hallucinogens	_____	<input type="checkbox"/>
Barbiturates	_____	<input type="checkbox"/>
Heroin or other narcotics	_____	<input type="checkbox"/>
Amphetamines	_____	<input type="checkbox"/>
PCP	_____	<input type="checkbox"/>
Ecstasy	_____	<input type="checkbox"/>

36. How often have you used each of the following drugs during the past 12 months? (Please tick \checkmark one answer for each drug)

Marijuana or hashish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<i>1-2 times in the past 12 mths</i>	<i>3-5 times in the past 12 mths</i>	<i>about once a month</i>	<i>2-3 times a month</i>	<i>1-2 times a week</i>	<i>several times a week</i>	<i>every day</i>
Inhalants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tranquillisers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin or narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PCP <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

37. How do you obtain the illegal drugs that you use?

- A friend
- Brother/sister
- Drug dealer/supplier
- Drugs/Medicine from others

38. Do you pay for your drugs supply?

- Never
- Sometimes
- Always

39. If you do not pay for your drugs supply, please go to Question 40 on the next page, if you do pay for your drugs, where do you get the funds?

- Pocket money
- Earnings
- Savings
- Steal

40. The following list comprises some reasons why people take drugs, please indicate if any of these apply to your drug taking. If none apply, please specify your reasons for taking illegal drugs.

Boredom

Recreation

Everyone does it

Curiosity

Loneliness

Insight

Relaxation

Rebellion

Medical

My friends do it

Calm nerves

To feel better

Fun

Energy

Other (please specify) _____

41. Please read each statement and decide on the extent to which you agree or disagree with the statement. (Please tick = one box for each statement)

	<i>Agree a lot</i>	<i>Agree a little</i>	<i>Not sure</i>	<i>Disagree a little</i>	<i>Disagree a lot</i>
Taking an illegal drug once won't do you any harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking drugs you know are illegal is half the fun	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People start taking illegal drugs just to keep up with their friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People who have drug problems need help not punishment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A lot of young people take illegal drugs nowadays	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injecting illegal drugs is very dangerous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs can be harmful to my health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs make you look older	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs make you feel bad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I will never take illegal drugs in my life time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is easy to obtain illegal drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Agree a lot	Agree a little	Not sure	Disagree a little	Disagree a lot
I hope to attend a third level institution/college when I complete my leaving certificate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If I knew someone (e.g. a class-mate) taking an illegal drug(s) I would report him/her to the appropriate authorities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

42. Please read each statement and decide how dangerous the activity is. (Please tick one box for each statement)

	Not dangerous	A little dangerous	Very dangerous	Don't know
Smoking less than 10 cigarettes every day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trying Ecstasy once or twice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking grass or hash (marijuana) occasionally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using acid, LSD or magic mushrooms (hallucinogens) regularly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking more than 20 cigarettes every day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trying drugs like heroin or morphine (narcotics) once or twice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using stimulants (such as speed) every day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sniffing glue or spray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having one or two drinks of beer, wine or spirits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking one or two cigarettes occasionally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trying stimulants (such as speed) once or twice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking drugs like heroin or morphine (narcotics) regularly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sniffing petrol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having four or five drinks of beer, wine or spirits nearly every day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking cannabis regularly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trying acid, LSD or magic mushrooms (hallucinogens) once or twice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking ecstasy regularly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

43. What effect(s) do you think the following drugs have upon a person?

Cannabis _____
 Inhalants _____
 Cocaine _____
 Tranquillisers _____
 Hallucinogens _____
 Barbiturates _____
 Heroin or narcotics _____
 Amphetamines _____
 PCP _____
 Ecstasy _____

44. If you have been offered an illegal drug, where were you (e.g. at a disco)?

45. What do you think you might do if you were offered an illegal drug?

46. How much do the following drugs cost?

	£	Don't know
Cannabis	_____	_____
Inhalants	_____	_____
Cocaine	_____	_____
Tranquillisers	_____	_____
Hallucinogens	_____	_____
Barbiturates	_____	_____
Heroin or narcotics	_____	_____
Amphetamines	_____	_____
PCP	_____	_____
Ecstasy	_____	_____

THANK YOU FOR COMPLETING THIS SURVEY QUESTIONNAIRE

7.2 TABLE OF PARTICIPATING SCHOOLS

	SCHOOL NAME	Programme	Boys/Girls
01	Clochar na Toirbhirte, Ballingarry	Repeat Leaving and Sixth Year	Boys & Girls
02	C.B.S. Thurles	Transition Year	Boys
03	Clochar na Toirbhirte, Thurles	Transition Year	Girls
04	Ursuline Convent, Thurles	Leaving Cert 5th Year	Girls
05	Vocational School, Thurles	Leaving Cert 5th Year	Boys & Girls
06	C.B.S. Clonmel	Leaving Cert 5th Year	Boys
07	C.B.S. Carrick-on-Suir	Transition Year	Boys
08	Presentation Convent, Clonmel	Leaving Cert 5th Year	Girls
09	Clonmel Vocational School	Leaving Cert 5th Year	Boys & Girls
10	Scoil Criost Ri, Cahir	Transition Year	Girls
11	Cahir Vocational School	Repeat Leaving, 5th, 6th Year	Boys & Girls
12	Cashel Community School	Transition Year	Boys & Girls
13	C.B.S. Nenagh	Leaving Cert 5th Year	Boys
14	St. Mary's Convent of Mercy, Nenagh	Leaving Cert 6th Year	Girls
15	Our Lady's Secondary, Templemore	Leaving Cert 5th Year	Boys & Girls
16	Coláiste Sheosaimh, Borrisoleigh	Leaving Cert 5th Year	Boys & Girls
17	St. Joseph's Boys Secondary, Cahir	Repeat Leaving, 5th, 6th Year	Boys
18	Roscrea Vocational School	Repeat Leaving, 6th Year	Boys & Girls
19	The Abbey C.B.S. Tipperary Town	Leaving Cert 5th Year	Boys
20	St. Anne's Convent, Tipperary Town	Transition Year	Girls
21	Tipperary Vocational School	Leaving Cert 6th Year	Boys & Girls
22	C.B.S. Roscrea	Leaving Cert 6th Year	Boys
23	Sacred Heart Convent, Roscrea	Leaving Cert 6th Year	Girls

