# Adolescent Drug Use

# in

## The North Eastern Health Board

1997

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**North Eastern Health Board, 1999**

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# Foreword

The North Eastern Health Board is happy to make available the report "Adolescent Drug Use in the North Eastern Health Board, 1997". This report was commissioned as part of the Board's overall strategy to deal with the issue of drug misuse among adolescents and to establish the extent of drug use among young people in the region. Detailed presentation of the findings of this research was presented to the board members, health board personnel, Gardaí, parents and teachers, and other agencies in the region involved with families and young people. Following on from these presentations, and as a result of a consultative process involving the Board's Committees, Gardaí, parents, teachers and agencies involved with families and young people themselves, a series of recommendations emerged as to how one might best tackle the problem of drug misuse within the region.

A collaborative, inter-agency approach is considered the best way forward for service providers and the provision of a series of co-ordinated and integrated programmes for adolescents is considered necessary. All agencies will work together to ensure that there is collaboration in relation to existing health promotion programmes and other strategies in relation to drug and substance abuse. For example, ad-hoc arrangements in relation to various statutory and voluntary agencies providing lectures and information to schools and other centres for young people will be replaced by a co-ordinated programme under the auspices of the Regional Drugs Co-Ordinating Committee. The recommendations from this consultative process are as follows:

- Research into the use of drugs and illegal substances among the 19+ age group should be carried out;
- Quantitative and qualitative research should be carried out into the problem of drug and substance abuse among isolated and marginalised young people;
- The value of positive peer pressure was highlighted in the studies and our Board will therefore engage in dialogue with young people, their parents, youth workers and those involved in education, to properly focus our Health Promotion Programmes;
- Detailed discussions will commence with local authorities, the education system and the business community, particularly with representative organisations of alcohol and tobacco vendors, with a view to seeking their co-operation in a new 'reduce the supply'

initiative in the North East that centres around the sale of alcohol and drugs to young people and reduces the distribution of illicit drugs;

- Provide high support services to individual families where drug and substance abuse has been identified as a problem. Outreach workers, addiction counsellors, mental health professionals and community based agencies will work together on implementing care plans for specific families;
- Develop, in co-operation with health promotion programmes and with other existing parenting programmes in the region, a new parent focused approach to disseminating information and enhancing parenting skills. All existing preventive and interventive programmes with parents will be evaluated before a new programme is prepared;
- All staff and partnership agencies involved in the provision of child care and family support services will be informed, educated and trained in relation to the drug and substance abuse, particularly among vulnerable families and children, to ensure an early referral and support service and to ensure that all other aspects of the multi-faceted programme are fully understood by staff and agencies involved in family work;
- Young people have asked for drop-in and information centres to be developed. These centres should have a range of information programmes and activities, with strong youth and community involvement;
- Co-operation with the Gardaí will continue, particularly to enhance the already good working relationship established between the Health Board and the Gardaí and existing structures through which the Board and Gardaí co-ordinate closely, for example, in relation to child care.

The Regional Drugs Co-Ordinating Committee in co-ordination with the Health Promotion Unit of the Health Board will keep the situation under constant review.

I would like to thank Dr. Ciaran Brown and Ms. Anne Stakelum from the Department of Public Health, who carried out the bulk of the research. In addition, I would like to thank Dr. Fenton Howell, Ms. Ita Hegarty and Dr. Declan Bedford for putting this report together. The North Eastern Health Board is extremely grateful to all of those who co-operated in this research project. Without the support of the schools, our own staff, external agencies and the children who participated, we would not have this rich source of knowledge.

Donal O Shea, Chief Executive Officer

# Executive Summary

## Introduction

As part of the Board's overall strategy to deal with the issue of drug misuse among adolescents, research was commissioned to establish the extent of drug use among young people in the region. A quantitative study to assess and document the prevalence and pattern of drug usage by adolescents has been completed. A qualitative study, also carried out, provides information on the experience and knowledge of young people in relation to drugs and explores barriers and motivating factors to illicit drug use. The adolescents' views on the current drug education and health promotion initiatives were also sought.

## Quantitative Study

Adolescents numbering 1,516, aged between 13 and 19 years of age, from 21 schools in the four counties of the North Eastern Health Board region were randomly administered a confidential questionnaire.

### *Results*

#### *Smoking and alcohol use*

This research showed that smoking and alcohol rates are high, especially when compared to national figures. Regular smoking prevalence rates were substantially higher in the Board's area compared to 1993 national rates for both male and female adolescents. At age 16 years, 40% of males and 34% of females in the region were regular smokers compared to 26% and 23% nationally, respectively. Regular consumption of alcohol (i.e., one or more drinks per week) varied between 26% at age 13 years, 81% at age 17 years and 57% overall. Patterns of male and female consumption were similar. Adolescents tended to show binge drinking patterns, with most alcohol being consumed on a Friday or Saturday night.

#### *Illicit drug use*

The findings in relation to drug use overall were very heartening. More than 92% of adolescents who were canvassed in the study had never used drugs, the only exceptions being the use of glue/solvents and cannabis as the following table shows:

**Table a. Percentage illicit drug use for each user category**

| Drug type | Never | Once | Sporadic* | Regular* |
|---|---|---|---|---|
| Glue of solvents | 80.7 | 7.7 | 9.6 | 2.0 |
| Cannabis | 75.1 | 5.2 | 10.2 | 9.5 |
| Ecstasy | 94.7 | 2.4 | 1.3 | 1.6 |
| L.S.D | 94.3 | 2.8 | 2.1 | 0.8 |
| Speed | 94.2 | 2.4 | 2.0 | 1.4 |
| Psilocybin*(magic mushrooms) | 92.5 | 2.9 | 3.8 | 0.8 |
| Heroin (smoked) | 98.1 | 1.2 | 0.4 | 0.4 |
| Heroin (injected) | 99.7 | 0.2 | 0.0 | 0.1 |
| Cocaine | 98.4 | 0.9 | 0.3 | 0.4 |
| Barbiturates | 98.8 | 0.5 | 0.4 | 0.3 |
| Cough Syrup | 95.4 | 2.0 | 20. | 0.7 |
| Other | 96.2 | 1.0 | 2.1 | 0.7 |

* Sporadic – adolescents who had used the drug on number of occasions but not regularly
* Regular – adolescents using drugs on a monthly or weekly basis

Adolescents who are regular smokers or drinkers were offered drugs more frequently than those who are not. Those who had been offered drugs were first offered drugs between 12-15 years of age at discos (28%), on the street (22%) and at house parties (18%). These adolescents are primarily offered drugs by a best or very good friend (29%) or someone their friend knew (29%).

## Qualitative Study

This research was carried out in order to gain an understanding of the views, experiences and knowledge of young people in relation to drug misuse in the North East. The focus groups included young people of both sexes, aged between 13-19 years from a variety of social, geographical, and educational backgrounds. A particular effort was made to include young people not attending main stream schools who were not included in the quantitative study.

In addition, views of adults, who, through their work, are closely involved with young people were sought. In addition to the above, seven in-depth interviews were held with young people who are still abusing or had abused in the past.

## *Results*

Most adolescents named a series of illicit drugs with little difficulty. However, there were knowledge gaps among both users and non users. All knew where drug could be purchased locally. Most people agreed cannabis, ecstasy and acid were easily available.

As with previous studies, this study found that the reasons for drug use are varied and many. The following are the reasons most commonly given by the users themselves:

- Boredom
- Personal problems almost always involving family problems
- Experimentation
- Enjoyment and sociability
- Peer influence

Research showed that peers can have a positive, as well as have a negative effect, in terms of both encouraging and discouraging drug use among themselves. While initiation into the drug world is often something that 'just happens', there are barriers to initial use and these were identified principally as follows:

- Fear
- Parents (concept of guilt, shame, 'letting them down')
- Positive peer association also acts as a barrier to initial use

Barriers to further drug use were identified and revolved around four main headings:

- Being caught by the Gardaí
- Fear of damage to health
- Bad experience either experienced themselves or witnessed in a best friend
- Changing peer group

Similar to the quantitative study, drugs that are most frequently used are glues/solvents (particularly in the 13-14 year olds) Cannabis, Ecstasy, and LSD. Recommendations were sought from this group to expand and improve drug education and health promotion initiatives and included:

- Providing more amenities for young people
- Providing drop in social centres, run by young people under the mentorship of adults
- Getting young people to help with advertising
- Devising a holistic approach to education in primary school
- Devising appropriate and effective health promotion programmes in schools as part of the education curriculum on an ongoing basis
- Harm reduction
- Alcohol abuse was a bigger problem than drug abuse and should be addressed

Those adults interviewed felt that underage drinking was a far more serious problem than illicit drugs. Recommendations included:

- A range of appropriate community responses should be prepared
- More amenities, (natural buzz to replace artificial buzz)
- Peer education
- Social drop in centres
- Parental education
- 'Reality Checking' by Health Promotion in the development of their new initiatives by including both young people and youth workers
- Outcome measurement by Health Promotion Unit of their strategies
- Harm reduction. Whilst this was recommended by some concerned adults, not all were in agreement

# 1. Introduction

## 1.1 Background

> *Drug misuse constitutes a major public health problem and initiatives to combat this problem will be given a high priority ... In addition, the experience of those working with drug misusers would indicate that use of cannabis, ecstasy, opiate and non-opiate drugs generally is increasing amongst teenagers* (Dept of Health, 1995).

The use of both licit and illicit drugs by adolescents continues to be of concern to parents, voluntary organisations, health boards and society as a whole. Empirical evidence of a high quality, at both local and national level is scarce, making estimates of drug usage rates in Ireland, as a whole and within regions, difficult. Evidence of the extent of drug misuse is needed for a number of reasons – from a public health perspective such evidence allows for more effective planning of services and health education / promotion activities. Media and newspaper coverage seems to suggest an alarming increase in smoking, alcohol and illicit drug use amongst adolescents. However, it is far from easy to discern if such reporting is reflective of a real increase in drug use amongst this group.

Given the paucity of information and the need to effectively and realistically plan for the drug situation, it is imperative that parents, health, and education professionals have reliable information on changing trends in drug use. Local data to compare with and between regions is also needed. With this in mind the North Eastern Health Board (NEHB) decided to commission a study which would address and explore issues surrounding licit and illicit drug use in the region. The study, which is reported on here, utilised both quantitative and qualitative methodologies in addressing the problem.

## 1.2 Aims and Objectives

Whilst the overall purpose of the study was to understand the extent of the problem of drug misuse in the region and to develop a multi agency approach to reduce drug misuse, each arm of the study had its own specific aims and objectives:

### *Quantitative study*

The aims and objectives of the quantitative study were as follows:

1. To document the prevalence and patterns of both licit and illicit drug usage in the school going age group (13-18 years) in the NEHB region.
2. To present a profile of users and drugs being used within this age group
3. To provide useful information to assist targeted health promotion campaigns

### *1.2.1 Qualitative study*

The aims and objectives of the quantitative study were as follows:

1. To gain an understanding of the views, experience and knowledge of young people in relation to illicit drug use in the region.
2. To explore the views of young people on current health promotion and educational strategies on illicit drug use and how such strategies could be improved.
3. To explore the level of convergence between the adult world and adolescent worlds by listening to the views of adults, who through their work and leisure, intermittently bisect adolescent worlds.

Whilst the quantitative approach is concerned with calculating the prevalence of illicit drug use in the region, the qualitative approach is concerned with exploring adolescents' knowledge, beliefs and experiences in relation to illicit drugs and their use. The use of both research techniques strives to capture the complexity, diversity, and interconnectedness of the factors shaping health behaviour and lifestyle choices. In what follows, both approaches are reported separately, however, they compliment one another, thus increasing the validity of the overall findings and the recommendations that emerge.

# 2. Quantitative study

## 2.1 Methods

The study population consisted of those attending 57-second level schools in the region. From these, 21 schools were randomly selected for inclusion in the study. The sample was stratified by county and type of school to ensure a good representation of the profile of adolescents across the region. Once selected, the principal of the selected school was contacted. After explaining the nature of the study their permission was sought to involve students in the school in a survey of licit and illicit drug use. One school felt unable to participate in the study and a replacement school was selected. Once permission was granted for access, a further random sample of 3 classes from each school was selected. The principals in each school then arranged for parental consent forms to be distributed to and collected from the students in the selected classes.
The lifestyle questionnaire used in the survey was constructed using previously published questionnaires. The main areas surveyed included; smoking, alcohol consumption and illicit drug use, dietary habits, exercise regimens and road safety behaviours. This report deals only with the results from the smoking, alcohol and illicit drug use questions.

The administration of questionnaires took place during a class period, typically 30 minutes. A researcher from the NEHB Department of Public Health performed this task. Each class was given an introductory briefing detailing the purpose of the survey, the type of questions asked, the assurance of confidentiality and the proposed outcome of the results. Students were taken through a series of practice questions to familiarise them with answering frames. Questions regarding clarification were then invited. The researcher remained in the classroom during the administration to clarify any other queries or problems arising. Teachers normally did not remain in the class. On completion, students were thanked for their participation. Completed questionnaires were checked, coded and entered on computer for analysis. Appropriate analysis was carried out using the SPSS statistical package.

## 2.2 Results

### *2.2.1 Survey population profile*

From the 21 randomly selected schools invited to participate in the survey, 1,516 adolescents were administered a lifestyle questionnaire. Table 1 outlines a profile of these students.

**Table 1. Profile of survey participants**

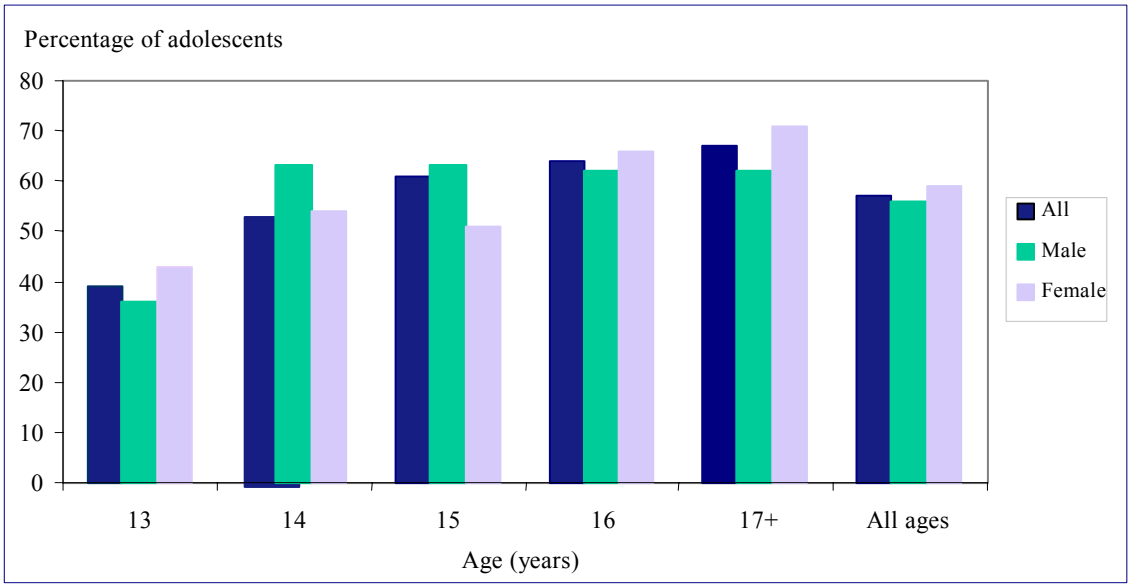
| | N = 1,516 | % |
|---|---|---|
| **County of origin** | | |
| Meath | 336 | 22 |
| Louth | 517 | 34 |
| Cavan | 372 | 25 |
| Monaghan | 291 | 19 |
| **Gender** | | |
| Male | 886 | 58 |
| Female | 622 | 41 |
| No answer | 8 | 1 |
| **Age** | | |
| 13 years or under | 372 | 24 |
| 14 | 232 | 15 |
| 15 | 236 | 16 |
| 16 | 331 | 22 |
| 17 years or over | 345 | 23 |
| **Father's occupation (1-6)** | | |
| **1.** Higher professional or managerial /farmer | 244 | 16 |
| **2.** Lower professional or managerial /farmer | 176 | 12 |
| **3.** Other non-manual | 175 | 12 |
| **4.** Skilled manual /farmer | 514 | 34 |
| **5.** Semi-skilled manual /farmer | 226 | 15 |
| **6.** Unskilled manual | 66 | 4 |
| **7.** Not answered | 115 | 8 |
| **Type of school** | | |
| Girls' Secondary | 145 | 10 |
| Boys' Secondary | 274 | 18 |
| Mixed Secondary | 301 | 20 |
| Community | 216 | 14 |
| Vocational | 580 | 38 |

In general, there was a good representation of adolescents from each county, age group and socio-economic status within the sample. As a result of the randomisation and stratification procedures, one can be confident that this sample is representative of adolescents attending secondary schools in the NEHB region.

