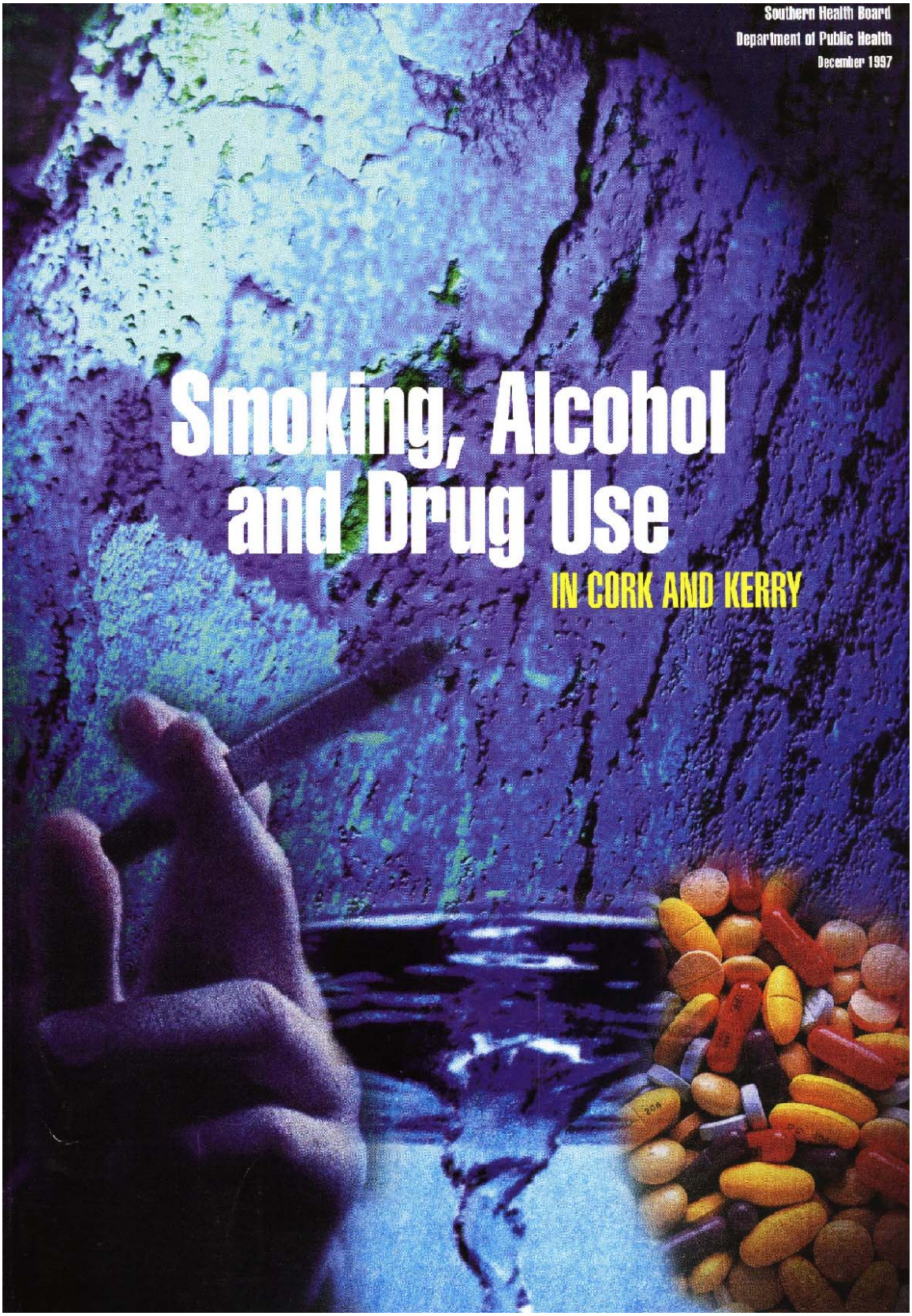
Southern Health Board
Department of Public Health
December 1997



Smoking, Alcohol and Drug Use

IN CORK AND KERRY

SMOKING, ALCOHOL AND DRUG USE IN CORK AND KERRY

Southern Health Board
Bord Sláinte an Deiscirt

Caring for People

This research was undertaken
Dr T.M.R. Jackson
BA.MB.DCH.DPH.MFPHMI.
Specialist in Public Health Mec

Department of Public Health
Southern Health Board

Department of Public Health. [

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Dr T.M.R. Jackson BA.MB.DCH.DPH.MFPHMI.
Specialist in Public Health Medicine Department of
Public Health Southern Health Board

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FOREWORD

The Department of Health published its strategy document on the development of effective health care, *Shaping a Healthier Future* in 1994. This gave guidance to the Health Boards on the direction that they should take in managing the health services during the 1990s. One of the key concepts in that strategy is that efforts should be made to determine **Health Gain** and **Social Gain,** and to refine these concepts with appropriate measures of population health,

The National Health Promotion Strategy recognises that Smoking, Alcohol and Drug Misuse have a huge impact on health. They interact with each other and are responsible for significant damage to personal and social life. Appropriate control of these substances could improve the health of our population.

This survey on *Smoking, Alcohol and Drug Use in Cork and Kerry* is a comprehensive and scientific examination of the interaction between these substances in Cork and Kerry. It provides a baseline epidemiological profile of substance use in the community The survey's findings are being used to guide the Health Board in developing prevention and treatment strategies, and will therefore be an important contribution to our measures of health and social gain in this area.

The Southern Health Board is striving for excellence, quality and a committed and caring service to our community I have no doubt that this survey will help us to fulfil these aspirations, and congratulate the Department of Public Health for undertaking this research.

Sean Hurley
Chief Executive Officer
Southern Health Board

CONTENTS

INTRODUCTION

All this the world well knows; yet none knows well
To shun the heaven that leads men to this hell.
W. Shakespeare - Sonnet 129

Drugs in History
A drug is a chemical that changes human functioning - mentally, physically, or emotionally[1]. Drugs include many familiar substances such as coffee, tea, alcohol, and tobacco.

Drug sources are varied[1]. Some are *natural* ie Opium, Cannabis and coca. Some are *semisynthetic* derived from original products such as morphine and heroin from Opium. Some are *synthetic* chemical products ie: Amphetamines, tranquillizers, LSD.

Drugs have been known for millennia. The Bible[2] tells how "Noah drank of the wine, and was drunken". Beer was brewed by the Bronze Age civilisations of Egypt and Mesopotamia, which were already familiar with winemaking from dates and grapes[3]. Neolithic groups in Central Europe cultivated the Opium poppy[3]. Hemp *(Cannabis Sativa)* was a traditional fibreplant of the Steppes and was cultivated in China since the Neolithic[3]. An elaborate tobacco complex was present in Prehistoric North America[3]. A local chieftain of the West Indies is reputed to have solemnly presented Columbus with a small roll of dried leaves with an elegant little forked stick to hold it[4]. These examples illustrate the antiquity of man's relationship with chemicals that affect his behaviour.

Drug Use
Drugs can be used for varied purposes[1]. *Medically, a* huge pharmacopoeia has been developed for pain-relief, antibiotics, cancer therapy, cardiovascular, and psychiatric problems. These are usually taken under medical advice and supervision. *Recreationally,* alcohol and smoking are permitted in western societies with appropriate controls. Some drugs are illegally taken without medical prescription e.g. narcotics, or outside their routine use e.g. solvents, or are formally scheduled as illegal per se e.g. LSD, Cannabis, Ecstasy. Their main use is for their psychic effects. All drugs regardless of their status, have risks and side-effects which can be serious.

Drug Misuse
WHO offered a classification of Drug Misuse in 1981[5]:

- **Unsanctioned Use - the drug is not approved by society.**
- **Hazardous Use -** the drug may lead to harmful consequences i.e. increased risk.
- **Dysfunctional Use -** the drug leads to impaired psychological or social functioning.
- **Harmful Use -** the drug is known to have caused tissue damage or mental illness.

The Hazards of Drug Misuse and their definitions[1]

Hazards of drug misuse can be ***acute*** resulting from intoxication, overdose, or idiosyncrasy where effects can happen unpredictably. **Chronic** effects are more long term, effecting both mental and physical status.

Dependence or Addiction can occur with certain drugs. This has varying definitions. One of the more concise is that of the WHO 1964 which describes addiction as a:

> **Compulsion** to take a drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes **to avoid the discomfort of its absence. Tolerance** may or may not be present.

The American Psychiatric Association considers **drug dependence** to be present if three or more of the following situations are present[6]:

- Taking the substance more often or in larger amounts than intended
- Unsuccessful efforts to terminate or reduce drug use
- Large amounts of time spent in acquiring or using the drug, or recovering from its effects.
- Frequent intoxication or withdrawal symptoms
- Abandonment of social and occupational activities because of drug use
- Continued use despite adverse psychological or physical effects
- Marked tolerance
- Frequent use of the drug to relieve withdrawal symptoms

The individual effects of drugs are too complex and numerous to discuss in this report. Corrigan[1] gives an excellent summary of the main effects. He also summarises the legislation in force to deal with drugs. DSM-IV[7] gives a summary chart outlining briefly the range of effects of varied drugs. This is included in appendix 6.

Substance Abuse is seen as a pattern of maladaptive behaviour involving recurrent adverse consequences to repeated substance use. It is **distinct from substance dependence.** DSM-IV[7] lists the following behaviours as indicating substance abuse.

Substance Abuse:

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following occurring within a year:

- Recurrent substance use, resulting in failure to fulfil major role obligations at work, school, or home (e.g., repeated absences, poor work performance, suspensions/ expulsions from school, neglect of children, or household)
- Recurrent substance use in situations in which it is physically hazardous (e.g., driving a car, or operating machinery when impaired by substance use)
- Recurrent substance-related legal problems (e.g. arrests)
- Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.(e.g., arguments about consequences of use, fighting)

Drug Use Definitions
In this survey, frequency of drug use was classified into:

- **Lifetime Use -** drugs **ever taken** in a person's lifetime
- **Recent Use -** drugs taken in the **past year**
- **Current Use -** drugs taken in the **past month**

Recent and **Current** use are more likely to include people taking the drug for the first time, and may be approximations of incidence. However these figures are usually very small for low prevalence drugs, making statistical inferences difficult. Lifetime use includes casual experimenters, but can be useful in making community comparisons.

Classification of Drugs
There are several ways of classifying drugs. This survey has adopted the system in use by the Health Research Board[8].

- **Cannabis**
- **Opiates -** Methadone, DF118, Heroin
- **Sedatives/hypnotics -** Barbiturates, Tranquillizers
- **Stimulants -** Amphetamines, Ecstasy, Cocaine
- **Hallucinogens -** LSD, Magic Mushrooms
- **Solvents -** glue, Tipp-ex, etc

Alcohol is usually considered separately, but can be classed as a sedative/hypnotic. Caffeine and Nicotine are classed as stimulants. (Appendix 3)

The Extent of Substance Use as seen by Earlier Surveys
Earlier surveys on substance use have been carried out in the Southern Health Board area and in Ireland. These are discussed here to give a background to the present research.

Previous Surveys in the Southern Health Board and Ireland
There is little systematic data on drug use patterns for the Southern Health Board Area. These consist of school surveys and data on those attending treatment centres.

A. School Surveys in the Southern Health Board area:
7990 - *Post Primary Students (Dr M O'Fathaigh Cork Youth Federation/UCC)*[9]. This survey found a 20% lifetime prevalence of drug use, with 6% claiming to contact a regular source. 15% had taken marihuana, and 10% had taken Solvents.

1993 - *Post Primary Students 15-17 years (Southern Health Board 1994)*[10] This survey found a 20% lifetime prevalence of drug use. 15% had used Cannabis and 19% had used Solvents.

B. Treated Drug Misuse in Ireland Report 1995 (Health Research Board)[11]. The Treated Drug Misuse Report of the Health Research Board was published in 1995. This report includes other Health Boards outside the Eastern Health Board for the first time, and offers comparisons between the greater Dublin area, and drug misusers in treatment in other areas.

This is a very **selective** sample of the drug misuse picture, referring only to those attending recognised treatment centres. The figures are dependent on full reporting by the participant centres. The report also deliberately excludes alcohol as a **primary** drug of misuse.

The Southern Health Board picture from the Treated Drug Misuse Report
Total treatment cases in the Southern Health Board numbered 336, less than 1/10th of the Dublin area.

Two-thirds were from the city area. 80-85% were male. 3/4 are under 24 years old, and half were under the age of 20, and 4% were at institutions or homeless. 50% were unemployed or taking casual work. 3% had injected or shared drugs.

First treatment cases
These were taking treatment for the first time. They numbered 203, 1/7th of the Dublin area.

One half were taking Cannabis, while almost one half were taking Hallucinogens, and more than a quarter were taking stimulants. Only 2% were taking Opiates or Solvents. One-third had taken their first drug by the age of 15 years, and almost all by the age of 19 years.

One-third had used Cannabis or stimulants as a secondary drug, and half had used hypnotics or sedatives.

None of this group had injected or shared drugs.

Conclusions from Treated Drug Misuse data

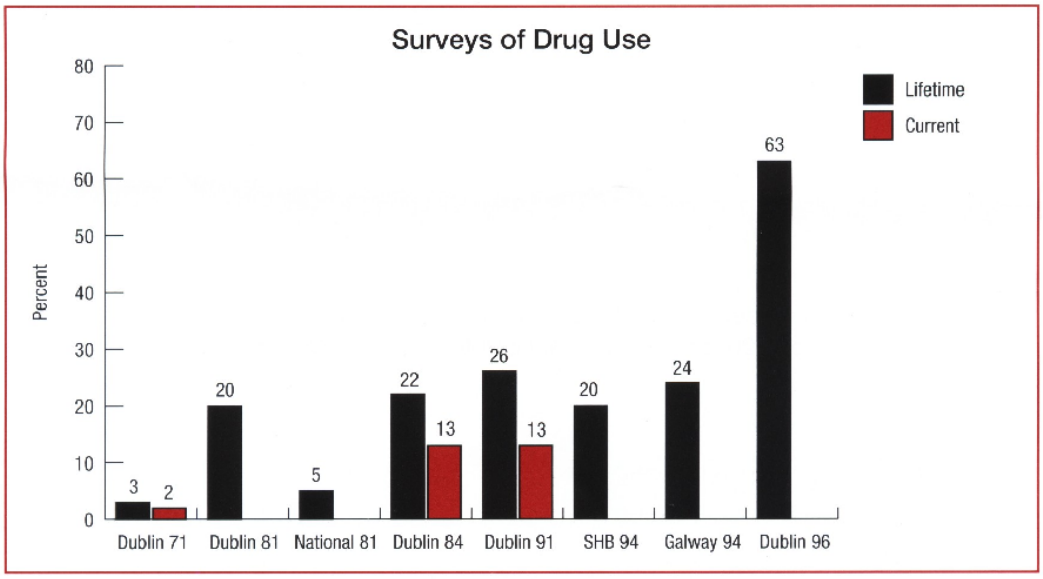
Cannabis, Hallucinogens, and stimulants are thus the main groups of drugs taken in the Southern Health Board as recorded by the Treated Drug Misuse Database. Most had started their drugs before 20 years, were from the city, and were mainly men, often unemployed. About 14 (4%) were in institutions or homeless, needing residential support.

Previous Surveys of Drug Use in Ireland[12-20]

Several surveys of drug use have been made in Ireland mainly in Dublin and are summarised below. Most of these surveys have focused on secondary schools, adolescents and young adults.

Lifetime drug use was only 3% in 1971 in Dublin[18] and then rose to 20% by 1981[19] and 26% in 1991[20]. A recent survey in schools in North Dublin in 1996[16] for the four commonest used drugs Cannabis, Amphetamines, Ecstasy, and LSD, found Lifetime use at 60%,

The Southern Health Board showed 20% Lifetime use in 1994[17].



SUMMARY OF MAIN FINDINGS OF SURVEY

Smoking
Almost two thirds had ever smoked. Over a third were currently smoking (38%). Numbers of current smokers in women were almost equal to men.
The level of current smoking dramatically increased, from 10% at 15 years, to 31% by 16 years (the legal age of sale of tobacco), and 40% at 20 years. Boys started smoking more than a year earlier than girls, and reported smoking more cigarettes per day.

Alcohol
78% of the population drank alcohol currently - 81 % of men and 75% of women. Almost 90% of those in age group 20-24 years were current drinkers. Almost half of those under the legal age of 18 years, were current drinkers (44%) - half of these were boys (50%) and a fifth were girls (20%).

Almost a quarter of the men drank in excess of recognised guidelines of 21 units per week. As estimated by the CAGE screening test, there were high numbers of men with problem/dependent drinking - almost one in ten (8%). This was highest for the age group 20-24 years at 13%. Such high levels at that young age group has serious implications.

Drug Use
This is the only survey of drug consumption in general population in Ireland into adulthood. Other surveys in Ireland are on young populations who are either at school or have just left school.

The drug user in this survey tends to be young, male, from urban areas, is also a smoker or drinker and has smoked or drank from an earlier age than non-drug users. Part-time employment, high frequency of pub and disco attendance, and low frequency of attendance at church are all associated with increased drug use. Recent and Current drug use are highest at younger ages, and fall almost to nil over age 35 years.

The lack of a significant difference in drug use (except for small numbers taking sedatives and Opiates) for booster areas, when corrected for age suggests that drug use is widespread across all communities, regardless of deprivation status.

Almost one in five had used a drug in their lifetime **(Lifetime use** - 18%). Drugs used were mainly Cannabis, Hallucinogens, and Stimulants. One in fourteen had used a drug in the last year **(Recent use** - 7%), and one in twenty five had used a drug in the last month **(Current use** - 4%). Only 1 % had taken Opiates in their lifetime. Heroin use was scarcely detected, and there was almost no injecting drug use. Age group 20-24 years showed the highest **Lifetime use** of drugs at one in three (30%).

Regionally, the highest drug use was in Cork City - 25% **Lifetime use** (twice that of other regions), especially in the city electoral areas of North Central, South West, and South East where **Lifetime** numbers for any drug use was about one third, with **Recent** use 15%, and **Current** use more than 10%. All areas showed some use, and deprived areas, when corrected for age did not show significant increases for drug use.

Drug use showed a strong association with current smoking and alcohol use. Smokers and drinkers showed drug use of up to three times that of those who did not smoke or drink.

Men in Cork City under the age of 35 years showed almost 40% **Lifetime** use and 20% **Recent** use of drugs. Almost half the men (46%) who were employed part-time at a rate of 17 hours or less, had taken drugs in their lifetime. This was twice those fully employed or unemployed.

Children 15-16 years
In Southern Health Board children aged 15-16 years, 22% smoke, 33% drink, 19% have taken a drug, and 18% have taken Cannabis. Solvents, LSD, Amphetamines and Ecstasy have been taken by a smaller proportion of 2-5%.

Attitudes
Cannabis was seen as the least harmful and most used drug. Within each drug category perception of harm was inversely related to drug use. This was especially shown for Cannabis where use was 5 times more frequent among those who think it least harmful compared with those who see it as harmful. This has important implications for health education and information about Cannabis use.

There was widespread knowledge and contact with situations where drugs were being taken. There was reluctance to agree with increasing tax or age limits on alcohol or tobacco. One fifth thought that Cannabis should be at least partly legalised.

GP's, Psychiatrists, Treatment Centres, and police were all recognised as main services for advice for alcohol and drug use.

Drug use was associated with frequency of attendance at pubs, rave dances, discos, and with decreased frequency of church attendance.

Comparison with other surveys
The 15-25 year age group showed more Lifetime use of several drugs than in Galway in 1994 and much less use of key drugs than in Dublin in 1996. The pattern of use had some similarity to Dublin in 1991 (except for Solvents, Cocaine and Heroin, which were scarce in the Southern Health Board area).

Overall
Alcohol is still the dominant drug of misuse in terms of prevalence and problem use. Smoking and Alcohol use precede drug use and are highly associated with increased drug use. Cannabis, LSD and Ecstasy are the main drugs used and are widely available. Opiate use is minimal, but this could change rapidly in the current climate of widespread drug tolerance.

METHODOLOGY

Background to the main Southern Health Board survey
This survey was approved in principle by the Southern Health Board in 1995. The Department of Public Health gave a commitment to carry out a community survey of tobacco, alcohol, and drug use in the Board's area of Cork and Kerry. This was in the context of the need for precise epidemiological data on substance use to guide policy.

Literature Review
The literature was reviewed to examine other drug studies and identify a suitable approach to this research. Leitner, Shapland, and Wiles' study in the UK[21] was particularly interesting, because of its community emphasis in examining the population of four cities for drug use and attitudes. Their questionnaire was modified for the SHB situation, with supplementary questions on alcohol, smoking, and attitudes to drug policy. The full questionnaire is in Appendix 2.

Survey
The survey was designed as a multi-staged quota controlled household survey with random location starting points. The target populations were the three main regions of the Southern Health Board: Cork City, Cork County and Co. Kerry as identified by the Census[22-24]. The sample was structured into two groups:

1. The **Main Sample** totalled 1500, age groups 15-44, with 500 each taken from the *general population* of the three regions of Cork City, Cork Co, and Co Kerry.
2. A **Booster Sample** was designed to boost the numbers of those involved in substance use detected by the survey. This was done by choosing a younger age group from *deprived* areas.
   The Booster Sample totalled 600, age groups 15-24, 200 each taken from Local Authority Housing in most deprived Urban Areas of each region. The areas identified as most deprived was based on earlier work by Ryan[25].

The detailed structure of the population sampling is described in Appendix 1. A map of the Southern Health Board area is in Appendix 7.

The issues examined in the questionnaire were:

- Local perception of drug problems
- Knowledge of Drugs
- Attitudes on drug policies
- Knowledge of services available in the area
- Leisure activities
- Alcohol and Tobacco use
- Personal Drug Use, and Alcohol problem use (recorded in separate confidential self-completion booklet)

A dummy drug **Semeron** was included in the list of drugs to check false entries.

Alcohol consumption was measured in units where 1 unit = 1 standard drink:

E.G: One drink = 1/2 pint of beer
1/2 pint of cider
1/2 pint of alcoholic lemonade
A glass of wine
A glass of sherry
A measure of spirits

Alcohol Problem/Dependent use was measured by response to the four CAGE screening questions. The CAGE questions are:

- Have you ever felt that you should **Cut down** on your drinking?
- Have people **Annoyed** you by criticising your drinking?
- Have you ever felt bad or **Guilty** about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover **(Eye-opener)?**

Two or more positive answers were considered to be CAGE positive indicating problem or dependent use of alcohol.

Social Class
The Central Statistics Office[22-24] codes the population into social classes as follows:

1 Higher professional, higher managerial, proprietors employing others and farmers farming 200 or more acres
2 Lower professionals, lower managerial, proprietors without employees and farmers farming 100-199 acres
3 Other non-manual and farmers farming 50-99 acres
4 Skilled manual and farmers farming 30-49 acres
5 Semi-skilled manual and farmers farming less than 30 acres
6 Unskilled manual
7 Unknown

These were grouped into classes 1 -3 and 4-6 for analysis. The Socio-economic Class Groupings in the questionnaire (Appendix 2, Part F Classification) were converted to Social Class groups as above.

The draft questionnaire and proposed survey structure were sent to several survey companies, and the MRBI was chosen to carry out the field interviewing. Detailed work was required to tailor the questionnaire and finalise the details of survey structure. The survey was piloted in May 1996, and finally carried out during the Summer of 1996.

Data Analysis
The data was coded in SPSS[26-27]. After piloting the survey, 800 variables had to be re-coded into readable variables and mistakes checked and corrected. After the survey was carried out during the summer, the Main Data Set was sent in late October 1996, for final analysis.

Questionnaire Response
This was a quota-based survey with interviewers working towards establishing full quotas from each category. Technically, the issue of non-responders does not formally arise. However it was reported that the attitude of clients was most encouraging, with most people glad to cooperate. It is estimated that less than 5% actually refused interview.

RESULTS SECTION

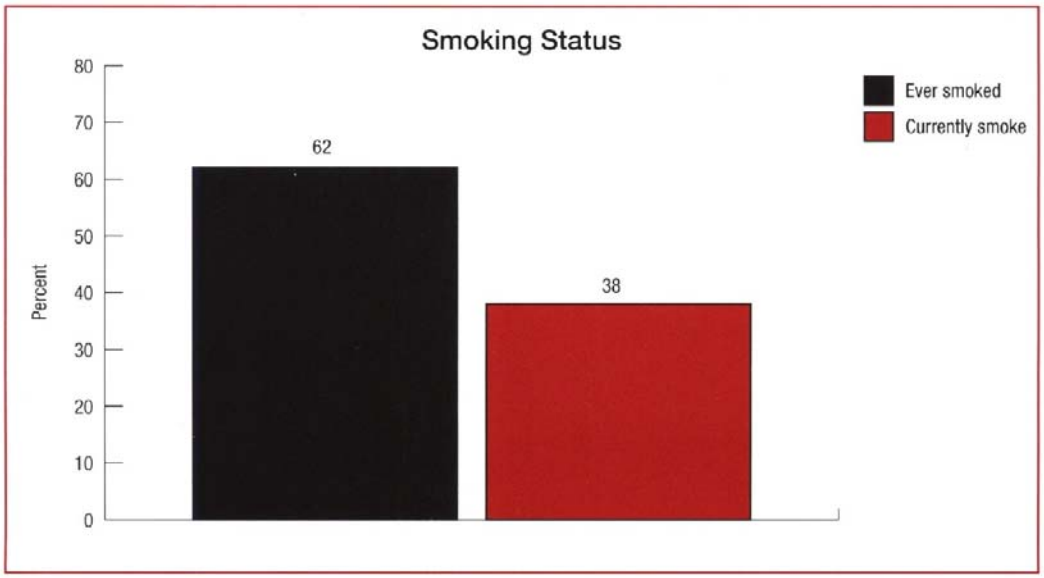
Sections

SECTION 1 - SMOKING

Smoking Status

61.5% have ever smoked, and 37.9% currently smoke. (Fig 1,1)

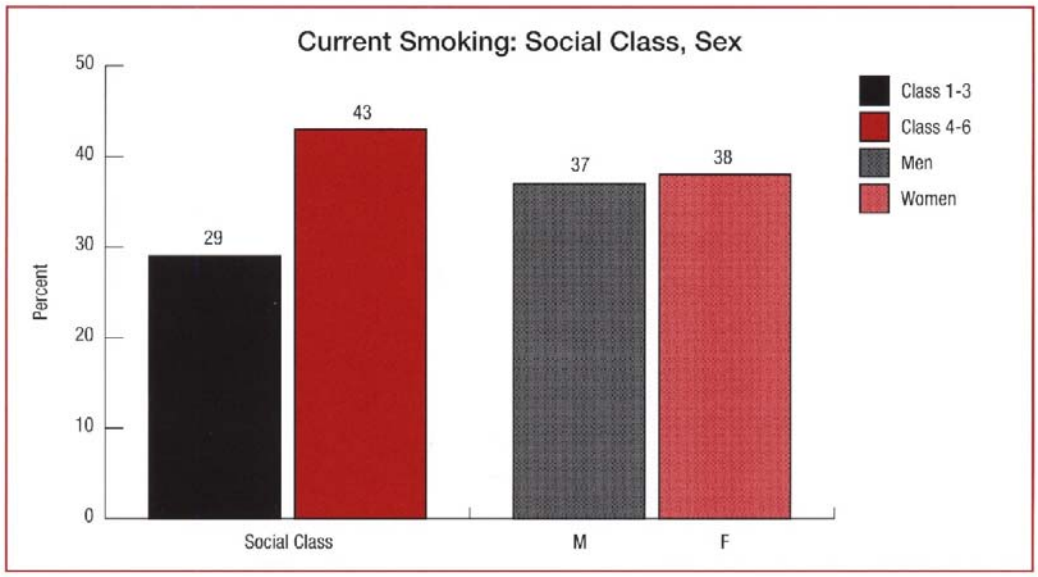
Fig 1,1



Social Class, Sex

Social Class 4-6 (43%) was 14% higher than class 1 -3 (Fig 1,2). Men and women were almost equal at 37-38%

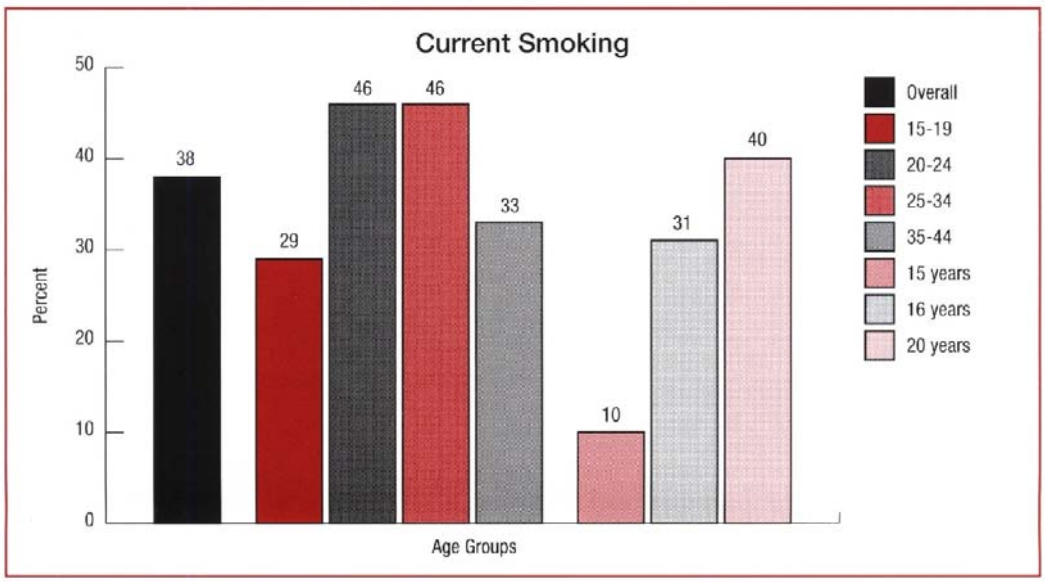
Fig 1,2



Age Groups

Current Smoking was highest in age groups 20-34 at 46% before dropping to 33% at 35-44 years (Fig 1,3). There is a very rapid increase in current smokers from 10% at 15 years to 31 at 16 years and 40% at 20 years.

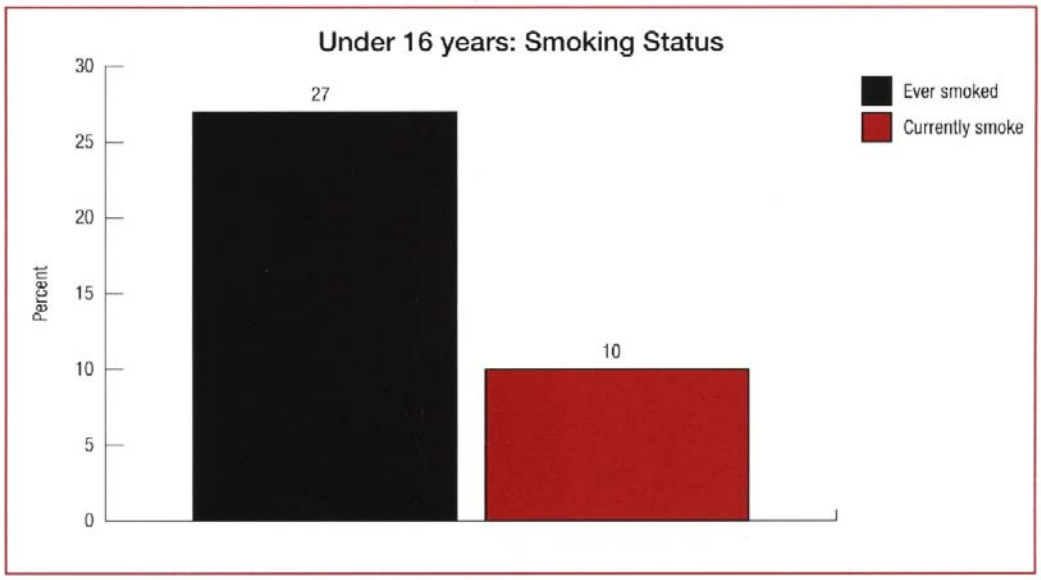
Fig 1,3



Under-age Smoking

27% of under-16 year olds had smoked, and 10% were Current smokers.(Fig 1,4).