7.3 SOCIO-ECONOMIC GROUP CODES

CODE	Socio-economic group	f(x) Fathers	f(x) Mothers
0	Fanners, fanner' relatives and farm managers	138	4
1	Other agricultural occupations and fishermen	3	0
2	Higher professional	25	7
3	Lower professional	23	37
4	Self-employed - employs others and managers	48	29
5	Salaried employees	12	0
6	Intermediate non-manual workers	32	57
7	Other non-manual workers	40	72
8	Skilled manual workers	122	1
9	Semi-skilled manual workers	34	21
10	Housewife		329
X	Unskilled manual workers	0	0
Y	Unknown	70	13
	Total	547	570

7.4 LIST OF LESSONS/CLASSES EMPLOYED TO TEACH DRUGS EDUCATION

Biology
Science
Social Studies
Religious Education
Not within a scheduled class
Social Studies and Religious Education
Religious Education and Home Economics
Health Education
Science and Religious Education
Science, Religion and Social Studies/Civics
Religious Education and Health Education
Health Education and Home Economics
Biology, Home Economics, and Religious Education
Social Studies, Home Economics and Religion
Social and Health Studies
Science and Social Studies
Biology and Religious Education
Geography
Education for living/civics and Religion
Don't know
Education for Living/life skills
Religion and English
Religion and French
Home Economics
Biology, Social Studies, Home Economics
Life skills. Science, Religion, Home Economics
Life skills, Science, Home Economics
Biology, Social Studies, Religion, Home Economics
6th Class - Primary School
Civics/Religious Education
Religion, Home Economics, Biology and English

**7.5 LIST OF DRINKING LOCATIONS: (I) CURRENT AND (II) FIRST DRINK
LIST OF PERSONS WITH WHOM RESPONDENTS NORMALLY DRINK**

(i) current drinking locations

Pub
 Disco
 Home
 Friend's house
 Field, lonely areas, place where I won't get caught
 Pubs, discos and friend's house
 Home and pub
 Home and friend's house
 Pub and disco
 Pub and friend's house
 Special occasions and friend's house
 Pubs, discos and home
 Pub, discos and nightclubs
 Friend's house and fields
 Parties
 Down the mall (river)
 Pub, disco and backyard
 Disco and party
 Pub and nightclub
 Pub, discos and parties
 Nightclub
 Pub, nightclub and parties
 Disco and friend's house
 Camping
 Anywhere/everywhere
 Pub, disco, friend's house and special occasions
 Pub, friend's house and isolated place
 Nacker drinking/ditch drinking
 Friends
 Pub and isolated areas/street
 Pubs, discos, fields, houses
 Disco and fields
 Pub, disco, friend's house, field and home
 In town
 Pub, home, and field
 Disco and home
 Friends/pub
 House
 Pub, home, friend's house
 Pub and before disco
 Friend's house and around town

Pub, disco, friend's house
 Pub, friend's house, home and around town

(ii) Locations of first alcoholic drink

Home
 Wedding/family celebration
 Cousin's house
 Friend's house
 Pub
 Pub and home
 Friend's house and pub
 Rave party
 Disco
 Hotel
 Pub and Féile
 Nacker drinking (and field with friend/ditch)
 Public park/fields/isolated places/town/beach
 Home when parents were absent
 In a restaurant with employer
 Party
 Down the mall (river)
 Nightclub
 Someone aged 18 yrs got it from an off-licence
 Camping
 Festival/music festival
 Pub/party
 Concert
 Pub and nightclub
 Nightclub and disco
 Before a concert on a bus
 Dance
 Work
 Boarding school/school playground
 From a friend/with friends
 Relative's house
 Got the drink from home/friend's house and drank outside
 Church
 House
 Friend's house and isolated place
 Pub and disco
 Outside a disco
 Friend's house and home

(iii) Persons with whom respondents normally drink

Parents

Friends

Brother(s)/sister(s)

Cousins/other relatives

Alone/on my own

Parents, sisters, friends

Parents and friends

Relations and friends

Parents of friends

Siblings/parents and relations

Boss or friends

Friends and sometimes alone

Anybody

7.6 TABLES OF YOUNG PEOPLE DRINKING BEER, CIDER, WINE, WINE COOLERS AND SPIRITS

Table 7.6.1 Table of young people drinking beer

Count Row Pct Col Pct Tot Pct	“Yes” response	“No” response	Total
15 years	92 55.4 22.5 15.9	74 44.6 43.8 12.8	166 28.8
16 years	148 74.0 36.3 25.6	52 26.0 30.8 9.0	200 34.7
17 years	122 80.3 29.9 21.1	30 19.7 17.8 5.2	152 26.3
18+ years	46 78.0 11.3 8.0	13 22.0 7.7 2.3	59 10.2
Total	408 70.7	169 29.3	577 100.0

(40 Missing observations)

Table 7.6.2 Table of young people drinking cider

Count Row Pct Col Pct Tot Pct	“Yes” response	“No” Response	Total
15 years	99 57.9 23.5 16.9	72 42.1 43.6 12.3	171 29.2
16 years	146 71.9 34.7 24.9	57 28.1 34.5 9.7	203 34.6
17 years	125 81.7 29.7 21.3	28 18.3 17.0 4.8	153 26.1
18+ years	51 86.4 12.1 8.7	8 13.6 4.8 1.4	59 10.1
Total	421 71.8	165 28.2	586 10.1