### *2.2.2 Smoking*

This section outlines the data relating to smoking among the respondents. Figure 1 presents the percentage of adolescents who reported ever smoking at least one whole cigarette (i.e. lifetime smoking prevalence). For both genders, the lifetime smoking prevalence rate was 57% (n=865, 59% female, 56% male) across all age groups. At age 13 years more females reported ever having smoked than males (43% vs 36%), while at age 16, 66% of female and 62% of male adolescents reported having smoked at least one cigarette.

**Figure 1. Lifetime smoking prevalence amongst adolescents**




Whilst lifetime prevalence of smoking is important, of far greater importance is the proportion of adolescents who have progressed to regular smoking. Adolescents smoking at least 1 cigarette daily have, for the purpose of this study, been categorised as regular smokers. Figure 2 presents the percentage of adolescents smoking at least 1 cigarette daily for each age in years. For all ages, 31% (n=466) of adolescents were regularly smoking with more females regularly smoking than males (33% vs 30%). At age 13 years 20% of adolescents were regularly smoking (male 19%, female 22%), whilst at age 16 years, 37% of adolescents were smoking regularly (male 40%, female 34%).

**Figure 2. Prevalance of regular smoking amongst adolscents**

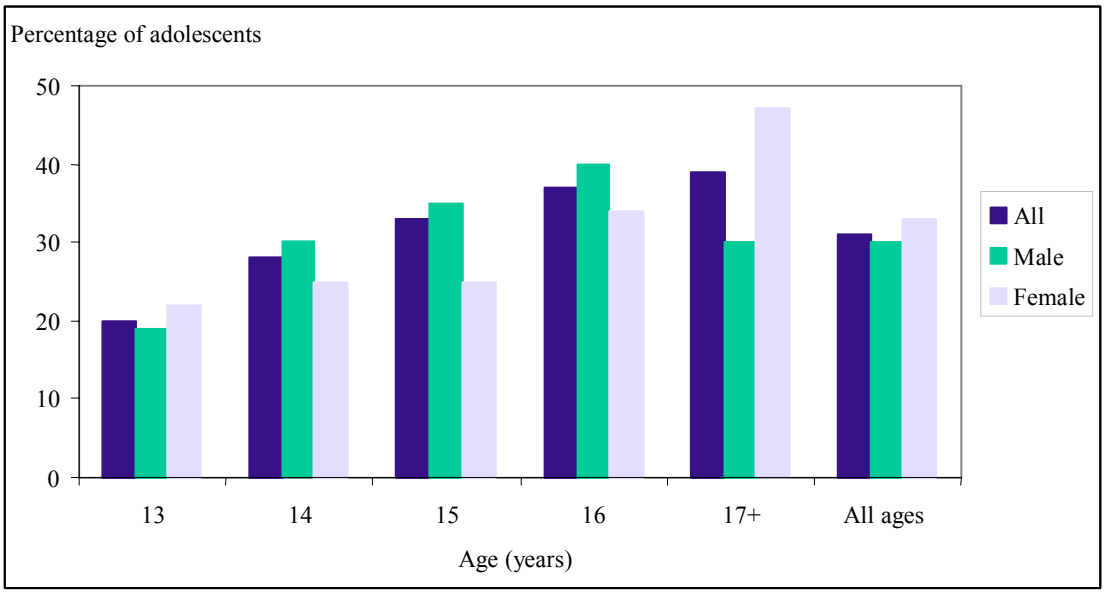
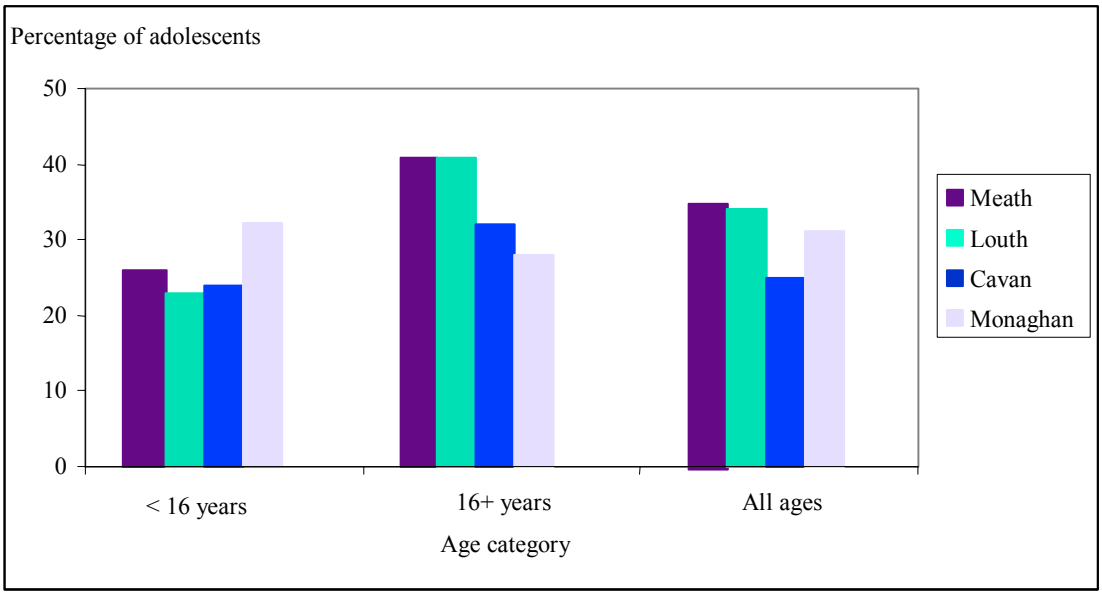



Figure 3 presents the percentage of regular smokers for each county before and after 16 years of age and across all age groups. Across all ages, Meath and Louth demonstrate the highest prevalence of regular smokers in the NEHB.

**Figure 3: Percentage regular smokers in each NEHB county**




For adolescents who report being regular smokers, Figure 4 presents the number of cigarettes being smoked daily. At age 13 years, 62% of adolescent smokers reported smoking 1-2 cigarettes a day, 29% 3-10 a day and 9% 10-20 day. For each age group beyond 14 years of age, there is a steady percentage increase in those reporting smoking 3-

10 and 10-20 cigarettes a day and a decrease in adolescent smokers smoking 1-2 a day. Very few adolescent smokers smoke more than 20 cigarettes a day.

**Figure 4. Number of cigarettes smoked daily by regular smokers**

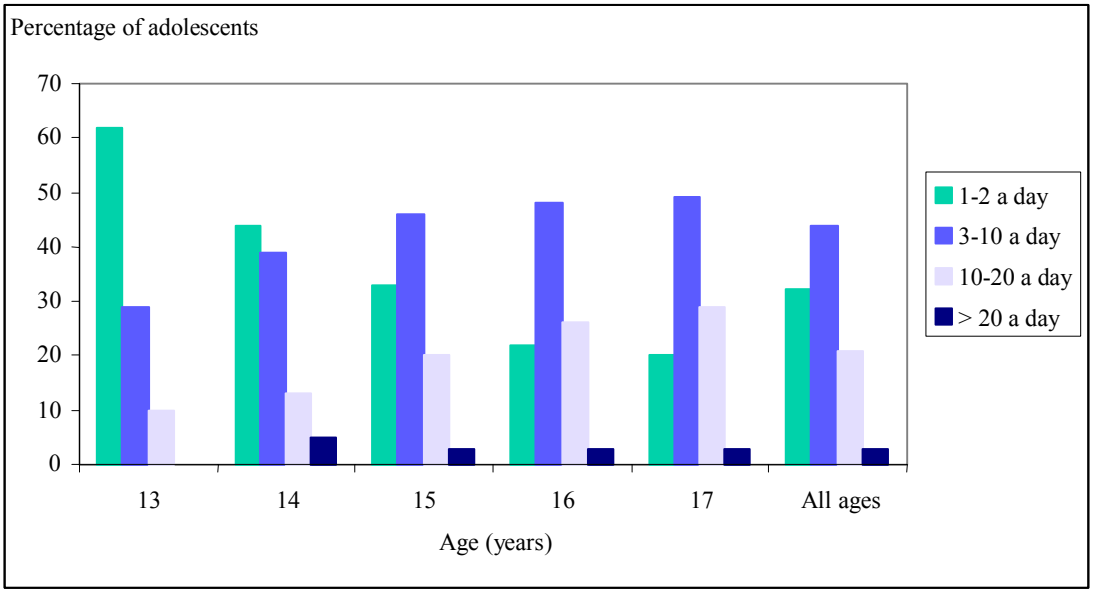



Figure 5 illustrates the age at which regular adolescent smokers report smoking their first cigarette. Six percent of regular smokers reported starting before 10 years of age. For adolescents who are regular smokers, the median age of first cigarette smoked was 12 years of age (mean = 11.95, S.D. = 1.98).

**Figure 5. Age regular adolescent smokers report smoking first cigarette**

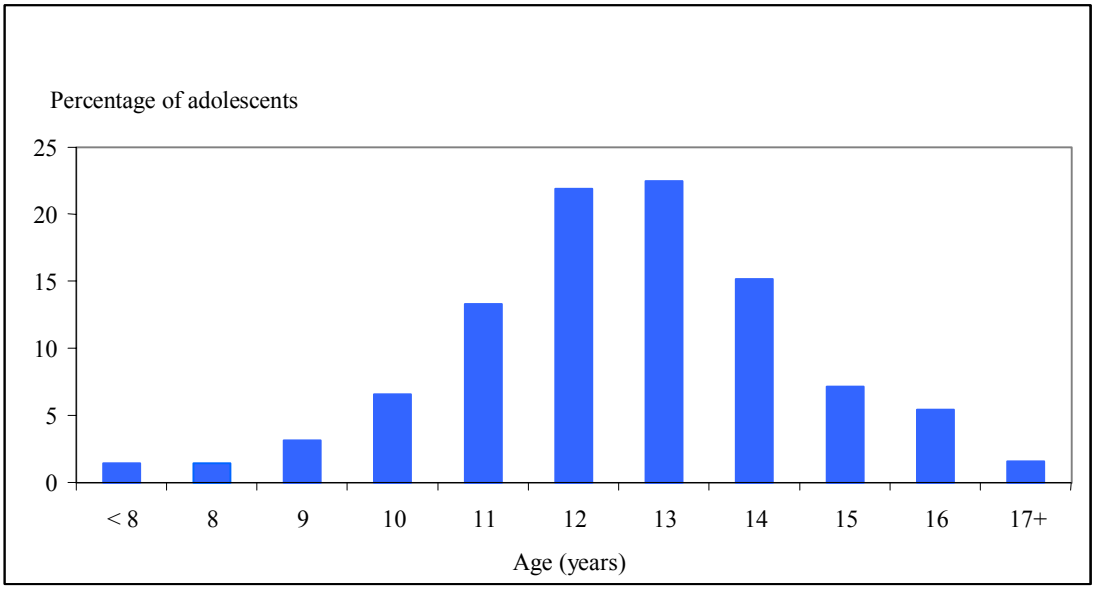



Table 2 below outlines the percentage of adolescents smoking according to social class status. Of interest is the proportion in the higher social class groups who are regular smokers.

**Table 2. Social class status of regular smokers**

| Social class | N | Smokers (%) |
|---|---|---|
| **1.** Higher professional or managerial | 244 | 86 (35) |
| **2.** Lower professional or managerial | 176 | 47 (27) |
| **3.** Other non-manual | 175 | 49 (28) |
| **4.** Skilled manual | 514 | 163 (32) |
| **5.** Semi-skilled manual | 226 | 63 (28) |
| **6.** Unskilled manual | 66 | 19 (29) |
| **7.** Not answered | 115 | 39 (34) |
| **Total** | 1516 | 466 (31) |

Although it is illegal to sell cigarettes to anyone under 16 years of age, before 16 years of age, 77% of adolescent smokers claimed to be able to negotiate the sale of cigarettes themselves. After 16 years of age, this percentage was 91%.

Table 3 outlines the percentage of adolescents who share a house with a family member who smokes. Overall, 63% of adolescents live in a house where a family member smokes. This proportion differs between adolescents who do and do not smoke. Adolescents who smoke are more likely to live in a house where at least one person smokes (76% for smokers vs 57% for non-smokers).

**Table 3. Number of people living in house who smoke**

| Number of other people living in house who smoke | 0 (%) | 1 (%) | 2 (%) | 3 (%) | 4 (%) | ≥ 5 (%) |
|---|---|---|---|---|---|---|
| All adolescents | 37 | 33 | 20 | 7 | 2 | 1 |
| Adolescent Smokers | 24 | 34 | 24 | 13 | 4 | 1 |
| Non-smoking adolescents | 43 | 32 | 18 | 4 | 2 | 1 |

Of the adolescents who smoke, 53% stated that their parents were aware that they smoked. Before age 16 years, 38% of adolescents reported that their parents were aware they smoked and after 16 years of age, 68% report parental knowledge.

### *2.2.3 Alcohol*

This section outlines the data relating to alcohol consumption among the respondents. Figure 6 shows the percentage of adolescents who have consumed at least one whole alcoholic drink (i.e. lifetime prevalence for consuming alcohol). Overall, 73% of the sample had ever drank a whole alcoholic beverage at some point (male 74%, female 71%). At age 13 and 14 years, male adolescents reported higher lifetime prevalence rates than females with 71% of 14 year old males having consumed at least one alcoholic drink compared with 52% of females. However, for adolescents aged 15 years and older this gender difference all but disappears.