Fig 1,4

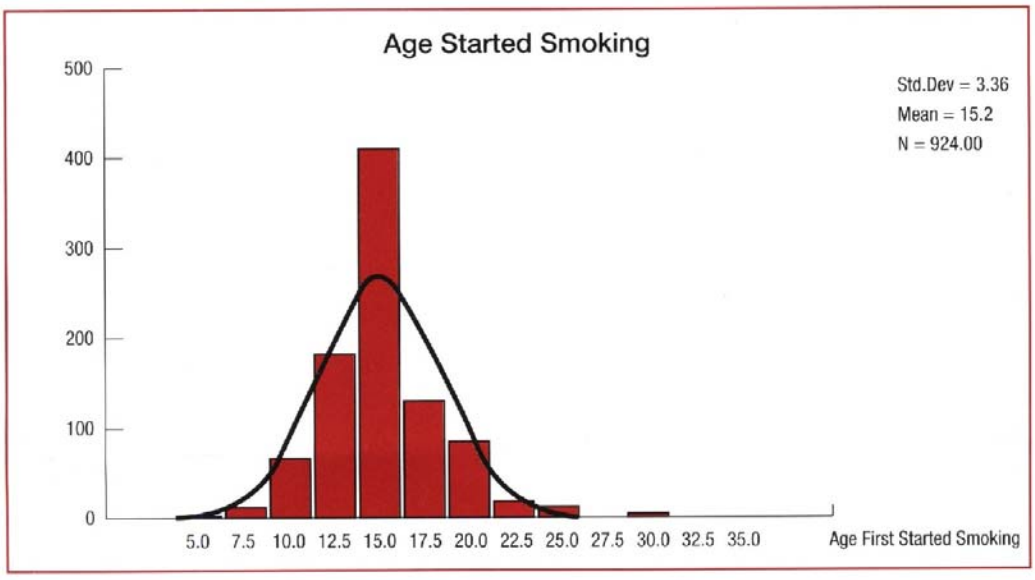


Age First Started Smoking

In those who had ever smoked, the mean age of first smoking was 15.2 years. 25% had tried smoking by 13 years. (Fig 1,5).

Age of First Smoking was 1.2 years less in men than women at 14.6 years, but did not vary significantly for social class, region, or deprivation.

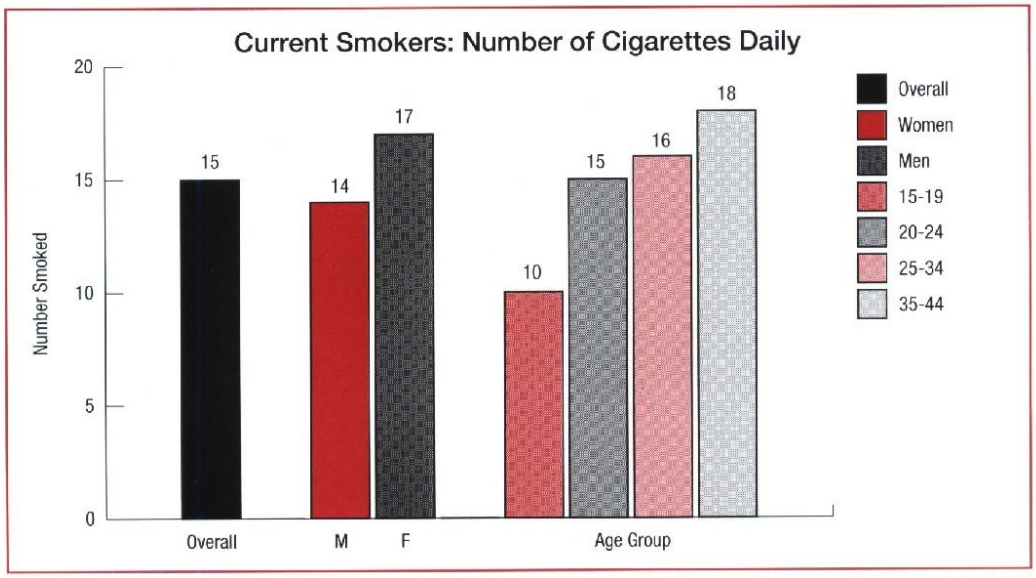
Fig 1,5



Amount of Smoking

In Current smokers, the mean number of cigarettes smoked daily was 15 (Fig 1,6). Men smoked 3.5 more than women, and a similar difference was found between social classes. For age groups the highest mean was 18 daily for 35-44 years. This was 4 greater than ages 20-24, and almost 8 more than 15-19 years.

Fig 1,6

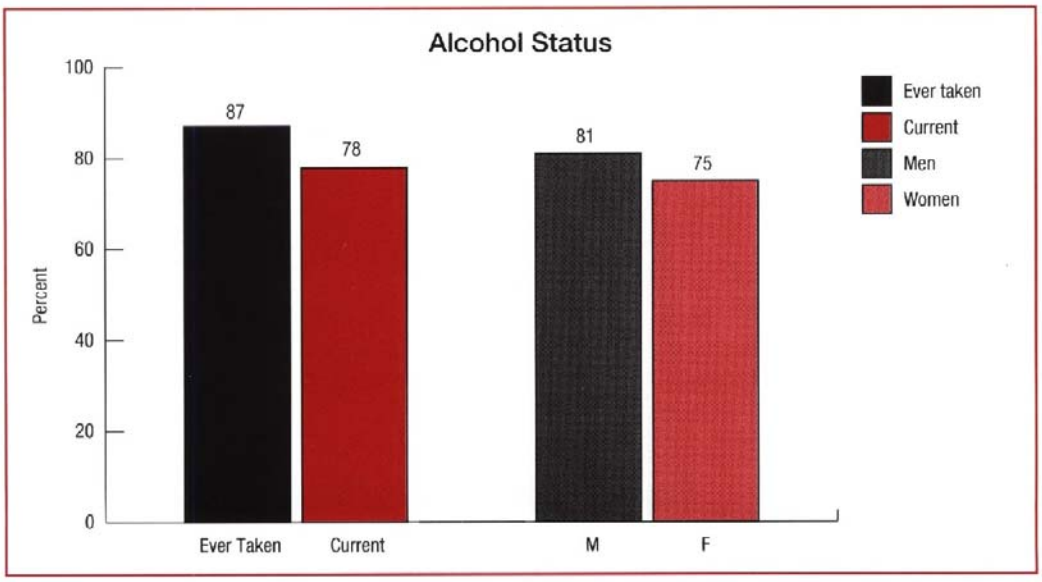


SECTION 2 - ALCOHOL

Lifetime Use, Current Use, Sex

87% had ever taken alcohol, and 78% were Current drinkers (Fig 2,1). The number of women (75%) taking alcohol was only 5% less than men, although this difference was significant. There was little difference between regions.

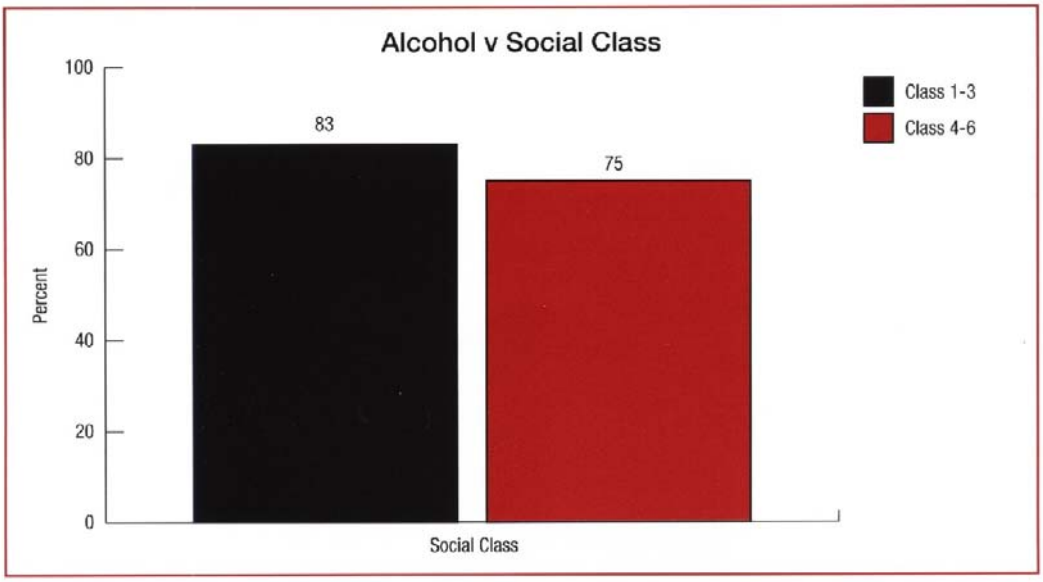
Fig 2,1



Social Class

Social classes 1-3 (83%) had 8% more Current drinkers (Fig 2,2) than classes 4-6.

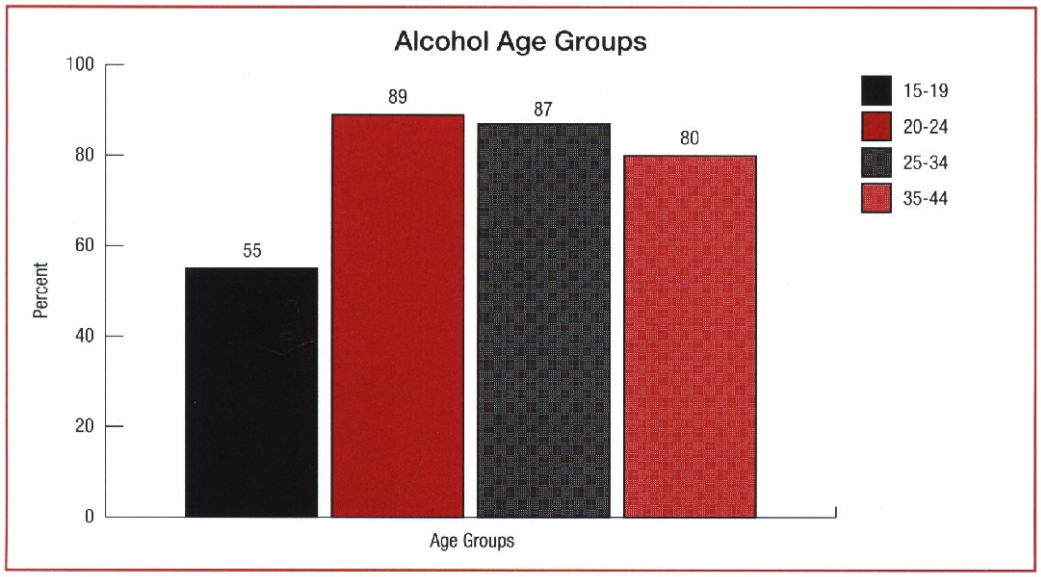
Fig 2,2



Age Groups

Age groups 20-24 years showed 89% Current drinkers, similar to 25-30 age group, but 10% more than 35-44, and 35% more than 15-19 years (Fig 2,3).

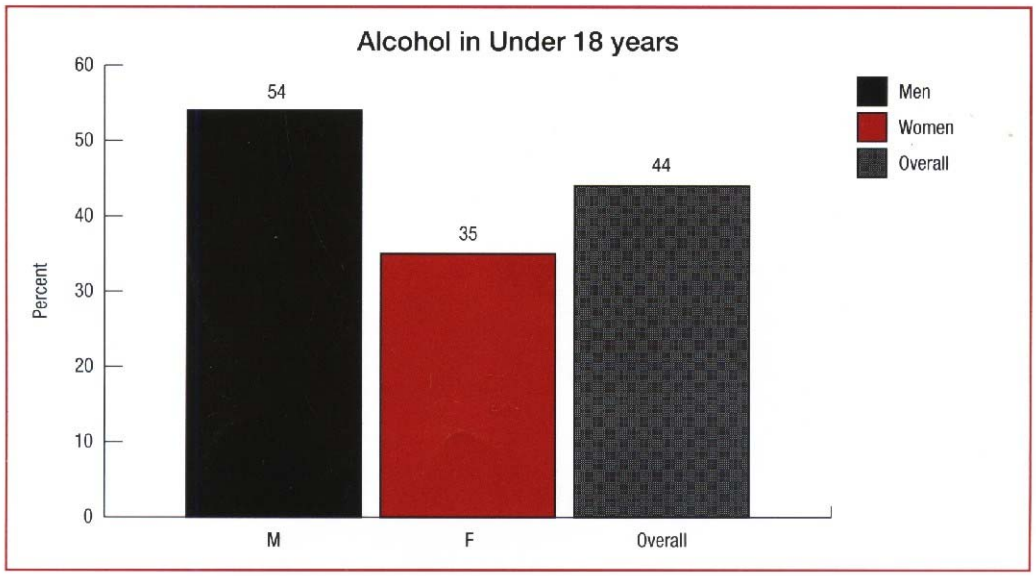
Fig 2,3



Under 18 years

44% of those under the legal age for sale of alcohol, claim to be currently drinking (Fig 2,4). In this category 54% were men, 19% more than women (35%) (Fig 2,4). 33% of those aged 15-16 years report Current drinking.

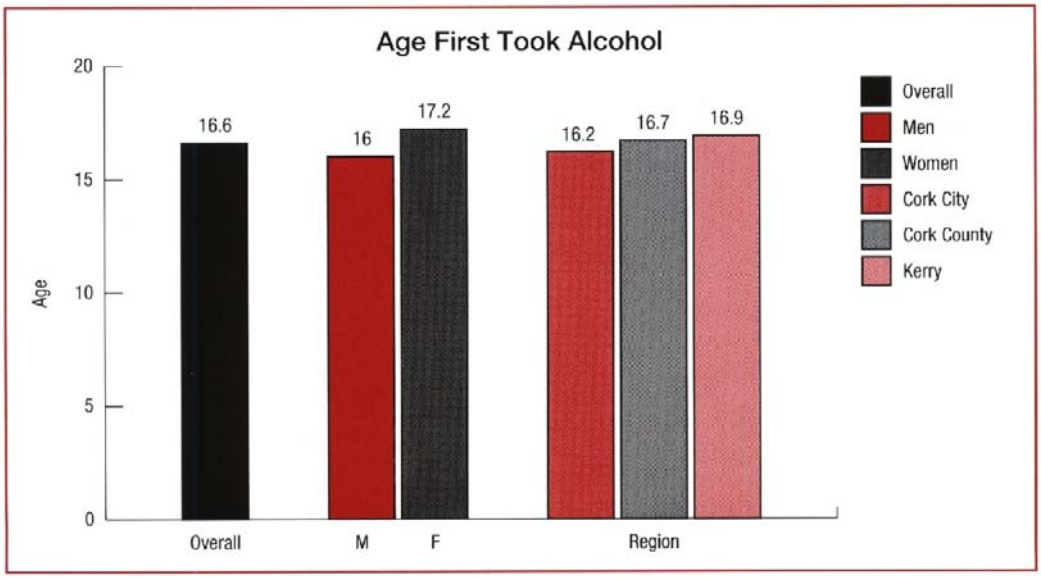
Fig 2,4



Age First Taking Alcohol

The mean age of first taking alcohol was 16.6 years (Fig 2,5), with a quarter having taken alcohol by 15 years. Men took alcohol 13 months younger than women. People in Cork city were about 6 months younger in starting alcohol than those in Cork County or Kerry.

Fig 2,5

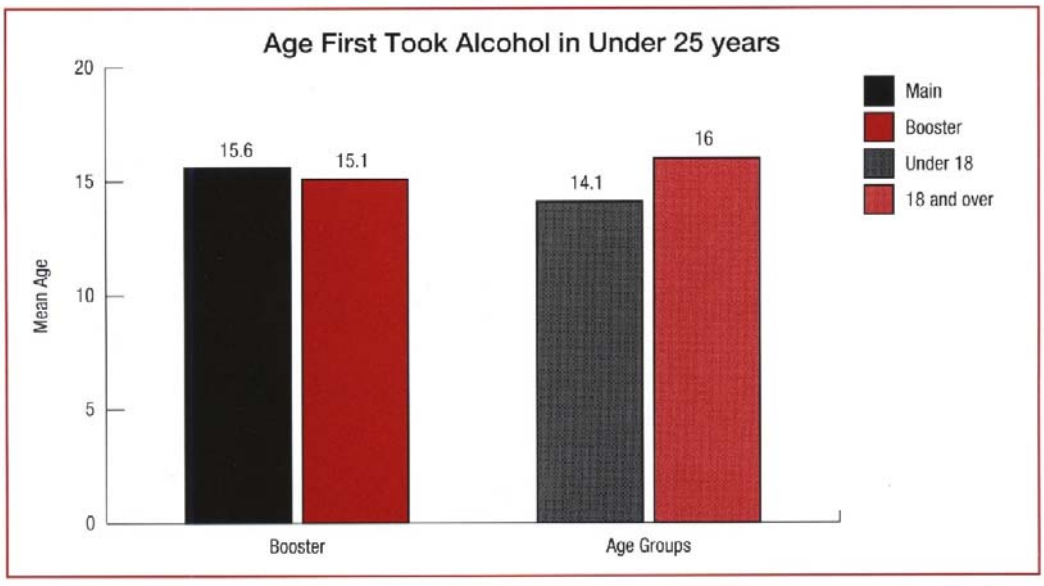


Age First Taking Alcohol in Under 25 years

The mean age was 6 months younger for booster areas (Fig 2,6).

Selecting those **under 18 years** only, the mean age of first taking alcohol was 14.1 years, with half taking their first drink by age 15. This age was almost 2 years younger than those 18 years and over.

Fig 2,6



Types of Alcohol Consumed

Beer is the most frequently consumed drink overall at almost 60% (Fig 2,7). Beer and Cider are mostly consumed by men, whereas women have a relative preference for wine and spirits (Fig 2,8).

Fig 2,7

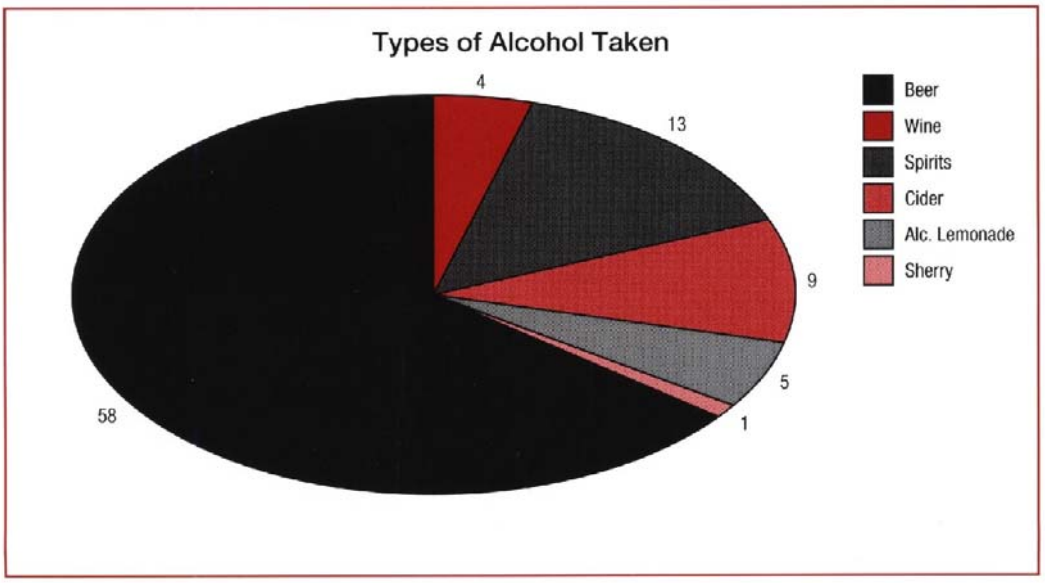
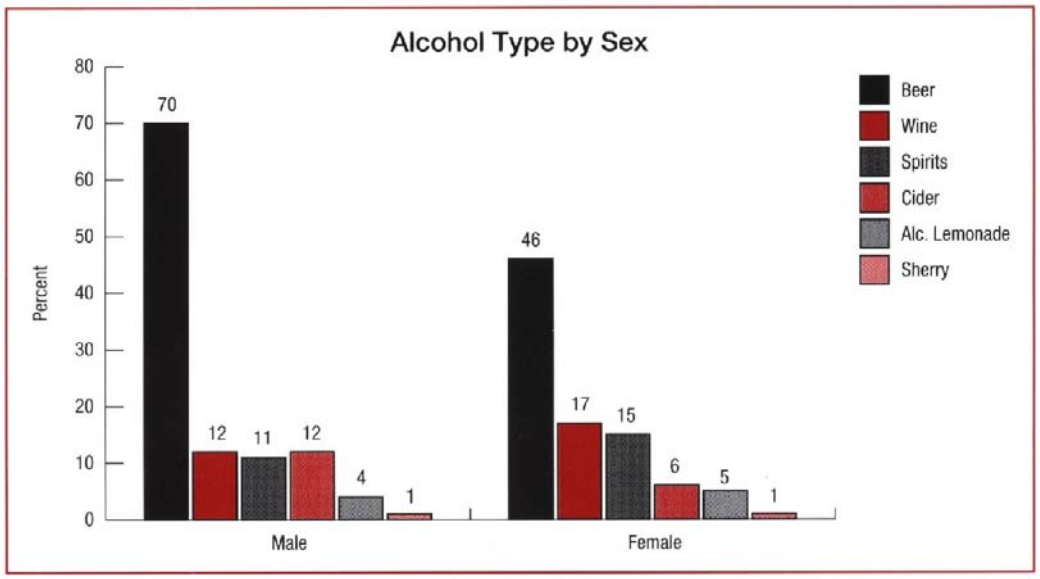


Fig 2,8

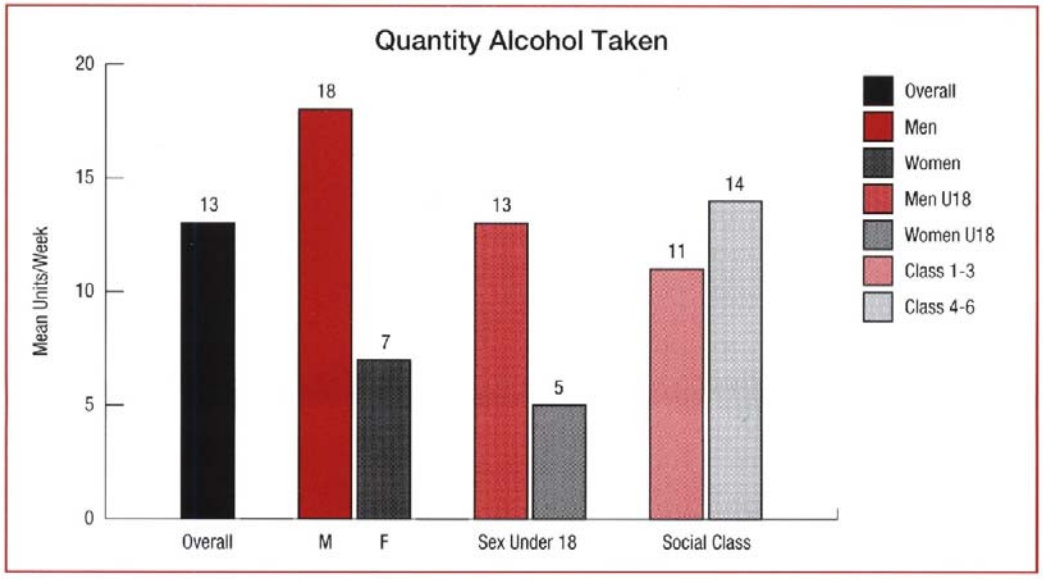


Total Quantity of Alcohol Taken

In Current drinkers, the mean amount of alcohol taken was 13 units per week, with half taking 8 units per week (Fig 2,9). Men took a mean of 18 units per week which was almost three times as much women. This difference was maintained in the Under-18 category with men taking 13 units a week, and women 5 units.

Those in lower Social Class 4-6 took slightly more than classes 1-3, and there was no significant difference between regions, deprivation, or age groups over 18 years.

Fig 2,9

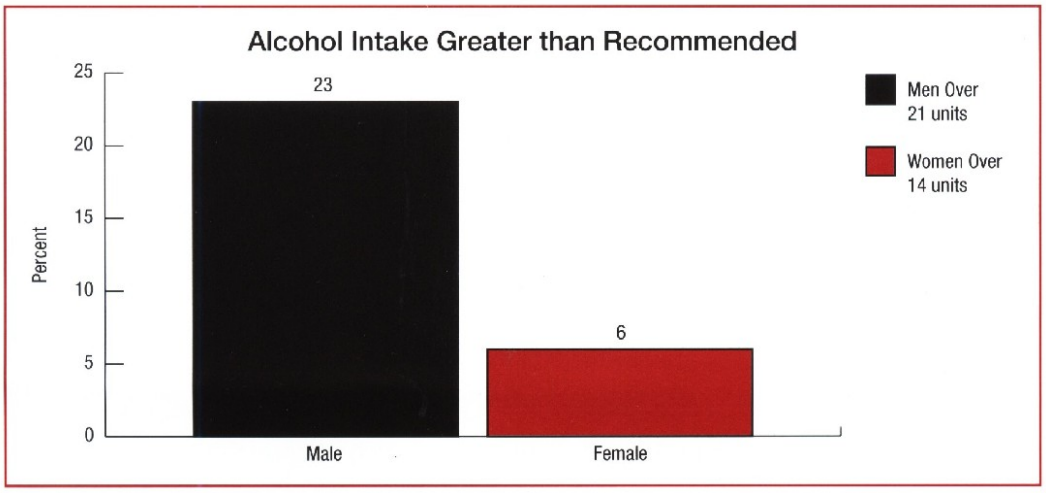


Alcohol - Current Drinkers Taking Amounts Greater Than Recommended
It is recommended that men take less than 21 units of alcohol per week, and women less than 14 units[60].

23% of men took more than 21 units of alcohol per week. These had started to take alcohol 1.2 years earlier than those who took less (Fig 2,10).

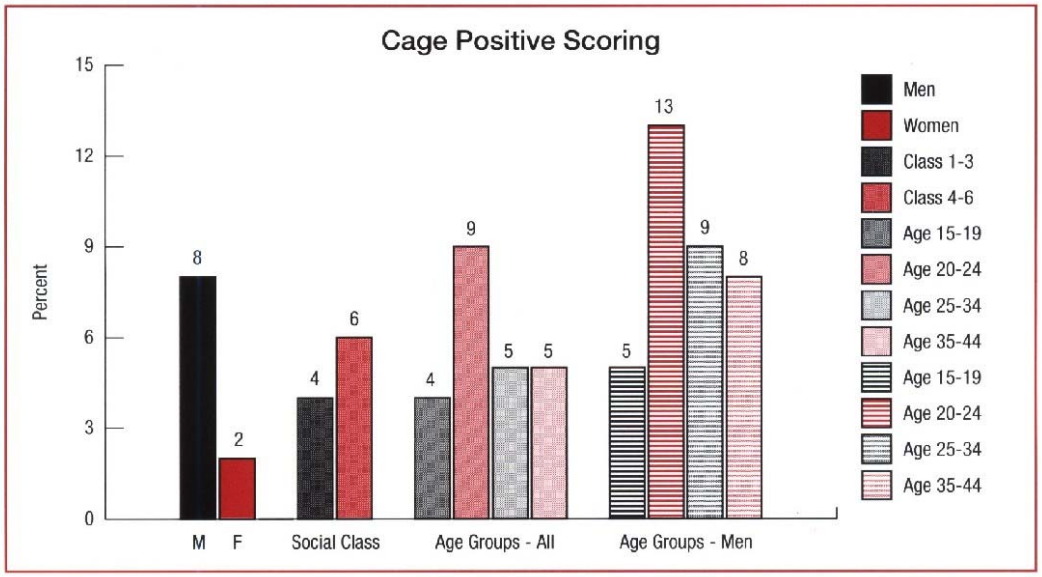
5.5% of women took more than 14 units per week (Fig 2,10). These had started taking alcohol 1.5 years younger than those who took less.

Fig 2,10



Cage Positive Testing in Current Drinkers
Cage positive scoring was 8% in men, 4 times higher than in women (Fig 2,11).
Social Class 4-6 was higher, and Age Group 20-24 was highest, especially in men, where it reached 13%.

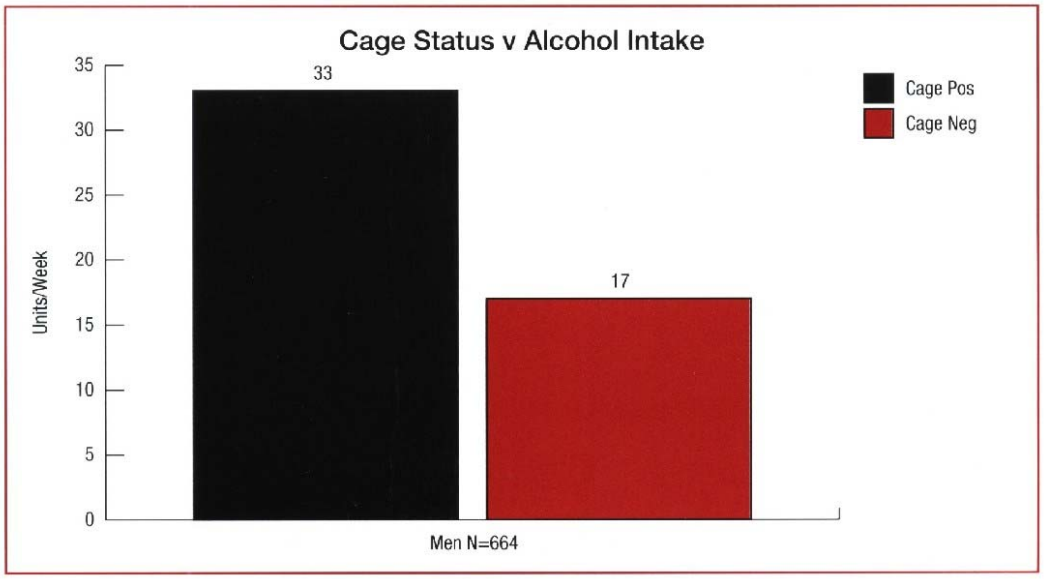
Fig 2,11



Mean Alcohol Intake in Cage Positive Men

Men who were Cage positive showed a mean alcohol intake per week of 33 units, almost 17 units more than in Cage negative scorers (Fig 2,12).

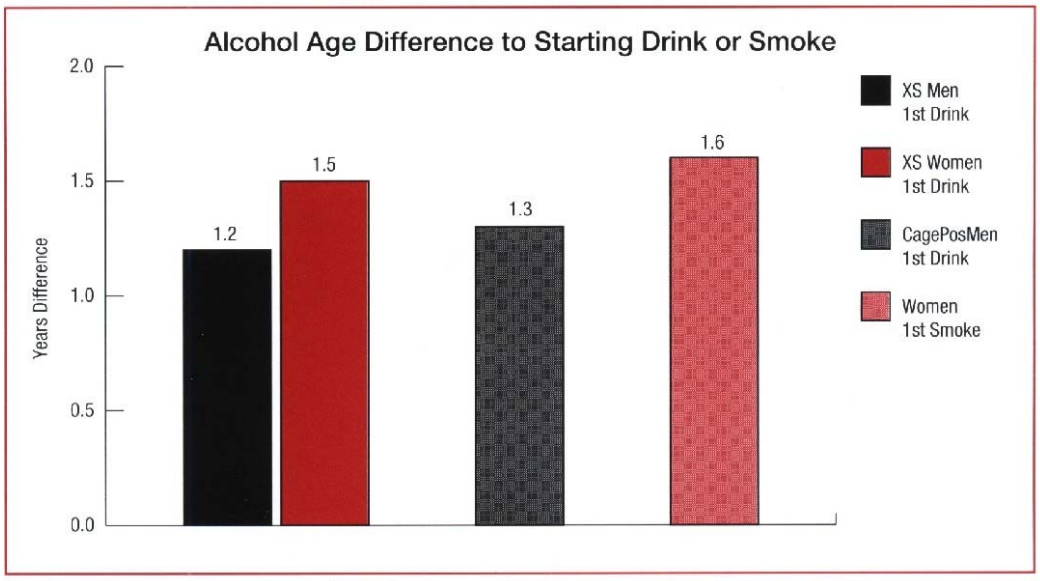
Fig 2,12



Age differences in starting drinking or smoking for Cage Positive

In Cage Positive cases, the age of first taking alcohol was 1.3 years younger than those who were Cage Negative. This was little different from the age difference in those drinking **in excess** of the guidelines (XS men/women) compared to those drinking within the guidelines of 21/14 units per week (Fig 2,13).