(31 Missing observations)

Table 7.6.3 Table of young people drinking wine

Count Row Pct Col Pct Tot Pct	“Yes” response	“No” response	Total
15 years	85 52.1 25.9 15.3	78 47.9 34.2 14.0	163 29.3
16 years	110 58.2 33.5 19.8	79 41.8 34.6 14.2	189 34.0
17 years	90 62.1 27.4 16.2	55 37.9 24.1 9.9	145 26.1
18+ years	43 72.9 13.1 7.7	16 27.1 7.0 2.9	59 10.6
Total	328 59.0	228 41.0	556 100.0

(61 Missing observations)

Table 7.6.4 Table of young people drinking wine cooler

Count Row Pct Col Pct Tot Pct	“Yes” response	“No” response	Total
15 years	31 20.1 20.5 6.0	123 79.9 33.8 23.9	154 29.9
16 years	48 27.1 31.8 9.3	129 72.9 35.4 25.0	177 34.4
17 years	46 34.8 30.5 8.9	86 65.2 23.6 16.7	132 25.6
18+ years	26 50.0 17.2 5.0	26 50.0 7.1 5.0	52 10.1
Total	151 29.3	364 70.7	515 100.0

Table 7.6.5 Table of young people drinking Spirits

Count Row Pct Col Pct Tot Pct	“Yes” Response	“No” response	Total
15 years	101	66	167
	60.5 25.2 17.6	39.5 37.9 11.5	29.0
16 years	138	60	198
	69.7 34.4 24.0	30.3 34.5 10.4	34.4
17 years	117	35	152
	77.0 29.2 20.3	23.0 20.1 6.1	26.4
18+ years	45	13	58
	77.6 11.2 7.8	22.4 7.5 2.3	10.1
Total	401	174	575
	69.7	30.3	100.0

7.7 LIST OF LOCATIONS WHERE RESPONDENTS HAVE BEEN OFFERED DRUGS

Disco
Rave
Pub
Abroad/on holidays
Dublin
Down town
Party
On the street
In my home place
Friend/friend's house
Disco/rave
A concert & friend's house
Féile & a disco
Disco, walking down the street, park & down town
Pub & disco
School
Féile & down town
Down town, pubs, disco & school
Public toilet & disco
Concert
Home
Féile & back of swimming pool
Disco, shopping & party
In a town & car park
Disco, night-club & pub
Night-club
Arcade in Dublin
At work
Disco & night-club
Dance
Féile, concert & holiday
Concert & disco
Féile
Disco & friend's house
Grandparents' house
Friends & walking down the street
Disco, parties & concerts
Féile & on the streets in Dublin
Pub, disco, street, friend's house
Disco, snooker hall, pub, school, soccer club
Walking through a field
Disco, housing estates & school
School & disco
Camping

Snooker hall
Disco & town
Disco & work
Concert & arcade
Disco & home
Club & home
Discos, pubs & cities
Discos, schools, pubs & friends
Abroad, disco & pubs
Pub, disco & friend's house
In a house
Disco, friend's house & street
Outside a disco
Disco, Féile & concerts
Pubs, discos & street
Beach or park
On the street, night-club, rave & Dublin
Pubs, parties, friend's house & disco
School and pub
Disco & St.Stephen's Green, Dublin
School, playing with a band, disco & pub
Outside of my house
Anywhere
Town, street & school

7.8 LIST OF POSSIBLE ACTIONS TAKEN IN THE EVENT OF BEING OFFERED AN ILLEGAL DRUG

Don't know
 Take it
 Refuse it
 Say no - possibly
 Depends what the drug is
 Take a pull of a joint/hash smoke it - anything stronger - no!
 Report the person/say no!
 Afraid and tell the Guards
 Refuse and tell the Guards
 Depend where I was/What it was/on the situation
 Take it if it was free. If it cost walk away
 Ask what it was, what was in it and how much
 Say no as probably too expensive
 Possibly say yes
 Throw it away
 Take it and sell it again
 Take and dispose of it or give it to the Gardai
 Refuse now since we've been educated about it
 Don't know, might if everyone else does and curiosity
 I'd only take cannabis, not mushrooms anymore
 Say no unless magic mushrooms
 Depends who offered, if friend, go loony with them
 Depends, cannabis or mushrooms take but nothing else
 Panic/Don't know but probably shocked and run away
 Say no to hard drugs
 Not tell unless the same person twice
 Ask how much it cost
 Try it if it was a soft drug
 Probably take it but not tablets or anything like that
 Refuse unless I knew the person
 If for free take them and sell them or dispose of them or use them
 Depend on what it was - probably say no
 Refuse if its ecstasy
 Think about it but probably refuse most of the time
 Accept if had money and little risk of addiction
 Take it because of the consequences if you didn't
 If had the money and knew who was offering I would take it

7.9 EFFECTS OF ILLEGAL DRUGS (extracts taken from: Corrigan (1994) Facts about Drug Abuse in Ireland. Dublin: Health Promotion Unit)