**Figure 6. Lifetime prevalence for alcohol consumption by adolescents**

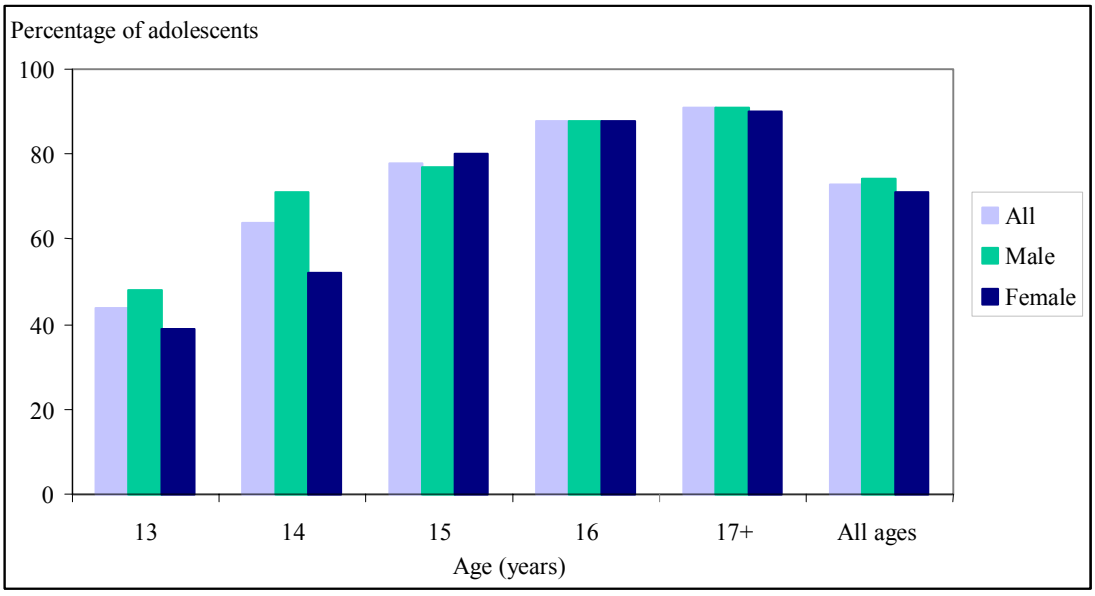
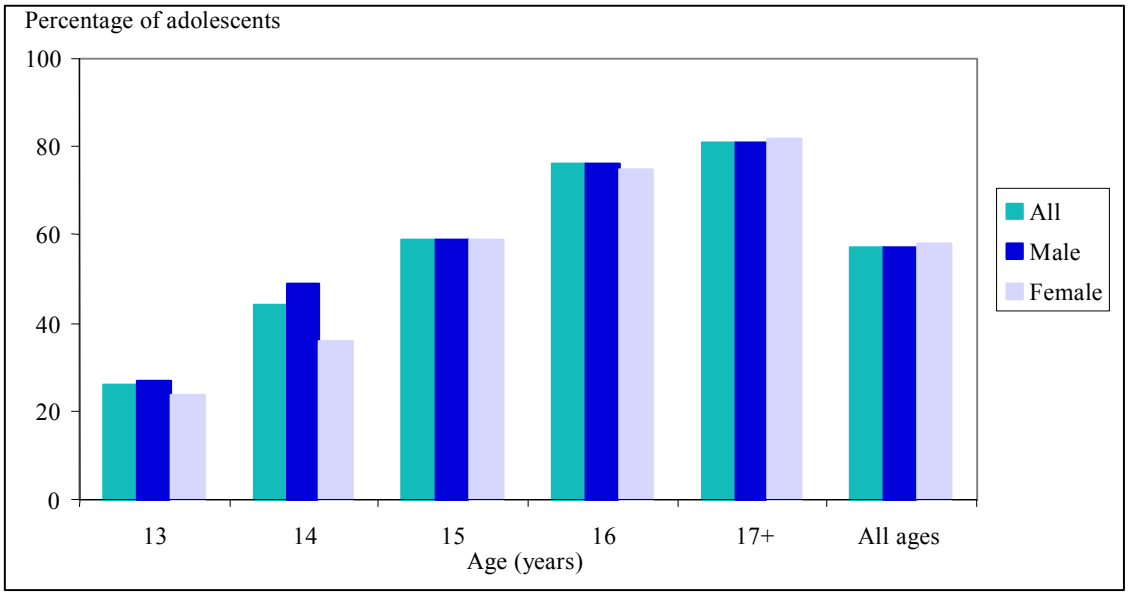



Figure 7 depicts the percentage of adolescents (male and female) who reported regularly consuming alcohol. For the purpose of this study, regularly consuming alcohol is defined as consuming 1 or more alcoholic drinks per week. At age 13 years 26% of adolescents reported regular weekly consumption of alcohol while by 17 years this figure had risen to 81%. At age 13 and 14 years, males are regularly consuming alcohol more frequently than females but after 15 years of age regular patterns of alcohol use between the sexes become similar. Further analysis of the data reveals that by 13 years of age, 3% of adolescents regularly consume 10 or more alcoholic drinks per week. At age 17 years, 39% (47% male, 32% female) of adolescents are consuming 10 or more alcoholic drinks per week. Across all ages from 14 years, males have higher regular consumption rates of more than 10 alcoholic drinks per week than females.

**Figure 7. Regular alcohol consumption by adolescents**




For those who have drunk at least one alcoholic beverage, figure 8 presents the number of times adolescents reported being drunk. At age 13 years, 42% of adolescents reported never being drunk with 34% reporting being drunk 1-2 times. With increasing age, adolescents reporting never being drunk decreases from 42% at age 13 years to 8% at age 17 years.

**Figure 8. Number of times adolescents report being drunk in lifetime**

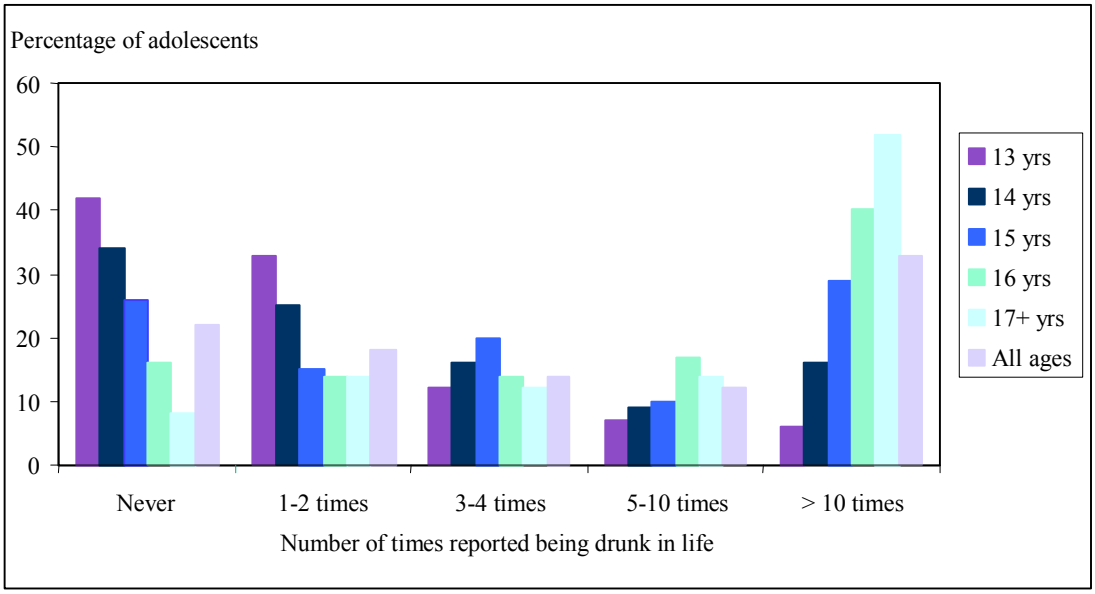



Figure 9 presents the number of reported alcoholic drinks consumed by adolescents on each week and weekend night. It is clear from the pattern of consumption that binge

drinking on weekend nights is the most common pattern with between 2 -10 drinks being the typical number of beverages consumed.

**Figure 9. Number of alcoholic drinks consumed by adolescents over typical week**

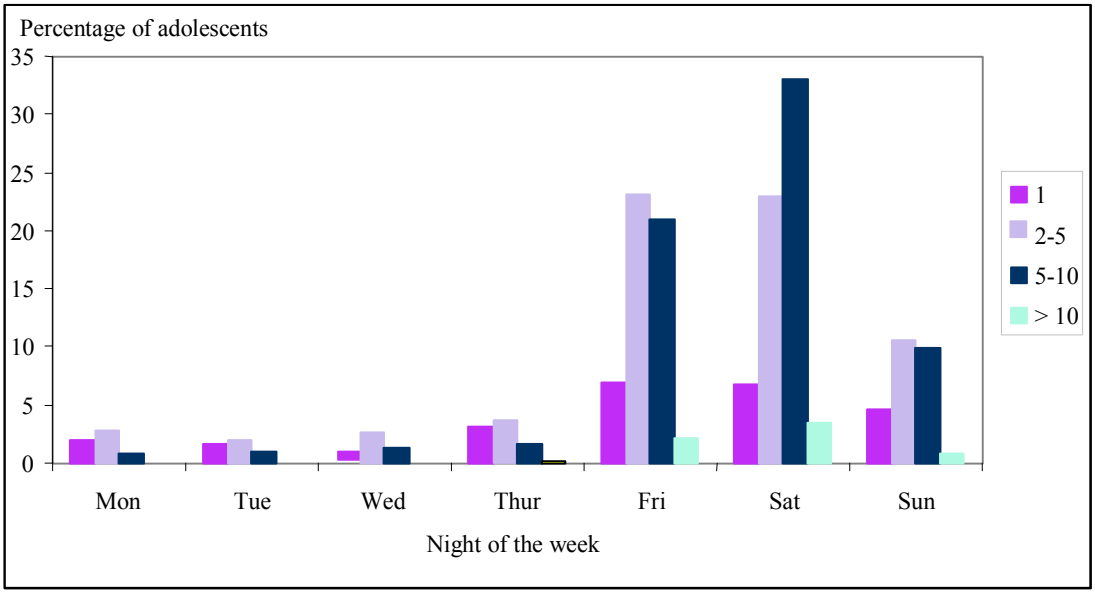
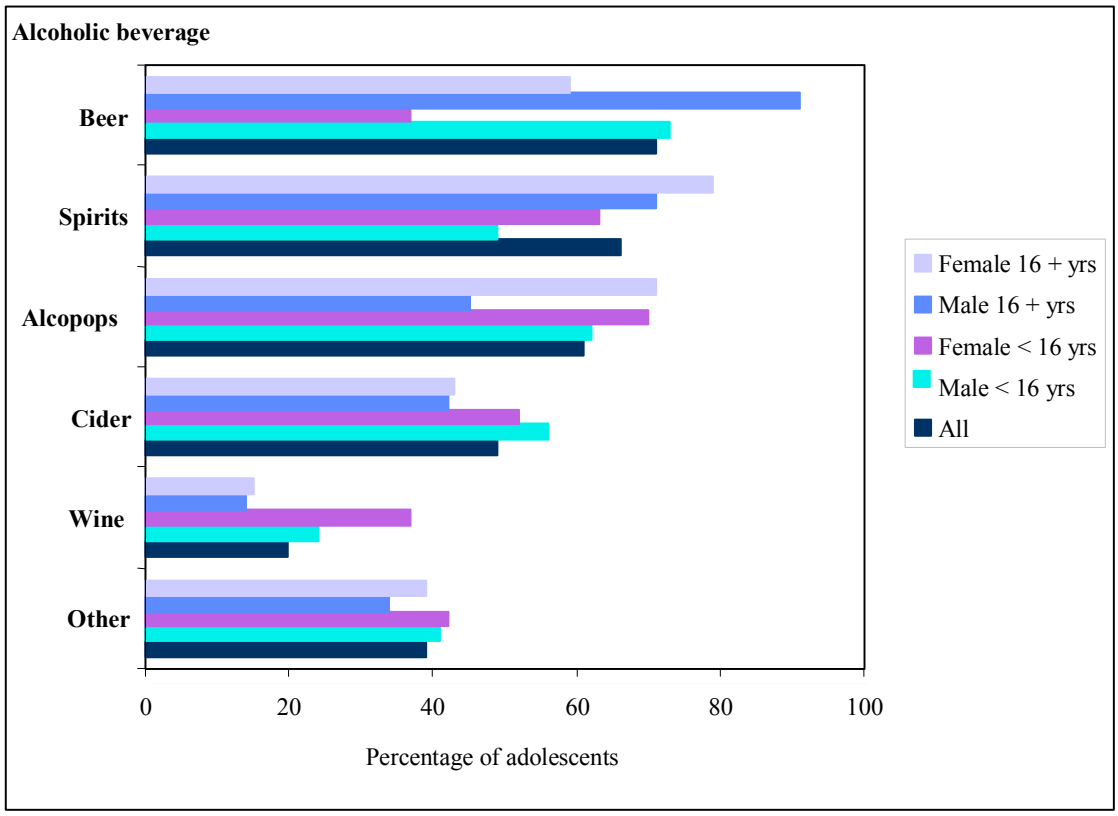



Figure 10 illustrates the type of alcoholic drinks typically consumed by adolescents.

**Figure 10. Type of alcoholic beverages consumed by adolscents**



Males typically consumed more beer than females, while females tended to favour spirits, Alcopops and wine. Cider tended to be drunk equally by both genders. This pattern was consistent for adolescents younger and older than 16 years of age.

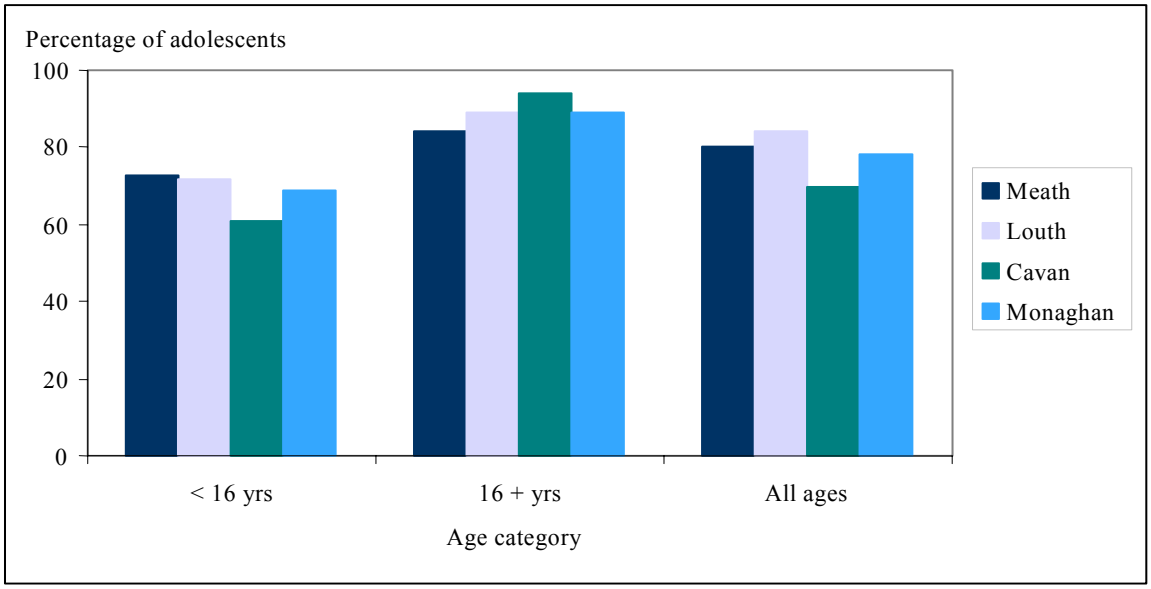
Table 4 sets out the number of alcoholic drinks consumed by adolescents per week as a function of the social class of their father.

**Table 4. Number of drinks consumed by adolescents per week by social class of father**

| Number of drinks consumed per week | Social class 1-2 (%) | Social class 3-4 (%) | Social class 5-6 (%) |
|---|---|---|---|
| 0 | 19 | 22 | 24 |
| 1 - 5 | 34 | 32 | 26 |
| 6 - 10 | 23 | 21 | 24 |
| > 10 | 24 | 25 | 26 |

Figure 11 depicts the percentage of regular alcohol consumption in each county for all adolescents and for adolescents aged younger and older than 16 years. It is clear from this graph that regular alcohol consumption is equally distributed across all NEHB counties.

**Figure 11. Regular alcohol consumption in each NEHB county**



### *2.2.4 Illicit drug use*

This section outlines the data relating to illicit drug use among the respondents.
For the purpose of this study, the use of illicit drugs is categorised as:

**(i)** ***never:*** adolescents who have never taken any of the illicit drugs listed

**(ii)** ***once:*** adolescents who have taken an illicit drug once but not more than once

**(iii)** ***sporadic:*** adolescents who have taken an illicit drug more than once but not regularly

**(iv)** ***regular:*** adolescents who have taken an illicit drug once / twice in the last week or month

Figure 12 shows the percentage of adolescents who reported ever having taken an illicit drug (i.e. lifetime prevalence). At age 13 years, 21% of adolescents had taken one or more illicit drugs at least once (21% male vs 21% female), while at age 17 years, 43% had taken one or more illicit drugs (46% male vs 39% female). Across all ages, males tended to have taken illicit drugs more frequently than females.