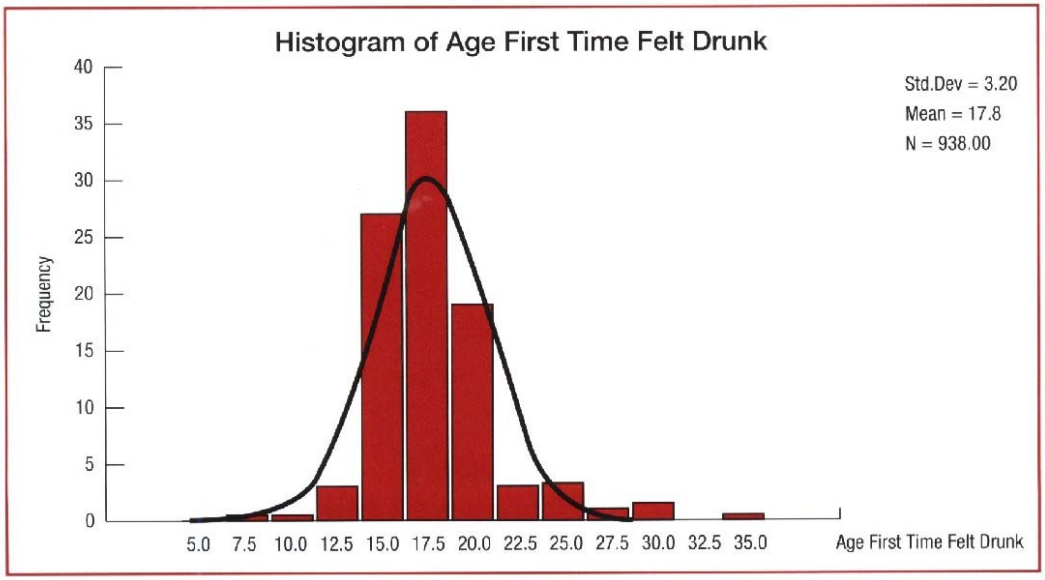
Fig 2,13



Alcohol Intoxication - Drunkenness

Fig 2,14 shows the ages at which people reported their first drunkenness. 72% said that they had ever been drunk. The mean age for first drunkenness was 17.8 years, but a quarter had been drunk by 16 years. Men were 1.3 years younger than women for age of first drunkenness. The average age for first drunkenness in Cork City was about 9 months younger than in Cork County or Kerry. Those in Social Class 1 -3 reported a mean age of first drunkenness at six months younger than those in classes 4-6.

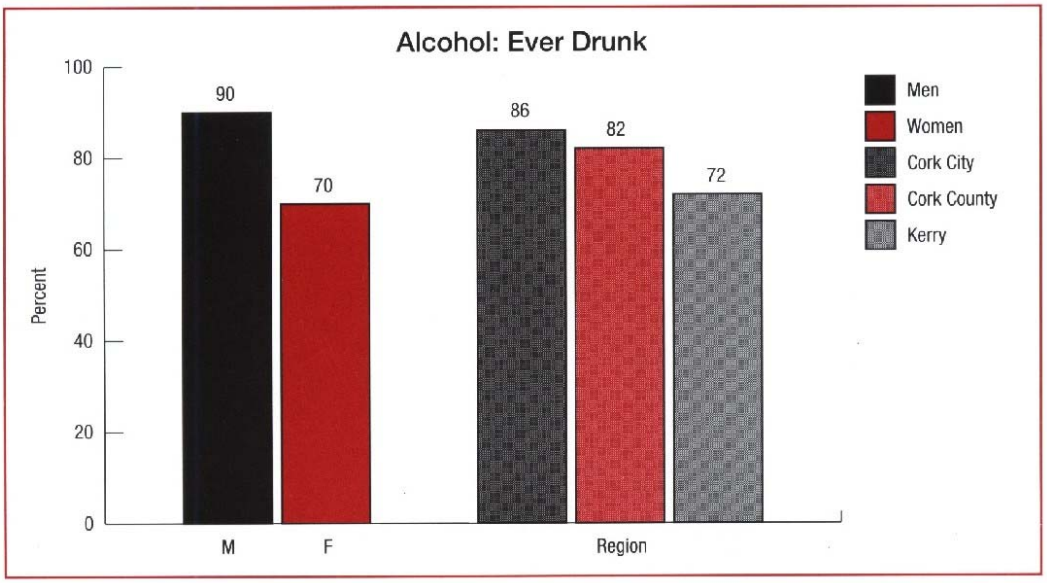
Fig 2,14



In Current drinkers, 90% of men had been drunk, compared to 70% of women (Fig 2,15).

Cork City and County had higher numbers of those who had ever been drunk than Kerry.

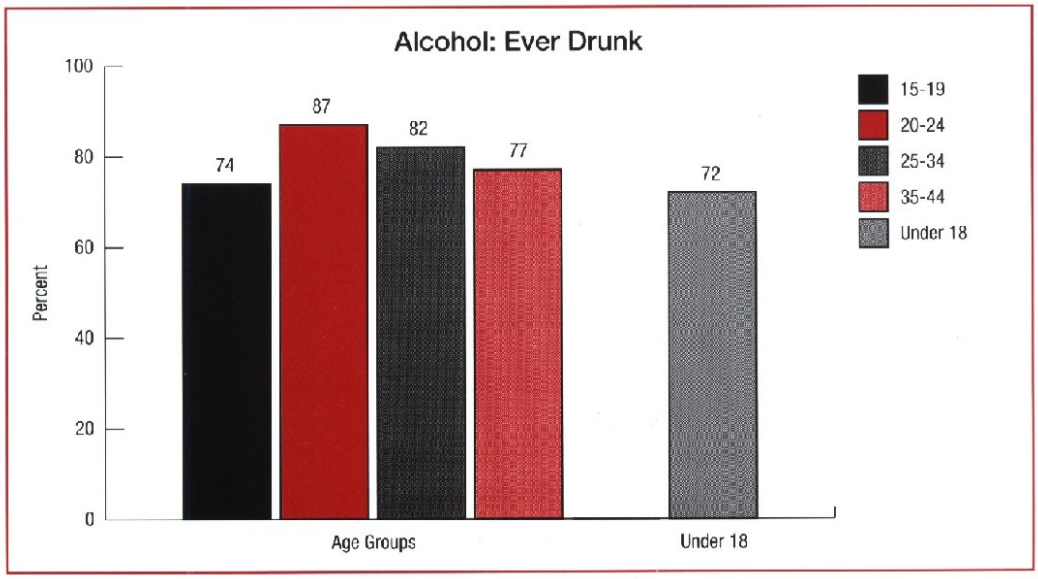
Fig 2,15



Age Groups and Drunkenness in Current Drinkers

Those in age group 20-24 years reported the highest levels of ever being drunk at 87%. 72% of those drinking under 18 had been drunk (Fig 2,16). Social Class and Deprivation showed little difference.

Fig 2,16



Frequency of Intoxication in Current Drinkers

Overall, 7% reported drunkenness at weekends and 14% a couple of times per month (Fig 2,17). Men were twice the rate of women for being drunk at these times, with 10% at weekends and 19% 1-2 times a month. Age Group 20-24 showed the highest rates with 15% and 21% at these periods (Fig 2,18). The under 18s showed similar rates as those over 18 years for these periods. There were no differences between Social Class or Urban or Rural residence.

Fig 2,17

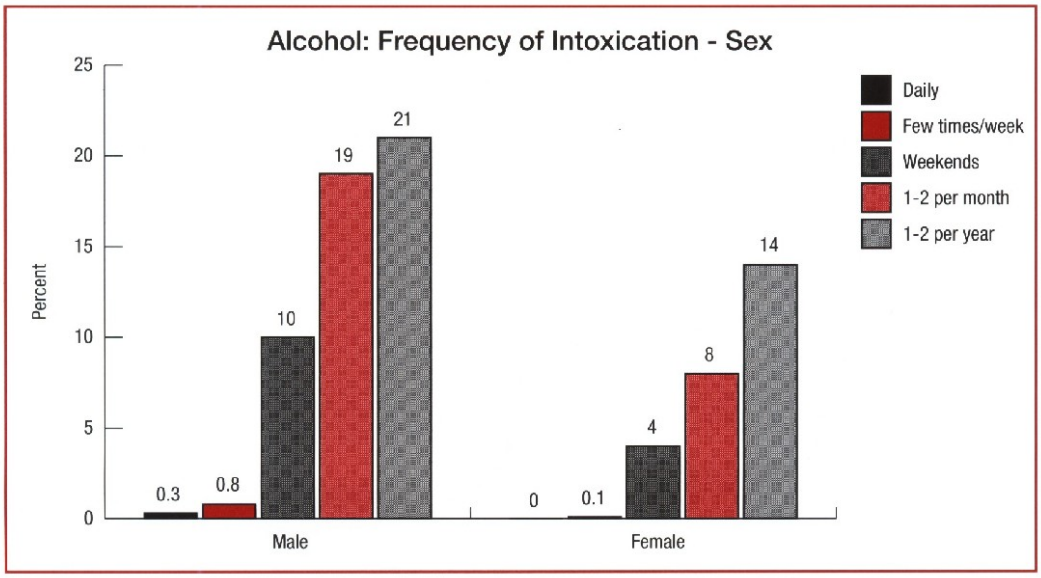
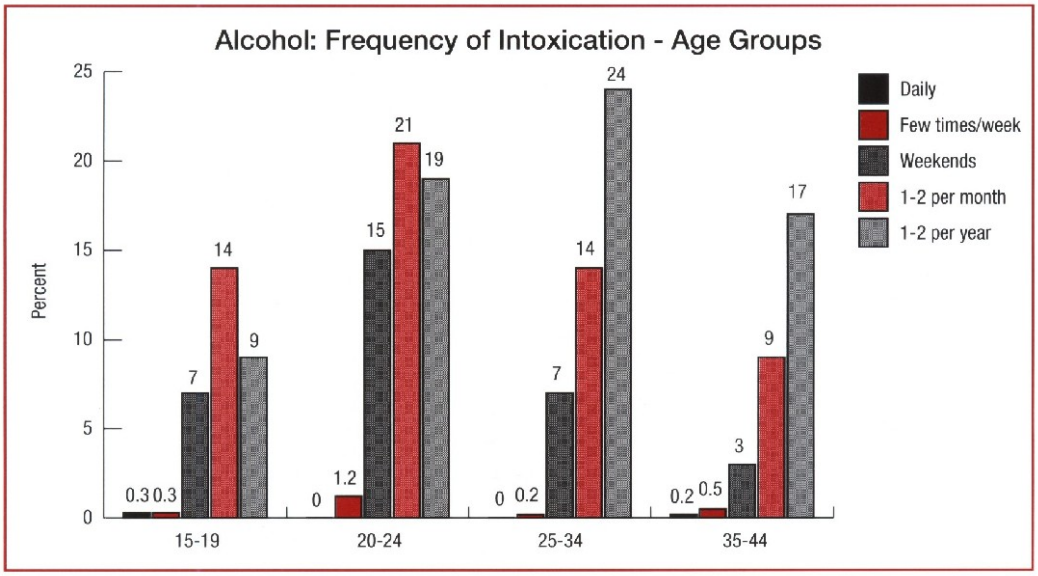


Fig 2,18



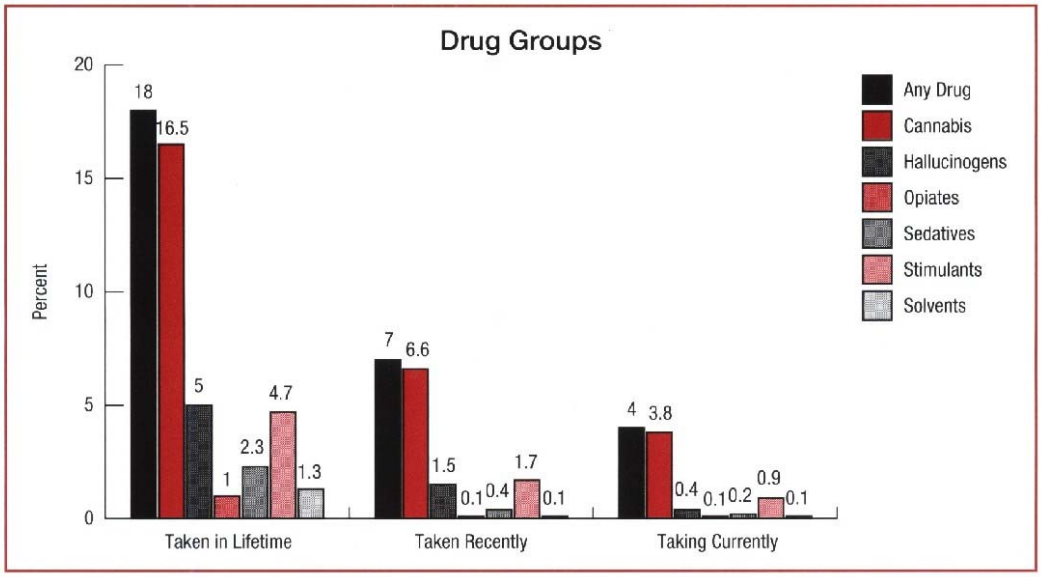
SECTION 3 - DRUGS [OVERALL USE]

Lifetime Use: 18% admitted to ever taking an illegal drug in their life (Fig 3,1). The main drugs used were Cannabis 16.5%, Hallucinogens 5%, and stimulants 5%. Sedatives were less at 2%, and Solvents and Opiates were only 1%.

Recent Use: Drug use in the last year showed that 7% had taken Any drug or Cannabis, and 2% had taken Hallucinogens or Stimulants. Less than 0.5% took other drugs.

Current Use: Drugs taken in the last month showed that 4% took Cannabis and 1 % took stimulants. Less than 0.5% took other drugs.

Fig 3,1



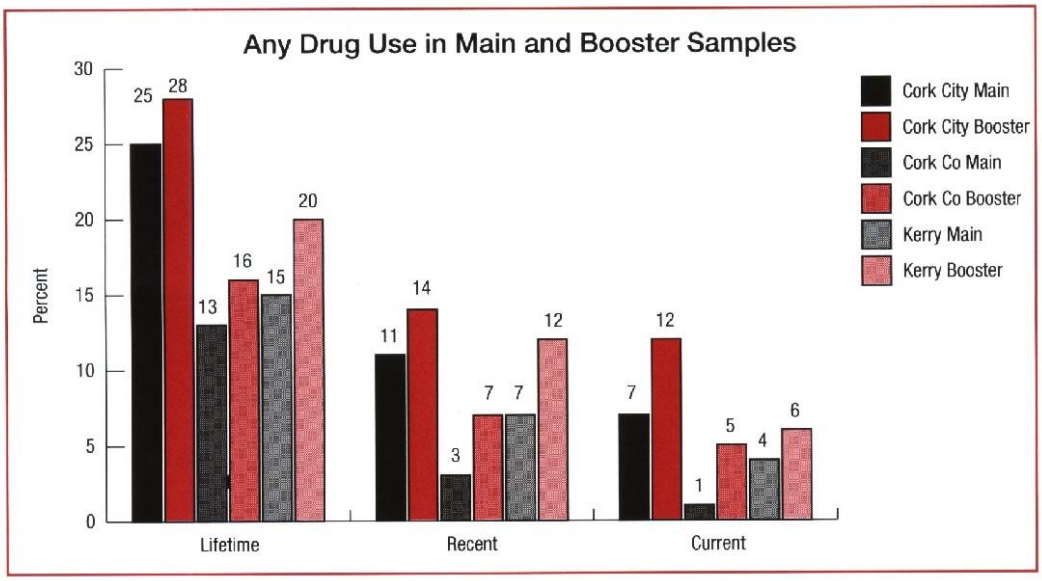
Main and Booster Samples

As explained in the Methodology Section, the Main sample examined those aged 15-44 years in the general population. The Booster Sample examined those aged 15-24 years **and** from deprived areas.

Booster Samples show higher drug use in all categories and regions (Fig 3,2). This difference mainly reflects the lower age of the booster sample (under 25 years), and ceases to be significant when age is corrected.

However it is important to note that the booster sample in Cork City showed 28% Lifetime use, 14% Recent use, and 12% Current use of any drug. These levels are twice that of other regions except for Recent use in Co Kerry (12%).

Fig 3,2

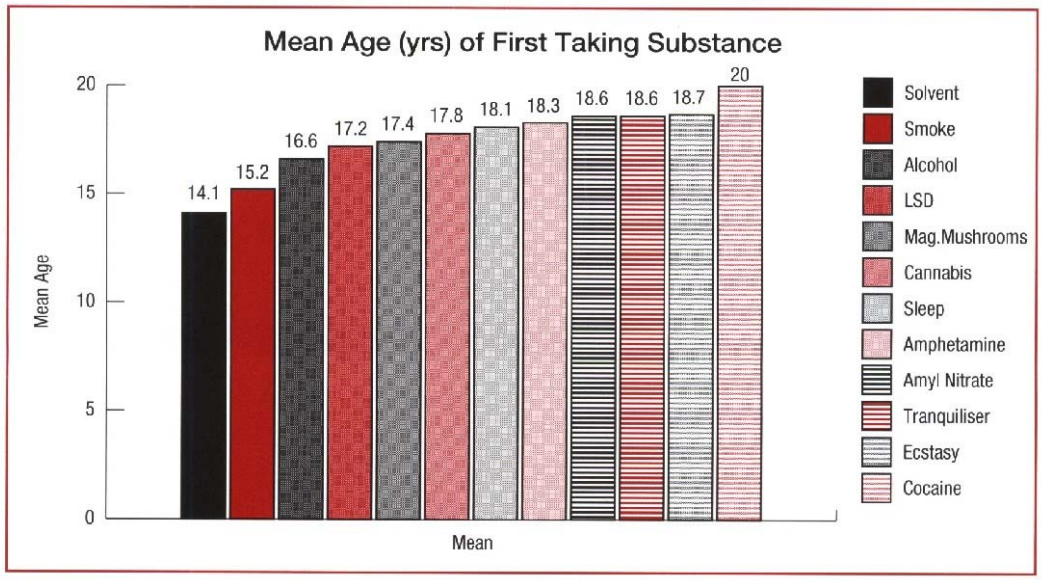


Age of 1st Taking Substance

Substances which were taken by at least 1 % of the survey were analysed for the mean age at which they were first used (Fig 3,3). This gives an indication of the general sequence in which any drugs are taken.

Solvents, smoking, and alcohol are all taken in earlier years before illegal drugs. The Hallucinogens (LSD, and Magic Mushrooms), preceded Cannabis, followed mainly by stimulants - Amphetamines, Amyl Nitrate, Ecstasy, and finally Cocaine at the older age of 20 years. Medically prescribed drugs e.g. sleeping tablets and tranquillizers were first tried at 18 years.

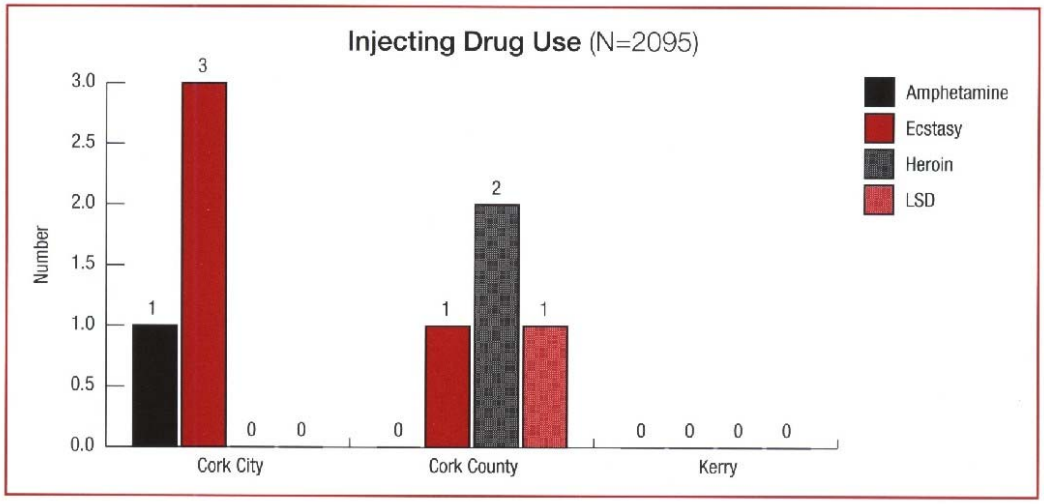
Fig 3,3



Injecting drug use

Only 10 people (<0.5%) in the entire survey (main and booster samples combined) reported injecting drug use (Fig 3,4). Only two claimed to be injecting Heroin (<0.1%).

Fig 3,4

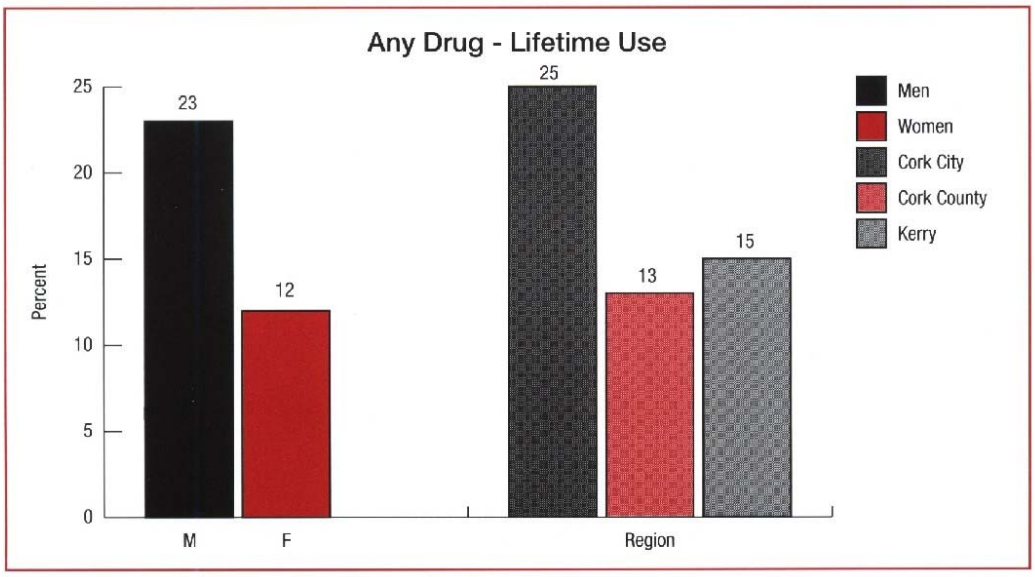


ANY DRUG USE

Sex and Region

Men had twice the rate of Lifetime use as women at 23% (Fig 3,5). Cork City had 25% which was almost twice the rate of Cork County (13%), and 10% more than Kerry (15%).

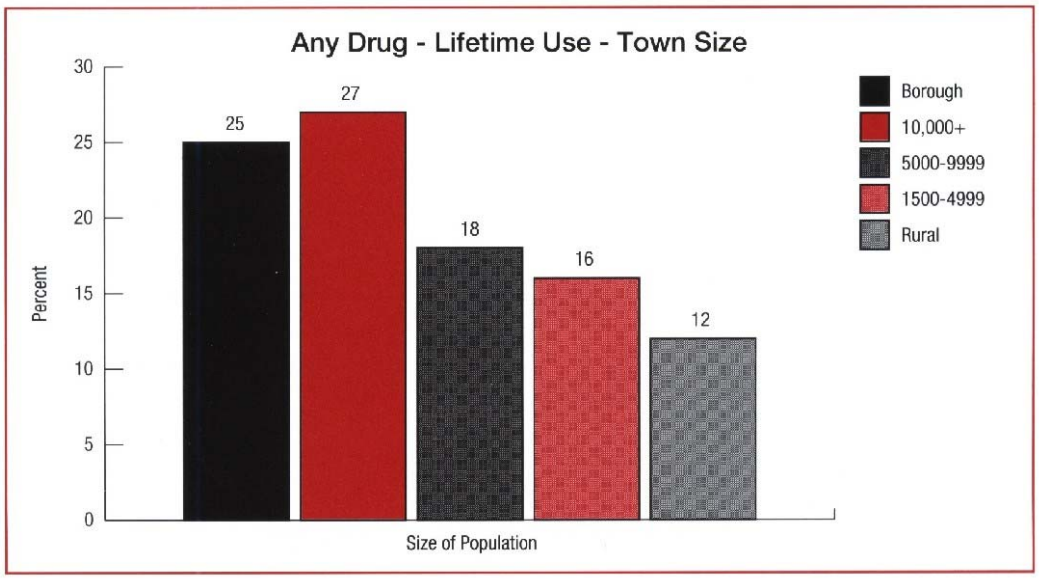
Fig 3,5



Town Size

Town size reflected these figures, showing drug use highest in the larger towns at 25- 27%, and least in the rural areas at 12% (Fig 3,6).

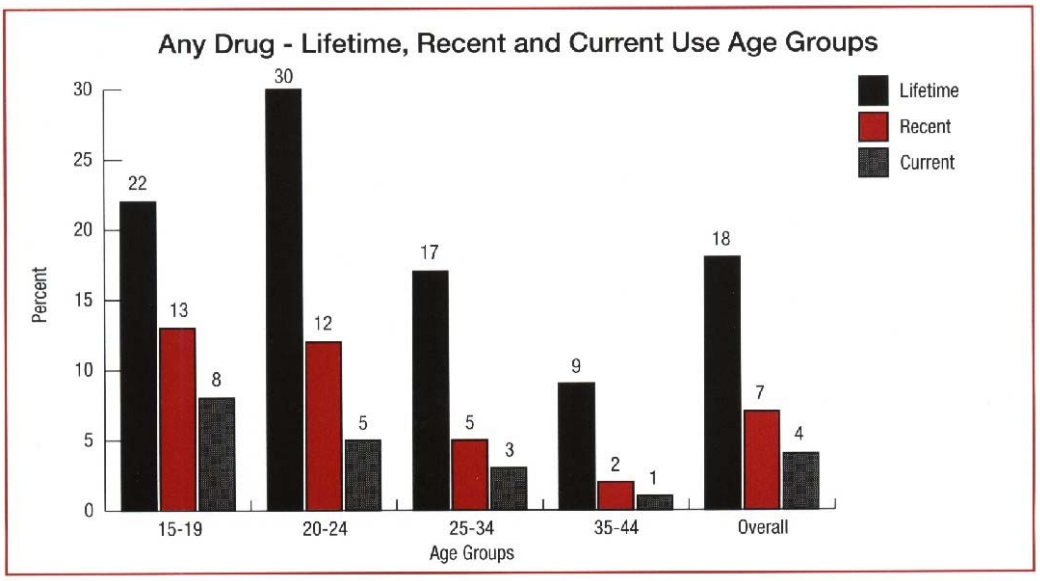
Fig 3,6



Age Group

Age Group 20-24 years showed the highest Lifetime use at 30% with age group 15-19 showing 22%. Recent and Current use were highest in the 15-19 year age group. The oldest group of 35-44 showed a lowest use for all categories, with almost no Recent or Current use (Fig 3,7).

Fig 3,7

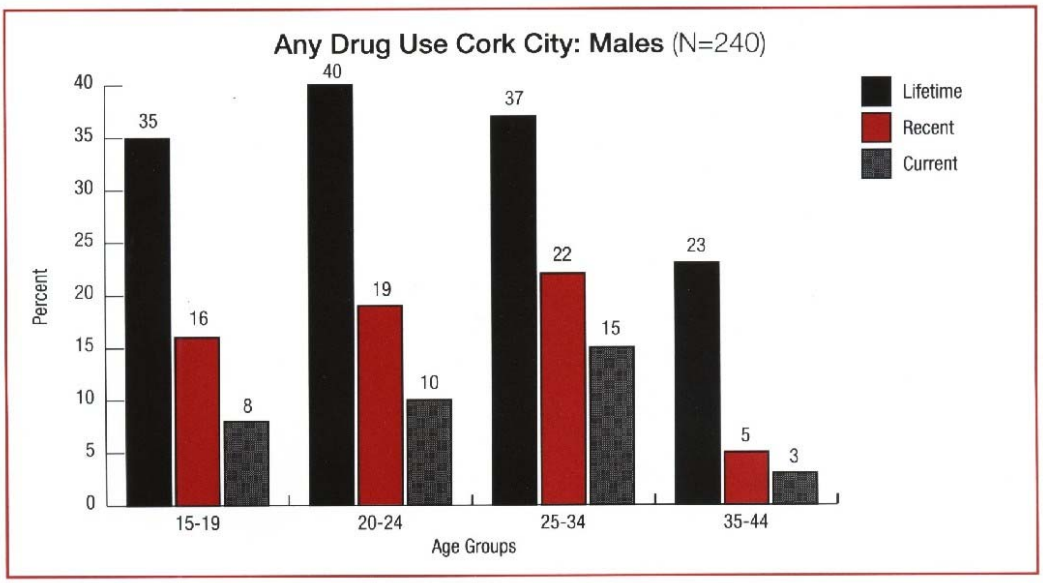


There was no significant difference between social classes, or main and booster areas.

Men in Cork City

Up to 40% of men in Cork City had ever taken drugs in ages under 35 and about a fifth had taken a drug in the last year. Only the oldest age group showed a reduction to 23% Lifetime use.

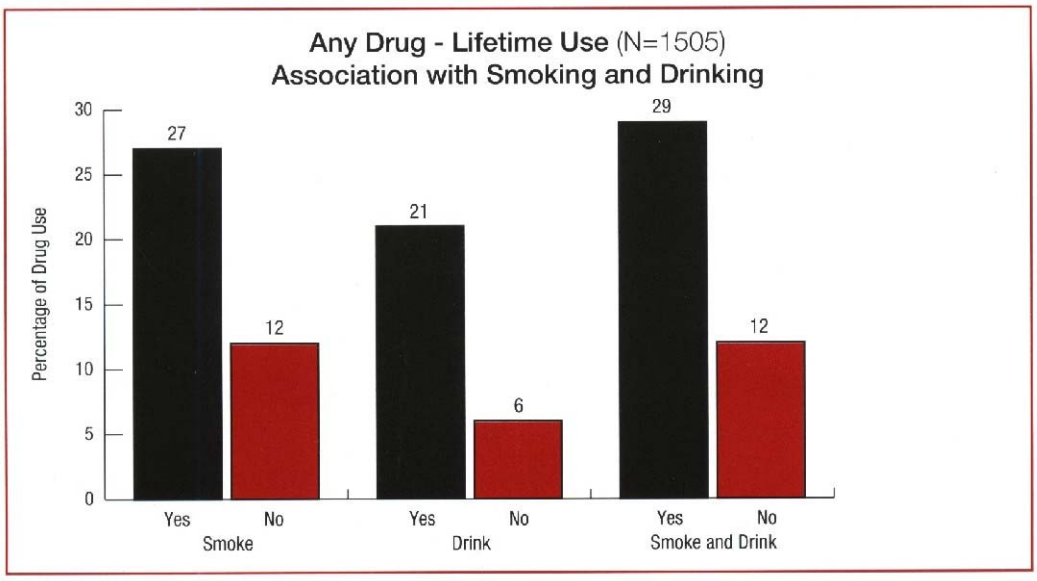
Fig 3,8



Association with Smoking and Drinking

Current smokers (27%), Current drinkers (21%), and those who drink and smoke (29%) all showed marked increases in any drug use over non-smokers and non-drinkers with over twice the rates of drug use (Fig 3,8).

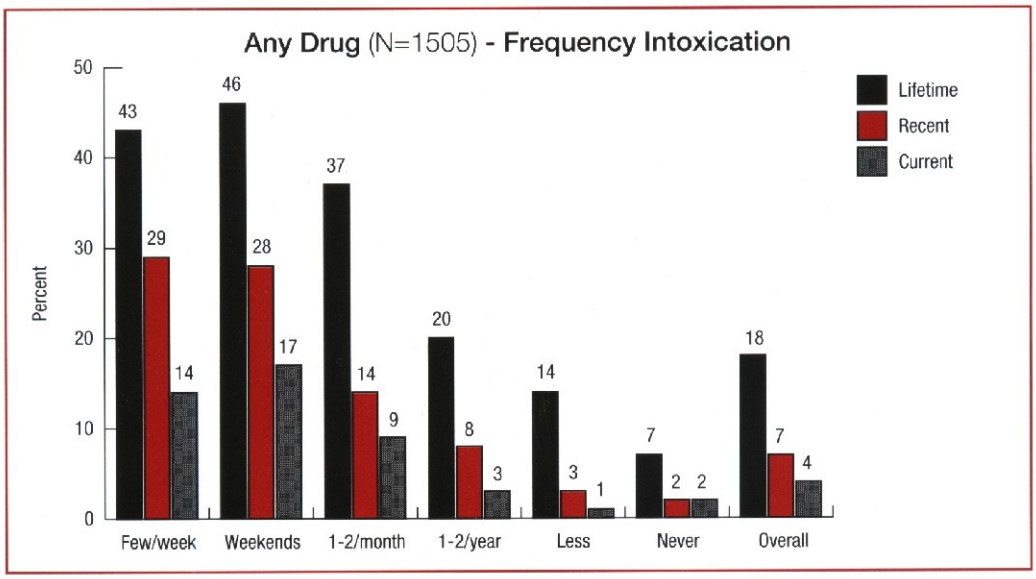
Fig 3,9



Association with Alcohol Intoxication

Those who get drunk once or twice a month or more frequently, show at least twice the rate of use of drugs than those who get less frequently intoxicated. 17% of those who got drunk at weekends, admitted Current drug use (Fig 3,9).