DRUG	Experience	Short-term effects	Long-term use
Cannabis	High, talkativeness, hilarity, disinhibition, laugh a lot, relaxation and effects person's sense of time and space- May hear sound more musically and see colours more vividly. Person will eventually become tired and need a lot of sleep. Co-ordination is affected. Person may change mood very quickly and forget things. Mild hallucinations may occur and the individual may feel slightly out of touch with reality.	Can interfere with short-term memory and learning ability. Due to poor judgement, mistakes and accidents often transpire. Poor academic records, high levels of absenteeism from class, and a high drop-out rate from the educational system among students. The impairment of motor co-ordination will affect a person's ability to operate machinery and drive. Strong forms of the drug have produced adverse reactions such as tearfulness, anxiety, confusion, severe panic and anxiety, paranoid reactions and hallucinations-	No danger of overdose or death. Some researchers believe that cannabis has long-term harmful effects on the brain which increase the risk of certain cancers. Prolonged use causes chronic bronchitis, cough, hoarseness, laryngitis and pre-cancerous changes in the lungs similar to those produced by cigarette smoke. Cannabis is not thought to produce physical dependence, although a person will be come tolerant of it. Physical withdrawal symptoms and psychological addiction have been noted in some users. Apathy and loss of ambition may be experienced. Groups at risk from cannabis include suffers of heart disease, angina, blood pressure, bronchitis or mental illness, epileptics, teenagers, women of child-bearing age, and people with a history of "bad trips". Long-term use may have adverse effects on the reproductive systems of both sexes and unborn children if taken during pregnancy.
Inhalants	Relaxation and contentment similar to the effects of alcohol. The person may become aggressive, experience distorted vision, slurred speech and appear drunk. Visual and/or auditory hallucinations may occur. Depression and, if enough is taken, unconsciousness can result from sniffing. Other effects include impaired judgement, severe headache, rapid heartbeat, low blood pressure, acute psychosis, coma, and in rare cases death	Anti-social problems such as vandalism and aggression. While deaths from inhalant abuse are rare they can occur. The chief concern is their unpredictability. Many deaths are accidental and related to the effects of taking the drug (i.e. "drunkenness").	Although the medical evidence is inconclusive, physical organ damage is not a significant problem. Behavioural problems include: family disruption, absenteeism from school, deterioration in school performance and possibly drop-out, vandalism and aggression, disturbed sleep patterns, glue sniffers rash (around nose), and loss of appetite and weight. Long-term abusers may become depressed, moody, suspicious, forgetful and lose concentration. Withdrawal symptoms include sleep disturbance, nausea, stomach cramps, general irritability and facial tics and may take some weeks to arise.

Effects of illegal drugs continued

Drug	Experience	Short-term effects	Long-term use
Cocaine	Stimulation, reduction in hunger and thirst, and a superhuman feeling of great energy and alertness. Large doses can cause anxiety, depression and fainting. A 'binge' over a few days can produce bizarre, aggressive and violent behaviour, with severe persecution complexes. Euphoria is often used to describe the experience.	Excessive doses can cause death through heart failure or lung damage.	Cocaine produces psychological dependence but is not physically addictive. Death may occur as a consequence of heart attacks, clots, damage to the heart muscles or lungs. Risk of HIV infection through multiple sexual partners. Risk to foetus. Withdrawal symptoms comprise severe depression and fatigue as well as excessive eating and sleeping. For chronic users the excitement is substituted by restlessness, insomnia, weight loss, developing into paranoid psychosis with delusions of persecution, violent tendencies, visual disturbance called 'snow lights', and unpleasant skin sensations ('cocaine bugs'). Persistent use can lead to damage of the membranes in the nose.
Tranquillisers	Drowsiness, forgetfulness and a decrease in the ability to perform complicated tasks due to impaired memory and reduced coordination. There can be a hangover effect.	Sleep may be induced, confusion and disinhibition in some users leading to a loss of self-control, recklessness and even violence	Physical and psychological tolerance and dependence is likely to result with long-term use. Withdrawal symptoms can include irritability, nervousness, insomnia, nausea, twitching and sometimes convulsions, which can be fatal. Withdrawal symptoms if the drug is stopped suddenly can be tremor, sweating, headaches, sensitivity to light, sound and touch, insomnia, nausea, vomiting, anxiety, depression, muscle spasms, vertigo and a feeling of continues movement. Serious reactions may comprise psychotic reactions such as hallucinations, depersonalisation and paranoid delusions. Regular users are also prone to pneumonia and hypothermia. Also associated risks of using needles.

Effects of illegal drugs continued

DRUG	Experience	Short-term effects	Long-term use
Hallucinogens (LSD)	Increased heart rate and blood pressure. widening of pupils and a rise in temperature. Psychological effects include changes in body images, distorted shapes and sizes and intensified colours. Distortions of hearing, changes in sense of time (stowed down) and of place. Emotional reactions may comprise heightened self-awareness, mystical experiences and insight into childhood memories. Changes in mood can be very pleasant or frightening.	Psychological tasks such as learning, remembering and concentration are impaired.	Individuals who are mentally unstable, anxious or depressed are more prone to unpleasant reactions such as fear, anxiety, depersonalisation, depression, disorientation, and panic. Serious panic or even psychotic reactions can occur. Prolonged mental illhealth may be triggered by an LSD trip. People can injure or kill themselves during a good trip as because of delusions. Fatalities due to overdose are non-existent. No physical dependence occurs, but tolerance develops- "Flashbacks" can occur weeks/months after the trip which can cause disorientation, anxiety, and distress and can be dangerous if one is operating machinery (e.g. a car).
Hallucinogens (Psilybin -Magic mushrooms)	Experience is similar to a mild LSD trip (but not as unpleasant). Experience is dependent on the users mood, environment and intentions. The experience included euphoria, hilarity, visual hallucinations (although auditory can occur), dilated pupils, increased pulse rate and high blood pressure. Sensation of objects changing shape and heightened awareness of sound and colour.	Users often report nausea, vomiting and abdominal pain but this may be a consequence of mistaking liberty caps for psilybin.	Bad trips may involve feelings of depersonalisation, panic, anxiety and even psychotic reactions. Some users have been aggressive and hyperactive, and reported frightening experiences which involve tingling limbs and flushing. Recurrent panic and anxiety attacks can be triggered (often by alcohol) afterwards. Rash behaviour such as running out in traffic has been observed. Tolerance develops rapidly and there is a cross-over effect between psilybin and LSD. No physical dependence or withdrawal symptoms.