**Figure 12. Percentage of adolescents who have ever taken an illicit drug**

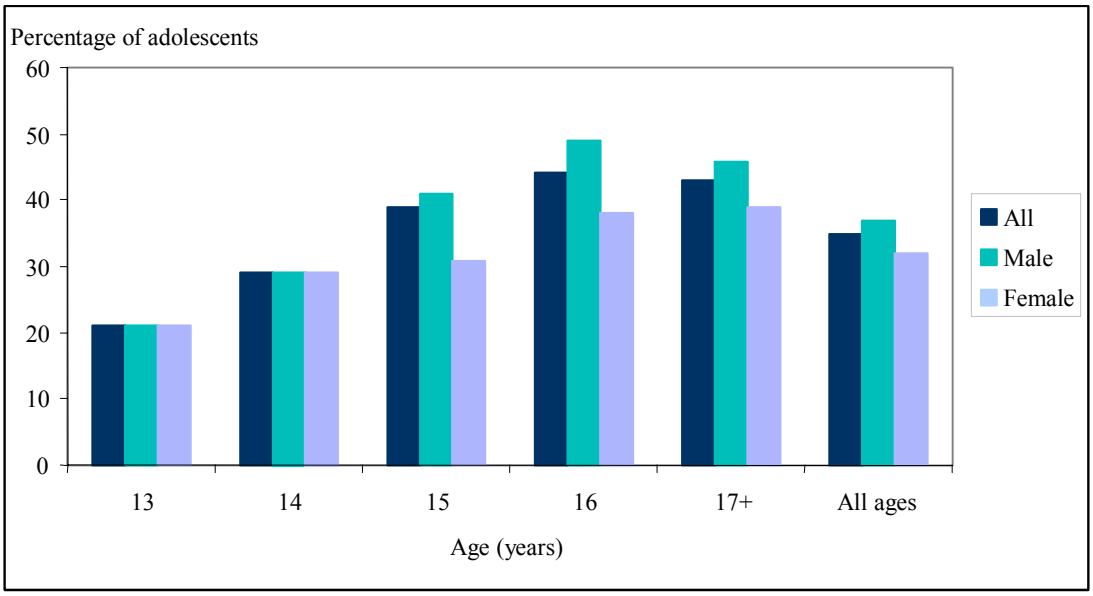



Table 5 illustrates the overall percentage prevalence use of illicit drugs for each user category for all age groups. The commonest drug used by adolescents was cannabis. Approximately 15% of adolescents had used cannabis once or a couple of times and approximately 10% of adolescents were regularly users. Solvent use tended to be once off

or sporadic with 10 - 18% of adolescents using the drug once or a couple of times. Two percent of adolescents were regularly using solvents. Use of L.S.D., psilocybin and speed tended to be once off or sporadic with prevalence of regular use low (i.e. less than 1.5%). The use of harder drugs such as cocaine, heroin and barbiturates was less than 1% across the differing user categories. Approximately 4% of adolescents reported using cough syrup once or sporadically to get high. The use of other drugs to get high was reported by 4% of adolescents in total.

**Table 5. Percentage illicit drug use across all age groups for each user category**

| Drug type | Never | Once | Sporadic | Regular |
|---|---|---|---|---|
| Glue or solvents | 80.7 | 7.7 | 9.6 | 2.0 |
| Cannabis | 75.1 | 5.2 | 10.2 | 9.5 |
| Ecstasy | 94.7 | 2.4 | 1.3 | 1.6 |
| L.S.D. | 94.3 | 2.8 | 2.1 | 0.8 |
| Speed | 94.2 | 2.4 | 2.0 | 1.4 |
| Psilocybin | 92.5 | 2.9 | 3.8 | 0.8 |
| Heroin (smoked) | 98.1 | 1.2 | 0.4 | 0.4 |
| Heroin (injected) | 99.7 | 0.2 | 0.0 | 0.1 |
| Cocaine | 98.4 | 0.9 | 0.3 | 0.4 |
| Barbiturates | 98.8 | 0.5 | 0.4 | 0.3 |
| Cough syrup | 95.4 | 2.0 | 2.0 | 0.7 |
| Other | 96.2 | 1.0 | 2.1 | 0.7 |

Decimal places are shown because of the small numbers in many of the cells

Table 6 presents the number of drugs consumed i) ever/at least once and ii) regularly for all adolescents and each sex. Overall, 17% of adolescents had ever consumed one or more illicit drug with 4% reporting having used five or more illicit drugs.

For adolescents who had ever consumed an illicit drug, it was typical for one to two types of drugs to be used. Overall, 8% of adolescents were regularly using one illicit drug with 4% using two or more illicit drugs. Males tended to have used or be regularly using more illicit drugs than females.

**Table 6. Total number of illicit drugs consumed by adolescents i) ever/at least once and ii) regularly**

| Number of drugs ever taken in lifetime | 0 drugs | 1 drug | 2 drugs | 3 drugs | 4 drugs | 5 + drugs |
|---|---|---|---|---|---|---|
| All | 65% | 17% | 8% | 4% | 2% | 4% |
| Male | 63% | 17% | 9% | 4% | 2% | 5% |
| Female | 68% | 17% | 6% | 4% | 2% | 3% |
| | | | | | | |
| **Number of drugs being regularly used** | **0 drugs** | **1 drugs** | **2 drugs** | **3 + drugs** | | |
| All | 88% | 8% | 2% | 2% | | |
| Male | 88% | 9% | 2% | 1% | | |
| Female | 90% | 8% | 1% | 1% | | |

Table 7 sets out the percentage of adolescents who have viewed each type of drug in real life for those above and below 16 years of age and across all ages. Adolescents over 16 years of age reported having seen more illicit drugs than younger adolescents did. It should be noted that some adolescents reported having seen some of these drugs in drug awareness classes given by Gardaí and other agencies.

**Table 7. Percentage of adolescents who have seen each type of drug in real life**

| Drug type | Overall (%) | < 16 years (%) | 16 + years (%) |
|---|---|---|---|
| Solvents | 45 | 40 | 52 |
| Cannabis | 51 | 35 | 69 |
| Ecstasy | 32 | 23 | 43 |
| Psilocybin | 27 | 20 | 35 |
| LSD | 21 | 13 | 31 |
| Speed | 20 | 13 | 28 |
| Cocaine | 11 | 11 | 11 |
| Heroin | 10 | 10 | 11 |
| Barbiturates | 4 | 4 | 5 |
| Other | 8 | 7 | 10 |

Table 8 outlines the percentage of adolescents who have actually been offered each type of illicit drug for all ages and for adolescents younger and older than 16 years. Cannabis, ecstasy and solvents are the three mostly commonly reported drugs offered to

adolescents. Before ages 16, adolescents tended to be offered cannabis and solvents. After 16 years, approximately 60% of adolescents were offered cannabis at some time, over one-third ecstasy and a quarter LSD and speed.

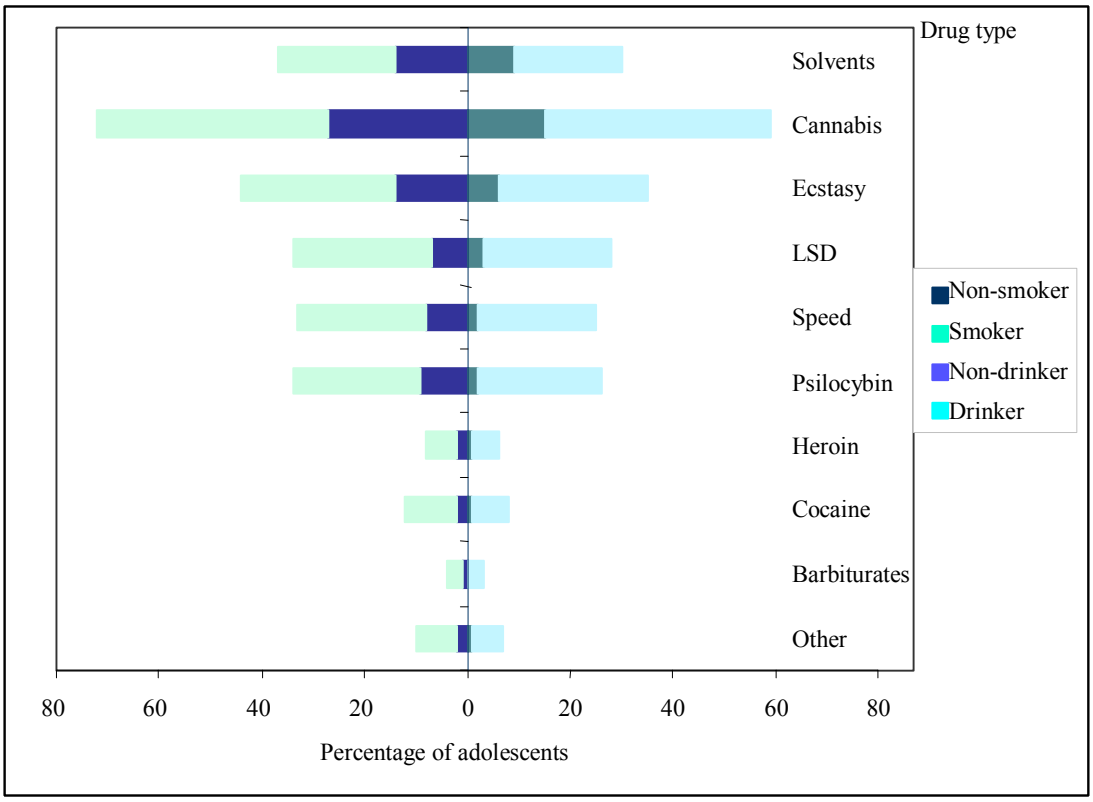
**Table 8. Percentage of adolescents who have actually been offered each type of drug**

| Drug type | Overall (%) | < 16 years (%) | 16 + years (%) |
|---|---|---|---|
| Solvents | 21 | 20 | 22 |
| Cannabis | 41 | 26 | 59 |
| Ecstasy | 23 | 13 | 36 |
| Psilocybin | 16 | 11 | 23 |
| LSD | 15 | 8 | 24 |
| Speed | 15 | 8 | 24 |
| Cocaine | 5 | 5 | 6 |
| Heroin | 4 | 4 | 4 |
| Barbiturates | 2 | 1 | 3 |
| Other | 4 | 3 | 5 |

Figure 14 depicts the percentage of smoking and non-smoking adolescents and drinking and non-drinking adolescents who have been offered an illicit drug. This graph exhibits cumulative percentages. For example, the dark blue part of this graph represents the percentage of adolescent non-smokers who have ever been offered drugs. The light green part of this graph represents the additional percentage of adolescents who have been offered drugs who are smokers. Similarly, the dark green part on the right hand of this graph exhibits the percentage of adolescent non-drinkers who have ever been offered drugs. The light blue part represents the additional percentage of adolescents who drink who have ever been offered drugs.

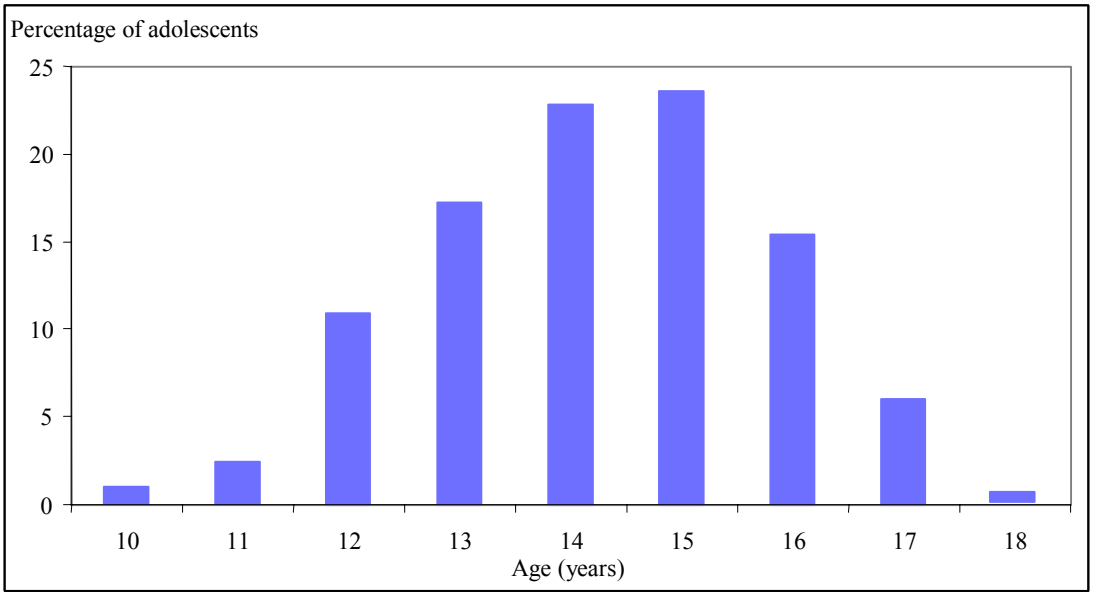
Non-smokers and non-drinkers reported being offered drugs far less often than smokers and drinkers, respectively. For example, 14% of non-smokers as opposed to 23% of smokers were offered solvents (total 37%). Across the category of non-smoker and non-drinker, cannabis, ecstasy, solvents, LSD, speed and psilocybin were the typical drugs offered to adolescents. However, rates of being offered these drugs were much higher for adolescents who smoked or drank, especially for cannabis.

**Figure 14: Percentage of adolescents offered drugs that are non-smoker or non- drinkers**




For adolescents who have been offered drugs, figure 15 shows the age at which this incident first occurred.

**Figure 15. Age adolescents report being first offered illicit drugs**




Adolescents who were offered drugs tended to be offered them between the ages 12 to 15 / 16 years of age. Across the whole sample, 46% of adolescents reported being offered

drugs at some stage. Table 8 delineates the locations where adolescents report being offered drugs. Across all ages, adolescents reported being offered drugs primarily at social events (discos, house parties, pubs and concerts) and on the street. Adolescents 16 years or younger tended to be offered drugs on street and at school more often than adolescents older than 16 years are.

**Table 8. Locations where adolescents report being offered drugs**

| Where offered | All ages (%) | < 16 years (%) | 16 + years (%) |
|---|---|---|---|
| Discos | 28 | 29 | 28 |
| On the street | 22 | 28 | 18 |
| House parties | 18 | 12 | 22 |
| Public house | 13 | 7 | 16 |
| Concerts | 9 | 8 | 10 |
| School | 9 | 14 | 5 |
| Youth clubs | 1 | 2 | 1 |

Table 9 reports from whom adolescents are offered drugs for all ages and adolescents older and younger than 16 years.

**Table 9. Person offering drugs to adolescents**

| Who offered drugs | All ages (%) | < 16 years (%) | 16 + years (%) |
|---|---|---|---|
| Best / very good friend | 29 | 26 | 31 |
| Someone friend knows | 29 | 32 | 28 |
| Stranger | 24 | 25 | 23 |
| Drug dealer | 18 | 17 | 18 |

Adolescents were asked also if they know someone from whom they could buy drugs. Fifty five percent of adolescents surveyed reported knowing someone from who they could buy drugs. Forty-three percent of those older than 16 years and 69% of those younger than 16 years reported knowing somebody from whom they could buy drugs. Those cited most often, as suppliers of drugs were drug dealers or someone their friends knew.