Fig 3,9



Polydrug Use

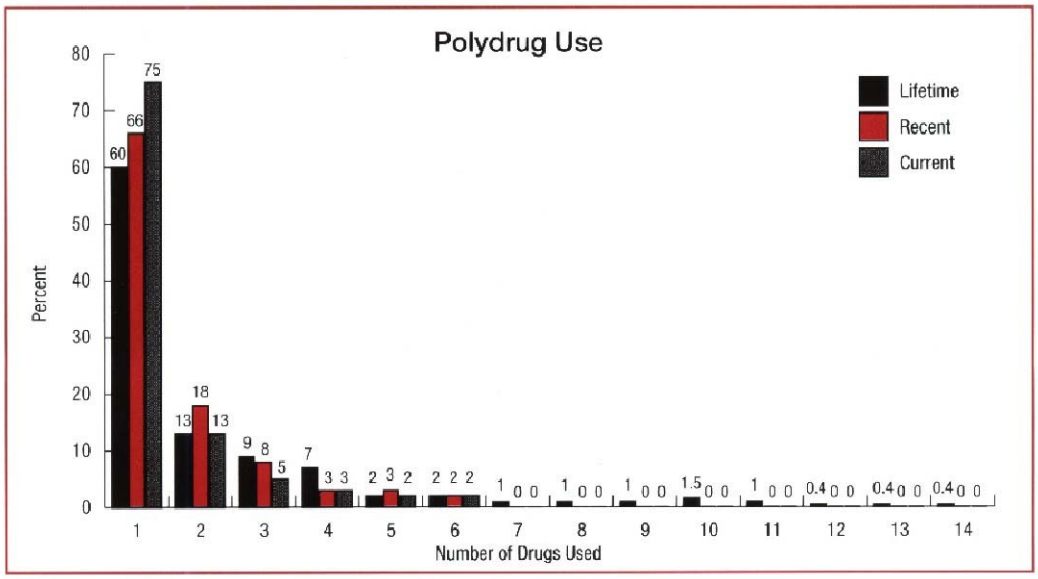
Lifetime Users reported up to 14 drugs used. 60% had used one drug. 40% used more than one drug (Fig 3,10).

13% used 2 drugs; 9% had used 3 drugs, 7% 4 drugs, and a remaining 10% had used 5 drugs or more.

Recent Users had used up to 6 drugs. 66% used one drug. 34% used more than one drug. 18% used 2 drugs; 11 % used 3-4 drugs, and the remaining 4% used 5-6 drugs.

Current Users took up to 6 drugs. 75% took one, 25% used more than one drug. 13% took two, 5% took 3, and 7% took 4-5 drugs.

Fig 3,10



SECTION 4 - CANNABIS

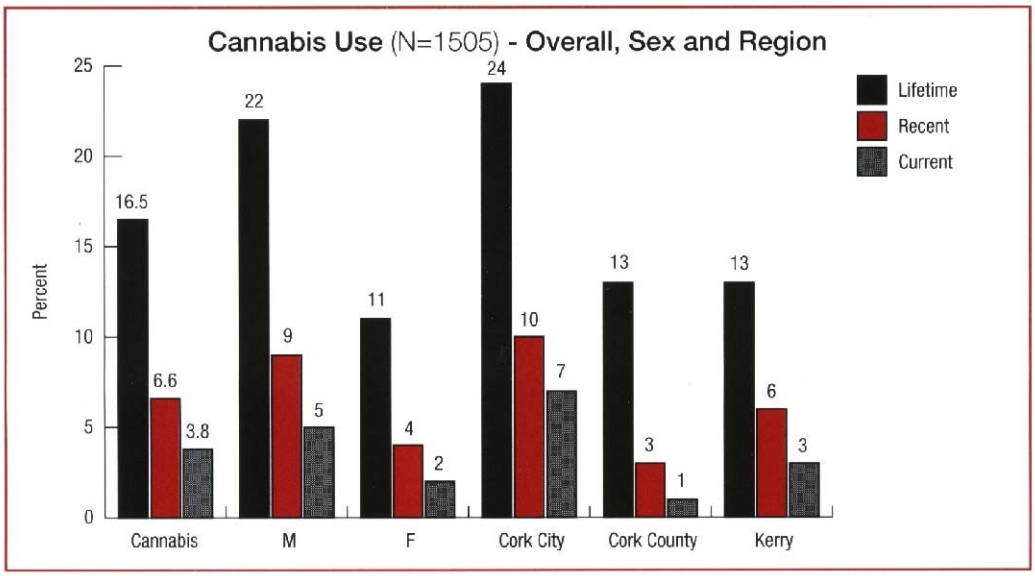
Overall, Sex and Region

Overall, Lifetime use for Cannabis was 16.5% (Fig 4,1). Recent use was 7%, and Current usage 4%. Because Cannabis is the dominant drug used, the findings for/Any *Drug Use* mainly reflect Cannabis use.

Males use Cannabis twice as much as females, slightly more in Recent and Current use.

Cork city has twice the Cannabis rates of other areas for Lifetime use, but in Recent use Kerry is only slightly less (6%). Current use in Cork City (7%) is twice that of Kerry (3%).

Fig 4,1

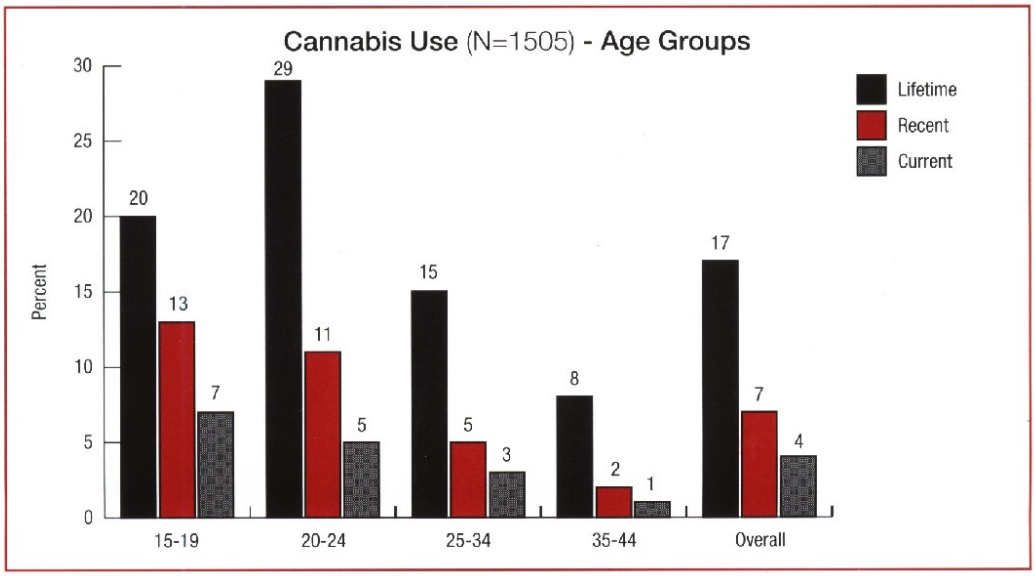


There was no significant difference for Social classes or Deprivation.

Age Groups

Age Groups 20-24 years showed highest Lifetime use (29%). Recent and Current use were highest at 15-19 years (13-7%) (Fig 4,2).

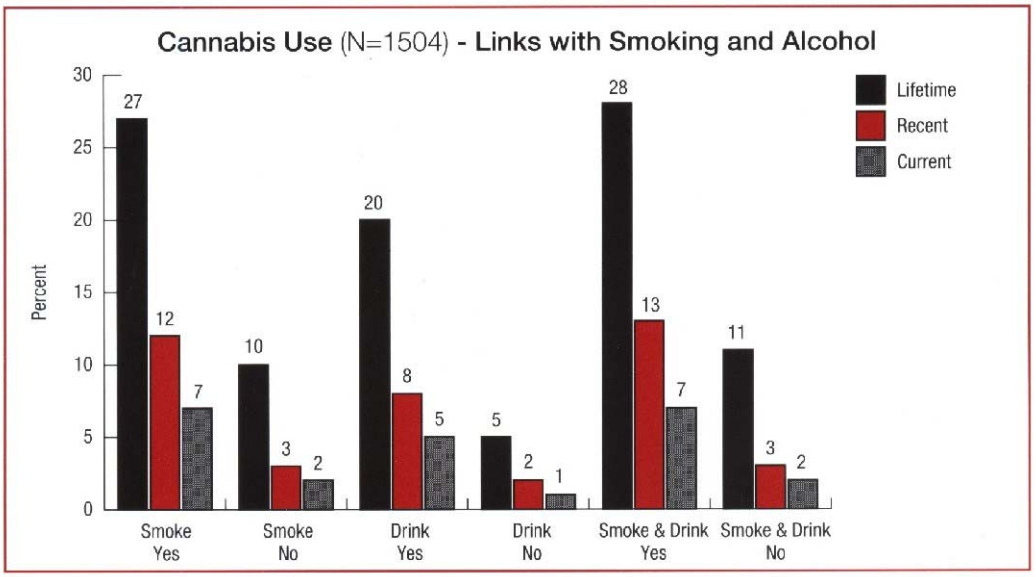
Fig 4,2



Association with Smoking and Drinking

Current Smokers and Current Drinkers showed twice as many Cannabis users for Lifetime use (26%) and 3-4 times as many for Recent use (10%), especially if they both drink and smoke (Fig 4,3).

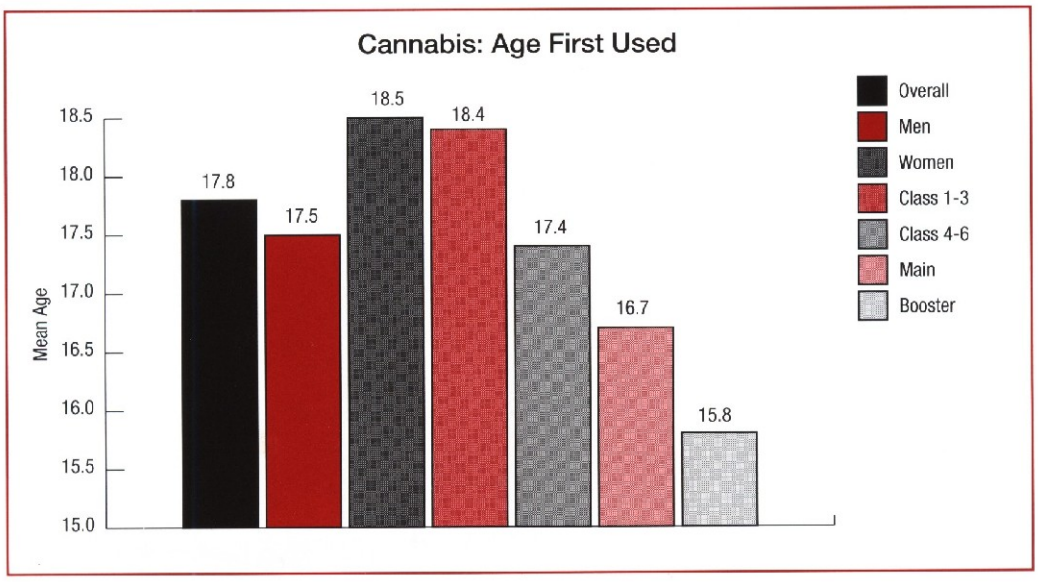
Fig 4,3



Age First Taking Cannabis

The mean age of first taking Cannabis is 17.8 years, and a quarter had taken Cannabis by 16 years (Fig 4,4). Men started taking Cannabis a year earlier than women. Social Class 4-6, and Booster sample were younger by one year also. There was no age difference in Cannabis users between regions.

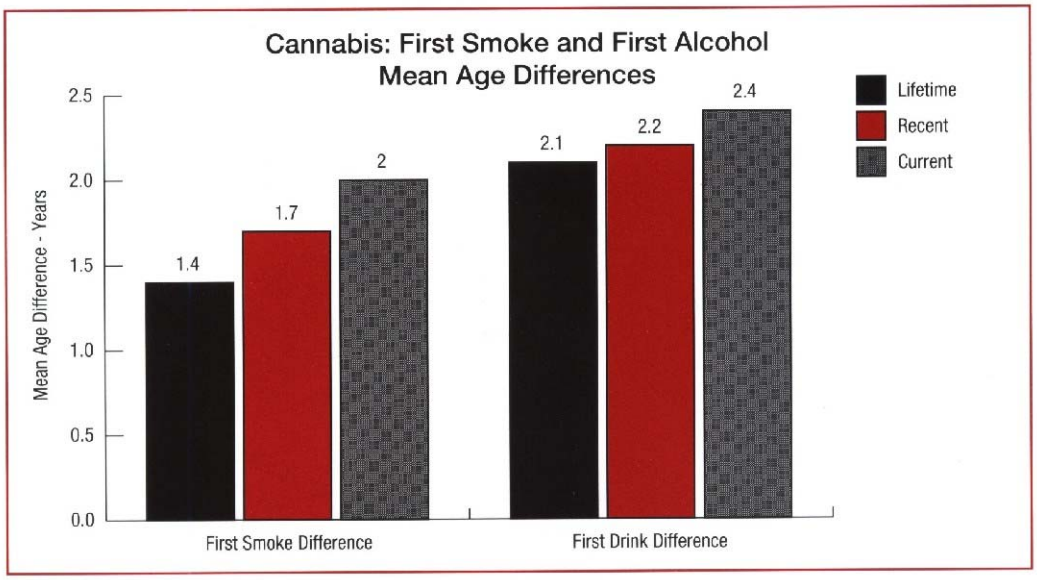
Fig 4,4



Age of First Smoking and Drinking in Cannabis Users

Age of first smoking and drinking were younger for Cannabis takers, especially for first alcohol - 2 years younger for Lifetime use (Fig 4,5). These differences were higher with Recent and Current usage of Cannabis.

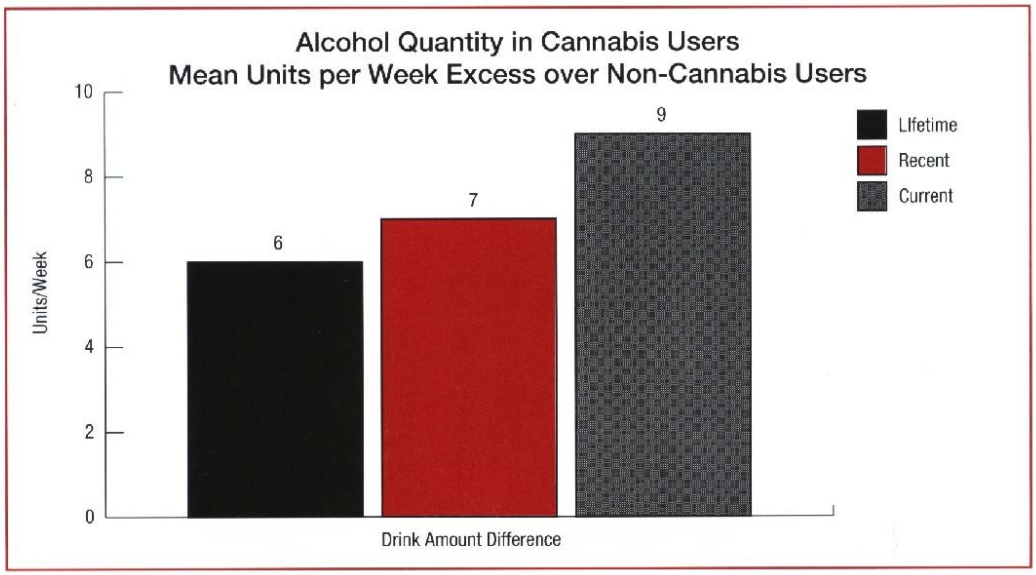
Fig 4,5



Alcohol Intake in Cannabis Users

Alcohol taken per week, was increased in those who took Cannabis. The mean increase was proportional to the frequency of Cannabis use (Fig 4,6), with Recent Cannabis users drinking 9 units a week more than Current users.

Fig 4,6



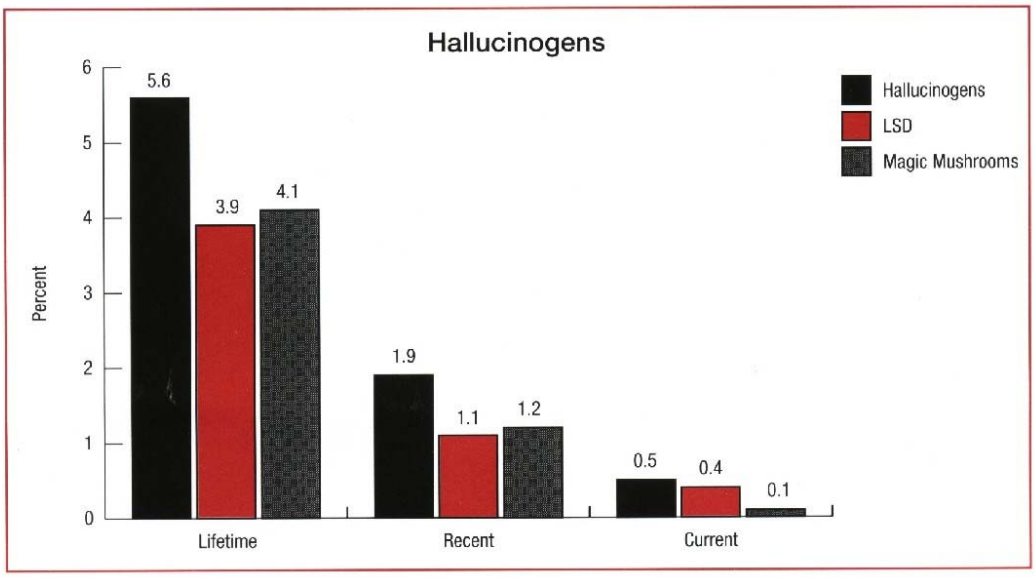
SECTION 5 - HALLUCINOGENS

LSD
Magic Mushrooms

Lifetime, Recent and Current Use
For Lifetime use Hallucinogens were taken by 6%, 4% took LSD, and 4% took Magic Mushrooms (Fig 5,1). The numbers do not sum because of cross-taking of drugs.

Recent and Current use of Hallucinogens were at 2% and 0.5% and were too small for statistical analysis. The following results are for Lifetime use.

Fig 5,1

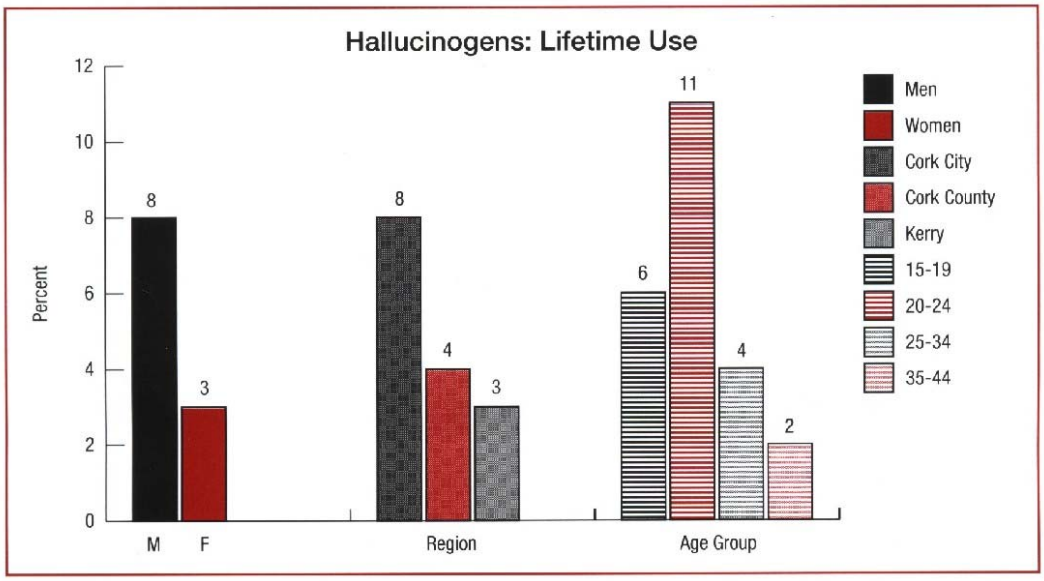


Sex, Region and Age Group
Twice as many men (8%) as women (3%) took Hallucinogens. Cork City 8% had twice the other regions.

11 % of those in age group 20-24 took Hallucinogens, with 6% at 15-19 years. Other age groups showed only 2-4%.

There was no significant difference for Social Class or Booster sample.

Fig 5,2



SECTION 6 - STIMULANTS

Amphetamines
Amyl Nitrate
Cocaine
Crack
Ecstasy

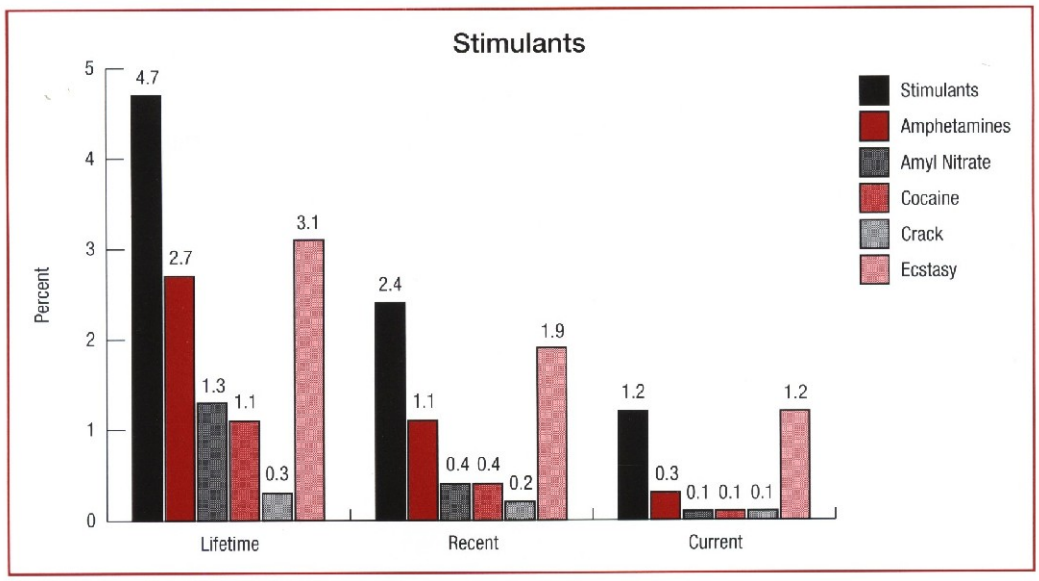
Lifetime, Recent and Current Use
For Lifetime use Stimulants were taken by 5% (Fig 6,1). 3% took Amphetamine, and 3% Ecstasy. Amyl Nitrate and Cocaine were 1% each, and Crack was 0.3%. The numbers do not sum because of cross taking of drugs.

Recent and Current use of Stimulants were at 2% and 1 % and were too small for statistical analysis. The following results are for Lifetime use.

There was no significant difference for Social Class or Deprivation.

Current Drinker and Smokers had levels of up to 8% when combined. Smoking seemed to have the greatest association with 7.9% of Current smokers taking Stimulants.

Fig 6,1

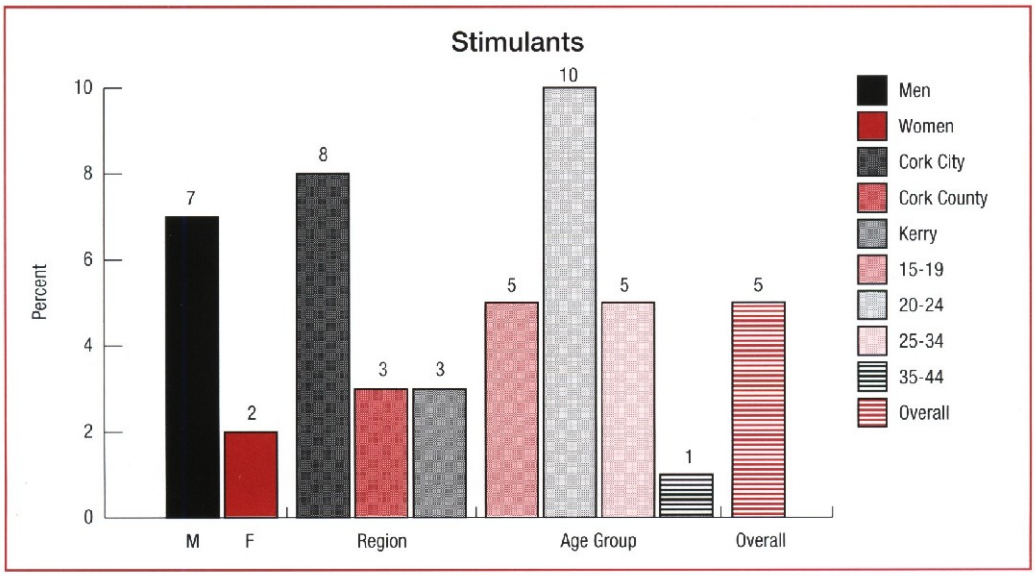


Sex, Region and Age Group

Three times as many men (7%) as women (2%) took stimulants (Fig 6,2). Cork City (8%) had twice the other regions.

Age Group 20-24 showed maximum use 10%. Other age groups showed 5% except the oldest group at 1%.

Fig 6,2



SECTION 7 - SEDATIVES

Barbiturates
Sleeping Tablets
Temazepam
Tranquillizers
Temgesic
Triazolam

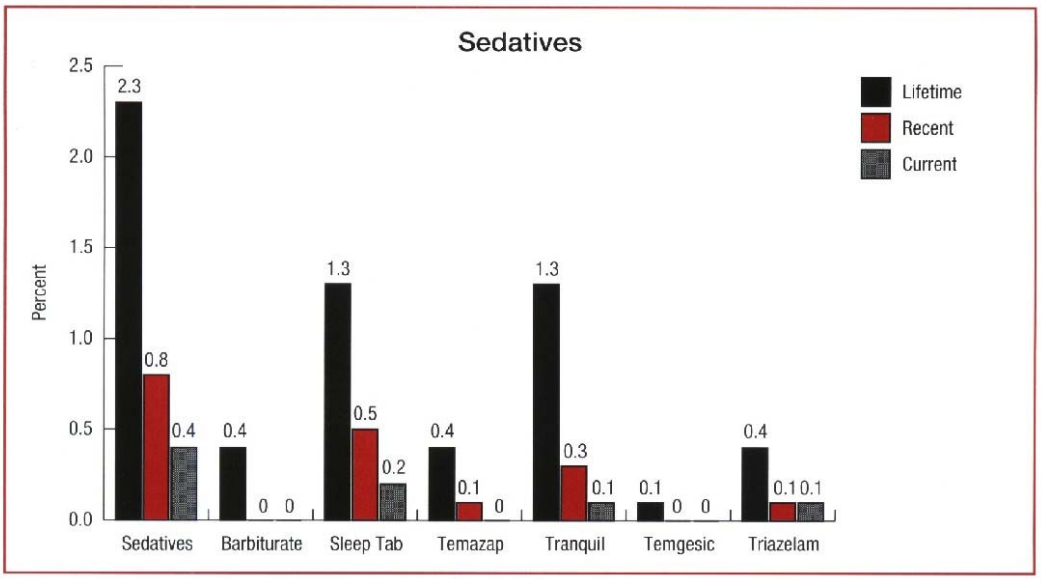
Lifetime, Recent and Current Use
For Lifetime use Sedatives were taken by 2% (Fig 7,1). 1.3% took tranquillizers and sleeping tablets. 0.4% took Barbiturates, Temazepam, or Triazolam. 0.1% took Temgesic. The numbers do not sum because of cross-taking of drugs.

Recent and Current use of Sedatives were at 2% and 0.5% and were too small for statistical analysis. The following results are for Lifetime use.

There was no significant difference for Social Class but Booster areas showed twice the Main sample at 6%.

Current Smokers had levels of 4% twice that of non-smokers. Alcohol did not show an effect.

Fig 7,1

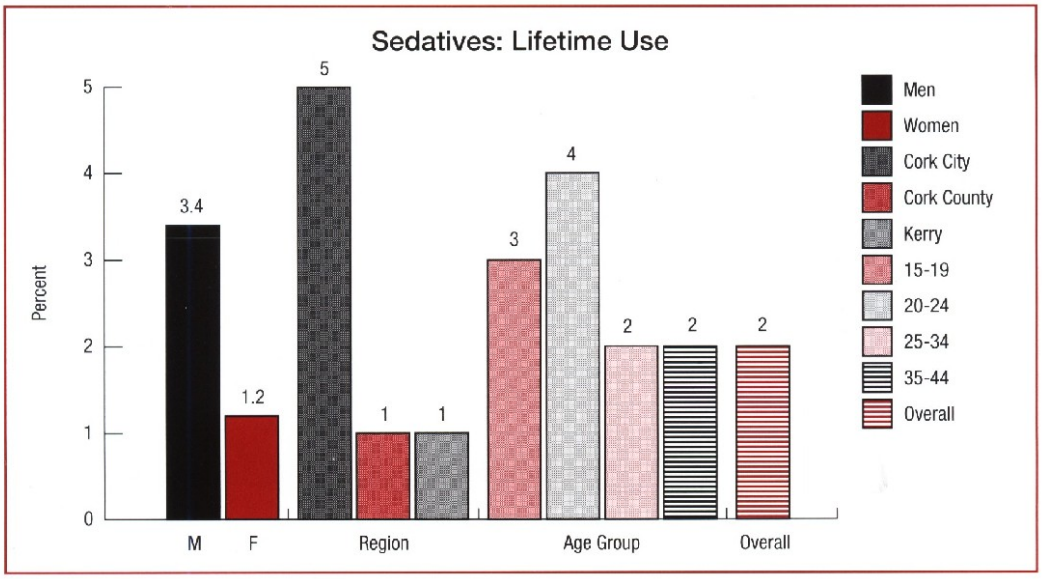


Sex, Region and Age Group

Men (3%) were over twice women (1.2%) (Fig 7,2). Cork City (5%) had five times the other regions (1%).

Age Group 20-24 showed maximum use 4%, with 15-19 years showing 3%. Other age groups showed less than 2%.

Fig 7,2



SECTION 8 - OPIATES

Diconal
DF118
Heroin
Methadone

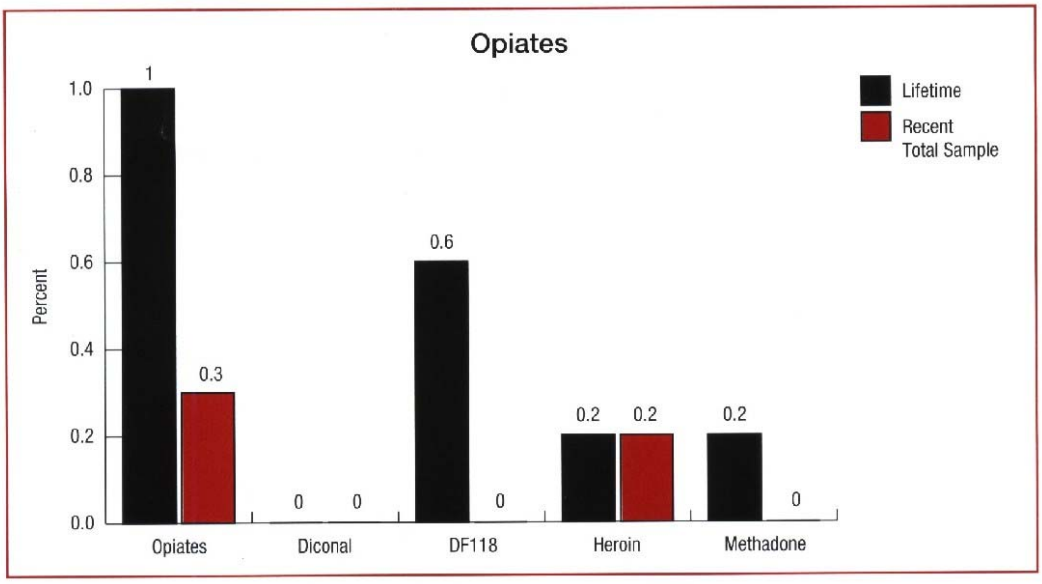
Lifetime and Recent Use
For Lifetime use Opiates were taken by 1% (Fig 8,1). 0.6% took DF118. Only 3 (0.2%) took Heroin or Methadone.