Effects of illegal drugs continued

DRUG	Experience	Short-term effects	Long-term use
Barbiturates	Small doses make individuals feel relaxed and sociable (similar to alcohol), With larger measures there is a sedative effect. A moderate to large dose will make the person unsteady, with poor control of speech and body, rendering them liable to injury. Some people may become aggressive as with alcohol.	Larger doses can cause unconsciousness and eventually respiratory failure and death.	Habitual use of barbiturates is liable to lead to tolerance and strong psychological and physical dependence. Withdrawal symptoms include irritability, nervousness, insomnia, nausea, twitching and sometimes convulsions, which can be fatal. Heavy users are prone to pneumonia and hypothermia. Hazards of injecting also present.
Heroin or other narcotics	Physical effects include analgesia, suppression of coughing, depression of bowel activity leading to constipation, depression of respiration and dilation of blood vessels giving feeling of warmth. When injected heroin produces a very rapid "rush" lasting less than a minute and entails a warm flushing of the skin and sexual excitement. The initial rush is followed by a pleasant, dreamlike state of peacefulness and contentment, pain is reduced, as are aggressive tendencies and sexual drives. The first experience usually included nausea and vomiting.	Higher doses induce sleep followed by coma. Death from respiratory depression can occur, especially if the opiate is combined with other depressant drugs such as alcohol or barbiturates. Much of the euphoria apparently occurs in the early stages of an addicts career, and those truly dependent experience little euphoria	There is evidence that repeated use of heroin does not invariably lead to compulsive daily use. Psychological and physical dependence is likely but not inevitable. Dependence is determined by various factors such as the individual's mental make-up, quantity and frequency of heroin consumption. The onset of withdrawal symptoms is 4-12 hours after the last dose and include yawning, tears, running nose, sneezing, tremors, headache, sweating, anxiety, irritability, insomnia, spontaneous orgasm, loss of appetite, nausea, vomiting, diarrhoea, cramps and muscle spasm. High relapse rate due to psychological dependence. Physical damage associated with unhygienic injection practices and can cause blood poisoning, infection of the heart valves, abscesses, clots in the lungs, gangrene, loss of limbs and risk of contracting HIV. Some chronic users may have lung problems including bronchitis.

Effects of illegal drugs continued

Drug	Experience	Short-term effects	Long-term use
Amphetamines	Breathing and heart rate speed up, blood pressure increases, the pupils widen and appetite is suppressed. The user feels more active, more alert and energetic. There is a lessening of fatigue and an increase in mental activity, with better concentration and clearer thinking. The change in mood leads to a general feeling of well-being. Irritability, confusion and dizziness may be experienced after repeated small doses.	Severe psychological dependence can develop because of the pleasant effects. Withdrawal reactions may occur such as fatigue and depression. High doses intravenously administered give rise to a “rush” of pleasurable experience. Users on a binge for several days become overactive, boastful and indulge in repetitive behaviour. High measures can produce panic, hallucinations and feelings of being persecuted.	Tolerance develops rapidly- Withdrawal includes depression, fatigue, hunger. Regular users may develop “amphetamine psychosis” which resembles schizophrenia with thought disorders, hallucinations and feelings of being persecuted. These latter feelings may lead to hostility, aggression and violence as individuals defend themselves against imaginary enemies. Not a high risk of death, although injectors of the drug run all the risks associated with this practice (mentioned above) and violence associated with the experience can cause death. The user normally has a lower resistance to \ disease.
PCP (Phencyclidine - Angel dust)	There is little information on the experience and effects of PCP. However they are thought to be similar to those of		

Effects of illegal drugs continued

Drug	Experience	Short-term effects	Long-term use
Ecstasy	The experience of ecstasy is widely known and includes being relaxed but energetic, happy and calm with a warm friendly feeling towards others. Aggressive, violent feelings are suppressed, there may be an increase in self-awareness and increased perception of visions and music.	Dry mouth, tremors, palpitations and sweating are common after using this drug. When the effects subside there is a feeling of tiredness and lassitude for up to 24 hours. Deaths have occurred and have been due to delusional behaviour under the influence of the drug or to pre-existing heart or asthmatic disease. Many death have been caused by heatstroke. The drug causes a serious rise in body temperature. The atmosphere in which the drug is taken (usually raves, discos) contributes to the hypothermia and death results due to muscle breakdown, clotting of blood inside the body and kidney failure. Kidney failure and complications such as convulsions (fits), stroke and severe chest pains have lead to death. Large doses can cause: agitation, high blood pressure, muscular pains, insomnia, lethargy and flash-backs. "Head rushes" have been reported which involve blanking out of sensory perceptions of sight and hearing for up to three minutes while dancing.	Anorexia and weight loss. Depression and anxiety, panic attacks, paranoia and psychotic symptoms may result

7.10 QUALITATIVE DATA FOR THE EFFECTS OF DRUGS

Effects of Cannabis

Code Response

0	Don't know
1	Hallucinations and euphoria/relax
2	Hallucinations
3	Feel good/buzz/fun/better
4	Can kill you
5	High/good/spaced/dizziness/euphoric/light-headed/buzz
6	Relaxed
7	Addiction (steal to pay for them because they don't care about anything else)
8	Hallucinations, giddiness, confusion, lost sense of time
9	Happy
10	Very bad for you/harmful/serious
11	High and withdrawal/low
12	Relaxed/feel good/calming/relieves stress/tired/high/stoned
13	Violent but full of life
14	Damages kidneys and liver/bums you up inside
15	Mood swings/paranoid (paranoid and relaxed)/moody
16	Not addictive/tired relaxed feeling
17	Mellow out
18	good/high/energy
19	Dangerous to health and life/Dangerous effect
20	Relaxed/high
21	Excited
22	Loose control/thinking you can do something when you can't
23	Stupid and high
24	Addiction, death through AID S
25	Bad tempered
26	Death and/or brain damage
27	Relaxed/lose inhibitions/buzz
28	Addiction + high/spaced out/rowdy
29	Paranoid and relaxed
30	Addiction and effect on body
31	Forgetful/loss of memory
32	Mental problems/destroys mind and relations with others
33	Headaches/stress
34	Cough
35	Delirious/flash backs/legless - laughing at everything/not know where you are/world of your own
36	Hyper
37	High and sick