## 2.3 Discussion

This quantitative survey reveals the prevalence rates for smoking, alcohol and illicit drug use for adolescent's aged 13 - 19 years of age attending secondary schools within the NEHB. What follows is a brief summary of results and a discussion detailing comparison rates with other relevant studies in this area. Two main comparison studies will be used. These are a) a study by Kiernan (1995) conducted within the Western Health Board (WHB) and b) a national study on smoking and alcohol use by adolescents conducted in 1993 (Dept of Health, 1996). Both these studies were of a high quality and used similar methodologies and questionnaires to the present study. However, given the time frame and geographical differences between this survey and these comparative studies, care should be exercised in interpreting direct comparisons between these studies and our investigation.

### *2.3.1 Smoking*

Lifetime smoking prevalence rates across all ages for adolescents in the NEHB sample was 57% (56% male, 59% female). In comparison, lifetime smoking prevalence rates in the WHB were 67% with those nationally being 55%. The present study revealed that for all ages, 31% of adolescents regularly smoked, ranging between 20% at age 13 years and 39% at 17 years. These rates are above the WHB for each age category. In the WHB, 27% of adolescents regularly smoked with 7% doing so at age 13 years and 39% at 17 years. The present figures also compare unfavourably with 1993 national smoking rates. Nationally for all ages, 16% of adolescents were regularly smoking with 6% of those aged 13 years doing so, climbing to 23% at age 17 years. Within the NEHB, Meath and Louth showed slightly higher rates of regular smokers, particularly for adolescents aged 16 years and over. Adolescents in the NEHB typically smoked 1-2 or 3-10 cigarettes daily. No clear pattern of smoking rates or number of cigarettes smoked was noted for differing social class. Both these findings are consistent with the WHB and the national study. The age at which adolescents first smoke was typically between 10 and 13 years. Eighty-five percent of adolescents who smoked reported being able to purchase cigarettes themselves, a finding consistent with other studies which found that five twelve year old boys were able to buy cigarettes in 81% of retail stores visited (Doorley and Hynes, 1995). Adolescents who smoked were more likely to live in a house where at least one person smoked (73% vs 57%, respectively). This is also consistent with the national figures.

In summary, rates of regular smoking in the NEHB sample were higher than those in similar studies conducted in the WHB and nationally. Adolescents typically smoked less than 10 cigarettes a day. Most adolescents who regularly smoked, smoked their first cigarette before 13 years of age with most adolescents being able to negotiate the sale of cigarettes before 16 years of age. Finally, adolescents who smoked were more likely to reside in a household where somebody else smoked.

### *2.3.2 Alcohol*

Lifetime prevalence consumption rates in the NEHB sample was 73% (74% male, 71% female). Comparative WHB lifetime prevalence rates was 67% and national rates (1993) were 63%. For all ages in the NEHB sample, 57% of adolescents were regularly consuming alcohol. Rates of regular alcohol consumption ranged between 26% and 81% at age 13 and 17 years, respectively. Males and females after 15 years of age demonstrated similar lifetime prevalence and regular alcoholic consumption rates. For all ages, 22% of adolescents were consuming more than 10 alcoholic drinks per week. Rates of consumption of more than 10 drinks per week ranged between 3% and 39% at age 13 and 17 years, respectively. More males than females were consuming 10 or more alcoholic drinks per week.

For all ages, 22% of adolescent's reported never being drunk, 18% reported being drunk once, 26% between 3 and 10 times and 33% more than 10 times. At age 13 years, 42% of the NEHB sample reported never having been drunk compared to 91% in the WHB and 84% nationally. At age 13 years, 6% of the NEHB sample reported being drunken 10 or more times compared to 3% in the WHB. At age 17 years, 8% of adolescents in the NEHB sample report never having felt drunk. At the same age, 31% of the WHB sample and 37% of the national sample reported never feeling drunk. Fifty-two percent of the NEHB sample had been drunk more than 10 times by age 17 compared with 30% in the WHB. Adolescents in the NEHB displayed binge-drinking patterns with typically 2 to 10 drinks consumed on weekend nights of Friday and Saturday. Males and females younger and older than 16 years tended to prefer different categories of alcohol. For adolescents younger than 16 years, males tended to favour beer, Alcopops and cider and females tended to consume Alcopops, spirits and cider. For adolescents older than 16 years, males tended to favour beer, spirits and Alcopops and females spirits, Alcopops and beer.

### *2.3.3 Illicit drugs*

Lifetime prevalence of illicit drugs across all ages for adolescents in the NEHB sample was 35% (37% male, 32% female). In comparison, lifetime prevalence in the WHB across all ages was 24%. The overall reported use of illicit drugs by adolescents in the NEHB region is low. Adolescents reported using solvents, speed and ecstasy on a once off or sporadic basis. Cannabis, with 10% usage, was the only drug that appeared to be used by adolescents on regular basis. Adolescents tended to have used or be using one or two types of drugs with males using slightly more drugs occasionally or regularly than females. Of adolescents who have been offered a drug, cannabis, ecstasy and solvents tend to be the typical substances offered. Adolescents over 16 years were offered drugs more often than adolescents younger than 16, as were those who smoked and drank. This pattern was particular relevant for cannabis. If offered, adolescents tended to be first offered an illicit drug between 12 and16 years of age. Adolescents tended to be offered drugs at social events such as discos, house parties and in the pub and they primarily obtained drugs from a best or very good friend or at least someone their friends knew. Typical patterns of usage of drugs were:

- **Solvents** - their use tended to be once off or sporadic and occurred most often in the 12 – 15 age group. Approximately 10% of adolescents had used solvents sporadically with the highest concentration being in Louth and Monaghan.
- **Cannabis** - regular use of cannabis was strongly associated with age. At age 13 years, 1% of adolescents were consuming cannabis regularly whilst at age 17 years, the prevalence of regular consumption was 17%. Cannabis use was also related to an adolescent's wealth (derived from pocket money or job money). Adolescents with more individual wealth consumed cannabis at higher rates for each user category. Cannabis use across each user category was highest in Louth and Meath.
- **Ecstasy** - use of ecstasy in absolute terms was low with 0.3% of adolescents at age 13 years and 3% at age 17 years using ecstasy regularly. Ecstasy use was highest in Meath and Louth but differences between the counties were small.
- **Other drugs** - the use of other drugs such as LSD, speed and magic mushrooms tended to be sporadic with regular use highest amongst older adolescents (16 – 17 years). The use of amphetamines such as cocaine, opiates such as heroin and barbiturates was less than 1.5%.

# 3. Qualitative Study

## 3.0 Introduction

*While quantitative research surveys the field qualitative research mines it*

In order to develop effective future strategies to deal with adolescent drug misuse in the North East it was felt that, in addition to exploring the prevalence of drug misuse, a qualitative approach which explores why, when and how adolescents use drugs was also necessary.

Adolescents too are concerned about drugs, but their concerns are of a different kind. They are the ones who choose which drugs, if any, to try; who decide which patterns of use to settle on; who experience the effects of drugs and; who live and move in the underworld of drugs. Their story is their reality, a reality that has consequences for both parents and health educators alike and hence it was vital that we heard this story.

## 3.1 Methods

Eighteen focus groups were held in total, the average group size being eight. Eleven of these focus groups were with adolescents and seven with adults referred to as 'Concerned Agents'. Focus group methodology does not provide data which is generalisable, because a random sample is not selected. Rather, the sample is selected to provide the most meaningful information in terms of the study objectives. In this instance the focus groups aimed to explore diversity rather than to establish any kind of 'representativeness'.
The focus groups with young people included males and females aged between 13-19 years drawn from a variety of social, geographical and educational backgrounds. A particular effort was made to include young people not attending main stream schools, as these had previously been included in the quantitative study. To this end the sample was taken from a number of sources:

- ❏ Third level institutions in the North East (First Year Students)
- ❏ Early School Leaving Programmes (FÁS, Youth Reach Programmes)
- ❏ Youth Clubs
- ❏ Children not in any kind of formal education ('Street Kids')

Within the above there was an attempt to achieve balance in the following areas of representation: urban / rural, upper and lower end of the adolescent age spectrum, male/female, social class and the settled and travelling community.

The adult focus groups, were drawn from sectors of the adult population who, through their work, are closely involved with young people. These ranged from Juvenile Liaison Officers, Home School Liaison Officers, various strands of Youth Workers from Foróige, to Out Reach Workers, and members of a Drug Awareness Group. In addition to the focus groups outlined above, seven in-depth interviews were held with people who are still abusing or who have abused illicit drugs in the past. This dimension facilitated greater exploration of issues that arose at the level of the focus groups and, in addition, allowed the researcher to explore in greater depth the social biography or 'career' of the drug user.

All interviews, each lasting approximately 1hour 30minutes, were audiotaped with the consent of the participants. These were later transcribed verbatim. Initially, transcribed interviews were read and summary memos prepared. Following this all interviews were read again and first level codes were assigned. These first level codes were then later clustered into categories and analysed by means of a case order matrix, using a social worlds approach as a methodological framework. This social worlds approach which is used to frame this study, suggests that it is unhelpful to speak of *the* ***world of illicit drug use***, but rather that illicit drug use is best understood as occurring, within and between different adolescent social worlds.

## 3.2 Results from Adolescent Interviews

### *3.2.1 Knowledge and beliefs: From ignorance to folk pharmacology*

There is a popular perception that young people are very 'au fait' with the effects of different types of illicit drugs. However, during focus group discussions this perception came under some degree of scrutiny. The focus groups all contained both users and non-users, which facilitated some insight into the user non-user dichotomy. Early in the discussion it emerged that while most members could name a series of illicit drugs with little difficulty - citing solvents, cannabis (hash), ecstasy (E), amphetamines (speed) and LSD (acid) as the most readily available -there were information gaps from both users and non-users. The non-users were vague at best and ignorant at worst when it came to

discussing illicit drugs in more detail. This was particularly true of younger adolescents and members of the travelling community. The following quotes reveal this:

*Q: What's Coke ?*
*A: That's heroin as well.*

Fourteen year old - travelling community (female)

*Q: What are uppers?*
*A: I don't know.*

RTC Student

*Q: What's hash? is that powdery stuff or tablets or what?*

Fifteen year old – travelling community (female)

The users on the other hand were quite familiar with the commonly used drugs, and often, in the course of the focus group discussion gave a lesson to those less well informed. This group, however, relies on an elaborate belief system about the immediate and long-term effects of different types of drugs. They have their own "Folk Pharmacology" and evidence of this runs throughout the transcripts.

The term "Folk Pharmacology" refers to the way in which knowledge is 'remanufactured' about drugs in adolescent worlds, which is not always consistent with that found in scientific literature. The belief system, revolves around four types of reasoning illustrated below:

**1.** Side Effects of Different Drugs

*The only thing addictive in the hash is the nicotine, it is the tobacco. A lot of people who are getting addicted to it...they think it is the joint but it is more the nicotine.*

RTC Student (male)

**2.** Variation in Drug Effect by Social Setting

Users believe that the mood you yourself are in, the people you are with, and the general ambience in which the drugs are used, all contribute in a positive or negative way to the drug experience. Pharmacological make up of the drug may have some part to play, but the emphasis here is more social than scientific:

(a) Regarding Effects of Cannabis

Female: *Sometimes it is good and sometimes it is not.*
Researcher: *And that depends on?*

Female: *It depends on the mood you are in, the atmosphere.*

RTC Student (female)

(b) Regarding Effects of ecstasy

Male: *It depends again on the atmosphere you take it in and the type of people you hang around with. If you are with friends it doesn't really matter but if you are with people you don't know, well then you are in trouble.*

RTC Student (male)

**3.** Pharmacological Make Up of Illicit Drugs They Use

In the in-depth interviews in particular, users were sometimes anxious to explain how they classified the drugs that they had used. In some instances, as the following quote reveals, there was an attempt to refine previous pharmacological explanations:

*I don't know a lot about LSD, you know like, but there are loads of different kinds of LSD, The LSD 25 that is the hallucinogenic, potent one ... the other forms of LSD do nothing. I don't think they are hallucinogenic - 25 is the one that is hallucinogenic.*

Nineteen year old - unemployed (male)

Regular ecstasy user (Past): *You see there is heroin in E.*

Seventeen year old - early school leaver (male)

**4.** Categories of Drugs

For the most part young people did not categorise drugs into 'hard drugs' and 'soft drugs', rather, they spoke of drugs that 'normal people' use and then 'other drugs'. While ecstasy was sometimes seen as the interface between these two worlds it was still part of the *'normal'* repertoire of drugs. Cocaine and cannabis were different worlds altogether as this adolescents explains:

*I don't think that there is a connection between drugs like hash, LSD or E which I would consider drugs that normal people would be using as compared to like cocaine & heroin.*

Nineteen year old - third level student (male)

At the other end of the spectrum , for some glue sniffing and drug taking are not compatible activities at all.

*I was sniffing but I wasn't doing drugs.*
*They are probably not taking drugs, but they are sniffing or something.*

Fifteen year old - school drop out (male)

The term 'druggie' was only used for those involved in heroin use. Users in this study would never categorise themselves as 'druggies' rather they were involved in what they referred to as *'normal'* drug use or *'occasional'* drug use.

### *3.3.2 Availability, procurement & distribution networks in adolescent worlds*

**(a) Availability**

While knowledge gaps existed between users and non-users in relation to the specifics of illicit drugs, this same gap was not replicated when exploring their knowledge on the availability of illicit drugs. In all youth groups, both users and non-users were familiar with where drugs could be purchased locally. Most people agreed that cannabis and acid were easily available, while a few said that, although it was not at as easy to get hold of heroin if you really wanted to you could get it. This finding suggests that while ease of access to the illicit drug market may facilitate use, availability on its own is not a motivating factor.

**(b) Procurement & Distribution Networks**

While both users and non-users knew generally, how to go about getting drugs if they wished, the nuances of actual drug procurement were, however, confined to the user. In this instance what emerged was that unlike the adult world of drug dealing where the distribution system of drugs revolves around large quantities of money, is fed on a value system of greed and sustained by an elaborate crime network, procurement of drugs in adolescent worlds, for most part revolves around concepts of *friendship, reciprocity and sharing***,** where money is pooled and drugs are shared among friends. The stakes involve friendship not profit.

*Q: Do you think drugs could be related to crime?*
*A: I'm sure some of it is but that's because they are like that anyway, if you are smoking dope it doesn't cause you to go out and get money for it ... you buy drugs if you have the money and if you have none you don't really buy them.*

Nineteen year old - unemployed (male)

Sometimes in fact the transaction involved no money at all as the following respondent points out:

R: *I wouldn't pay for it.*
*Q:Any time you got them then you didn't pay?*
*R: I paid once and my friend paid the other time.*

Fifteen year old - secondary school student (female)

They go '*halfers*, '*save*' what resources they have, all the time *sharing* what they get. The following quotes sum up this process:

> *Q: How much is it (acid)*
> *A: A fiver for one... but like that's two fifty each if you go halfers ...*
>
> Fifteen year old - Street Kid

> *Every one puts their money together to get it… (hash)*
>
> Eighteen year old (male)

While friends use drugs together, it is also friends who are the main suppliers of drugs. Very few drug purchasers are anonymous. Adolescents in this study described three activities that are involved in the procurement of drugs, dealing, selling and 'middle men who get drugs'. While these terms are not always consistent they refer to patterns of behaviour, which are described by youths defining their own activity as well as the activity of others. One young lad summed it up when he said:

> *There is a difference between a small dealer who sells it for his own personal gain and the big dealers who are basically into it for the money.*

**(i) Dealing:** This refers to the process where drugs are bought directly from the adult world. This level of activity involves a lot of drugs and cash. Profit margins can be substantial.

**(ii) Selling:** This refers to the process where adolescents sell drugs directly to individual customers in relatively small amounts. They obtain their supply from another adolescent. The profit margins here are relatively small.

**(iii) 'Middle Men Who Get Drugs':** This refers to the process where adolescents know how to *'get drugs'* on behalf of their friends, they never hold any drugs for sale themselves, they do not make a profit but some are rewarded with a free joint for their efforts.