Regional analysis showed 10 out of 15 Opiate users to be in Cork City (2%). Of these, the vast majority were men (14), with only one woman.

Age Group showed the maximal use of Opiates was in ages 20-24 years. None of the Opiate users were under 20 years.

There were 10 (0.3%) Recent users of Opiates in the **total sample** (n=2095). No Current use was detected.

Fig 8,1



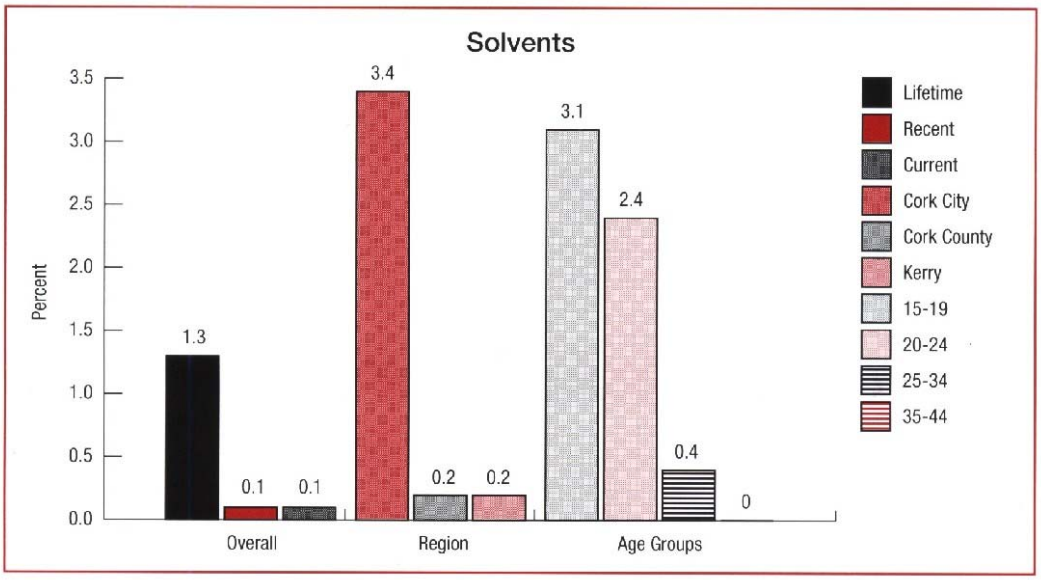
SECTION 9 - SOLVENTS

Glue
Aerosols
Gas

Overall, Region and Age Group Use
For Lifetime use Solvents were taken by 1 % (Fig 9,1). Recent and Current use was only 0.1 %. These figures were too small for statistical analysis.

Solvent users were almost all in Cork City (3.4%), with the majority in the 15-19 age group.

Fig 9,1

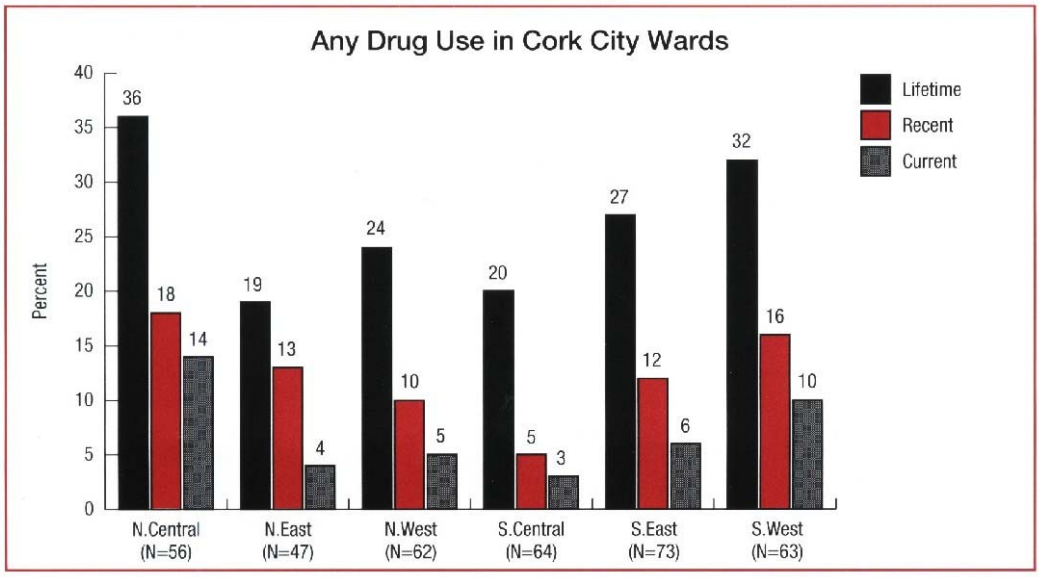


SECTION 10 - DRUG USE IN REGIONS

Use of drugs in Cork City Wards (Fig 10,1). [See map for Wards in Appendix 7.] It can be seen that Cork North Central, Cork South West and Cork South East all have Lifetime usage of about 30%.

All wards except Cork South Central (5%), have **Recent** drug use of 10% or more. Cork North Central and Cork South West have **Current** drug use at 10-14%. Cork South Central has the lowest use in all categories.

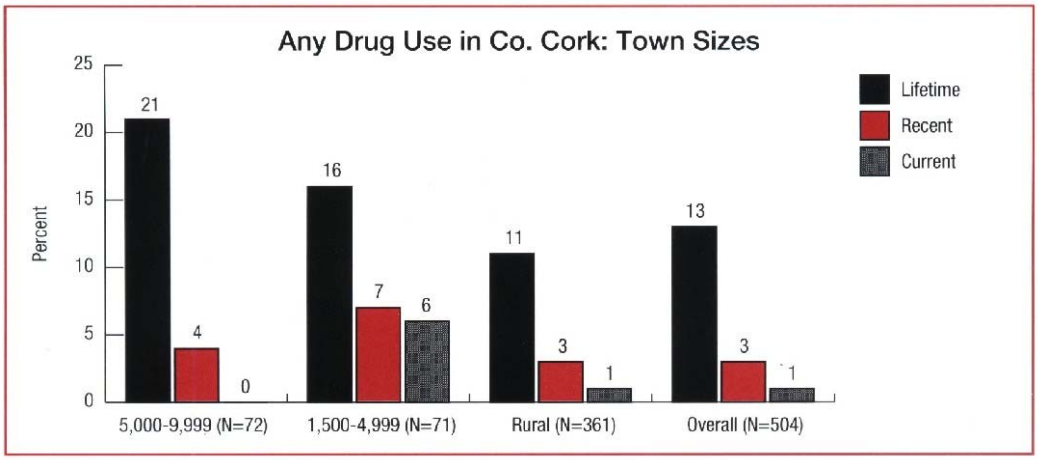
Fig 10,1



Drug Use in Co. Cork (Fig 10,2)
Cobh, Mallow, Carrigaline, Midleton, and Youghal are medium sized towns in County Cork, and showed 21% Lifetime use, 4% Recent use, and no Current use.

Smaller towns showed slightly higher Recent (7%), and Current use (4%). Those in Rural areas (11 %) showed half the Lifetime use of urban areas (21 %).

Fig 10,2

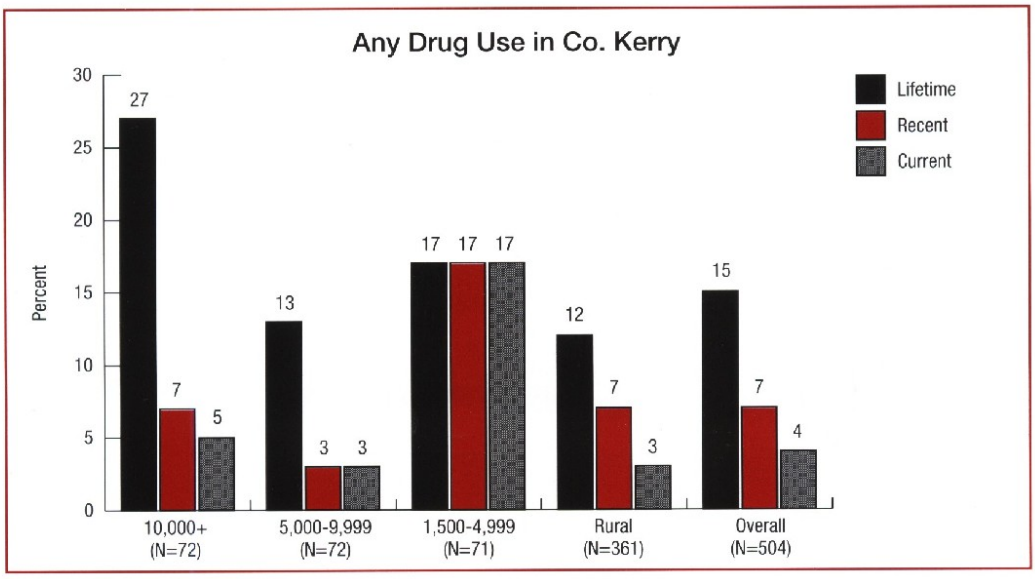


Drug Use in Co. Kerry (Fig 10,3)
Tralee is the only large town in Kerry of 10,000+ population. This showed 27% Lifetime use, 7% Recent use, and 5% Current use.

Some smaller towns showed as much as 17% for all types of use.

Rural areas showed half Tralee's Lifetime use but equivalent Recent and Current use.

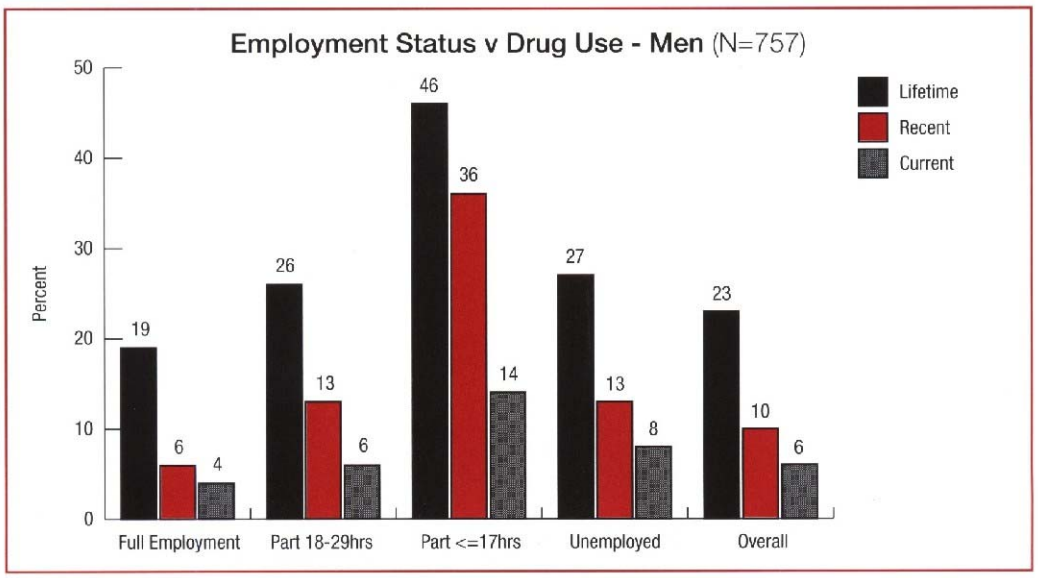
Fig 10,3



Drug Use and Occupation Status in Men

Part-Time employment of 17 hours or less per week, (Fig 10,4) shows the highest association with taking of drugs at 46% for Lifetime use, 36% for Recent use, and 14% for Current use. All of these are about twice the unemployed rates and up to five times the full time employment rates.

Fig 10,4



SECTION 11 - PUBLIC ATTITUDES AND PERCEPTIONS TO SUBSTANCE USE ISSUES

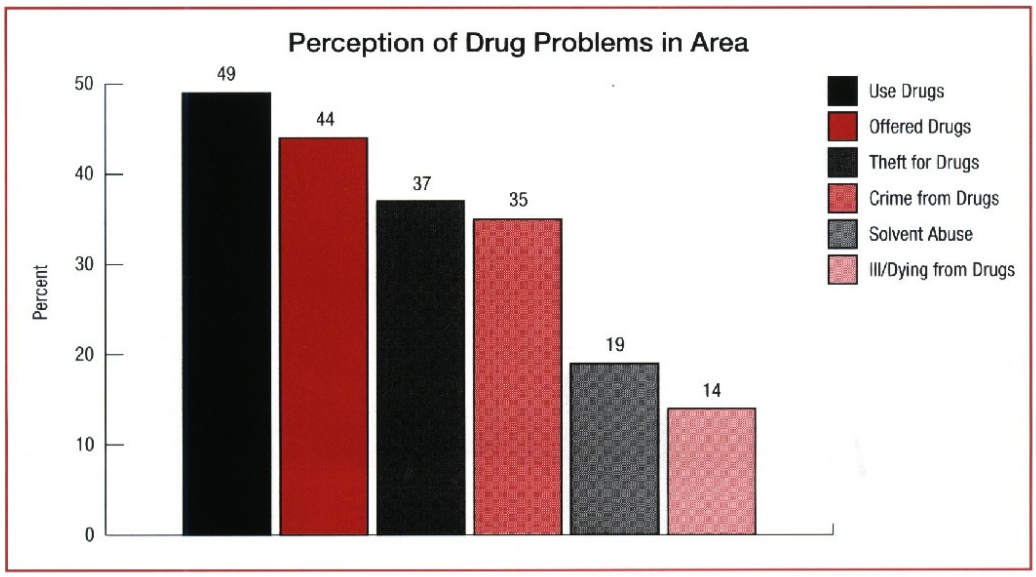
Problems Perceived in Area

The overall perception of problems in the community area is ranked below, with the percentage of people agreeing that there was a problem (Fig 11,1).

Use of drugs, people being offered drugs, and theft relating to drugs were the highest ranked.

All of these problems were ranked significantly higher for Cork City.

Fig 11,1



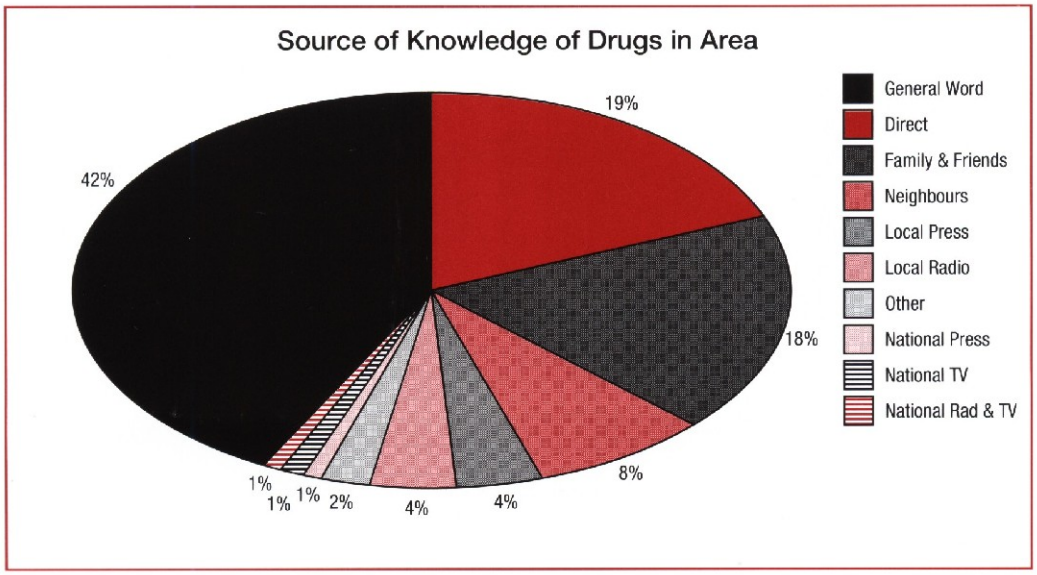
Source of Knowledge of Drug Use in Area

This was in response to the question: ***How*** *are you aware of people taking drugs in the area?* The major sources of information on drug use in the area were due to personal contact (88%). Local and national media only accounted for 12% of responses (Fig 11,2).

"General Word of Mouth" was highest in Kerry at almost 50%.

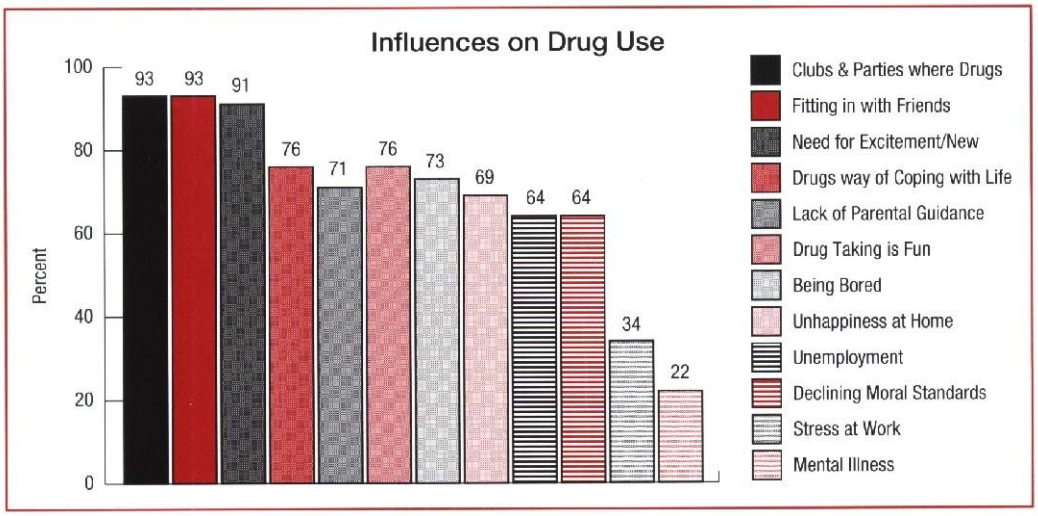
Local Press was 8% in Cork compared to 1 -2% elsewhere.

Fig 11,2



Perceived Influence of Factors on Drug Use (Fig 11,3)
There was high agreement with the general factors listed as important influences. However Stress at Work and Mental Illness were ranked lowest with only minority agreement.

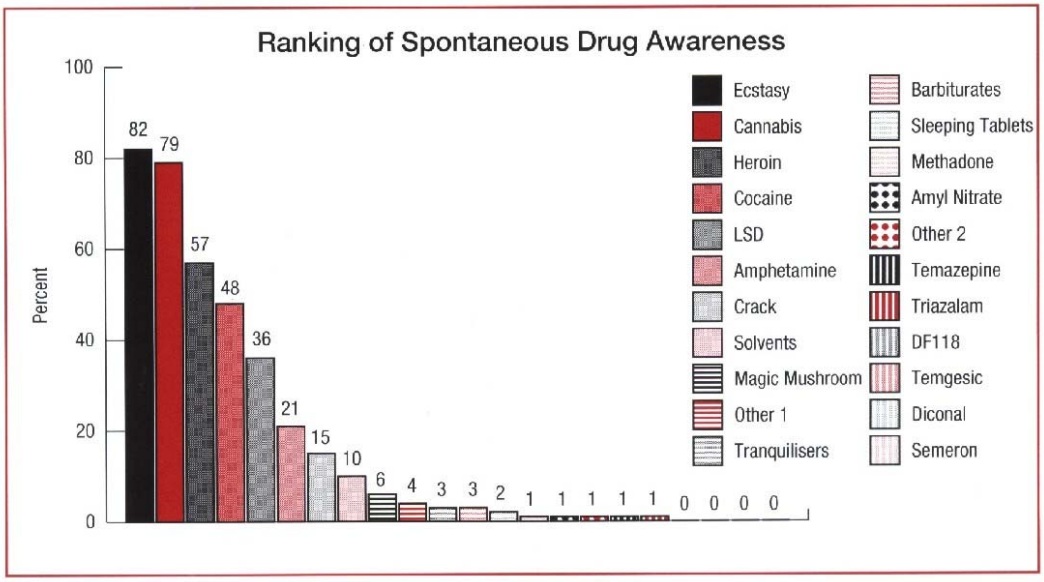
Fig 11,3



Drug Awareness (Fig 11,4)

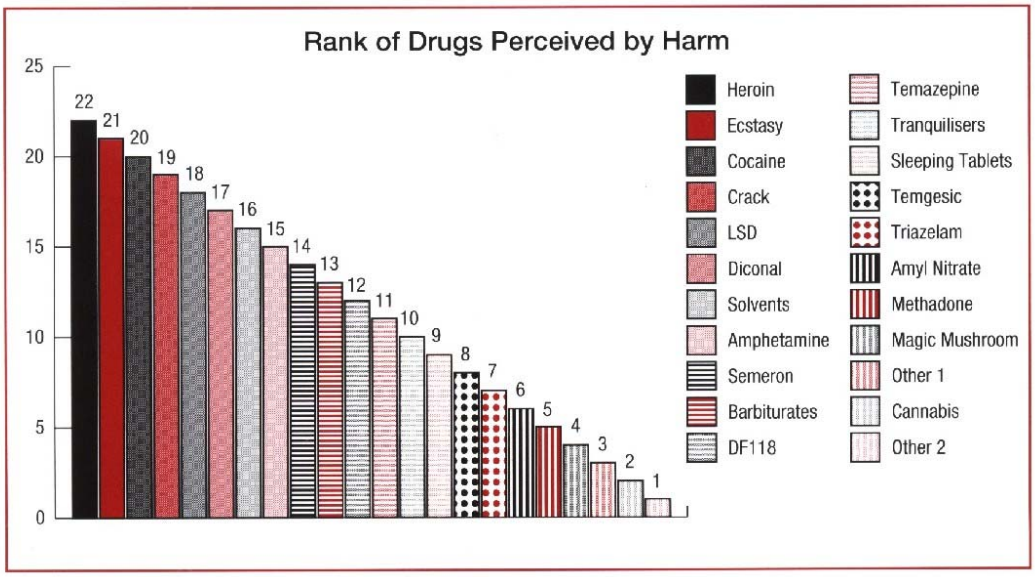
When they were asked about what drugs they could name, people mentioned seven drugs most frequently: Ecstasy, Cannabis, Heroin, Cocaine, LSD, Amphetamine and Crack. There seemed to be little awareness of prescription substances that could be abused - sedatives, tranquillizers, and sleeping tablets.

Fig 11,4



Perceived Harmfulness of Drugs (Fig 11,5)
Heroin, Ecstasy, Cocaine, Crack, LSD, diconal, and glue are seen as most harmful. Barbiturates and Sedatives are midway in the ranking. Cannabis is ranked lowest as least harmful.

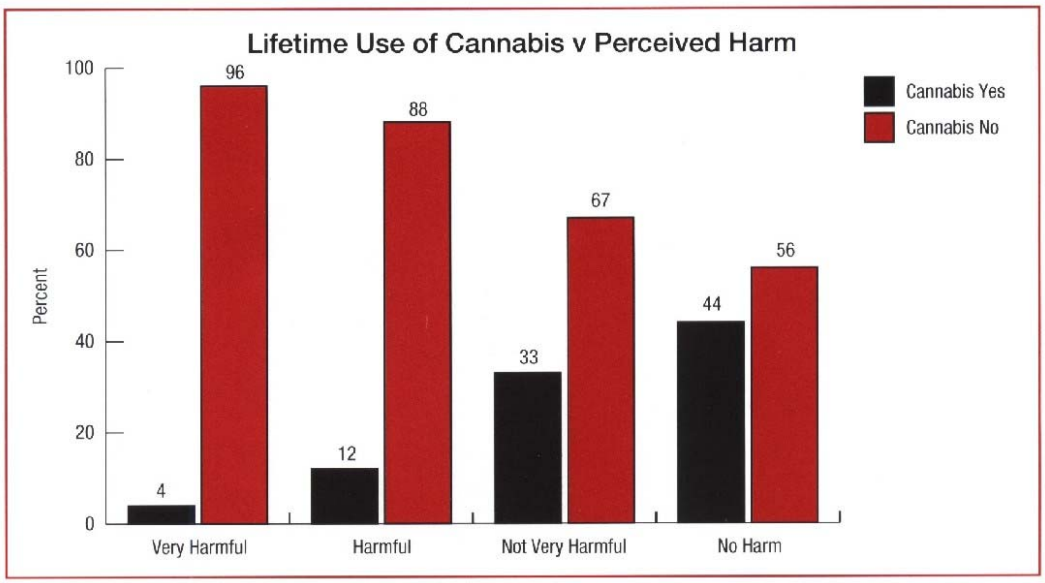
Fig 11,5



Perceived Harm and Drug Use
Those who regard Cannabis as least harmful take it most - 77% compared with 16% of those who consider it harmful (Fig 11,6).

A similar situation occurs with those who take Ecstasy - 16% of those who considered it not harmful took Ecstasy. Only 2.5% of those who consider Ecstasy very harmful took it.

Fig 11,6



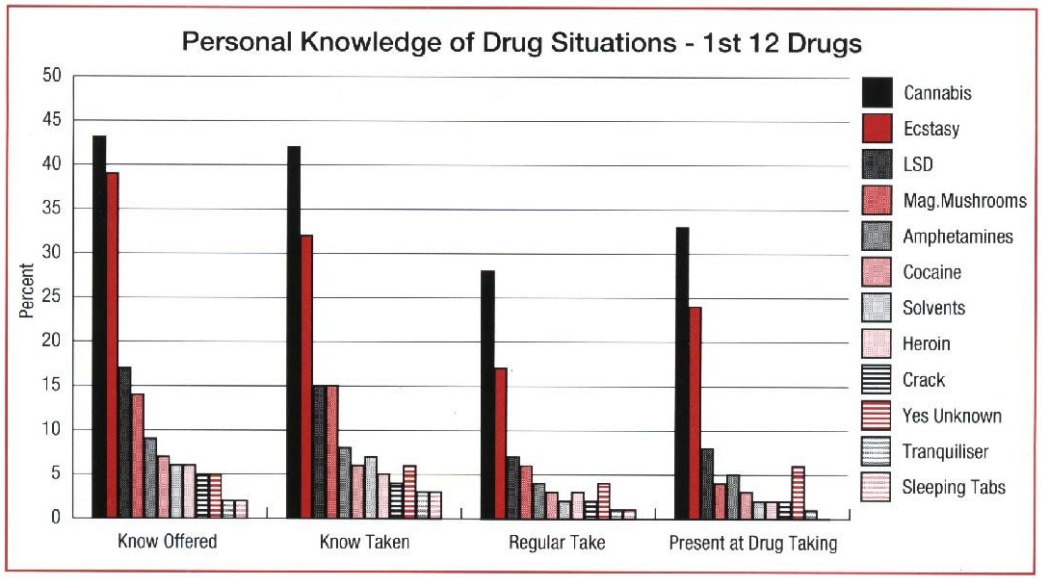
Personal Knowledge of Drug Situations (Fig 11,7)
Those knowing someone who had been Offered drugs
43% knew someone offered Cannabis, 39% Ecstasy, 17% LSD, and 14% Magic Mushrooms. There was little knowledge of medical drugs being offered. Sedative medical drugs such as Barbiturates and Tranquillizers were at 2% or less.

Those knowing someone who had **Taken** drugs
Cannabis 42%, Ecstasy 32%, LSD 15%, and Magic Mushrooms 15%, were the highest frequencies for knowledge of someone who had taken drugs.

Those knowing someone **Regularly Taking** drugs
28% knew someone regularly taking Cannabis, and 18% Ecstasy. 3% claimed to know someone regularly taking Heroin.

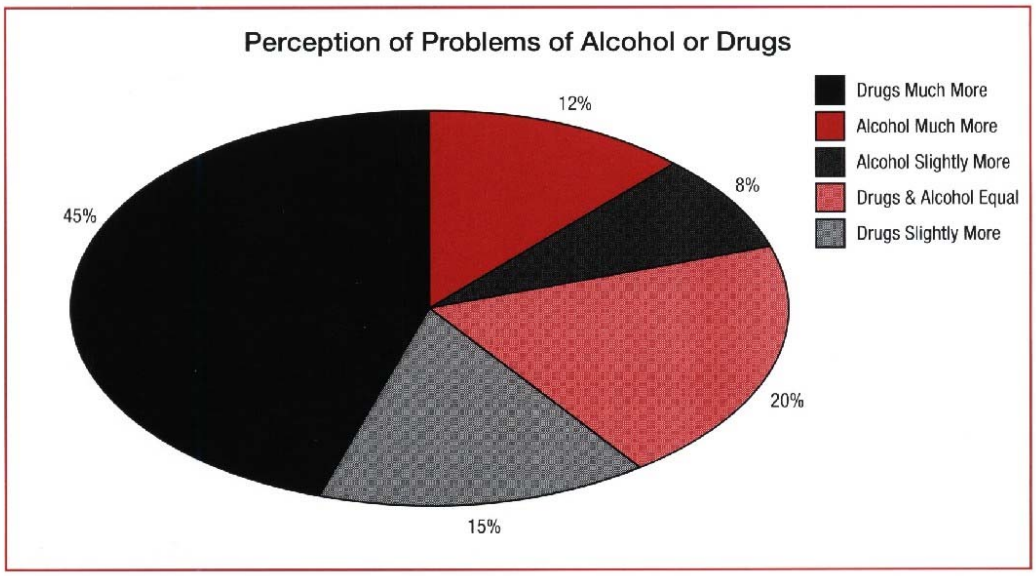
Those who had **been where Drugs Taken**
33% claimed to be at a gathering where Cannabis was taken, and 23% where Ecstasy was taken. 2% were where Heroin was taken.

Fig 11,7



Perception of Scale of Problems posed by Alcohol or Drugs (Fig 11,8)
60% considered drugs to be a greater problem than alcohol, and only 20% perceived alcohol to be a greater problem. 20% thought drug and alcohol problems to be equivalent.

Fig 11,8



Agreement with statements on various drug policies (Fig 11,9 -10)
Several statements about policies for controlling substance use were ranked for increasing order of agreement. The least agreement was for raising the tax on alcohol (25%), or tobacco (35%). 40% agreed with the statement that the minimum age for smoking and drinking could be raised. 40% thought that Cannabis was little different from tobacco or alcohol.

There was strong support for other statements, especially those on law enforcement and penalties, and agreement that soft drug users could progress to hard drugs.

When Lifetime users of drugs were checked for these opinions, there was almost 80% disapproval of increasing tax on alcohol, only 25% approval for increasing the minimum ages for smoking and drinking, and over half agreed that Cannabis was little different from tobacco or alcohol.

Lifetime users did however support stricter laws and penalties against drugs.