- 38 Schizophrenia
- 39 Sickness, giving out, nightmares
- 40 Increase blood pressure
- 41 No effect/very little
- 42 Forget and have fun
- 43 Drowsy/dopey/tired
- 44 Sickness and brain damage/fits/destroys the body
- 45 Bad breath, smelly
- 46 Stealing
- 47 Changes personality and life
- 48 Similar to cigarettes
- 49 Relaxed, giggly + thirsty
- 50 High and unconscious
- 51 Sick
- 52 Addiction + death + effect on personality + high
- 53 Health will get bad and attitude change
- 54 Always down and out
- 55 Risk of bad trips but good
- 56 Drunk feeling
- 57 Addiction and depression
- 59 High, drowsy, sick/calm and sick
- 60 Relaxed and at one with music
- 61 Destroys brain, relaxed, makes you see interesting things
- 62 Nerve wrecked

Effects of Inhalants

Code Response

- 0 Don't know
- 1 Excitement/happy/gives you a lift
- 2 High/good/stoned/rush/better/greater
- 3 Hallucinations
- 4 Makes it difficult to breath/bad for respiratory system
- 5 Addiction
- 6 Dizzy, light-headed, then a
headache/dizziness/headaches/giddy/lightness/walking on air/High + headache
- 7 Could kill (Could kill but good)
- 8 Buzz- not very strong - you're flying
- 9 High, then sleepy/low
- 10 Dangerous/harmful/serious
- 11 Lung damage/blocks your adenoids/lung cancer
- 12 Violent but full of life
- 13 Possible brain damage + sickness/destroys mind and relations with others/wrecks your
brain/head blocks up/effects brain
- 14 Speed up heart rate
- 15 Calms nerves
- 16 Good/high/energy/light-headed/happy

- 17 Dangerous to health (and life)/hospital
- 18 Not much/no effect
- 19 Bad
- 20 Stupid and silly
- 21 Stimulating/hyper
- 22 Addiction (+ death through AIDS)/+ effect on personality + high
- 23 Break down membrane in the nose - effects lungs
- 24 Sore nose/nose bleeds
- 25 High/dangerous/brain damage/ unconscious
- 26 Damage insides/serious medical problems/damages health (effects breathing and brain)
- 27 Drowsy/out of it
- 28 Addiction and high
- 29 Addiction and effect on body
- 30 Hallucinations and death/brain damage
- 31 Delirious
- 32 Depressed/grumpy
- 33 Not very bad
- 34 Become addicted. Turn to crime
- 35 Sickness, giving out, nightmares/sick
- 36 High + bums nose and throat
- 37 Convulsions
- 38 Changes personality and life
- 39 Relaxes person
- 40 High + death
- 41 Lacking in homework
- 42 Laugh
- 43 Think they're tough
- 44 Like being drunk

Effects of Cocaine

Code Response

- 0 Don't know
- 1 Feel good/happy/enjoyment
- 2 Can kill you
- 3 High/out of your face/dizzy/ high and hyper/high and rush/better/high +
drowsy/stoned/spaced
- 4 Addiction
- 5 Hallucinations
- 6 AIDS
- 7 Dangerous/harmful/serious
- 8 Gives edge in sports
- 9 High then very low
- 10 High and good/happy
- 11 Violent but full of life
- 12 Physical damage and hallucinations

- 13 Hyper
- 14 Forget your problems
- 15 good/high/energy/buzz
- 16 Dangerous to health (and life)
- 17 Bad
- 18 Dopey/drowsy/sleepy
- 19 Liver failure/damage to the heart/damage to lungs
- 20 Addiction, death through AIDS/effect on personality/death/high
- 21 Relaxed (and feel good)
- 22 Could kill and/or brain damage
- 23 Become irrational
- 24 Addictive and good feeling/high
- 25 Peacefulness and calm
- 26 Addiction and effect on the body/effect on person
- 27 High and can kill
- 28 Brain damage/destroys mind and relations with others
- 29 Mood altering/moody/bad moods
- 30 Headaches
- 31 Forgetfulness/memory loss
- 32 Mad
- 33 Sickness, giving out, nightmares/sick
- 34 Become addicted/turn to crime
- 35 Relaxed and illusions
- 36 No effect
- 37 Addiction + dopey/foolish
- 38 Confidence (and relaxed)
- 39 Stealing
- 40 Fits
- 41 Changes personality and life
- 42 Energy and euphoric
- 43 Depression
- 44 Loss of reality
- 45 Think they're tough
- 46 Energy and relaxed
- 47 Destroys nose, brain and energy
- 48 Increase blood pressure

Effects of Tranquillisers

Code Response

- 0 Don't know
- 1 Relaxes muscles
- 2 Relax and calm nerves/calm down
- 3 Sleep
- 4 Spread blood diseases through needles
- 5 HIV/AIDS