**Dealing:** In this instance while *dealing* was mentioned as an activity that occurs in relation to the distribution of illicit drugs there was little evidence to suggest that any of the adolescents in this study were involved at this level. One or two young people did admit to being involved in selling, but even then the profit margins were relatively small. The

following quote displays this activity:

**Selling**: *It was raining and your man came up to me and he said do you want half an acid tablet. He wasn't really a friend he was hanging around with my friends *** was his name or something and he was from Dublin.*

*I took whatever your man gave me to sell so I still owe him money...one hundred and fifty pounds.*

Seventeen year old - early school leaver (male)

Selling, as the above quote suggests, was in evidence in this study but 'getting drugs via a middleman' was the activity most used in the procurement of drugs. The following quotes highlight this point:

*Q:Where would you get your supply from? (hash)*
*A: I used to get them from a friend.*

Fourteen year old ( female)

*I couldn't get to ****** but I have a friend up there and he gets it for me.*

Sixteen year old – Youth Reach

*Word spreads around, everyone knows the same kind of people everyone just knows what to do.*

Seventeen year old (female)

*It's always the friend who knows someone who will get it for you.*

Eighteen year old (male)

Adolescents buy from another adolescent, or they will approach a middleman who gets drugs on their behalf, but they always know whom they are buying from. This is important, according to the young people, not so much for health reasons, but for economic reasons. Knowing the person they believe, ensures that what they get will be good value for money. This is particularly true with cannabis.

*I wouldn't take nothing from a stranger, I wouldn't give my money to a stranger ... they might try to rip you off or something. Yes put it in the microwave it goes big, but there is nothing in the middle of it.*

Thirteen year old - school dropout

*You would buy it from someone you know if you know them better.*

*Q: Why?*
*A: Because they will give you a better deal.*

Fourteen year old (male)

With ecstasy, health reasons are given greater priority, friends somehow they believe will not sell them something contaminated that might damage or injure them.

> *Well if you are really good friends with them they wouldn't do that. You would be more convinced that they wouldn't do anything to harm you, you would be safer like.*
>
> Fifteen year old (female)

Risk, it would seem, is not just a biological fact but it also has a social aspect to it. As the above quote suggests, risk in relation to ecstasy for some users is defined not in biological terms, but in terms of social distance, i.e., friendship. Good friendship acts in some way to reduce harm, that is what they believe, that is how they define risk. If adolescents, for the most part, get drugs for one another and from one another, how relevant is the stereotypical image of the drug pusher? The term drug pushing is often used to describe the drug distribution network in operation in the adolescent world. In fact, in the Concerned Agent groups [adult groups] this came up on a few occasions. In reality, drug pushing it would seem, is no longer apt at describing what is happening in the adolescent world. Pushing depicts passive adolescents who are coerced into taking drugs against their will – this is not their reality. They describe being offered drugs or seeking out drugs for themselves:

> *Ah you would have to root for it (acid)*
> *Q: How about E ?*
> *A: You still have to kind of...*
> *Q: And hash.....?*
> *A: You don't have to root for hash.....you go to someone that gets it for you.*
>
> Nineteen year old (male)

The way that an adolescent comes into contact with illicit drugs, is offered them and accepts them does not just happen out of the blue, because a 'pusher emerges' selling his 'stuff'. Rather adolescents are initiated into illicit drug use via social mechanisms that include ideologies as to what constitutes acceptable and unacceptable behaviour. Thus contrary to popular perception these finding would suggest that illicit drug use is more likely to spread along friendship lines, and social networks than via 'the evil pusher'. The quantitative study confirmed this.

### *3.2.3 Motivating factors to illicit drug use*

While insights into the knowledge base that adolescents have on illicit drugs and the distribution network that they use is important, the constant question on most adults lips, and in particular the health professionals, is 'why do young people use drugs?' Like previous studies, this study found that the reasons for drug use are variable and in most cases multiple. The following, however, are the reasons most commonly given by the users themselves:

**1.** BoredomThroughout the transcripts boredom was a theme that arose regularly when users discussed what motivated them to take drugs. They describe their experience of having nothing to do.

> *Because there is nothing like to do, what is there to do here, there is pubs, there is an arcade, there is a cinema.*
>
> Fifteen year old - secondary school student (female)

> *Q: Why do you smoke the hash?*
> *R: To get out of your boredom.*
>
> Fifteen year old - school dropout (male)

> *R: It does, you have to admit if you are sitting there and there is nothing to do and you are smoking and getting the buzz.*
>
> Sixteen year old (female)

The emphasis here is on structural deficiencies in the adolescent's world. The boredom these adolescents describe is that of being located in a society where readily available activities are unavailable, either because they are too expensive or not suitable to their needs

**2.** Personal Problems Both users and non-users also referred to problems in their lives as motivating factors for drug use. These problems did not revolve around exam pressure, boy/girl relationships, etc., but rather they almost always involved family matters. This female attending a youth reach programme explains why she, like others in the focus groups, began taking cannabis:

> *You know from my own family, like my father is an alcoholic right and my mother was looking after him so when I did have problems I couldn't go and ask them to talk to me ... I had no one to talk to and I had problems and who was I meant to sort these out with, so the way I dealt with them for a while anyway was taking hash.*
>
> Fifteen year old - youth trainee (female)

Some explanations are more oblique:

*Q: So you kind of half expected it some day?* (family breakdown*)*
*A: I' didn't even think about it.*
*Q: Who did you live with when they split up?*
*A: My father, I never really think about them I have so much other shit going on in my head.*

Nineteen year old - school dropout (male)

**3.** Experimentation For others, induction into the drug scene was often explained, not as something planned, but rather, something that 'happened' primarily driven by the motive of experimentation. They took drugs for '*the craic,' 'out of curiosity,'* just to *'see what it was like*'. For some this is the main motivating reason.

*Q: Why do you think young people get involved in drugs, if you were to say one thing what is it?*
*A: Curiosity and the excitement of it.*

Nineteen year - old unemployed (male)

**4.** Enjoyment & Sociability All users, in discussing their own drug use, however, emphasise that they take drugs primarily because they enjoy their effect and sociability. This despite the fact that their induction into the drug scene was often unpleasant or ineffective at the outset. For some, their unpleasant experience reduced their use of that particular drug, for others it was just deemed a rite of passage as the following extracts hi-light:

*Q: What was it like the first time you took it? (hash)*
*A: Sickening to tell you the truth, sickening.* (Continued to take it)

Nineteen year old - in employment (male)

For others a bad induction phase reduced subsequent use. This was particularly true for the hallucinogenic type drugs - LSD and some of the solvents:

*Q: Have you tried LSD - acid?*
*A: Acid just twice, I don't know if I would do it again.*
*I did it once and I freaked my first time.* (He used it again, once, but not since.)

Student (male)

For others, unpleasant induction was just deemed a 'rite of passage':

> *It was horrible (Acid), I thought it was horrible with hallucinations and that, you feel horrible. At first it is all right, but you'd freak out and that on it you know, get bad trips and you won't like it...*

*Q: And did you ever get a bad trip?*
*A: Most of the time.*
*Q: And still you kept taking it?*
*A: I'd stop when I would get a bad trip, I would stop for a week or so and then go back on it again.*
*Q: And why would you go back on it even though it was horrible?*
*A: Don't know, I was just acting the big man around the big boys.*

Seventeen year old (male)

**5.** Peer Pressure in Context: Peer Pressure or Peer Preference? As the previous quote suggests, peers do influence other peers to take drugs. However, the stereotypical view of peer pressure as that of a ' *negative social force that results in unwilled behaviour and involvement in proscribed behaviours'* (Glassner & Loughlin 1989) seems is no longer apt in describing what is happening in adolescent worlds as it obfuscates the positive influence peers have on one another. In addition, it ignores that fact that young people are individuals with a capacity to choose. They choose which peer groups to join, which peer groups to leave, and which new peer combinations to associate with. The following quotes display the many aspects of peer association and in doing so go give credence to the notion that peer group affiliation arises more from peer selection than peer pressure. Most users, in describing how friends influenced their own drug use rarely used the term pressure. What they described was more peer empathy or modelling. Pressure and friendship for adolescents it seems are incompatible concepts:

> *There was no pressure involved like you know. I know I should have said no, but I didn't I don't know whether that is because, I think it was more to do with emotional bonding with the lads who were taking it you know what I mean. They were taking it so I was taking it. You know a mate is a mate.*

Nineteen year old (male)

The tendency of friends to be similar in attitudes and behaviour has long been acknowledged and the part played by the selection of similar friends in producing this group homogeneity is well recognised. It does appear from this study, as with previous studies, that it is not the group that seeks the young person, but rather the young person who wishes to experiment or use drugs on a more regular basis who seeks out a drug-using

group. In addition, while adolescents who wish to use or experiment with illicit drugs select peers with a similar worldview, the reverse is also true. Peer association can also be based on a value system that revokes the use of illicit drugs. The following extracts highlight these points:

**(a) Peers As Protectors: Peers Influence Conformity To The Legal Norms**

> *I went to a good few of them (Raves), but I don't go to take drugs, I go for a night out with my friends like. We wouldn't attempt to take them.*
>
> Sixteen year old - youth reach participant (female)

> *I was offered some ... it was the white powdery stuff I think it was speed or something like that.*
>
> *Q: Why did you decide not to take it?*
> *A: Cause, like I don't know my friend was sitting down beside me and she doesn't do anything like that.*
>
> Sixteen year old - secondary school student (female)

**(b) Peers as Healers**

> *Q: Who was the mates you hung around with,?*
> *A: There was a fella I hung around with and he wouldn't touch it so I gave it up with him, he didn't touch it, so after a while I said fuck it and I gave it up.*
>
> Eighteen year old (male)

While males and females within the same group take drugs together, one influencing the other's habits, the reverse is also true. Female non-users, it appeared, did have a positive influence on the drug use of their boyfriends as the following quote suggests:

> *Q: What made you give them up?*
> *A: The girl I was going with. Well any girl I went with they said to me. Marie was the same she said to me she didn't like it, she wouldn't like me doing it so I said well I won't.*
>
> Seventeen year old (male)

This is in keeping with the social worlds approach, where the conceptual imagery is of groups emerging within social worlds, evolving, developing, splintering, and disintegrating. In the sub world of adolescent drug users, peer groups disintegrate and new ones are formed all the time. While new peer groups can have a negative influence on some of its members, the reverse is also true, users seek out new peers and places as they

'try to quit' or as a long term protective barrier to further use. This of course can be a difficult process, and realigning with another peer group may take some time. Nonetheless, it is possible, as this male adolescent explains:

> *I don't hang around with anyone (from the group)...*
> *Yes sure I know I can't hang around with the lads and that's just it you know what I mean.... you have to stop hanging around with the people you were with, stop going to the places you were going to, and...* [doing the things you were doing].
>
> Nineteen year old (male)

*Q: Do you think peers can dictate a lot of what you do?*
*R: Yes in a lot of cases they can yes, but then again there is choice even in a group situation.*

It would seem from these findings that adolescents choose friends to correspond with their own usage preferences rather than changing their drug taking patterns simply to respond to friends pressure. These findings suggest that the influence of peers is far more intricate than the term 'peer pressure' suggests.

### *3.2.4 Barriers to initial & subsequent use*

Understanding why and how young people use illicit drugs is important to the development of future health strategies but so too is understanding why some young people do not take drugs. Barriers and motivating factors are, in a sense, mutually related**.** All focus groups contained both users and non-users so this provided a fertile opportunity for exploring the user non-user dichotomy. Early in the discussions it emerged that the 'non-using group' are not a stable group, but rather is comprised of 'vulnerable non-users and 'resistant non-users'. Vulnerable non-users refers to those non-users who, while they are presently abstaining, express the possibility that this might not be a stable pattern of abstention. Some of them often fluctuate in thinking about the possibility of using drugs at some time in the future.

**(a) Vulnerable Non-Users**

> *I'm saying now that I probably won't take drugs, but I have a feeling that sometime I will.*
>
> Fourteen year old (female)

> *I have never taken drugs but I have been around it like but I mean I don't want to. I drink and I smoke ... but maybe I'll lash out sometime I don't know.*
>
> Third level student (female)

**(b) Resistant Non-Users** In contrast this group was adamant that they would never use drugs.

Barriers to initial use according to the resistant non-users revolved around three main findings:

**1.** Fear: Fear of damage to their health, fear of addiction, fear of death (ecstasy).

> *I wouldn't take drugs or anything. It's stupid.*
>
> Fourteen year old (female)

> *But you could die on just one E.*
> *Well that case of Leah Betts in England she took just one that night...she took it and it killed her.*
>
> Fifteen year old (female)

**2.** Drug Use, Shame and Parents In discussions with females, particularly middle class females, concepts *of 'shame' 'guilt' and 'letting parents down'* emerged as barriers to use in this group. It seems that the notion of 'shame,' 'respectability' and 'reputation' act as agents of social control for some adolescents. This theme was less in evidence among male teenagers. However, this maybe due more to their reluctance to disclose this, rather than the absence of '*shame'* as a potential barrier for them.

> *My Dad kind of trusts me not to take them. I told them I would never take them.*
>
> Fifteen year old - secondary schools student (female)

> *I smoke and I drink but I would never take drugs because it would break my parents heart and I could never do that.'*
>
> Nineteen year old - third level student (female)

> *They won't do it to such extremes, I think if parents care you know and you know they care...you feel guilty.*
>
> Drug user (male)

**3.** Positive Peer Association: This concept also acts as a barrier as discussed earlier. Adolescents can and do change their peer group, which acts as a barrier to subsequent drug use.

Not everyone who starts taking drugs continues to take them, so it was also necessary to explore why some young people give up. In this instance, barriers to further use revolved around three main findings, which can be summarised as follows:

**1.** Being caught by the Gardaí: Fear of being caught by the Gardaí did not deter young people from taking drugs. They do no think in the long term but in the 'here and now' or as this third level male student put it...

> *You don't think of the 'later on' now.*
>
> Third level student (male)

However, actually being caught by the Gardaí did emerge as a partial barrier (reduced use) or as a total barrier to further use. This was not confined to any social class.

> *Yes and he( The Judge ) read me and I just said to myself I am getting no where fast, so I just stopped, so I wouldn't drink as much any more and I definitely won't take hash.*
>
> Early school leaver and Youth Reach participant

> *I am very very afraid of anything to do with drugs at the moment and I think I will be for a long way to come. I mean I came close to going to jail.*
>
> Third level student (male)

> *As soon as I was arrested it clicked into my head never do it again*
>
> Early school leaver (male)

**2.** Fear of Damage to their Health or Death: For some the effects on their health, either real or anticipated, did provoke them into giving up the drugs they were using as these past users explain:

> *Because you know it is bad for you, it is just like anything you know your brain is in mush basically and you are talking like an idiot.... people just say like I'm not taking it anymore and then they stop.(cannabis)*
>
> Third level student (male)

> *I only took that (ecstasy) about five times. I never took it that often. When I seen how dangerous it was and all that we stopped taking it altogether.*
>
> Secondary school student (female)

Generally ecstasy was perceived as more dangerous than cannabis because its adverse effects were immediate and life threatening. The death of Leah Betts in the UK, particularly among the females in the groups, was often cited as testimony to this. For some this was the catalyst which initiated giving up ecstasy.