Fig 11,9

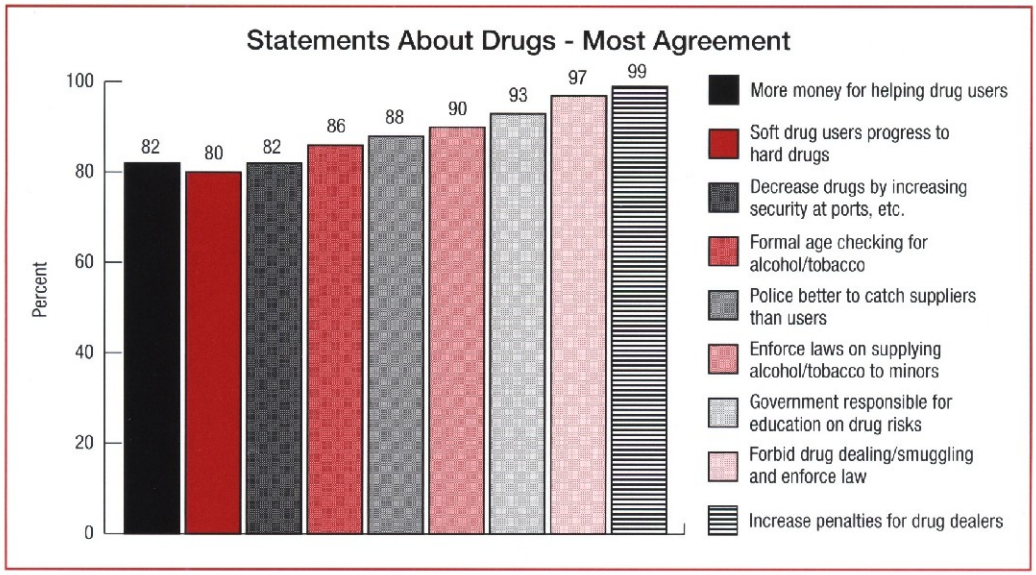
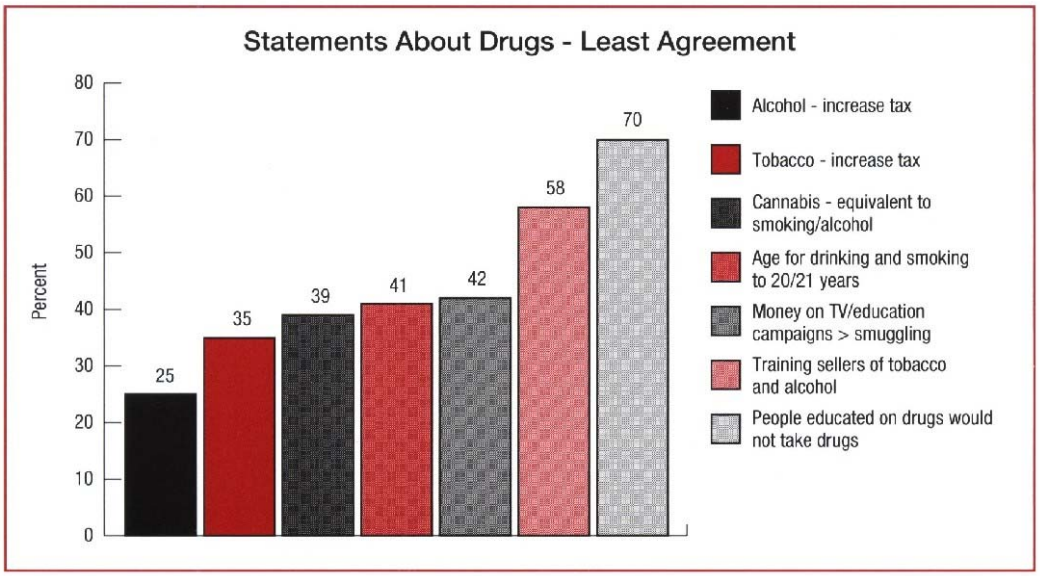


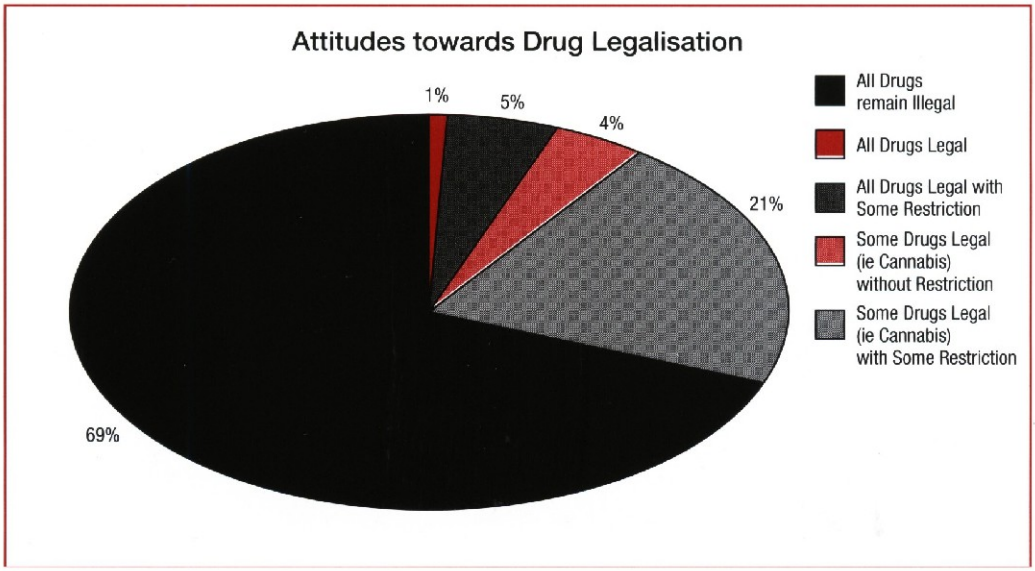
Fig 11,10


Statements About Drugs - Least Agreement
Percent
80
70
60
50
40
30
20
10
0
25
35
39
41
42
58
70
Alcohol - increase tax
Tobacco - increase tax
Cannabis - equivalent to smoking/alcohol
Age for drinking and smoking to 20/21 years
Money on TV/education campaigns > smuggling
Training sellers of tobacco and alcohol
People educated on drugs would not take drugs

Attitudes towards legalising drugs (Fig 11,11)

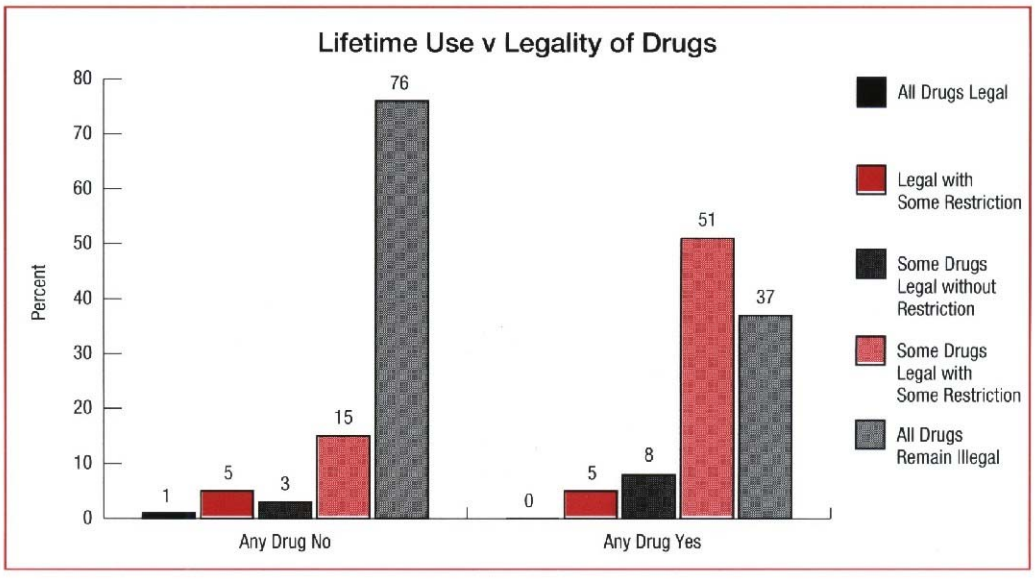
Almost 70% supported current prohibitions on drug use. However, 20% thought that Cannabis could be legalised with some restrictions. Lesser restrictions on drug use were supported by less than 10%.

Fig 11,11



Half of those who were Lifetime drug users agreed to some legalisation of Cannabis compared to 15% of non Lifetime users (Fig 11,12).

Fig 11,12



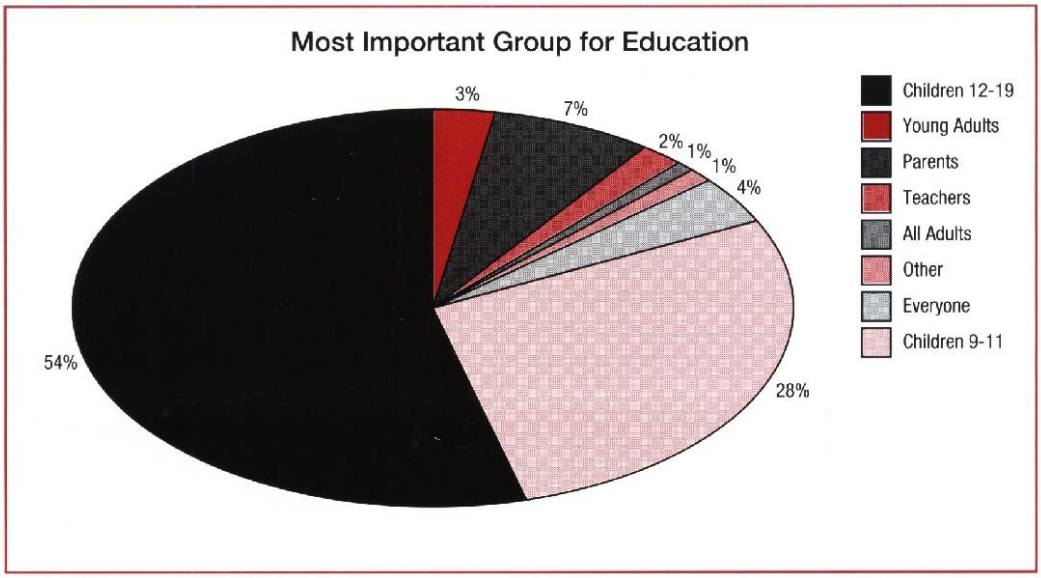
Targets for Education

Importance of Education (Fig 11,13)

There was almost total agreement on the importance of education on the effects and risks of drugs, with two thirds feeling it should be directed towards ages 12-18 years, and almost half stating that parents also should be targeted. Primary school age was ranked third with 44%.

When asked for the most important group to be targeted, secondary school children (54%), were followed by primary school children (28%), with parents chosen only by 7%

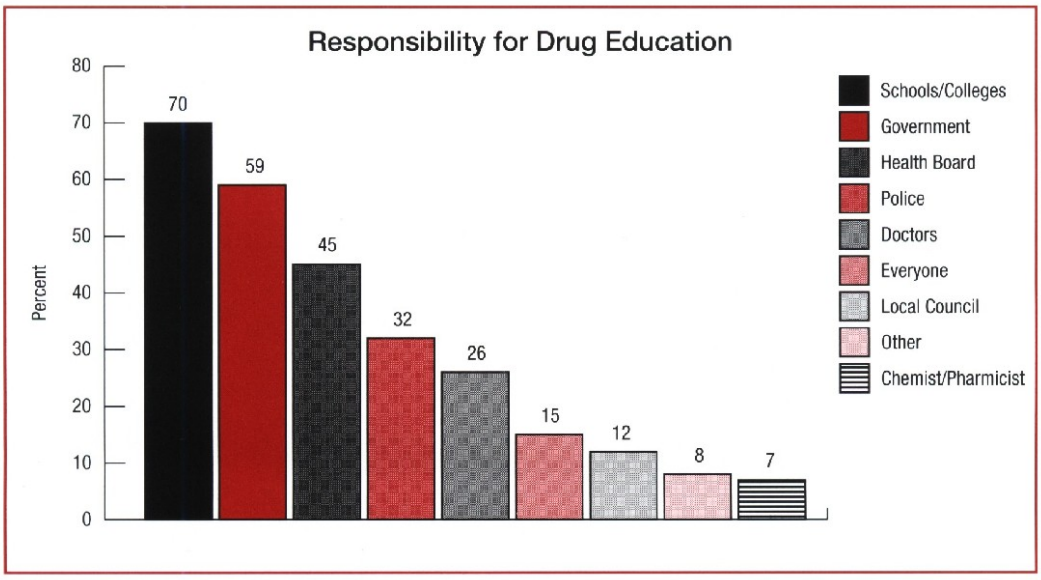
Fig 11,13



Responsibility for Education in Drugs (Fig 11,14)
70% felt that schools and colleges should have responsibility for drug education. Health Boards were ranked third with 45%. Police were 32%, and doctors 26%.

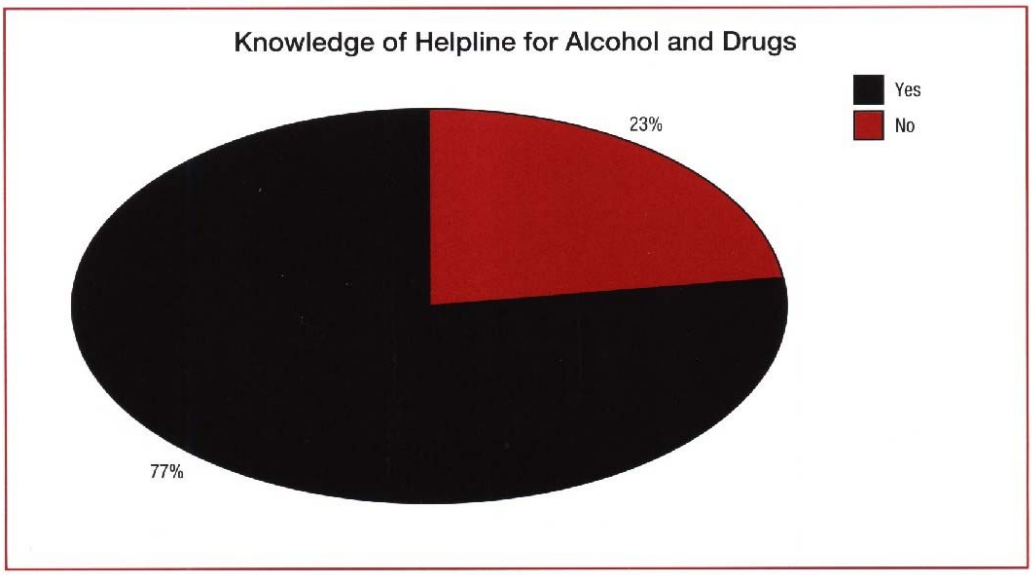
Despite chemists receiving low recognition, twice as many women (9%) as men chose them as having drug education responsibility.

Fig 11,14



Knowledge of Helpline for Alcohol and Drugs (Fig 11,15)
Almost one quarter knew of the drugs freephone helpline in the Southern Health Board. There was no significant difference in knowledge of the helpline between the regions, sex, social class, or age group although the younger age groups were 20%, and older ages 26%.

Fig 11,15



Knowledge of Services offering help for alcohol and drug use (Fig 11,16)
28% saw the GP as helpful in alcohol and drug abuse. Psychiatrist, Tabor Lodge, Arbour House and Police were the next groups at around 10%. Church and Social Worker were only 3%. Youth Clubs, Chemist, Coolmine and other institutions were only 1%.

Analysed by region there are distinct differences for some services. Arbour House and Tabor Lodge are well known in Cork City (15-20%), and County (6-11 %), but hardly heard of in Kerry at 1 % or less. Talbot Grove was known to 25% in Kerry but to less than 1 % in Cork.

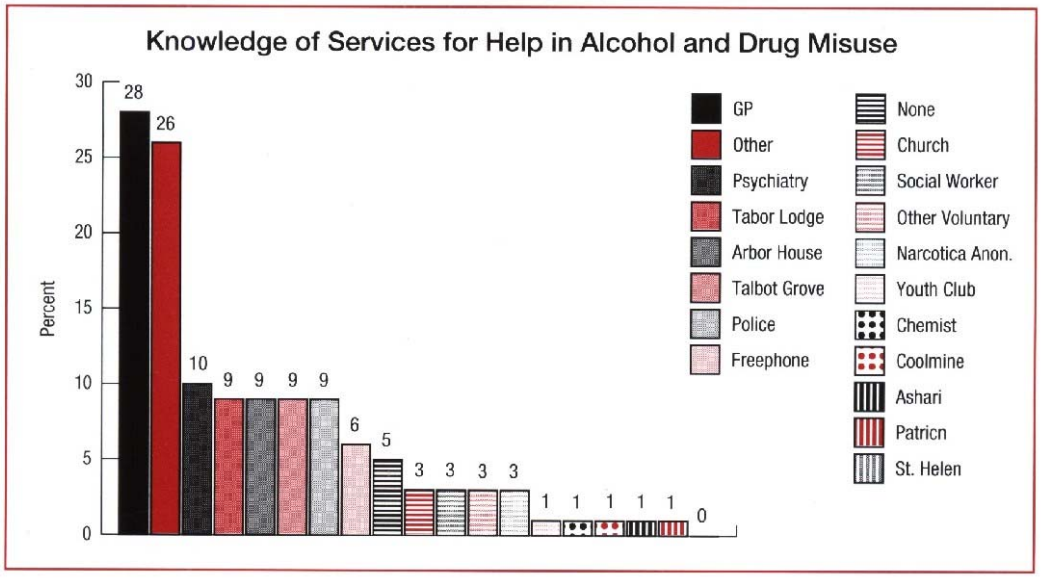
GPs are seen as a source of help twice as much outside Cork City at 30% compared with city levels of 15%.

Police are seen as a source of help only in Cork County 15%, but less in Kerry (7%) or Cork City (4%).

Youth Clubs were not seen as a source of help; only mentioned by 2% in Cork County.

Lifetime drug users had increased knowledge of Arbour House and Tabor Lodge about twice that of non-users. Talbot Grove in Kerry showed no such increase.

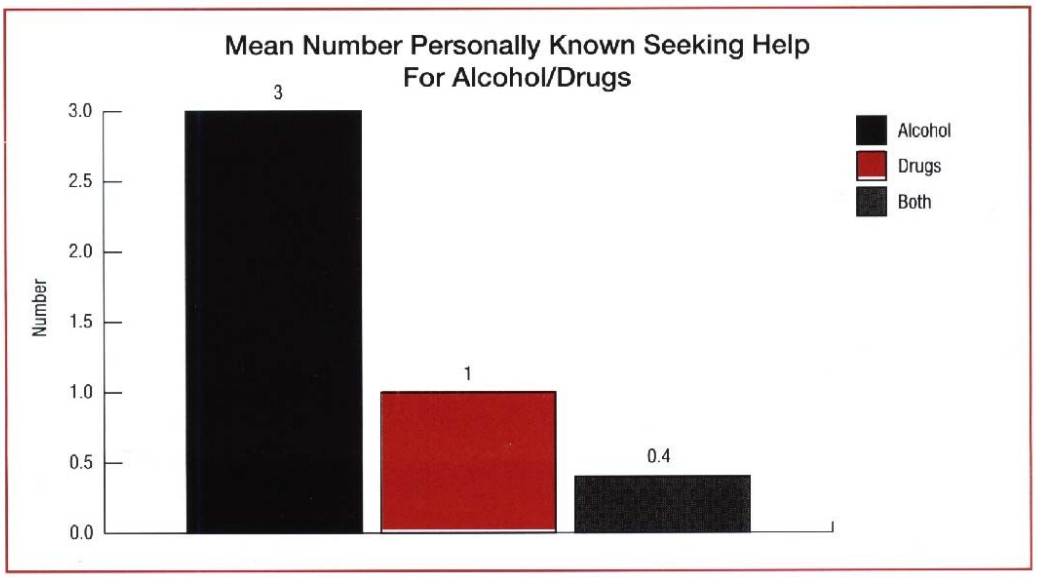
Fig 11,16



Personal Knowledge of those receiving professional help (Fig 11,17)
Each person knew almost 3 people receiving professional help for alcohol, and almost 1 person on average for drugs.

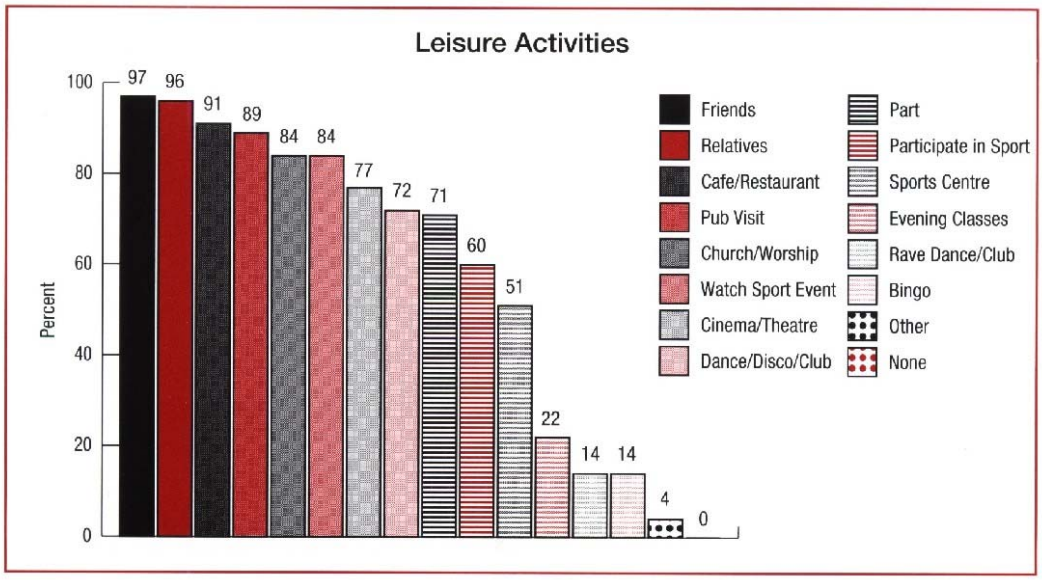
27% knew up to two people receiving help for alcohol, and 15% knew up to 2 people receiving professional help for drugs, and up to 6% knew up to two for both alcohol and drugs.

Fig 11,17



Leisure Activities (Fig 11,18)
Different leisure activities are listed below with the percentage attending each type of activity. 14% stated that they had been at a Rave dance.

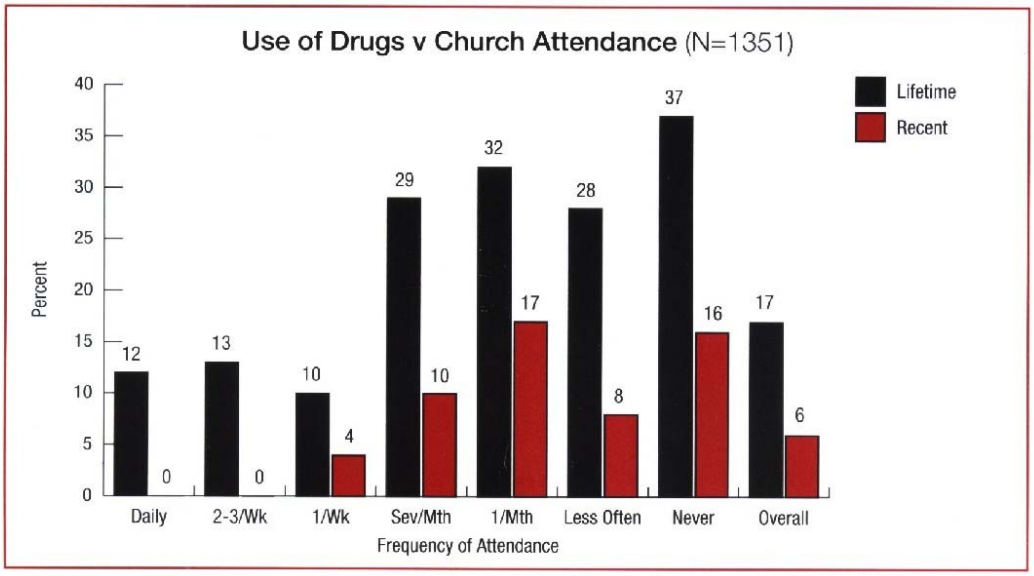
Fig 11,18



Activity Involvement v Drug Use
When examined for drug use, Dancing, Party Going, Participation in Sport, Attending Sports Centre, Cinema and Pub visiting all showed significant positive associations with Lifetime drug use. Non-attendance at Church showed more than twice the overall Lifetime use.

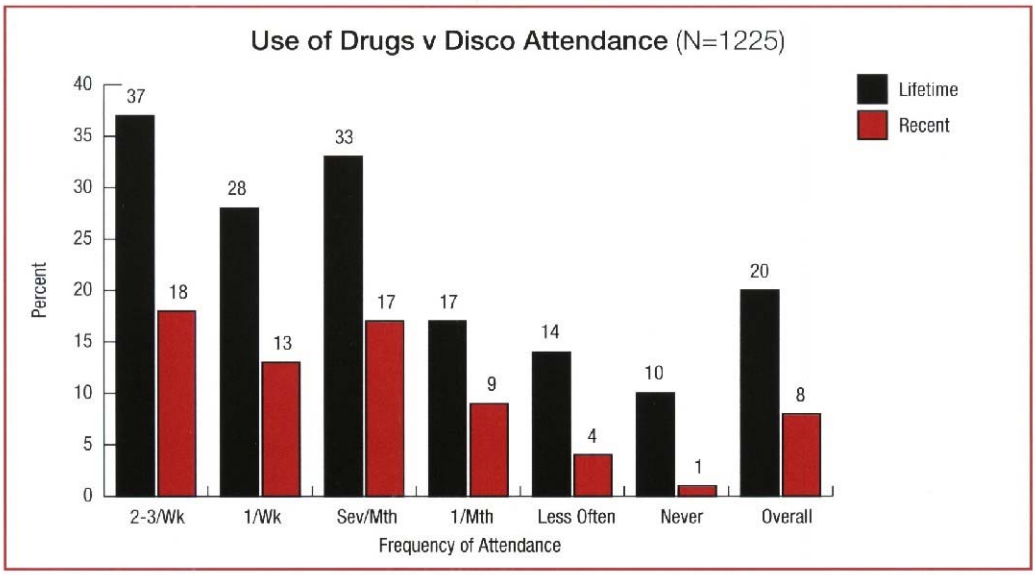
Frequency of **attendance at Church** of less than once a week, is associated with almost a three times increase in Lifetime and Recent drug use (Fig 11,19).

Fig 11,19



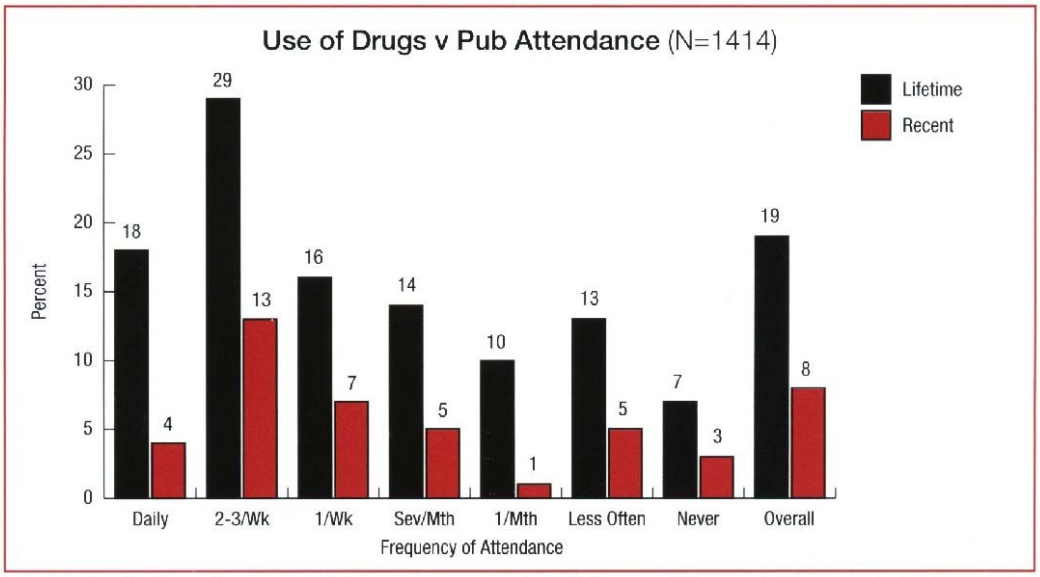
Attendance at Disco more than once a month is associated with similar increases (Fig 11,20). **Attendance at Cafe** more than once a week was linked to a 50% increase in Lifetime use.

Fig 11,20



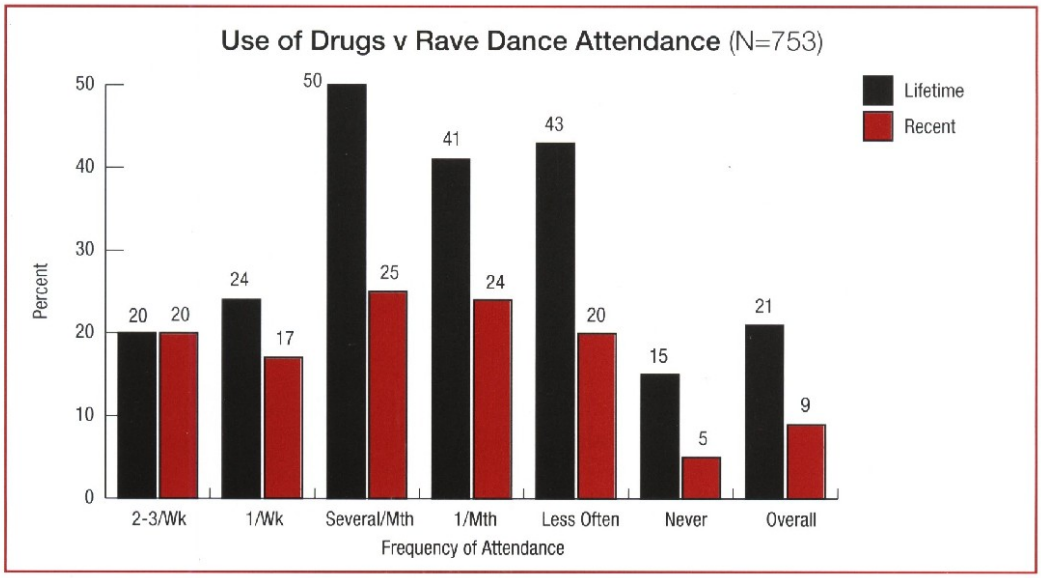
Pub frequency of 2-3 times a week was linked to a similar rise for Lifetime use and almost 100% increase in Recent use (Fig 11,21). However, daily pub attendance showed average use.

Fig 11,21



14% attended **rave dancing.** 40-50% of those attended more than monthly were Lifetime drug users, and a quarter were Recent users (Fig 11,22).

Fig 11,22



DISCUSSION

Smoking

In this survey, 62% of respondents reported Lifetime experience of smoking, with 38% smoking currently, with equal levels for men and women. 30% of those aged 15-19 were Current smokers. 27% of 15 year olds had smoked and 10% were Current smokers.

The Smoking and Drinking in Young People in Ireland (SDYPI) 1996 survey[34] for secondary school children found 55% Lifetime smokers and 29% Current smokers. Kieran in her survey in Galway 1994[15] found 67% Lifetime use, and 27% regular use rising to 42% regular use at 18 years.

The European School Survey Project on Alcohol and Drugs (ESPAD)[28] noted a high number of Current smokers in 15-16 year olds for Irish school children, with 37% of boys and 45% of girls smoking within the previous month. Ireland was the highest for Current smokers for girls in the ESPAD countries and third equal for boys.

Current smoking in The Happy Heart Study 1992[29-31] showed 36% for men and 22% for women in the 30-49 year age group.

These findings for school age are similar to other recent surveys, and show the same worrying pattern of increasing smoking in girls to a level equal to boys, and increasing use with age. There is a very rapid increase in Current smokers from 10% at 15 years to 31 % at 16 years, and 40% at 20 years. It is particularly worrying that young adults in the 20-34 year age group showed such high Current use at 46%, before a drop in Current use occurred to 33% at 35-44 years. Current smokers also tend to increase their doses over time, as shown by the increasing average number of cigarettes smoked daily with increasing age.

The SDYPI survey[34] showed that there was widespread knowledge of smoking being dangerous, although 14% of regular smokers still thought that smoking did not shorten life. It also showed that only 10% of those under 16 years were refused cigarettes at the point of sale.

The lack of enforcement of laws on sale of cigarettes to minors under 16 years[32], and the high smoking levels despite knowledge of harm, must be of concern to those devising health promotion strategies.

The price of cigarettes must be realistically increased to have any impact on consumption, and consideration should be given to increasing the legal age for cigarette sales to 18 years[87].

Alcohol

Almost everyone had Lifetime experience of drink (87%). 78% were Current drinkers. Women (75%) were only slightly less than men (81 %).

The **under-18** age group showed 44% Current drinkers with boys (54%) almost 20% more than girls (35%). 72% of under-18 Current drinkers had been drunk, with girls equal to boys. 10% of boys and 4% of girls were drunk at weekends.

This younger age group's experience was similar to the SDYPI '96[34] study showing 42% Current drinkers. Boys in that study were only 5% more than girls. 71 % of boys and 57% of girls had been drunk.

The UK National Survey 95[33] found that 78% of 15-16 year olds had been drunk.

ESPAD[28] found a rate of 37% for boys who had taken alcohol more than 40 times, and 31 % in girls, which ranks Ireland in the top 5 countries for Lifetime use. Drunkenness 3 times or more in previous month was 17% in boys and 14% in girls. This ranked 4th in ESPAD countries. This was higher than this survey's estimate of weekend drunkenness at 9% and 4% for boys and girls.

The Galway '94 Study[15] showed 62% Current drinkers overall, with 70% in boys and 53% in girls. Sexes were almost equal at 18 years at about 80% which is similar to the Southern Health Board study,

In adults, the Happy Heart Study '92[29-31] for the older age groups of 30-49 years showed Current drinking in men at 81%, 10% more than women at 71%.