- 6 To kill pain/make a person feel good/better/stop worrying/anti-depress ant/block things out
- 7 Could kill
- 8 Doped/out of it/drowsy/don't know what you're doing/zombie like/light and floaty
- 9 Happy/euphoric
- 10 Relax (quiet and easy going)
- 11 Calm down and make sleepy/tired (relax and tired)
- 12 Dangerous/harmful/serious
- 13 Violent but full of life
- 14 High
- 15 good/high/energy/satisfaction/better
- 16 Dangerous to health (and life)
- 17 Buzz/extra bit of life/lively/giddy
- 18 Bad
- 19 Stupid
- 20 Hallucinations
- 21 Unconscious
- 22 Addiction
- 23 Addiction, death through AIDS/high/death/effect on personality
- 24 Depression/downers/always grumpy
- 25 Put people in a trance
- 26 Dependent and start feeling down
- 27 Addiction and serious medical problems/effect on body
- 28 Side effects
- 29 Change personality/moody (Change personality and life)
- 30 Calmness, ease and mild depression
- 31 Sickness, giving out, nightmares /sick
- 32 Memory damage/brain damage
- 33 Relax and slow down reactions
- 34 No effect
- 35 To forget
- 36 High and sleepy/low
- 37 Giddy + energy
- 38 Destroys mind and relations with others
- 39 Injection
- 40 Addiction + stop pain/calm nerves
- 41 Want to be in the crowd
- 42 Sick
- 43 Bad tempered
- 44 Coming down from a high

Effect of Hallucinogens

Code Response

- 0 Don't know
- 1 Hallucinate/see things that aren't there
- 2 High/tripping
- 3 Funny time/weird effect/groovy feeling
- 4 Could kill
- 5 Relax
- 6 Dangerous/harmful/serious
- 7 Violent but full of life
- 8 Unaware of surroundings/don't know what's going on/world of your own/spaced
- 9 Good/high/energy/buzz/excitement/better/well-being
- 10 Dangerous to health (and life)
- 11 Seeing things
- 12 Bad/downer
- 13 Dopey
- 14 Addiction
- 15 Addiction, death through AIDS
- 16 You see weird things, everything turns purple/see colours
- 17 Happy/enjoy yourself
- 18 Energy
- 19 Addiction and serious medical problems/effect on body/high/death/effect on personality
- 20 Dizziness
- 21 Irrational behaviour/unusual behaviour/loss of judgement
- 22 Ease pain
- 23 Ruins your brain/destroys mind and relations with others/plays havoc with your mind
- 24 Depressive
- 25 Take you to a better place in your mind/make you feel in another place
- 26 Laugh/singing - don't know what you are doing
- 27 Sickness, giving out, nightmares
- 28 Memory damage
- 29 For a while it is fun but the comedown is scary/high then low
- 30 Think and react faster
- 31 Panic
- 32 Buzz
- 33 Fits
- 34 Changes personality and life
- 35 Calming
- 36 Moody (moody and unsociable)
- 37 Anxiety
- 38 Aware and active
- 39 Happy and full of energy

- 40 Good/bad trip
- 41 High then low /
- 42 Psychedelic
- 43 Bewilderment
- 44 Very little

Effects of Barbiturates

Code Response

- 0 Don't know
- 1 Enjoyment(high) followed by low
- 2 Brings you down from a high
- 3 Funny time
- 4 Could kill
- 5 Depresses people
- 6 Doped/Drowsy
- 7 Relax/tired
- 8 Dangerous/harmful/serious
- 9 Violent but full of life
- 10 High/tripping
- 11 Depresses your nervous system
- 12 High/good/energy /buzz/excitement/rush/better
- 13 Dangerous to health (and life)
- 14 Bad
- 15 Addiction/want more
- 16 Addiction, death through AIDS/high/death/effect on personality
- 17 Wow
- 18 Moody - away with the fairies/unusual or strange behaviour/mellows you out
- 19 Happy
- 20 Energy/stimulate your body
- 21 Addiction mad serious medical problems/effect on your body
- 22 Don't know what's going on
- 23 Calm nerves
- 24 Messes up the body
- 25 Dangerous and high
- 26 High and hallucinate
- 27 Kicks
- 28 Hyper
- 29 Not very bad
- 30 Sickness, giving out, nightmares
- 31 Dizziness
- 32 Relax and high
- 33 Memory damage/brain damage
- 34 To forget/makes you feel like you've no worries
- 35 Addiction + relaxed
- 36 Changes personality and life
- 37 Destroys mind and relations with others/lose interest in those around you

- 38 High then low
- 39 Fall around
- 40 Sedate you
- 41 Gets you up when depressed

Effects of Heroin or narcotics

Code Response

- 0 Don't know
- 1 Addictive + AIDS
- 2 Can kill you
- 3 High/spaced/tripping/out of your face/high and hyper/high and no worries/better/stoned/doped out/ rush
- 4 Hallucinations
- 5 Bad for the liver
- 6 Funny time
- 7 Happy/good/buzz/gives them a kick
- 8 Relax (& feel good)
- 9 Dangerous/harmful/serious
- 10 Violent but full of life
- 11 High then low + hallucinations/high then low
- 12 Mellows you out/out of it/blurry
- 13 Gives you energy/a boost
- 14 Depress your nervous system
- 15 Calms you
- 16 High/good/energy
- 17 Dangerous to health (and life)
- 18 Bad
- 19 Addiction
- 20 Addiction and high
- 21 Effects reproductive system/body organs
- 22 Puts you on a low/brings you down from a high
- 23 High and dependency
- 24 Paranoia
- 25 Delusions, addictive
- 26 Addiction + effect on body/death/high/effect on personality
- 27 High and can kill
- 28 Introverted
- 29 Unusual behaviour/strange behaviour
- 30 Hyper and damage to yourself and others
- 31 Delirious
- 32 Confidence (and relaxed)
- 33 Destroys brain cells/brain damage/and relations with others
- 34 Sickness, giving out, nightmares
- 35 Dizziness
- 36 Not in control
- 37 Anti-depressant