**3.** Near death experience, (personal or best friend): For others a bad, 'near death experience' was the stimulus to 'giving up'. This refers not just to a bad trip, but to a situation where they themselves or a very close friend *'got into a very bad state'* as this female teenager recalls:

> *He just got into a bad state, it frightened the life out of me when I saw the mad red eyes in Paul (from sniffing),and I was there, Jesus if he looks that bad what do I look like when I go home, so I mean I must have been in a right state, so it kind of frightened the life of me and I wouldn't really go near it again.*
>
> Fifteen year old (female)

### *3.2.5 Patterns of drug use: How and what are they using ?*

Similar to the quantitative study, the drugs that are most frequently used revolve around solvents (particularly at the younger end of the adolescent age spectrum), cannabis, ecstasy and LSD. Of this quartet, cannabis was perceived as the least harmful. While the focus of this study was on illicit drugs almost all the groups believed that underage drinking was a far more serious problem than illicit drugs. As one female third year student put it:

> *...lets face it you have a bigger chance of becoming an alcoholic that you ever have of becoming a junkie.*

In addition, some argued that the risks from taking cannabis were less than consuming alcohol or smoking cigarettes. Cannabis relaxed you and therefore reduced the possibility of violence often associated with too much alcohol.

> *Hash relaxes you when you take it, when you have drink in you, you are rowdy*.
>
> Youth trainee (male)

Ecstasy, on the other hand, was perceived as more risky than cannabis or alcohol, particularly by non-users, because of its immediate fatal effect. However, for those who have used drugs, this fear barrier becomes more porous.

> *I mean you go to these places and there are people there who have done these drugs and they seem to have a fairly normal life...we are not really sure what E does, it might effect you in 20 years time but that does not sound dangerous to someone who is around* 20 yr …
>
> Third level student – previous ecstasy user

While initiation into the drug world sometimes *'just happens'* for many, subsequent usage of the drugs is something that is *'under their control'*. There are certain drugs they prefer over others, there are certain thresholds they will never pass and there are some they pass on special occasion but return to their baseline. Some of course regularly pass their own thresholds. These, however, are the relatively few who are '*out of control'*. Using heroin is a threshold that only one member passed. For most, this is a threshold that they would never pass, even among those who were using cannabis '*all day every day'*. Heroin for many of the adolescents was viewed as a different *'sub world',* one they felt they would never enter. In all the focus groups heroin users were seen to belong to a remote and unattractive world, populated by helpless victims of habit and permeated by crime. These adolescents give their views:

*Q: Would you ever take heroin?*
*A: Jesus no no that's the only drug I would not touch...*

*Like I remember loads of times constantly sick, smoking (hash) and smoking it night after night after night, just to see how much I could smoke.*

*Q: Did you ever inject?*
*A: No, no I never done anything like that.*

Nineteen year old - employed (male)

*Heroin that's a serious drug that decays your body and everything.*

Nineteen year old - unemployed (male)

*Q: How about Heroin did you ever go that far?* (This respondent was a sporadic heavy user of ecstasy and LSD ).
*A: No that's for stupid people.*

Nineteen year old - sporadically employed (male)

Establishing one's own pattern revolves around two major themes, selective involvement and selective avoidance.

Selective involvement refers to young people who are currently using, but who use within the confines of subjective control:

*I like having to get it together you know. I don't like abusing it. I'll always, no matter how into drugs I got involved I would always keep it together. Maybe I wouldn't but I hope that I would, I like being in control. Drugs are just drugs, I don't like being involved in them all the time.*

Nineteen year old - unemployed (male)

> *Yes I would take it sometimes for the buzz, but I wouldn't go mad on it like nearly every week, but not every day and going mad over it.*

> *Q: Every weekend what would you take?*
> *A: Just the hash, I wouldn't be dying in the middle of the week, oh I'm dying for a smoke, I need that, it's if I hadn't got it, it wouldn't bother me like.*
>
> Sixteen year old - school going (female)

> *I smoke it nearly every day, but not at weekends.*

> *Q: And why not at weekends?*
> *A: Because I just cut it at the weekends - I just say there is a limit.*
>
> Third level student (male)

This sense of control is not just confined to cannabis:

> *A: (M) It is night time drug(* Ecstasy *)*
> *Q:'And weekend?*
> *A: (M)I'd say Friday, Saturday really.*
>
> Seventeen year old - youth trainee (male)

Selective Avoidance refers to where young people have moved from regular use to 'recreational use' they now only take drugs on *'big occasions'*. Big occasions usually referred to '*rag week*, *'end of term parties'*, or '*big reunions'*.

> *When I was doing the leaving I had to repeat because I did useless the first time because I was doing E every weekend then. I don't do it any more now only on and off on a big occasion and that is it.*
>
> *Third level student (male)*

As suggested earlier some users did pass their own threshold but even then, they spoke about *'loosing control'* as this extract highlights:

> *I used to always say I would only smoke hash and that ... I used to always say I would never go near magic mushrooms, that I'd never go near the trips or anything like that, and that is when I used to get really depressed, when I used to see myself starting to take them. I felt as if I was slipping ... I couldn't control myself. I had no control over my life.*

Not everyone who starts using illicit continues to exert control over their use, there are those, as the above quote suggests, who do loose control and become addicted to more serious drugs. However, in the scale of things these are relatively few compared to the amount of adolescents who *'try'* or *'experiment'* with illicit drugs.

Often drug users are depicted as weak passive individuals whose lives are 'out of control.' However, this it not the picture that emerged in this instance. For the most part, adolescents emerged as young people who make choices about which drugs, if any, to try and which patterns to settle for. Contrary to popular belief, this suggests that adolescents can and do exert control over their drug use.

Exerting control over one's drug use is also reflected in the different usage patterns that emerged. Although drugs may be used at any time and in any situation some of the adolescents suggested that different drugs may be used in different situations. The adolescents early on in the transcripts make distinctions between recreational drug use and instrumental drug use.

Recreational drug use refers to drugs used on social occasions to achieve special effects. Cannabis was viewed as a very social drug, mainly smoked in groups, primarily to relax. Ecstasy , on the other hand, was used when special energy was required - usually for dancing. For some, these drugs were used 1-2 times per week while for others it was only on special occasions.

> *Well I've never smoked it all the time, but if I was going out like. I would have the odd one, like maybe once or twice a week. I wouldn't have loads of it in a day like.*
>
> Student (female)

Instrumental drug use on the other hand refers to drugs taken to achieve special effect on occasion. These mainly were hallucinogenic type drugs like LSD/Acid.

> *LSD I like the way it opens your mind, but as far as feeling good you know, you know acid is like an out of mind encounter it is hallucinogenic-you don't actually feel good on it.*
>
> Unemployed (male)

> *But there is a big difference between alcohol, cannabis, and acid. Acid is not an escape, not for me anyway...acid is an experience, it opens up your mind...all other drugs you do take it's for escape even cannabis. Acid is a whole different thing.*
>
> Early school leaver (male)

Adolescent drug users are not a homogenous group but a cluster of subworlds within which different drugs are used to achieve different effects on different occasions. Not all users become heavy habitual users. For most, drug taking is something that is under their

control. This concept of 'control' over one's drug use is one that is often not recognised, more often the *'Hash leads to Heroin Thesis'* is one that abounds, the following is an examination of that proposition.

The concept of the gateway drug is one that has permeated the drug literature for some time. Previous research has found consistently that people who do use other drugs initially started with cannabis. This study confirmed this. However, this evidence alone does not suggest that the link between cannabis and other drugs, is linear and pre determined, but rather the street runs both ways. Some subjects who did move from cannabis to other drugs not only moved back to cannabis but some 'quit altogether'. In the course of the focus groups the researcher explored the *'gateway concept'*. This respondent sums his analysis of this thesis:

> *But that is like saying if you start off on beer you will go on to whiskey, and you don't like. Some people have started on hash like and never touched anything after that.*
>
> *Most cases I'd say that is what happens.*
>
> Third level student (male)

However there are ways in which cannabis may lead to other drugs but these reasons are as much social as they are pharmacological. For some users, the need for cannabis increases and light users become heavy users. These heavy users in turn seek out peer groups to correspond with their own usage pattern. They are attracted to groups within which heavy use of cannabis has become the cultural norm. Furthermore, cross fertilisation with other heavy users increases access to a larger repertoire of newer drugs. More drugs and a group norm that favour experimentation eventually opens the gateway to more serious drug involvement.

The following is an excerpt from and in-depth interview that follows this sequence of events.

> *That was the peak 3 times a day and it would have started off kind of once a week.*

Initially a 'ten spot' (£10 worth of cannabis) would last this respondent and his friend one week,

> *...and then it just becomes the norm I don't know we started and before you know it you are buying more and more of it.*

He worked in a bar where a lot of cannabis was being smoked (he was smoking cannabis on and off before working in the bar ).

> *...so at the end of the night when the bar closes like I would be out in the beer garden and I would say that is where I got introduced to it more.*
>
> *Firstly it was just the weekend and then I started hanging around with the lads during the week and then it just becomes the norm, I don't know we started and before you know it you are buying more and more, more of it...*
>
> *I Just took it (E) by accident, one of the mates [in the group] had it and I was looking at it and he gave it to me to keep and instead of putting it into my pocket I put it into my mouth.*

and finally:

> *Q: What other drugs did you dapple in?*
> *A: Trips, acid…and at one time I even smoked cocaine.*

He never used heroin, he has now quit everything and he no longer socialises with this group. This finding suggests that there is a connection between the social relations of marijuana-using adolescents and their experimentation with other drugs. However, the street runs both ways. Subjects who move from light to heavy drugs can move back again with some of the quitting altogether. It is the process of dabbling, quitting, slowly becoming a connoisseur which deserves our attention and not the fixed psychological traits said to be characteristic of the 'drug addict'.

### *3.2.6 Views on current drug education & health promotion initiatives*

The focus group methodology not only allowed the researcher to explore the antecedents and processes involved in illicit drug use but also provided the researcher with an opportunity to explore adolescents views on the current drug education and health promotion initiatives. In addition it allowed the young people to have an input into the design of future programmes.

School-based drug education is a popular preventative strategy. Yet despite such popularity, the evidence about the effectiveness of educationally oriented preventative programmes is compelling in its consistency... while they may impart knowledge, they

usually do not change behaviour (O Connor & Saunders, 1992). Why, one could ask, has so much endeavour resulted in so little? The answer to this question is complex, nonetheless in the course of this section, young people, who after all are the 'consumers' of this education go some way to providing us with the answers. Not only was the current 'ad hoc' system of one off lectures criticised but so too was the didactic manner of these presentations as the following respondents recall:

> *Like there is no set education at school, you might get a talk here and there but that's all it is, is a talk. They talk at you.*
>
> Fifteen year old - secondary school student (female)

> *It is a one way kind of education. They talk at you, they don't listen, they give you facts, they don't give you opinions, they don't like give you examples and they are talking really structured language. It's like they are reading from a book and it has absolutely no meaning for us at all.*
>
> Secondary school student (female)

Overall they really enjoyed talks from recovered drug users, like those given by Julian Madigan and his father for the following reasons:

> *He was on the level with you, like he was talking to you not at you, he wasn't dictating 'don't take drugs' just telling you, you know what happened him*
>
> Fifteen year old - secondary school student (female)

Some did mention that of all the health promotion leaflets they received on drugs the one that made some impact on them was the one on ecstasy '*with all the colours'.* While the video *'Best friend'* received popular comment, the same cannot be said of the video *'Say No':*

> *And that video 'Say No ' that is a load of **** it is so stupid ... the best one is Bliss magazine and you can see the place and you can see what's going on and that's brilliant because I look at it for ages and it just explained everything to you ... you don't have to read anything…*
>
> Fifteen year old secondary - school student (female)

Health Promotion literature and strategies it seems, are not their main source of information, but rather magazines, movies, in particular movies like Trainspotting, and TV advertisements.

It had been recognised for some time now that health promotion initiatives and school based programmes on their own are ineffective. However, their effects are even further diminished when the language, structure and reality they depict are at odds with the reality

of young people. Rarely have they, as consumers of these programmes, been asked for their opinions. Rather there has been a paternalistic assumption that young people are helpless victims of forces they are unable to resist and a corresponding assumption that adults and professionals 'always know best'.

In addition to exploring young peoples views on the current educational and health promotion strategies, their views on how things might be changed for the better in the future was also explored. Generally, young people felt that they need some 'drink free' social options. Among such options was the suggestion of a 'drop in' social centre, a place to meet other young people, '*have a cup of coffee and a chat'*. The emphasis here was on a social centre with flexible opening times, designed and run by young people under the mentorship of adults.

Other suggestions included:

- '*Get Young people like us to help with the advertising'.*
- A drug information line where accurate information could be got on all aspects of illicit drugs.
- Holistic education beginning in primary school. This suggestion refers to the need for programmes in early childhood that are not drugs specific, but rather revolve around such concepts as the healthy body, self esteem, etc.
- Harm Reduction Strategies involving a harm reduction stance arose in every group and are reflected in these quotes:

> *I think the leaflets should be more brought out to make sure that everyone knows the story if someone is on E and how to handle it.*
> *You know the way they give out condoms and the way they give out needles, I mean it saves a lot of hassle. You see the government are all saying bad, bad, and people are going I want to see the other side and they don't tell people OK if you take it this will happen to you and you do this.*

## 3.3 Results From Adult Interviews: A View From The Outside In

### *3.3.1 Introduction*

All Concerned Agents had a rich insight into drug misuse in adolescent worlds from their own vantage points, however, vantage points by definition mean that the view no matter how good, is restricted by virtue of that position. Gardaí, Probation & Welfare Officers, Teachers, etc., are all agents of social control, hence their view of drugs in adolescent worlds was more opaque than the transparency afforded to youth workers (including Youth Reach workers) whose rapport with the adolescents is driven by an ideology of 'befriending' rather than one of social control.

This level of transparency afforded by the youth workers was reflected in the transcripts in that there was a close fit between how they viewed drug use in adolescent worlds and how the adolescents themselves reported it. This would suggest that Youth Workers in particular are a vital component of any *'Reality Checking'* exercises and must be included in a real way in the planning of future responses.

### *3.3.2 Normalisation of drug use*

All the Concerned Agents believed that illicit drug use was no longer confined to geographical, gender or class divisions but that it straddles all classes. However, it would appear from their vantage point to be more prevalent in the lower socio-economic classes as this youth worker explains.

> *Recreational use is right across the board, [however] I would imagine dependency is generally from the more disadvantaged areas although we haven't come across a huge amount of that and again the closer you get to Dublin the more you meet up with the hard stuff.*
>
> Youth Reach worker (Group 1)

This normalisation, while it was a worrying trend, was still not as big an issue as under-age drinking. While the main aim of the focus groups was to explore illicit drug use in adolescent worlds from the perspective of the adults, the following two themes on licit drug misuse arose with such frequency that they warranted inclusion.

### *3.3.3 Underage drinking and the analytic lens*

Under age drinking was a theme that ran throughout the transcripts and one that poses a particularly difficult problem for our society. Similar to the views expressed by young people, the adults felt that focusing the analytic lens on illicit drugs while failing to tackle the damage done to our society by misuse of legal drugs in particular alcohol, may not be the best response. Alcohol has been, and still is a major problem for young people as these adults explain:

> *The problem you see political wise and all that is it is a great problem to shout about drugs and all that and what you are going to do about drugs and what you are setting up, but there is still a major alcohol problem.*
>
> Garda (Group 6)

> *Drink would be 90% a problem you couldn't always say that a person was drunk when arrested or whatever, but the effect alcohol abuse has in the home would be fierce and that hasn't changed over the years, there's probably more media gone into drugs rather than alcohol and that has highlighted the area but alcohol is still the main problem. That would be my experience.*
>
> Garda (Group 1)

> *Well from what I can see it seems to be a bigger problem. To my impression there would be more people involved in alcohol abuse that there would be into drugs. That's the impression I get from talking to other teachers.*
>
> *Teacher (Group 3)*

This abuse of alcohol is across the class divide and often has serious consequences, not only for their health, but also for their education where the weekend 'binge drinking' previously a phenomenon of the adult world is now replicating itself in the adolescent world. This Home School liaison officer highlights this point:

> *I mean I'm not teaching any more, but I know from listening to the staff, that the Monday morning class for a lot of people just doesn't really happen. They say the kids are there, they are there in body, particularly with we say 3rd, 5th, 6th years. It's a case that on the weekend they have been out late and whatever [binge drinking ]I think it is prevalent with the Leaving Cert. but you would have it in 5th years and 3rd years as well.*
>
> Home School Liaison Officer (Group3 )

A secondary teacher confirms this trend:

> *I'm talking about 16 yr olds among those yes you would definitely see absentees on a Monday morning because they were out over the weekend.*
>
> Secondary School Teacher (Group 7)

In addition, while parents strongly disapprove of the use of illicit drugs, this disapproval is replaced with great tolerance and poor role modelling when it comes to alcohol as this youth worker explains:

> *I think we are talking about what influences people. The biggest influence in people's lives from a very young age is the adult, parents and the other adults around. The biggest influence around us, are what we tolerate as a society and that is continued over use of drugs and alcohol is a drug. What has happened with society telling young people what to do, it is usually not truthful it is the one standard for the young people against the standards of the people who are using it [the adults].*
>
> Youth Worker (Male) (Group1)

As the above analysis suggests, adolescents do not exist in a vacuum and education of individuals can only succeed if the message of education is congruent with messages at other levels of the system. While society may condone underage drinking, the 'pill for every ill' society also condones inappropriate use of legally prescribed drugs as the next theme explores.