It is worrying that so many drink under the legal age of 18 years, and that 72% of these admitted to being drunk. Alcohol is readily available to teenagers. The SDYPI study[34] found that only 10% of under age drinkers were refused alcohol at discos, illustrating ready access to drink.

Recent Irish surveys of second level students showed that 32% of 13-14 year olds bought alcohol for themselves through pubs, off-licences, supermarkets, discos etc.[35] 1/3 bought their own drink, 1/3 got drink at home, 1/3 from friends, or stole[14]. Ease of access leads to increased alcohol consumption[36].

Designer Drinks and Alcohol Lemonades

Concern was expressed in recent British Medical Journal articles[37-38] about the increasing availability of new designer drinks increasingly available to the young.

A survey[37] of school children aged 13-15 in Scotland showed that such new drinks (ie: white ciders, fruit wines) could range from 8-15% in alcohol content. It found that consumers of these drinks were more likely to get drunk, and to drink significantly more by the age of 14 years.

The survey expresses concern at such relatively strong alcoholic drinks (in comparison to beer, alcohol = 5%) now being marketed and widely consumed.

In further correspondence to the survey, McKibben[38] comments that "alcoholic soft drinks" were only introduced to the UK in 1995, and there are now 80 brands on sale. Concern is expressed at such sweet fizzy drinks with high alcohol content being so available and affordable.

It has been difficult to get the precise range of such drinks here in Ireland. Mugshot (Alcohol = 5.5%), Woodies (Alcohol = 4.7%), and Corkers (Alcohol = 4.1%) are the main brands on sale locally in Cork, though retailers claim there is little interest in them. Their alcohol content is at least comparable to beer. No group has been able to supply a comprehensive list of products in this country with their prices and alcoholic contents, despite extensive enquiry.

Young teenagers have easy access to alcohol[39-40], and poor understanding of the intoxicating power of various drinks[41].

Raising the price of alcohol, improving compliance with drinking at the legal age, and increasing the legal age of alcohol sale to 21 years should all be considered.

Quantity of Alcohol

The survey showed that the mean alcohol intake in Current drinkers was 18 units per week for men and 7 units for women. This is very close to the limits of recommended guidelines of 21 units per week for men and 14 for women. 23% of men and 5% of women took amounts in excess of these limits.

This is greater than the Happy Heart Study[29-31] of 14.6 units per week for men aged 30-49 years.

CAGE scoring of two or more, gives an indicator of problem or dependent use of alcohol. 8% of men and 2% of women gave this level of scoring. In men, 5% at 15-19 years, and 13% at 20-24 years were CAGE positive. Men who were positive had a mean intake of 33 units per week, equivalent to 5 drinks a day

These findings are similar to Smart et al[42] in a Canadian study who noted CAGE positive scoring to be 11 % overall, with a 5/1 male: female ratio. They also noted that positive scoring correlated with mean intake of about four drinks a day, i.e. 28 units per week.

Several studies have confirmed the usefulness of CAGE screening in population and clinical settings[43-50].

CAGE screening should be routinely used in General Practice[51-55], and in hospital settings[56], to screen for problem drinking. This is especially important in the light of evidence suggesting that CAGE positive patients might be more ready to reduce their alcohol intake[57]. Problem drinkers are also more likely to respond to appropriate professional advice than dependent drinkers[58].

There must be concern at the finding that so many men as young adults are showing intake in excess of recommended guidelines and giving indicators of problem drinking, with the implication of more serious dependent drinking. Women, though showing less prevalence of these problems are increasingly vulnerable, and there is a worrying trend for equality of sexes in Current drinkers.

Public Health Implications of Alcohol Consumption

The Royal College of Psychiatry[59] expressed concern that problem and dependent drinking could not be simply separated as a "diseased population" from the mass of other drinkers. The average national intake of alcohol relates directly to the number of dependent drinkers. Thus even moderate reduction of alcohol intake in each person would lower the national average and would lead to less dependent and problem drinking. The College thus encouraged any attempts to delay onset of drinking and to reduce its availability by legal and price controls.

The BMJ in an editorial on *sensible drinking*[60] comments that 11 % of women and 27% of men drink more than the sensible limits of 14 units per week and 21 units respectively

The Government Alcohol policy[61] does encourage these approaches also. However it has allowed its Health Education message to be somewhat blurred by merely asking for "moderation" in drinking without clearly quantifying the safe limits. The Medical Council in the UK[62] has strongly criticised any re-setting of the safe limits to higher levels. It suggests that "on no account should the 21/14 units per week figures for men and women respectively be changed as this could lead to increased harm".

In the United States there is considerable evidence that raising the legal age of sale of alcohol from 18 to 21 years reduced drinking levels and car crashes in youths[88-89]. This occured despite low levels of enforcement of legislation.

Drugs

This is the only survey of drug consumption in a general population in Ireland that includes adults. Other surveys in Ireland are on young populations who are either at school or have just left school.

The drug user in this survey tends to be young, male, from urban areas, is also a Current smoker or drinker and has smoked or drank from an earlier age than non-drug users. Part-time employment, high frequency of pub and disco attendance, and low frequency of attendance at church are all associated with increased drug use. Recent and Current drug use are highest at younger ages, and fall almost to nil over age 35 years.

These characteristics are confirmed by many other studies. Nicotine, alcohol, and Cannabis dependence are seen to be closely linked[63-65].

The lack of a significant difference in drug use (except for small numbers taking sedatives and Opiates) for booster areas, when corrected for age suggests that drug use is widespread across all communities, regardless of deprivation status.

In selecting such booster areas, great effort was made to select specifically from areas identified on the basis of high unemployment and high proportion of social class 5-6[25]. However, selecting on the basis of Local Authority Housing from these areas may still not be sufficient to clearly identify deprivation.

The GMS percentage of each DED was found to be the best indicator of deprivation status in an EHB study[85]. However, consistent DED coding for each GMS patient is not yet achieved for all areas in the SHB[25]. Until better measures for deprivation in Ireland are developed, the method used in this survey based on Ryan[25] is the best estimate that could be made.

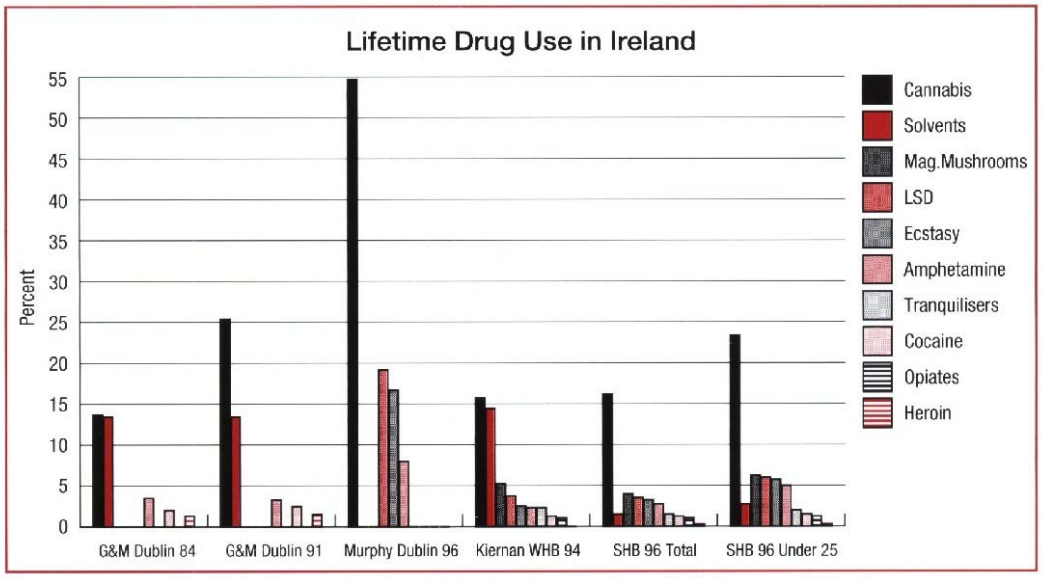
Comparison with Other Surveys

Overall, this survey gives similar Lifetime estimates to other regions in Ireland, being comparable to the Western Health Board (WHB) 94[15], and less than the Dublin areas (Fig D1).

However if one selects the **under 25 age-group** for closer comparison, the Southern Health Board is higher than Kiernan's WHB survey[15] for most drugs except Solvents and Opiates, with Cannabis (24%), hallucinogen (6%), and stimulant (6%) use similar, if not higher than Gruber and Morgan's Dublin survey in 91[14].

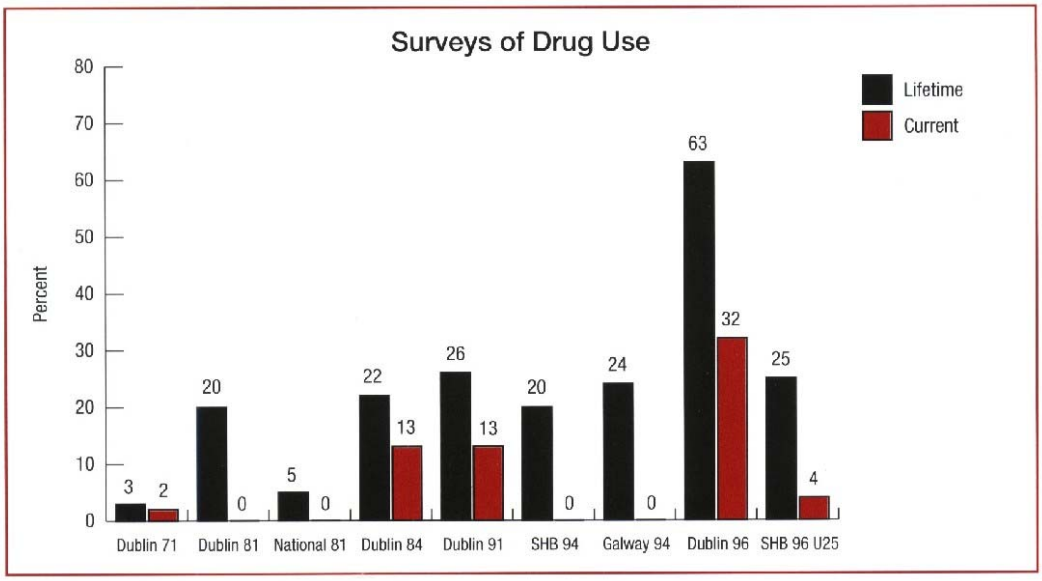
Murphy's 96 study[16] of North Dublin School children shows alarmingly high Lifetime use of four drugs - Cannabis (55%), LSD (20%), Ecstasy (17%), and Amphetamines (8%), reflecting the regional problems of that area.

Fig D1



Examining the trends of Irish Surveys since 1971[12-20], it can be seen that drug use in Ireland has progressively increased from only 3% Lifetime use in 1971 to about 25% in most areas. Murphy's North Dublin survey[16] shows levels 2-3 times this in 1996.

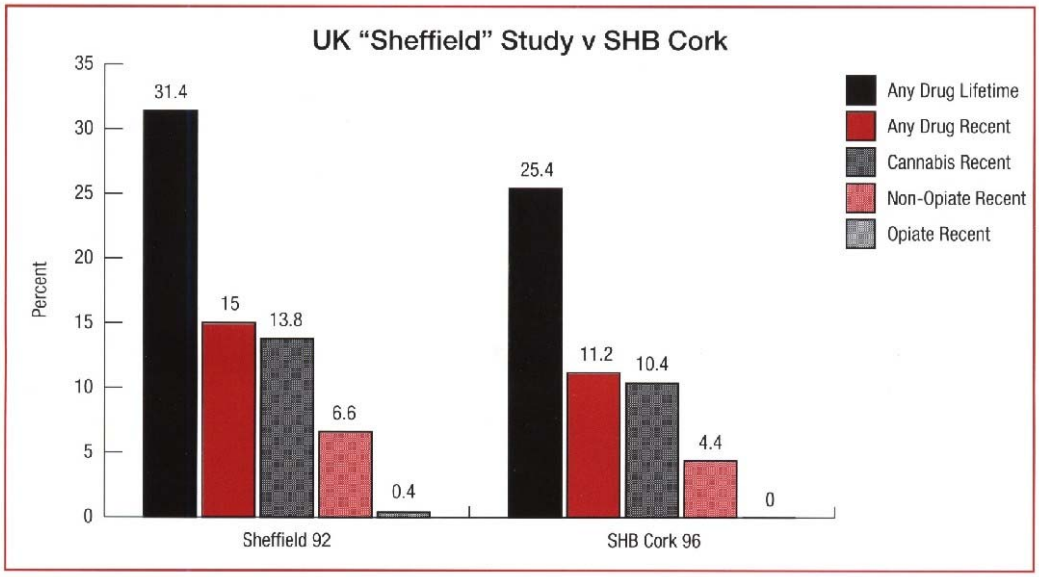
Fig D2



UK Studies
Leitner, Shapland and Wiles ("Sheffield Study")[21]

The Sheffield study examined drug use in four cities - Nottingham, Bradford, Leeds, and Lewisham. They classified drug use into Cannabis, Non-Opiates, and Opiates. The age group was 16-70 years. For reasonable comparison, only Cork City was selected, and compared with a subset of 16-44 years of the "Sheffield" dataset. Cork City showed a broadly similar pattern of use to the UK study, with Lifetime use of any drug being 6% less than in the UK. Recent use of any drug, Cannabis, non-Opiates, and Opiates were only slightly less than that in the UK.

Fig D3

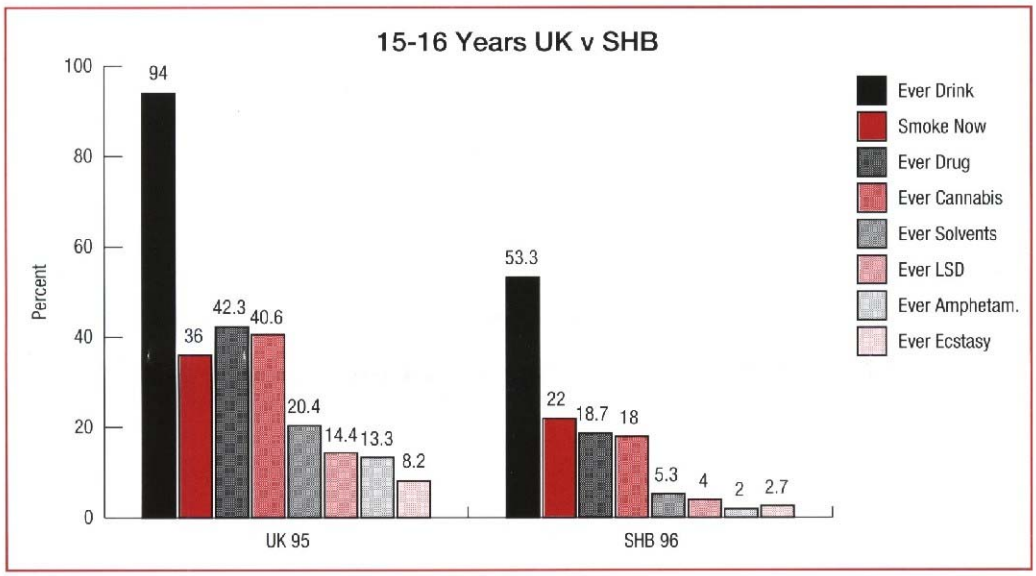


UK National Study of drinking, smoking, and illicit drug use among 15-16 year olds-1995[33]

For reasonable comparison 15-16 year olds in the Southern Health Board study were selected (Fig D4). Overall substance use in the UK survey is widespread at levels of 2-5 times that of the SHB. The only survey approximating this level of use is Murphy's '96 survey of school children in North Dublin[16].

Despite being less than the UK survey, it must be of concern to see that in Southern Health Board children, 22% smoke, 19% have taken a drug, and 18% have taken Cannabis. Solvents, LSD, Amphetamines, and Ecstasy have been taken by a smaller proportion of 2-5%.

Fig D4



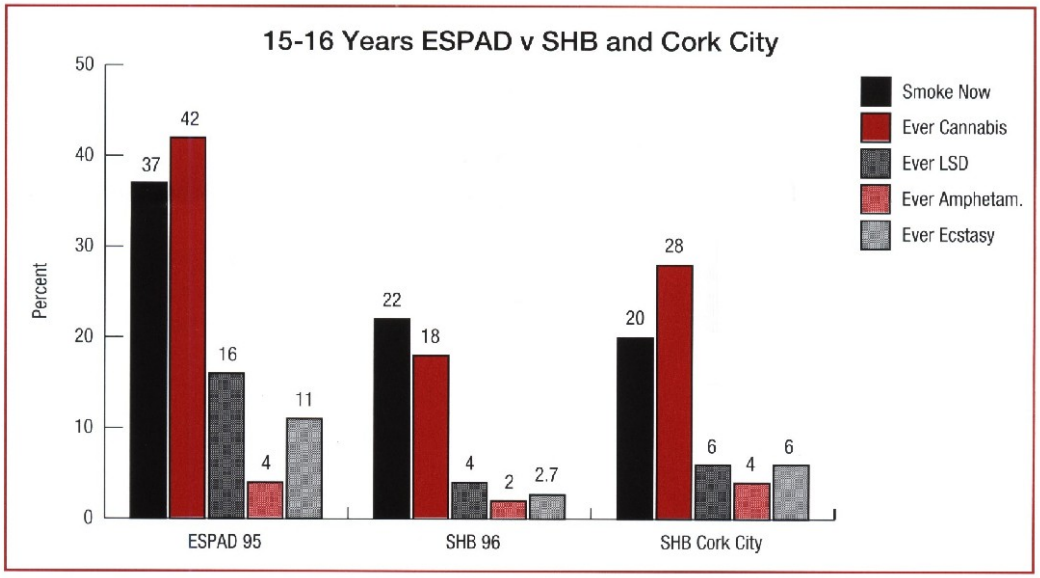
The European School Survey Project on Alcohol and Drugs (ESPAD) 1995[28]

The ESPAD findings for Ireland in 15-16 year olds are second only to the UK for Lifetime use of Cannabis, LSD, Amphetamines, and Ecstasy (Fig D5). This however, is almost twice as high as the Southern Health Board survey.

This may be because of the population being weighted towards the Dublin City area, which seems to be confirmed by the fact that these findings most closely reflect Murphy's North Dublin study[16]. These differences remain even if Cork City is selected, with the exception of Lifetime Amphetamine use, which is the same.

Studies in France and the USA are also mentioned in the ESPAD report. These show Lifetime Cannabis use at 13% and 33%, Lifetime LSD use at 1% and 8%, and Amphetamine use at 2% and 7%. The French figures are close to the general Southern Health Board findings but lower than the Cork City figures. The USA findings are close to the Cork City figures but less than the ESPAD findings for Ireland.

Fig D5



ESPAD as a whole found that Irish students at 15-16 years had more Current smokers 41% (32%), got drunk more than average 66% (48%), had higher Lifetime Cannabis use 37% (12%), and higher illicit drug use 16% (4%) than other ESPAD countries. Despite the Southern Health Board survey being lower than these, these overall comparisons must give cause for concern. As stated above, the high Irish findings may reflect the Dublin population weighting.

Attitude Survey

Perception of Drug Issues in Areas

The high perception of drug related problems, especially for drug use, drug-related theft, and crime in the Cork city area, reflects a wide awareness of drug issues, especially in urban areas.

Perception of Harm

This is related to information and publicity about drugs and personal experience. Ranking of drugs by perceived harm showed Heroin, Ecstasy, Cocaine, Crack, and LSD to be seen as most harmful, with Cannabis as least harmful. Medically prescribed drugs were ranked midway. Despite their position on this ranking, Ecstasy and LSD are still among the drugs more frequently used.

Within each drug category perception of harm is inversely related to drug use. This is especially shown for Cannabis where use is 5 times more frequent among those who think it least harmful compared with those who see it as harmful. This has important implications for health education and information about Cannabis use.

Cannabis has known detrimental effects on attention, psychomotor tasks, and short-term memory for up to 24 hours after use[66-67]. Acute anxiety or panic attacks and psychotic symptoms have been reported after use[68-69]. Carcinogenic and congenital effects have been reported but are still being evaluated[70-71]. Hall[90] has stated that the public health concern about Cannabis is less than that for tobacco and alcohol, which are consumed on a much greater scale, but there are no grounds for complacency.

Ecstasy too shows worrying evidence that long term neurological damage can occur[72]. These issues from research should be communicated to potential users so that they can at least have an understanding that these substances can have serious effects.

Personal Knowledge of Drug Situations

A high proportion claimed personal knowledge of drug situations. Especially in relation to Cannabis and Ecstasy where more than 30% claimed they knew those who had been offered or taken these substances.

Agreement with Statements on Drug Policies

Most statements received general support, but the lack of agreement for increasing tax on alcohol or tobacco might make it hard to initiate change in these areas. Quite a significant minority (21 %) seem to be agreeable to some legality for Cannabis.

Knowledge of Helpline and Services for Alcohol and Drug Use

One quarter were aware of the helpline. This might be improved by further publicity of where to seek service for help in substance use. Knowledge of specialised services from treatment centres or psychiatry were only at the 10% level, with increases in knowledge depending on the local awareness in the area the centre was placed. Youth Services and Chemists were not seen as potential services and may need to be included in a Health Education/Promotion strategy.

Personal Knowledge of those receiving professional help

This gave an indication of personal awareness of those receiving services for substance use. It gave an idea of the relative importance to the community of alcohol and drug problems. For every person known to be getting services for drugs there were three being treated for alcohol. Alcohol was thus the dominant substance for problem use.

Leisure Activities and Their Interaction with Drug Use

Several activities showed significantly increased association with stated drug use, especially those attending pubs 2-3 times a week, cafe more than once a week, disco and rave dance attendance more than once a month, and attendance at church less than once a week.

The associations with alcohol are already well recognised, as are the other social settings. Several studies confirm regular church attendance as a protective association for substance use of both alcohol and drugs[73-75].

IRISH TOBACCO ALCOHOL AND DRUG USE IN RELATION TO WHO HEALTH FUR ALL TARGETS

The World Health Organisation (WHO) set 38 regional targets for the European Region[76]. Target 17 involved use. WHO stated that:

> *By the year 2000, the health-damaging consumption of dependence-producing substances such as tobacco, alcohol and psychoactive drugs should have been significantly reduced in all Member states.*

This survey and the other surveys mentioned show that little progress has been made with this objective. The trend continues in Ireland for tobacco, alcohol, and drug use to be high, and increased from previous years. There is little evidence of the large reduction hoped for by Health For All 2000. If anything, there have been worrying increases in alcohol, and tobacco use among the young and especially in women. Older people however have shown reduction in cigarette smoking, as shown also in this survey where Current smoking dropped to 33% in the 35-44 age group.

The Irish Faculty of Public Health Medicine[77] discusses these targets in the context of the public health information systems that could be developed to monitor them. It notes that WHO suggests health-related behaviours could be tracked by population surveys every six years.

Cigarette Smoking, Alcohol and Drugs have already been surveyed several times, and these surveys all show significant amounts of alcohol, tobacco, and drug use.

Strategy and Policy Issues

Anderson[78] refers to the huge economic cost and burden of disease resulting from dependence-producing substances on a global scale. He discusses the Ottawa Charter for Health Promotion[79], which gives a strategic framework for preventing these problems. The key instruments for control are:

a) A healthy public policy which consists of controls in the areas of:
   - Trade
   - Availability
   - Price
   - Minimum legal age
   - Advertising

b) Develop Supportive Environments

c) Community Action

d) Development of personal skills

e) Reorienting the health services

Anderson stresses that healthy public policies must be intersectoral, involving many departments, e.g.: health, social welfare, criminal justice, trade, finance, agriculture, and education. The Government Task Force Reports on Drugs[80-81], and the Southern Health Board Drug Forum, all recognise the interdependent response that must be made by widely different disciplines to have any realistic effect on substance use.

Isolated programs without support and reinforcement from other sectors will not work. A comprehensive package of health, mental health, and social support services are needed to support the education system[82]. An integrated multilevel response such as suggested by the UK National Advisory Service for Children's Services should be put in place[83].

The Government Strategy to prevent Drug misuse[84] distinguishes between *Supply* and *Demand* Reduction Strategies. *Supply Reduction* aims at reinforcing legal constraints on drugs with potential for misuse, and empowering Gardai and Customs resources. *Demand Reduction* aims at Education for primary prevention, Outreach programs to minimise harm, and Treatment and Rehabilitation programmes.

The First and Second Task Force Reports[80-81] further explore the policies needed to integrate local organisations in reducing demand for drugs. The Second report[81] identified key geographical areas where drug use would justify regional response and resources. Cork North City was the only area identified outside Dublin on the grounds of Heroin potential. This survey confirms the high use of soft drugs in this region. It detects only minimum Heroin use. Given such a high awareness of drug use in these sectors of the Southern Health Board , it would take little to shift to more dangerous Opiate consumption patterns.

As previously stated, the Government Alcohol Strategy[60] recommends moderate use of alcohol but does not specify explicit limits. Safe limits should be part of our education. The British Medical Association and the Royal College of Psychiatrists are adamant that recommendations for safe limits should be retained at the old boundaries of 21 units per week for men, and 14 units per week for women. They resist the suggestion that these could be increased.

The Southern Health Board Health Promotion Strategy[85] is aimed at maximising health gain in target populations. Children in primary and secondary schools must not merely be informed on substance use, but also be taught life-skills, especially self-reliance, and the ability to make health-enhancing choices. Supportive systems should be in place for schools to cope with vulnerable children who are prone to poor performance and those who tend to leave school early. Early school leavers are particularly in need of training and support.

The recommendations arising from this survey take into consideration the intersectoral response needed, the multilevel involvement of services, and the support needed for schools, communities, and professionals.

Other Policy Issues: Methadone Maintenance

Methadone maintenance is an established method of reducing harm in Heroin users by reducing the likelihood of street use, crime and injecting drug use with the risks of AIDS and hepatitis. Its main defect is that it does not cure the dependence and, if not strictly controlled, it can lead to further Opiate addiction through addicts selling or sharing their Methadone supply.

The Southern Health Board's Non-Methadone policy was formulated to deter large centralised clinics of the type required for the Heroin addiction problem in Dublin. However, a recurrent problem is that of GPs prescribing for addicts. This has resulted in limited controls on addict registration and on variable drug formulations and unclear protocols for GPs and Pharmacists in handling these situations.

The Dept. of Health has recently circulated a professional protocol for Methadone prescribing to addicts by GPs[88]. It requires that the addict be centrally registered and possess an official identity card. He can only be treated by a GP trained in addiction and his card must be presented to the GP and pharmacist.

The proposed protocol aims at rigorously controlling the ad. hoc. informal systems of Opiate supply to addicts from medical practitioners. It will try to ensure that Heroin users are identified, linked to a treatment centre and offered pathways of treatment through the centre, GP and pharmacist.

This is considered to be a professionally appropriate response to Heroin addiction. This approach could ensure safer pathways for those persistently dependent. It need not conflict with the Southern Health Board mainstream Minnesota drug-free model of treatment, which should continue to be offered to all classes of addicts.

This scheme has the merits that it would control tightly any prescribing of Opiates to addicts. It would clearly identify the addicts, offer them treatment pathways by trained professionals and identify and limit unofficial prescribing.

The greatest concern is that it might attract Heroin addicts to areas outside the EHB, especially the Southern Health Board. It it did, controls would have to be extremely strict and GPs appropriately trained.

The current Non-Methadone policy has been suitable in the light of this survey, which showed almost no injection use in the Southern Health Board; but this might need to be reviewed if drug injection use increased.

If evidence showed such an increase, a harm reduction strategy involving Methadone maintenance and/or needle exchange would have to be considered.

CONCLUSIONS

Smoking
There is a high number of Current smokers (38%). Rates in men are almost equal to women. There is a rapid increase in Current smoking from 10% at 15 years, to 31% by 16 years, and 40% at 20 years. Men start smoking 1.2 years earlier than women, and report smoking 4 more cigarettes per day than women.

Alcohol
There is widespread experience of alcohol with 78% Current use. Current drinking was maximal at age group 20-24 at 89%. Women were only 6% less than men. Under 18 years, 44% were Current drinkers - 50% of boys and 20% of girls.

23% of men drink in excess of recognised guidelines. As estimated by the CAGE screening test, there is a high prevalence of Problem/Dependent drinking in men (8%), which is maximal at 20-24 years at 13%. Such high levels at that young age group has serious service implications.

Drug Use
Overall Lifetime drug use was 18%. Drugs used were mainly Cannabis, Hallucinogens, and Stimulants. Recent drug use was 7%, and Current use 4%. The Lifetime prevalence of Opiates was only 1% or less, and Heroin was almost nil. Age groups 20-24 showed highest Lifetime use of drugs at 30%.

Regionally, the highest drug use was in Cork City - 25% Lifetime use (twice that of other regions), especially in the city ward areas of North Central, South West and South East where Lifetime prevalence for any drug use was about 30%, with Recent use 15%, and Current use 10-14%. All areas showed some use, and deprived areas when corrected for age did not show significant increases for drug use except for Opiates, and sedatives.

There was strong association between drug use and Current smoking, frequency of drinking, and frequency of drunkenness. Men employed part-time for 17 hours or less showed highest drug use - 46% Lifetime use.

Attitudes
Cannabis was seen as the least harmful and most used drug. There was widespread knowledge and contact with situations where drugs were being taken. There was reluctance to agree with increasing tax or age limits on alcohol or tobacco. 21 % agreed to some legislation for Cannabis.

GP, Psychiatrist, Treatment Centres, police were all recognised as main sources of help for substance use. Drug use was associated with frequency of attendance at pubs, rave dances, discos, and decreased frequency of church attendance.

Overall
Alcohol is still the dominant drug of misuse in terms of prevalence and problem use. Smoking and alcohol use precede drug use and are highly associated with increased drug use. Cannabis, LSD and Ecstasy are the main drugs used, and are widely available. Opiate use is minimal, but this could change rapidly in the current climate of widespread drug tolerance. As already commented, Dublin in 1991 gave a similar pattern of drug use in children[14].

RECOMMENDATIONS

Prevention

Comprehensive Substance Use Prevention Policies and Programmes must be available and implemented. Validated programmes are available through the Health Promotion Unit of the Department of Health. These must be targeted to secondary and primary schools in all areas. As part of this programme, there should be provision for parental support and education. Supportive systems for vulnerable children in school should be devised. Early school leavers must be given particular support by training schemes such as Fas, and community workshops.

The Southern Health Board Health Promotion Action Plan[84] must be implemented with special emphasis on improving child self-reliance and resistance to substance use. The aim must be to delay the age of experimentation with substance use, especially tobacco and alcohol.

In any substance use prevention programme, there should be particular emphasis on Smoking & Alcohol use, with emphasis on clear information on safe limits for alcohol use. In relation to drug use, the programmes should emphasise accurate knowledge of the effects of Cannabis, Stimulants, and Hallucinogens.

The price of cigarettes and alcohol should be increased significantly to reduce consumption at younger ages.

The law against the sale of alcohol/cigarettes, for those under the legal age, should be respected and more strictly enforced.

The legal age for sale of cigarettes should be increased to 18 years, and consideration be given to increasing the legal age of sale of alcohol to 21 years.

Priority should be given to high prevalence areas.

Youth Services in the community must be developed and supported, especially for early school leavers.

Recreation and Sports facilities should be available in all areas, especially in high drug prevalence areas.

Progress in these areas needs to be evaluated regularly

Resources needed for Prevention issues:

Provide extra Health Education Officers to assist schools programmes, and to support communities, and evaluate programmes.

Provide extra Community Workers to develop and co-ordinate local community response.

Provide extra funding to relevant community youth and voluntary organisations, especially community workshops and their support facilities.

Information Systems
It is essential to maintain epidemiological data. The existing Treated Drug Misuse System should be computerised in the main drug treatment centres. Core data must be compatible with the National System, but allowance could be made for extra data fields amplifying other primary addictions, e.g. alcohol.

Develop a *"Drug Early-Warning Computerised System"* in Casualty Departments of the Southern Health Board.

Develop and maintain links with Customs and Gardai for information on seizures and street prices.

Repeat this type of community survey regularly to monitor community substance use. WHO recommends population surveys every six years.

Develop indicators of material deprivation on a small area basis. The percentage of a DED covered by GMS medical services is the best indicator. All patients must be coded by DED in all Southern Health Board areas.