- 38 Withdrawal very bad
- 39 Smelly and bad breath
- 40 Changes personality and life
- 41 High and ageing
- 42 Addiction + violence/will steal - bad effect on person
- 43 Attacks
- 44 Weak, tired, bad mood
- 45 Excitement
- 46 Unco-operative and steal
- 47 Drowsy
- 48 Makes you mad
- 49 Damages your insides
- 50 No energy - in a different world
- 51 Euphoric/relaxed
- 52 Change of mood, confidence and energy
- 53 AIDS
- 54 Energy and happy

Effects of Amphetamines

Code Response

- 0 Don't know
- 1 Lows when drug wears off/high then low
- 2 Gives lots of energy/buzz/get up and go feeling/speeds you up
- 3 Happy and euphoric
- 4 Could kill
- 5 Happy, high/tripping
- 6 Dangerous/harmful/serious
- 7 Violent but full of life
- 8 High/good/energy/great/uppers/delirious/better/spaced
- 9 Dangerous to health (and life)
- 10 Bad/downer/depression
- 11 Addiction
- 12 Addiction, death through AIDS/high/death/effect on personality
- 13 Addiction and serious medical problems/effect on body
- 14 Changes body reaction
- 15 Moody
- 16 Brain damage (and relations with others)
- 17 Forgetfulness, blackout
- 18 Relaxed
- 19 Tired and restless
- 20 Sickness, giving out, nightmares
- 21 Dizziness
- 22 Not in control
- 23 Convulsions/cause person to collapse
- 24 Changes personality and life
- 25 Drives you mental, hallucinate

- 26 Seeing things
- 27 Light-headed and laugh
- 28 Stimulant/keeps them awake
- 29 Don't care for anyone
- 30 Makes you feel strong and energetic
- 31 Dance and dehydration
- 32 Hallucinations
- 33 High then low
- 34 Not really dangerous
- 35 Destroy your nerves

Effects of PCP

Code Response

- 0 Don't know
- 1 Can make a person really sick
- 2 To give strength/makes them larger/put on weight
- 3 Could kill
- 4 Happy, high/tripping
- 5 Dangerous/harmful/serious
- 6 Violent but full of life
- 7 High/good/energy/buzz/better
- 8 Dangerous to health (and life)
- 9 Energy
- 10 Bad
- 11 Addiction
- 12 Addiction, death through AIDS/effect on personality/death/high
- 13 Turns fat into muscle/fattens you
- 14 Addiction and serious medical problems/effect on body
- 15 Alters/effects the mind/flash backs
- 16 Brain damage (and memory) (and relations with others)
- 17 Sickness, giving out, nightmares
- 18 Dizziness
- 19 Not in control
- 20 Hallucinations + energy
- 21 Crazy
- 22 Trip
- 23 Tired and moody
- 24 Changes personality and life
- 25 High then low
- 26 Irritable
- 27 Hallucinations
- 28 Dangerous + high
- 29 Ability to fly
- 30 Increase hormone activity

Effects of Ecstasy

Code Response

- 0 Don't know
- 1 Hallucinations and Euphoria
- 2 Dehydration and possible death
- 3 High and energy/high and hyper/fun and energy/happiness and energy
- 4 Hallucinate
- 5 High/spaced out
- 6 Energy (and loving feeling)
- 7 Can kill
- 8 Dehydration/need to drink water
- 9 Brain damage (and memory) (and relations with others)
- 10 Energy and speed-up heart rate
- 11 The body overheats/sweating/heat-stroke
- 12 Increases respiration
- 13 Feel happy/good/mad/the best/mad rush
- 14 Dance (and energy)
- 15 Horrific
- 16 Addictive
- 17 Hyperactivity/need to move body
- 18 Happy and dance
- 19 rush of adrenaline
- 20 Loss of sense/they think they can do anything
- 21 Energy and damage kidneys
- 22 Dangerous/harmful/serious
- 23 Dance/energy and dehydration/thirst
- 24 Violent but full of life
- 25 High/good/energy/fun
- 26 Dangerous to health (and life)
- 27 Bad/bad tripping/depression
- 28 Good/great buzz/better/happy/dance
- 29 Could kill/high temperature/slows down reaction/hallucinate
- 30 Thirst, getting hot, gives sex drive
- 31 Addiction, death through AIDS/high/death/effect on personality
- 32 Makes life look like a bed of roses but could kill
- 33 Addictive and buzz/high/good
- 34 Dance and possible death
- 35 End up in a coma
- 36 Energy, desire to dance/move/active at discos
- 37 Side effects
- 38 Addiction and effect on body
- 39 Energy and paranoid
- 40 High + dehydration (+ energy)
- 41 High and bad mixture can kill
- 42 Hallucination and dehydration

- 43 High and damage health/loss of control + possible danger to organs/high + death
- 44 Damage kidneys and liver failure/damages bodily functions/heart attack (+hallucinations and body temp up)/liver failure
- 46 Mood swings and drowsiness
- 47 High body temp which effects insides
- 48 Loss of weight, high, drinks water, energy, rush, dance a lot
- 50 Freedom
- 51 Sickness, giving out, nightmares
- 52 Buzz, hyper, rush
- 53 Dizziness
- 54 Flash backs
- 55 Loss of memory/get more into music
- 56 Lose weight
- 57 Indescribable
- 59 Energy and death
- 60 Changes personality and life
- 61 Makes people crazy and wild
- 62 Messes up health, brain, chip teeth, dehydration, heart failure
- 63 Energy and hallucination
- 64 High then low
- 65 Heart and nose problems
- 66 Fall down in school work etc. lose job /don't pay attention
- 67 Friendly but unstoppable
- 68 High and needs other drugs to come down
- 69 O.K. but the come down is bad
- 70 Out of their minds - out of control/think they can fly