### *3.3.4 Inappropriate use of legally available and prescribed drugs*

This was a theme that reoccurred in all focus groups with Concerned Agents, but only in isolated instances in the youth groups. While it was not viewed as a major problem in the spectrum of things, it is, nonetheless, a worrying trend. It is a trend that was seen as a by-product of the *'pill for every ill'* society we now live in. Their concerns are summarised in the following quote:

> *I don't think it is a problem but I think it's certainly that there are young people abusing prescribed drugs.... You'd have them from any side right across the board whether it is Panadol, sleeping tablets. I think it is something that seems to be happening young people...if they've a headache a tablet, or you cant' sleep here have a sleeping tablet ' the two just go hand in hand.*
>
> Youth Worker (Female) (Group 1)

While the above theme was one that did not feature strongly in focus groups with young people the next theme *'where the two worlds meet'* explores the over lap that occurs between both worlds.

### *3.3.5 Where the two worlds meet*

When exploring the adolescent drug scene through the eyes of the Concerned Agents some of the same themes that were common to adolescents re-emerged:

- The Drug Scene
- Drugs Distribution Network & Crime
- Refinement of Peer Pressure Hypothesis
- Limitations of current Health Promotion and Educational Strategies.

**1.** The Drug Scene: Similar to that found in the focus groups with young people, the Concerned Agents identified cannabis, ecstasy and LSD as the drugs that were most commonly used. They also reported that there were small traces of heroin and cocaine that varied across the region.

> *I would say that drugs are readily available in ****** town and that the principal drugs of abuse would be Cannabis, E and also at the moment acid is coming in big time.*
>
> Youth Worker (Group 6)

> *Well none of our kids would be taking cocaine as far as I know very little and they wouldn't have mentioned speed specifically but they would be taking E but I know myself if there is E there is speed and hash without a doubt and loads of drink.*
>
> Youth Reach Worker (Group 5)

Magic Mushrooms, were seasonal and this was reflected in their irregular use, solvent abuse occurred mainly in younger age groups, because it was free and it involved no '*transaction process'*. Cannabis in particular was seen, they believed, as totally innocuous by the young people:

> *The children I deal with their opinions and attitudes on it would be that cannabis is totally acceptable and as I said it is us that are out of step and not them.*
>
> Youth Reach Worker (Group 6)

Some did recognise that ecstasy usage did have a fear element to it and this placed it second in line to cannabis in the hierarchy of drugs used.

**2.** Drugs Distribution Network and Crime: Similar to the young people, some of the adults made distinctions between the activities involved in the procurement of drugs,

(dealing, selling & getting drugs), with activity clustering mainly around the latter 'getting drugs'.

> *And a lot of them wouldn't be carrying anything apart from the dealer. The majority of them just carry their own and what they would use on that night and they wouldn't be carrying it very far.*
>
> Youth Worker Female (Group 6)

Some believed that drug use among young people lead to serious crime, however, this was disputed by some of the youth workers whose views on this matter converged with the reports of young people as this quote displays:

> *I would disagree totally that this section of children would rob or commit crime, now and again some of them might but the majority would not. They wouldn't regard themselves as 'drug users' or druggies they would regard themselves as occasional users and I don't think those children would not be the norm for getting into crime because they would have their pocket money to buy hash.*
>
> Youth Worker(Group 6)

In the absence of true epidemiological data in relation to drug use in the NEHB, there was a tendency to use 'folk epidemiology' to describe patterns of drug. Despite this, they generally made a distinction between habitual use and recreational use, accepting for the most part, that the present drug activity existed at the level of recreational use.

> *There is a high tolerance of cannabis among all our clients and they don't see it as a problem with using it. I think we have to distinguish between experimentation and dependence. I think there is a lot of people...experimenting with cannabis not all go on to develop a problem.*
>
> Probation & Welfare Officer (Group 6)

However, this was not a static scenario and the potential for adolescents becoming involved in habitual use was one that caused some concern. The notion of control and illicit drug use was one that was not easily accepted:

> *I know there is a difference that some of them will use and won't get into addiction but the problem we have is if I put 20 people up there in front of you and they all use cannabis, I can't tell you which one of these is going to go on to addiction from using cannabis so we have to cut right across the board and put our foot down...we can't say which ones are going to become addicted.*
>
> Female Youth Worker (Group 6)

> *I think we have to be careful when we are talking about drugs, that we are actually trying to identify where the problem is, rather than say the whole thing is a problem, because if we see the whole thing as a problem we are left in the*

> *dark. The problem is with misuse where it is causing damage to peoples lives, damage to families...that's the area we need to concentrate on.*
>
> Probation & Welfare Officer (Group 1)

**3.** Refinement of Peer Pressure Hypothesis: This level of divergence occurs again when the role peers play in relation to illicit drugs is discussed. For some, peer pressure explained everything:

> *Peer pressure is massive at that age.*
>
> Female (Group 7)

> *Statistics will tell you and the experts will tell you that if you are going around with someone who is involved in drugs that you will get involved. You know if you rang me up about such a fella who is hanging around with a fella who is taking drugs, you automatically assume that he is too.*
>
> Garda (Group 6)

For others the concept was not so cut and dried, they recognised that drug taking involves choices:

> *I don't agree with that, I think there are children...and they don't do it themselves but they don't frown on their friends for doing it, so therefore they can remain in the group…*
>
> Youth Worker Female (Group 6)

This point is refined further by another participant:

> *It depends on the level of use. Kids who are using drugs in the weekends occasionally some of them won't use. If you are with a group that are very regular users, that are using every day obviously that risk is hugely increased 'cos you are not going to survive in the group...I am inclined to agree that they will eventually leave that group of* ***their own will*** *because they don't want to be with those drug users.*
>
> Youth Worker Female (Group 6)

While the unrefined concept of peer pressure still abounds among some adults, for others the influence peers have on one another is more 'nuanced'. Youth workers, similar to the reports of the young people themselves, see adolescents as people with a capacity to choose, rather than mere victims propelled along by forces outside their control. While there is strong evidence to suggest, as the Garda above mentioned, that association with drug using peers is one of the strongest predictors of initiation into marijuana use, choosing to join this group is, however, preceded by a belief and value system held by the adolescent

that is favourable to the use of marijuana. It is this that motivates an adolescent to join a peer group where illicit drugs are used rather than simply peer pressure. In addition, as the last quote highlights, peer groups are not a static concept - they change all the time. What was an acceptable level of drug use at the outset, for some members later becomes unacceptable, so they leave and realign themselves with another group. Peer association involves choices. While these may not appear rational from an adults perspective they are rational based on the frame of reference of the adolescent.

**4.** Limitations of Current Health Promotion and Educational Strategies:

While there were diverging views about the role peers play in relation to illicit drug use among the adults, this was not the finding when one explored their views on the current educational and health promotion initiatives. Comments by youth workers in particular, seemed to mirror the comments in this regard, made previously by the adolescents.

Generally, it was felt that information '*on its own'* was not enough to solve the problem of drug use in adolescents worlds. It was a complex issue that needed a *'continuum of responses'*. However, the information presently available from the Health Promotion Unit and the 'ad hoc' system of drug education needed to be re-evaluated as part of an overall response. It was felt that parents may well read the various leaflets on drugs but they are not reaching their intended audience. These comments echo, almost verbatim, the responses made by the young people themselves:

> *Any of the information that we would get, I think the majority of it is just top down and you know when you are young that approach gets a 'will you go way from me response'.*
>
> Youth Reach Worker (Female) (Group 5)

While some of the literature might not appeal in design and approach to some young people, for others with poor literacy skills it is inaccessible:

> *And with the promotional stuff that's out there a lot of them can't read it, others don't read it 'ah its not for me'. 'Even with the new colourful one, the new E one from the Health Promotion Unit...that they are giving them. They can write them out, you know copy the printing. But if you ask them, what can you tell me now about the facts or that they can't tell you anything at all…*
>
> Youth Reach Worker (Group 2)

The way forward, as they see it is:

> *I think we have to start any programme with young people using the language they understand. I think the information that's going out at the moment for young people and adults is in words and language that has absolutely no relevance what so ever particularly for young people.....it has to certainly to come from people on the ground, what they {Health Promotion) have produced is not effective.*
>
> Youth Worker Female (Group 1)

### 3.4 Summary

Adolescent worlds are located within particular and historical societies and the social location of adolescent drug users can only be understood in that larger context. In the 1960s hippie drug use was mainly confined to the middle class and was seen as a rejection of middle class values. Drugs were items that were symbolic of unconventionality and a refusal of normal obligations ( Wieder & Zimmerman, 1976). The counter-cultural stances of the hippies was later replaced by the 'punk' subculture in the 1970s and the 'rave' subculture in the 1980s. Today, adolescent drug users do not identify with any particular sub-culture, but rather, it seems to be a normal part of youth culture, straddling all classes and all geographical boundaries. Given this shift, the use of subcultural theory or traditional notions of deviance are no longer valid as explanatory models (Murphy, 1996; Redhead, 1995).

Drugs are readily available to the focus group participants in the North East and for many, their drug use is an accepted part of youth culture. However, not all young people are using drugs, therefore, availability on its own is not a motivating factor. Motivating factors rather, are multiple and reflect an interaction between various personal, social and cultural factors. Patterns of use also varied as did type of drugs used. Solvents were used in the lower end of the adolescent age spectrum, while cannabis, ecstasy, and LSD were the drugs most in use among older adolescents. Of these, cannabis was perceived as harmless and at times more socially acceptable than alcohol, less addictive than tobacco and unlikely to have any effects except in the long term. For adolescents who don't *'think of the later on now'* these long term effects are insignificant. While the focus of this study was on illicit drugs, drink, according to many of the young people, was a far bigger problem. As one student put it '*you have a much bigger chance of becoming an alcoholic that you ever have of becoming a junkie'*. In that sense they felt the analytic lens was tilted in the wrong direction. This theme reoccurred in the adult focus groups. Overall, the present pattern

of use is recreational where illicit drugs, mainly cannabis, are taken as part of normal social gathering or on special occasions only. There was no evidence to suggest from this qualitative research, that most young people in the North East region are involved in habitual illicit drugs use.
In addition, the study revealed that the reality of adolescent drug use, as revealed by the adolescents themselves, calls for a refinement of stereotypical images that currently abound.

Unlike the adult world of drug dealing - where the distribution system of drugs revolves around large profits, is fed on a value system of greed and sustained by an elaborate crime network - drugs in adolescent worlds, for the most part, revolves around concepts of friendship*, reciprocity* and *sharing,* - where money is pooled or saved to buy drugs and drug use itself is a highly sociable activity. While friends use drugs together it is also friends who are the main suppliers of drugs. Few transactions are anonymous. Contrary to popular belief, social networks are the routes through which illicit drugs are obtained, not 'evil pushers.' The emphasis here is on *'drug seeking'* not *'drug pushing'*.

Control and illicit drug use are concepts that do not sit easily together in the popular psyche, yet it does seem that adolescents can, and do, exert control over their drug use. They decide which drugs, if any, to take and it is they who decide what patterns to settle for. Furthermore, peer pressure, a concept the regularly occurs in discourse on adolescent drug use, it seems is no longer apt at describing what is really happening. Rather, the findings suggest that there are positive elements to peer association obfuscated by the predominance of the peer pressure hypothesis. In addition, it would seem that peers seek out friends to correspond to their own drug usage patterns, rather than change their drug pattern to correspond with friends pressure.

While it may seem that young people are very 'au fait' with all aspects of illicit drugs, the reality, in fact, was quite different. In this instance, knowledge surrounding illicit drugs was often vague among non-users and inaccurate among users, who, in the absence of true scientific knowledge on illicit drugs had developed their own 'Folk Pharmacology'. This finding suggests that the present method of educating young people about drugs is either not being absorbed by them, or not reaching them. Some children in the focus groups had dropped out of main stream schooling and were literally '*Street Kids'.* Others, while in

school, were not impressed by the current Health Promotion and educational strategies currently in operation. While it has been recognised that education on its own is not effective, ineffective education it would seem is a waste of resources.(Stuart, 1974; Degnan, 1972; Richardson et al., 1972; Kinder et al., 1980; O' Connor & Saunders, 1992). In the future, adolescents recommended that more drink free social options become available in the North East. Along these lines, they proposed a *'drop in social centre'* with flexible opening times - run by young people, under the mentorship of adults. In addition, they proposed the development of a drug information line where accurate information on illicit drugs could be got on all aspects of illicit drugs. In relation to the inadequacies of current health promotion, they suggested that they, as consumers of these programmes, might be involved in the design and distribution of new strategies. Currently, health promotion strategies, they believe, do not reflect their reality, consequently they have lost credence with young people. In addition, they believe that a harm reduction approach now needs to be considered, so that users can adopt safe practices. In addition to health promotion strategies, they suggested that holistic education should be developed in primary school where the emphasis is not drug specific, but focuses more on healthy living etc. While they did not explicitly advocate a peer education strategy as a means of distributing information, they all felt that 'past users' telling their stories impressed them far more than the current didactic form of drug education. Including lay health promoters, as part of new health promotion strategies is something that has recently been advocated by the HEA (Rogers et al., 1997) in the UK and, given these findings, is something that warrants further exploration.

Adults who work closely with adolescents in the North East, especially Youth Workers, (including Youth Reach, etc.) are well informed of the illicit drug scene, however, similar to the young people they feel that underage drinking is a very serious problem and should be looked at as closely as illicit drugs.

### 3.5 Conclusion

This report is predicated on the idea that the views and ideas of young people should form an integral part of future drug strategies. An effort has been made, not only to listen to what each of them had to say, but also, to identify common themes running through the focus groups and the in-depth interviews. The central messages in this report are:

- Soft drug use is not a problem for most young people in the North East. Those who are involved in illicit drug use feel in control of their drug use. However, underage drinking is the area where parental and professional attention should be directed.

- Young people do not see drugs as being on a continuum from soft to hard drugs, nor do the see themselves on a slippery slope from cannabis use to heroin. The distance between the world of cannabis use and heroin use in their eyes constitutes a wide chasm not a slippery slope.

- Drug use is not an isolated part of young peoples lives in the North East, but it is one of a number of ordinary, unremarkable activities which is part and parcel of growing up in contemporary Ireland.

- Current educational strategies, for the most part, are deemed irrelevant, primarily because they do not reflect their reality. Young people of all ages take drugs because they enjoy them 'rather than because they fall prey to some addictive illness which removes their capacity for voluntary behaviour' (Davis 1989).

- The role peers play in relation to illicit drug use is better served by striving to understand the process of friendship, rather than relying on the unrefined peer pressure hypothesis.

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