Resources needed for Information Systems
Provide appropriate computer hardware and software to participating treatment centres

Provide *technical and secretarial* support for managing such information systems

Provide support for DED coding at all health related information centres

Treatment

The Addiction Treatment Strategy should try to integrate all available services e.g.: Southern Health Board, Local Authority, Community, Education, Justice at all levels, rather than in isolation.

The Drug Strategy should offer an integrated multilevel service along the following principles[83]:

- **Level 1** Generic, Direct Access Services giving Information, Identification, Early Intervention
- **Level 2** Youth Targeted Response given by Practitioners with some specialised knowledge of drugs alcohol & young
- **Level 3** Specialist Addiction Services for complex cases. Team-based multidisciplinary
- **Level 4** Very Specialised & Intensive Intervention including residential care.

Satellite and Outreach Clinics should be developed to extend early treatment opportunities into the community. These could be based on existing alcohol and drug treatment centres.

Existing Alcohol and Drug treatment centres should be expanded. Patient care costs should get increased support. Psychiatric Hospitals have existing catchment areas, and due consideration should be given as to how they may be included in the strategy.

General Practitioners, Nurses, and other professionals may need further training in handling of alcohol and drug problems especially at key early stages. The value of brief intervention at such early phases should be recognised both in the clinical setting and in the workplace.

Residential Care for specialised intervention needs (Level 4) should be available for 16-20 adolescents and young adults.

Arbour House Treatment Centre should be a resource for training key people in the different sectors.

Alcohol is still the largest abused drug in the community, and resources should allow for this.

Resources Needed for Treatment Strategy
Appoint Alcohol and Drug Area Co-ordinator with appropriate administrative support.

Upgrade facilities and staff at Arbour House Treatment Centre.

- Improve existing accommodation
- Provide Professional Training Facilities - personnel, equipment, resources
- Improve Staffing levels
  - Assistant Director
  - Extra Counsellors
  - Outreach Staff for health board regions

Provide access to residential (Level 4) facilities especially for young addicts.

Develop Treatment Resources in Co. Kerry.

- Outpatient services based in Tralee with Outreach facilities to other areas
- Maintain links with Treatment Centres and Psychiatric Services

SAMPLE METHODOLOGY

1. Main Sample

1.1 Sample Universe and Sample Size

The target population was identified as all adults aged 15 - 44 years within the Southern Health Board area, on the basis that this is the most susceptible age of the population, as well as the fact that most drug users fall within this age bracket.

In order to allow for meaningful analysis of the findings by region, it was further agreed that the study should differentiate between the main regions of the Southern Health Board i.e. Cork City, Cork County and County Kerry. A total sample of 500 respondents was surveyed within each one of these three areas (i.e. total main sample size = 1,500).

1.2 Sampling Procedure

A multi-staged quota controlled probability sampling procedure, with randomly selected starting points was utilised for this study as follows;

1.2.1 Sample Distribution

As mentioned, the main sample of 1,500 adults aged 15-44 years was evenly dispersed between the three Health Board Regions, with 63 different locations (sampling points) selected within each region, and 8 interviews conducted at each sampling point (see Section 1.2.2).

In order to ensure as wide a geographical spread of sampling points as possible within the Health Board Region, the sample was first stratified by five community types (County Borough; Towns 10,000+; Towns 5,000-10,000; Towns 1,500-5,000; Rural <1,500) within the areas of Cork County Borough, Cork County and Kerry.

Within this matrix, Cork Co. Borough was further stratified by the six electoral areas of Cork South East, South Central, North West, South West, North Central and North East.

Table I sets down the aforementioned adult population matrix as derived from the 1991 Census of Population (the most recently published data available from the Central Statistics Office). Also included is the resulting distribution of sampling points across the various regions, and the achieved number of interviews.

Table I: Sample Distribution: Main Sample				
REGION AND COMMUNITY TYPE	**POPULATION**	**% WITHIN REGION**	**NO. SAMPLING POINTS**	**NO. INTERVIEWS**
CORK CO. BOROUGH	174,400	100%	63	504
CORK COUNTY				
Towns 10.000+	—	—	—	—
Towns 5,000 -10,000	34,001	14%	9	72
Towns 1,500 - 5,000	34,960	15%	9	72
Rural	167,008	71%	45	360
Total Cork County	235,969	100%	63	504
KERRY				
Towns 10.000+	17,862	15%	10	80
Towns 5,000-10,000	9,950	8%	5	40
Towns 1,500 - 5,000	5,804	5%	3	24
Rural	88,278	72%	45	360
Total Kerry	121,894	100%	63	504
Total Southern Health Board	**532,263**	**—**	**189**	**1,512**

1.2.2 Selection of Sampling Points

The sampling points chosen corresponded to CSO District Electoral Divisions/Wards (the smallest geographical areas for which population statistics are available). Within each cell of the sample distribution matrix (see Table I), the total number of constituent electoral areas was listed, and a cumulative population count calculated. Then, using a fixed interval (the cumulative population divided by the required number of sampling points in the cell), and a random starting point (taken from a set of statistical random numbers, its value not being greater than the value of the calculated interval), the sampling points were drawn.

This systematic sampling procedure ensures that the areas included in the survey are chosen with probability proportionate to their constituent populations. In other words, areas with higher population densities have a greater chance of being chosen than areas with lower populations.

Sampling points were drawn within each of the three regions, along with the randomly chosen starting address subsequently drawn at each sampling point (see Section 1.2.3).

1.2.3 Selection of Individuals

The final stage of the sampling procedure involved the systematic sampling of individuals within each of the pre-selected sampling points.

At each sampling point, the interviewer adhered to a quota control matrix based upon the known profile of 15 - 44 year old adults in each area in terms of age and marital status within sex, with socio-economic status subsequently emerging naturally. The quotas for age, marital status and sex were based upon the CSO Population Statistics from the 1991 Census.

Finally, within each sampling point the nucleus of each cluster of eight interviews was an address selected randomly from the current Register of Electors. From each address sampled, interviewers followed the random route procedure (first left, next right etc.) calling at every fifth house to complete an interview, until their quota controls had been fulfilled.

Within each house called to, the interviewer first ascertained whether there was an individual in the home who matched the required quotas, before proceeding with the formal interview. Regardless of how many individuals in a home matched the required quotas, only one individual was interviewed in any one home.

Tables II - IV which follow include the quota control matrices which were adhered to within each of the regions.

Table II: Quota Control Matrix: Cork Co. Borough

	MALES				FEMALES				TOTAL	
AGE	SINGLE		MARRIED		SINGLE		MARRIED			
	POP.	N.	POP.	N.	POP.	N.	POP.	N.	POP.	N.
15-19	6657	56 11%	5		6583	55 11%	18		13263	111 22%
20-24	6165	50 10%	332	5 10%	6056	51 10%	656	5 1%	13209	111 22%
25-34	4337	35 7%	4726	40 8%	3855	35 7%	5760	51 10%	18678	161 32%
35-44	416	15 3%	5691	46 9%	1084	10 2%	6125	50 10%	14316	121 24%
TOTAL	**18575**	**156 31%**	**10754**	**91 8%**	**17578**	**151 30%**	**12559**	**106 21%**	**59466**	**504 100%**

Table III: Quota Control Matrix: Cork County

	MALES				FEMALES				TOTAL	
AGE	SINGLE		MARRIED		SINGLE		MARRIED			
	POP.	N.	POP.	N.	POP.	N.	POP.	N.	POP.	N.
15-19	31494	55 11%	7		12253	51 10%	27		25781	106 21%
20-24	9312	36 10%	547	5 1%	7100	30 6%	1354	5 1%	18313	76 15%
25-34	8290	35 70%	11320	45 9%	5082	20 4%	14063	61 12%	38755	161 32%
35-44	3508	15 3%	16463	66 13%	1735	10 2%	17568	70 14%	39274	161 32%
TOTAL	**34604**	**141 28%**	**28337**	**116 23%**	**26170**	**111 22%**	**33012**	**136 27%**	**122123**	**504 100%**

Table IV: Quota Control Matrix: Kerry County

	MALES				FEMALES				TOTAL	
AGE	**SINGLE**		**MARRIED**		**SINGLE**		**MARRIED**			
	POP.	**N.**	**POP.**	**N.**	**POP.**	**N.**	**POP.**	**N.**	**POP.**	**N.**
15-19	5614	$55^{11\%}$	7		5216	$56^{11\%}$	21		10858	$111^{22\%}$
20-24	3658	$41^{8\%}$	253	$5^{1\%}$	2814	$25^{5\%}$	518	$5^{1\%}$	7243	$76^{15\%}$
25-34	3574	$35^{7\%}$	4170	$40^{8\%}$	2326	$25^{5\%}$	5353	$56^{11\%}$	15423	$156^{31\%}$
35-44	1905	$20^{4\%}$	6437	$66^{13\%}$	796	$5^{1\%}$	6945	$70^{14\%}$	16083	$161^{32\%}$
TOTAL	**14751**	$\mathbf{151^{30\%}}$	**10867**	$\mathbf{111^{22\%}}$	**11152**	$\mathbf{111^{22\%}}$	**12837**	$\mathbf{131^{26\%}}$	**49607**	$\mathbf{504^{100\%}}$

2. Booster Sample

2.1 Sample Universe and Sample Size

The objective in conducting booster samples of respondents was to potentially boost the numbers of drug users for the purposes of statistical analysis. It was thus necessary to conduct booster interviews amongst that section of the population which was deemed to be at greatest risk from the perspective of drug abuse.

Based in part upon a study into areas of deprivation, conducted by the Department of Public Health of the Southern Health Board in early 1996, it was decided that the booster sample universe should be defined as follows;

- All 15 - 24 year old adults living in local authority housing areas, within electoral areas with proportionately high levels of unemployment, and proportionately high percentages in social classes 5 and 6.

An analysis of all electoral areas in the three regions identified the following areas as falling within the defined sample universe:

Table V: Southern Health Board High Risk Areas

	% Unemployment	% SC 5 and 6*
Cork City		
Knocknaheeny	25%	55%
Churchfield	21%	61%
Farranferris B	20%	53%
Gurranbraher E	17%	51%
The Glen A	17%	50%
Gurranbraher A	16%	56%
Blackpool A	16%	53%
Mayfield	20%	47%
Mahon B	17%	38%
Fairhill C	16%	46%
Fairhill B	13%	55%
Gurranbraher D	14%	55%
Fairhill A	14%	53%
Cork County		
Youghal	13%	39%
Cobh	10%	36%
Fermoy	10%	40%
Kinsale	11%	35%
Midleton	9%	38%
Mallow	9%	36%
Kerry		
Tralee	10%	35%
Listowel	9%	34%

* Social Class 5 is defined by the CSO as all semi-skilled manual workers and farmers farming less than 30 acres, while Social Class 6 comprises all unskilled manual workers.

Local Authority streets/estates within each of these Electoral Areas were then identified by the relevant local authorities, and surveying restricted to these streets/estates. Appendix includes a listing of all the local authority areas sampled.

2.2 Sample Distribution

The sampling points were then allocated in a manner identical to that employed for the main sample, and were distributed as follows:

Table VI: Southern Health Board "High Risk Area" - Sample Distribution

	TOTAL NUMBER HOMES IN L.A. AREAS	%	NUMBER OF SAMPLING POINTS	NUMBER OF INTERVIEWS
CORK CITY				
Knocknaheeny	1146	17%	4	32
Churchfield	516	8%	2	16
Farranferris B	356	5%	1	8
Gurranabraher E	461	7%	2	16
The Glen A	607	9%	2	16
Gurranabraher A	307	5%	1	8
Blackpool A	230	3%	1	8
Mayfield	781	12%	3	24
Mahon B	649	10%	3	24
Fairhill C	631	9%	2	16
Fairhill B	337	5%	1	8
Gurranabraher D	384	6%	2	16
Fairhill A	284	4%	1	8
Total	**6,689**	**100%**	**25**	**200**
CORK COUNTY				
Youghal	576	24%	6	48
Cobh	574	24%	6	48
Fermoy	489	21%	5	40
Kinsale	187	8%	2	16
Midleton	244	10%	3	24
Mallow	287	12%	3	24
Total	**2,357**	**100%**	**25**	**200**
KERRY				
Tralee	2,400	87%	22	176
Listowel	368	13%	3	24
Total	**2,768**	**100%**	**25**	**200**

2.3 Selection of Individuals

The quota control matrices upon which the selection of individuals within each booster area was based is set down in Table VII below. In this instance, quotas were based on a special "Small Area Population Statistics" (SAPS) analysis conducted for MRBI by the CSO.

Table VII: Booster Sample: Quota Control Matrix

	15-19				20-24				
	MALE		FEMALE		MALE		FEMALE		
	SINGLE	MARRIED	SINGLE	MARRIED	SINGLE	MARRIED	SINGLE	MARRIED	%
CORK CITY	POP	POP	POP	POP	POP	POP	POP	POP	
BLACKPOOL A	33	—	35	—	23	6	33	10	2.4%
CHURCHFIELD	97	—	83	—	93	3	77	6	6.2%
FAIRHILLA	49	—	49	—	71	1	46	5	3.8%
FAIRHILL B	65	—	72	—	87	4	77	10	5.4%
FAIRHILL C	212	—	187	—	141	12	103	20	11.6%
FARRANFERRIS B	58	—	57	—	60	7	46	13	4.2%
GARRANBRAHERA	51	—	35	—	34	2	40	3	2.8%
GARRANBRAHER D	70	—	56	—	58	2	41	8	4.1%
GARRANBRAHER E	68	—	69	—	58	4	63	7	4.6%
KNOCKNAHEENY	340	—	331	—	137	40	108	64	17.6%
MAHON B	149	—	142	—	91	15	97	34	9.1%
MAYFIELD	243	—	203	1	180	30	180	46	15.2%
GLEN A	230	—	145	—	207	16	128	22	12.0%
TOTAL CITY	**1665**	**0**	**1464**	**1**	**1240**	**142**	**1039**	**248**	**5799**
	29%	0%	25%	0%	21%	3%	18%	4%	100%
SAMPLE NUMBER	58	—	50	—	42	6	36	8	200
CORK COUNTY	POP	POP	POP	POP	POP	POP	POP	POP	
YOUGHAL	257	—	270	—	172	15	178	30	15.2%
COBH	454	1	417	—	333	16	270	65	25.6%
FERMOY	243	—	228	—	143	9	139	22	12.9%
KINSALE	113	—	118	—	121	3	94	16	7.7%
MIDLETON	313	—	316	—	217	13	178	36	17.7%
MALLOW	361	1	348	—	263	19	223	55	20.9%
TOTAL COUNTY	**1741**	**2**	**1697**	**0**	**1249**	**75**	**1082**	**224**	**6070**
	29%	0%	28%	0%	20%	1%	18%	4%	100%
SAMPLE NUMBER	58	—	56	—	40	2	36	8	200
KERRY	POP	POP	POP	POP	POP	POP	POP	POP	
TRALEE	969	2	875	5	632	53	605	99	85%
LISTOWEL	186	—	145	1	120	8	101	18	15%
TOTAL KERRY	**1155**	**2**	**1020**	**6**	**752**	**61**	**706**	**117**	**3819**
	30%	0%	27%	0%	20%	2%	18%	3%	100%
SAMPLE NUMBER	60	—	54	—	40	4	36	6	200

APPENDIX 2

SURVEY QUESTIONNAIRE

SOUTHERN HEALTH BOARD
DRUG SURVEY
QUESTIONNAIRE
JUNE 1996

CONFIDENTIAL

Clients Interviewed by MRBI Survey Company

Ass. No._____ **Qst. No._____** **MRBI/4368/96**

1
2
3
4

Good morning/afternoon. My name is _____from MRBI Limited, an independent Irish market research agency.

We have been commissioned by the Department of Public Health of the Southern Health Board to carry out a survey concerning people's understanding and experience of various types of drugs. Since this is quite a private matter, there is very little local information available to the Health Board to help them get a clearer picture of the subject. This is in fact the first community based survey of its kind to be undertaken in Ireland.

The questionnaire itself covers a variety of topics, some more sensitive than others. I can assure you that your answers to these) questions will be treated in the strictest of confidence. Under no circumstances will any of your replies be attributed directly to yourself. They will in fact be added together with the replies of hundreds of other people across Cork and Kerry, in such a way that no one person could possibly be identified in any way.

If you have any queries whatsoever relating to the survey, either now or after the interview, please feel free to call Liz Parsons or Zoe Slattery at our main office, FREEPHONE 1800 306 400.

A. GENERAL VIEWS ON LOCAL AREA

ASK ALL

Q.1 **SHOW CARD D** For the following things I read out, can you tell me how much of a problem you think they are in your area (i.e. within 5 minutes walk). **READ OUT EACH IN TURN AND CODE BELOW**

	Very Big Problem	Fairly Big Problem	Not a very big problem	Not a problem at all	(Don't Know)
Children and young people sniffing glue, gas or aerosols	1	2	3	4	0
People using drugs	1	2	3	4	0
People being offered drugs for sale?	1	2	3	4	0
People becoming ill or dying due to the use of drugs?	1	2	3	4	0
People thieving in order to get money to buy drugs?	1	2	3	4	0
People committing crimes because they are acting under the influence of drugs?	1	2	3	4	0

ASK ALL

Q. 2 Thinking about this area (i.e. within 5 minutes walk) do you think the number of people using drugs here is higher, lower or about the same compared to the rest of **…….(TOWN IN WHICH RESPONDENT** LIVES)

Higher	**1**
The same	**2**
Lower	**3**
Don't Know	**0**

6

Q.3 Do you think that there are particular areas in this town where people take drugs? (**INTERVIEWER STRESS CONFIDENTIALITY)**

Yes (Ask Q. 4)	1
No (Skip to Q.6)	2
Don't Know (Skip to Q.6)	0

7

Q.4 In which areas in particular? **PROMPT:** "Which others"

WRITE IN ALL AREAS MENTIONED (INTERVIEWER STRESS CONFIDENTIALITY)

_____

_____

_____

8

ASK ALL AWARE OF ANY AREAS. REST SKIP TO QUESTION 6

Q.5 People hear about these things in different ways. How are you aware of people taking drugs in this/these areas? **PROMPT:** How else?

(INTERVIEWER STRESS CONFIDENTIALITY)

Direct knowledge/experience	01
From Family/ Friends	02
From Neighbours	03
General word of mouth	04
Local Press	05
National Press	06
Local Radio	07
National Radio	08
National TV	09
Other (Code and write in)	10
_____	
Don't know	00

ASK ALL

Q.6 **SHOW CARD F** I'd now like you to consider different influences that people have suggested for taking drugs. Using one of the phrases in this card, I would like you to tell me how important or otherwise you think each influence is.

So firstly.....**READ OUT EACH STATEMENT IN TURN AND CODE**

	Very important influence	Fairly important influence	Not very important influence	Not an important influence at all	(Don't know)
Being Bored	1	2	3	4	0
Stress at Work	1	2	3	4	0
Need for excitement/ something new	1	2	3	4	0
Lack of parental guidance	1	2	3	4	0
Going to clubs and parties where drugs are available	1	2	3	4	0
Unemployment	1	2	3	4	0
Unhappiness at Home	1	2	3	4	0
Mental Illness	1	2	3	4	0
Because taking drugs is fun	1	2	3	4	0
Fitting in with friends	1	2	3	4	0
Declining moral standards	1	2	3	4	0
Because taking drugs can be a way of coping with life	1	2	3	4	0

B. KNOWLEDGE OF SPECIFIC DRUGS

Having talked about drugs in general, I would now like to look at particular drugs and their effects. Note that when we are talking about specific drugs, we are referring to both *illegal* drugs, and to drugs *available* over a chemist's counter or on a doctor's prescription, but which are *not* being used *as prescribed.* Please remember that we are interested in everyone's views, regardless of how much or little they feel they know about particular drugs.

ASK ALL

Q.7 When you think about drugs, what names come to mind for drugs that people use other than as prescribed? **CODE ALL MENTIONED IN GRID**

ASK ALL

Q.8 **SHOW SORT CARDS**
(Beyond those you have just mentioned), which, if any, of these drugs have you heard of(as used without a doctor's prescription)?

PROMPT: Which others?

CODE IN GRID AND PUT ALL AWARE DRUGS TOGETHER (SPONTANEOUS AND PROMPTED)

CARD 1.

		Q.7 Spontaneous Awareness	Q.8 Prompt Awareness
1	**Cannabis** (also called Marijuana, Grass, Pot, Hash., Draw, Dope, Ganja, Nudge, Nine Bar, Soaps)	**01**	**01**
2	**Heroin** (also called Smack, Junk, Tackle, Gear, H., Skag)	**02**	**02**
3	**Amphetamines** (also called Speed, Whizz, Uppers, Sulph, Sulphate, Billy, Buzz)	**03**	**03**
4	**LSD** (also called Acid, Tabs, Trips)	**04**	**04**
5	**Cocaine** (also called Coke, Ice, Rocks, Snow , Base)	**05**	**05**
6	**Ecstasy** (also called E, MDMA, XTC, Disco Biscuits, Love Doves , Shamrock, Champagne, Chiefs)	**06**	**06**
7	**Crack** (also called Rock, Ice, Crack Cocaine)	**07**	**07**
8	**Magic Mushrooms** (also called Mushies)	**08**	**08**
9	Methadone (also called MST, Physeptone)	**09**	**09**
10	**Diconal**	**10**	**10**
11	**Amyl Nitrate** (also called Poppers, Liquid Gold, Rush)	**11**	**11**
12	**Temazepam** (also called Jellies, Eggs, Beans)	**12**	**12**
13	**Temgesic** (also called Terns, Midget, Gems)	**13**	**13**
14	**Semeron**	**14**	**14**
15	**Barbiturates** (also called Downers, Barbies, Blues, Reds, Sekkies)	**15**	**15**
16	**DF118s** (also called Dfs, Hydra, Scratchers)	**16**	**16**
17	**Triazelam** (also called Upjohns)	**17**	**17**
18	**Unprescribed use of Sleeping Tablets** (e.g. Rohypnol, Mogadon)	**18**	**18**
19	**Unprescribed use of Tranquilisers** (e.g. Valium, Librium, Ativan, Diazepam, Roche, D5s)	**19**	**19**
20	Sniffing Glue, Gas, Aerosol	**20**	**20**
21	Other (Code and write in) 1……. 2…….	**21** **22**	**21** **22**
22	**NONE of the above/NONE**	**00**	**00**

IF NO DRUGS MENTIONED AT 0. 7/8 SKIP TO 0.10. REST: 0.9.

Q.9 **SHOW SORT BOARD**

In your opinion how harmful are these drugs. (POINT TO THOSE AWARE OF). Please use this board to position the different drugs according to your opinion. **(ALLOW RESPONDENT TIME TO SORT CARDS AND THEN RECORD ANSWERS IN GRID)**

CARD 2

		Q.9				
		Very Harmful	Harmful	Not particularly Harmful	Not at all Harmful	(Don't Know)
1.	**Cannabis** (also called Marijuana, Grass, Pot, Hash, Draw, Dope, Ganja, Nudge, Nine Bar, Soaps)	**1**	**2**	**3**	**4**	**0**
2	**Heroin** (also called Smack, Tackle, Gear, H., Junk, Skag)	**1**	**2**	**3**	**4**	**0**
3	**Amphetamines** (also called Speed, Whizz, Uppers, Sulph, Sulphate, Billy, Buzz)	**1**	**2**	**3**	**4**	**0**
4	**LSD** (also called Acid, Tabs, Trips)	**1**	**2**	**3**	**4**	**0**
5	**Cocaine** (also called Coke, Ice, Rocks, Snow, Base)	**1**	**2**	**3**	**4**	**0**
6	**Ecstasy** (also called MDMA, E., XTC, Disco Biscuits, Love Doves, Shamrock, Champagne, Chiefs)	**1**	**2**	**3**	**4**	**0**
7	**Crack** (also called Rock, Ice, Crack Cocaine)	**1**	**2**	**3**	**4**	**0**
8	**Magic Mushrooms** (also called Mushies)	**I**	**2**	**3**	**4**	**0**
9	**Methadone** (also called MST, Physeptone)	**1**	**2**	**3**	**4**	**0**
10	**Diconal**	**1**	**2**	**3**	**4**	**0**
11	**Amyl Nitrate** (also called Poppers, Liquid Gold, Rush)	**1**	**2**	**3**	**4**	**0**
12	**Temazepam** (also called Jellies, Eggs, Beans)	**1**	**2**	**3**	**4**	**0**
13	**Temgesic** (also called Terns, Midget, Gems)	**1**	**2**	**3**	**4**	**0**
14	**Semeron**	**1**	**2**	**3**	**4**	**0**
15	**Barbiturates** (also called Downers, Barbies, Blues, Reds, Sekkies)	**1**	**2**	**3**	**4**	**0**
16	**DF118s** (also called Dfs, Hydra, Scratchers)	**1**	**2**	**3**	**4**	**0**
17	**Triazelam** (also called Upjohns)	**1**	**2**	**3**	**4**	**0**
18	**Unprescribed use of Sleeping Tablets** (e.g. Rohypnol, Mogadon)	**1**	**2**	**3**	**4**	**0**
19	**Unprescribed** use **of Tranquilisers** (e.g. Valium, Librium, Ativan, Diazepam, Roches, D5s)					
20	**Sniffing Glue, Gas, Aerosol**	**1**	**2**	**3**	**4**	**0**
	Other (Code and write in)					
1	…….	**1**	**2**	**3**	**4**	**0**
2	…….					
	NONE of the above/NONE					

C. USAGE OF DRUGS

REASSURE ABOUT CONFIDENTIALITY AND THAT WE ARE INTERESTED IN THE DRUGS, AND NOT THE INDIVIDUALS

ASK ALL

Q.10 SHOW CARD G

Are you aware of anyone who has been offered any of these drugs? (Apart from a doctor's prescription)
PROMPT: Which drugs?
PROMPT: Which others?
CODE ALL DRUGS MENTIONED

Q.11 STILL SHOWING CARD G

Are you aware of anyone who has taken any of these drugs (in the last 5 years)? (Apart from on a doctor's prescription)
PROMPT: Which Drugs?
PROMPT: Which others?
CODE ALL DRUGS MENTIONED

ASK ALL WHO KNOW SOMEONE WHO HAS TAKEN ANY DRUGS AT 0.11. REST SKIP TO 0.13

Q.12 STILL SHOWING CARD G

And are you aware of anyone who regularly takes any of these drugs (apart from on a doctor's prescription)?
PROMPT: Which drugs?
PROMPT: Which **others?**
CODE ALL DRUGS MENTIONED

ASK ALL

Q.13 STILL SHOWING CARD G.

Have you been at any social gathering (in the past 5 years) where others have been taking drugs?
CODE ALL DRUGS MENTIONED

	CARD G	Q. 10	Q11	Q12	Q13
		Known Offered	Known Taken	Regular Takers	Social Gatherings
1	**Cannabis**	01	01	01	01
2	**Heroin**	02	02	02	02
3	**Amphetamines**	03	03	03	03
4	**LSD**	04	04	04	04
5	**Cocaine**	05	05	05	05
6	**Ecstasy**	06	06	06	06
7	**Crack**	07	07	07	07
8	**Magic Mushrooms**	08	08	08	08
9	**Methadone**	09	09	09	09
10	**Diconal**	10	10	10	10
11	**Amyl Nitrate**	11	11	11	11
12	**Temazepam**	12	12	12	12
13	**Temgesic**	13	13	13	13
14	**Semeron**	14	14	14	14
15	**Barbiturates**	15	15	15	15
16	**DFUSs**	16	16	16	16
17	**Triazelam**	17	17	17	17
18	**Unprescribed use of Sleeping Pills**	18	18	18	18
19	**Unprescribed use of Tranquilisers**	19	19	19	19
20	**Sniffing Glue, Gas, Aerosol**	20	20	20	20
21	**Other (Code and write in)**				
	1……..	21	21	21	21
	2……..	22	22	22	22
22	**Yes, but don't know which drugs**	23	23	23	23
23	**None of the above/ None**	00	00	00	00

D. **ATTITUDES ABOUT DRUGS AND HOW THEY SHOULD BE DEALT WITH WITHIN THE COMMUNITY**

ASK ALL

Q.14 In your opinion, which one, alcohol or drugs, causes more problems in society? **One code only**

Alcohol, much more	1
Alcohol, slightly more	2
Both equally	3
Drugs, slightly more	4
Drugs, much more	5

Q.15 (a) **SHOW CARD H(a)** I am going to read out a list of statements that people have made about taking drugs, and I would like you to tell me how much you agree or disagree with each of the statements

ROTATE START POINT BETWEEN RESPONDENTS, TICK POINT STARTED

TICK START ↓ POINT	AGREE STRONGLY	AGREE SLIGHTLY	NEITHER NOR	DISAGREE SLIGHTLY	DISAGREE STRONGLY	DON'T KNOW
□ It is the responsibility of the government to provide education about the risks of taking drugs	**1**	**2**	**3**	**4**	**5**	**0**
□ The way to decrease the number of people using drugs is to increase the security at the ports and airports	**1**	**2**	**3**	**4**	**5**	**0**
□ There is little difference in health terms between smoking cannabis and smoking tobacco or drinking alcohol	**1**	**2**	**3**	**4**	**5**	**0**
□ Police time would be better spent catching drug suppliers rather than clamping down on users	**1**	**2**	**3**	**4**	**5**	**0**
□ Money would be better spent on education and TV campaigns rather than on trying to spot drugs being smuggled into the country	**1**	**2**	**3**	**4**	**5**	**0**
□ People who use cannabis (and other "softer' drugs) are likely to progress onto 'harder drugs" such as cocaine and heroin	**1**	**2**	**3**	**4**	**5**	**0**
□ If people were better educated about the risks of taking drugs, many of them would not take drugs	**1**	**2**	**3**	**4**	**5**	**0**
□ More money needs to be spent on helping drug users and giving them medical treatment	**1**	**2**	**3**	**4**	**5**	**0**

Q.15 (b) **SHOW CARD H (b)** I am going to read out a list of statements that people have made about the general control of tobacco, alcohol and drugs, and I would like you to tell me how much you agree or disagree with each of the statements

ROTATE START POINT BETWEEN RESPONDENTS, TICK POINT STARTED

	AGREE STRONGLY	AGREE SLIGHTLY	NEITHER NOR	DISAGREE SLIGHTLY	DISAGREE STRONGLY	DON'T KNOW
	1	**2**	**3**	**4**	**5**	**0**
TICK START POINT ↓						
□ The minimum age for drinking and smoking should be increased (i.e.: to 20 or 21 years)	**1**	**2**	**3**	**4**	**5**	**0**
□ There should be a formal age checking system for those purchasing alcohol or tobacco e.g. ID cards	**1**	**2**	**3**	**4**	**5**	**0**
□ There should be stricter enforcement of laws on supplying alcohol or tobacco to minors.	**1**	**2**	**3**	**4**	**5**	**0**
□ Start training programmes for those selling tobacco and alcohol	**1**	**2**	**3**	**4**	**5**	**0**
□ Continue to forbid drug dealing and smuggling, and enforce the law.	**1**	**2**	**3**	**4**	**5**	**0**
□ Increase penalties for drug dealers.	**1**	**2**	**3**	**4**	**5**	**0**
□ Increase price of alcohol through taxation	**1**	**2**	**3**	**4**	**5**	**0**
□ Increase price of tobacco through taxation	**1**	**2**	**3**	**4**	**5**	**0**

ASK ALL

Q.16 There has been talk about whether certain drugs should be made legal, perhaps with restrictions on their availability. **SHOW CARD J** Using one of the phrases on this card, please tell me your opinion of this idea?
ONE CODE ONLY

All drugs should be legal, without any restrictions	1
All drugs should be legal, but with some restrictions (e.g. only on doctor's prescriptions)	2
Some drugs (e.g. Cannabis) should be legal, without any restrictions	3
Some drugs (e.g. Cannabis) should be legal, but with restrictions (e.g. licensing of a few shops/bars only)	4
All drugs currently prohibited should remain illegal	5
Don't know	0

10

ASK ALL

Q.17 **SHOW CARD M**

How important do you think it is to *educate* people about the effects and risks of taking drugs?

Very Important	1	
Fairly important	2	**ASK Q.18**
Not very important	3	
Not at all important	4	**SKIP TO Q.20**
Don't know	0	

11

Q.18 **SHOW CARD** N What age-group do you think should be given such education?
PROMPT: Who else? **IF MORE** THAN **ONE ASK:**

For whom is it most important to receive this education?

	ALL MENTIONS	MOST IMPORTANT (ONE ONLY
Children aged 9 to 11	1	1
Children aged 12 to 18	2	2
Young Adults (19-25)	3	3
Parents	4	4
Teachers	5	5
All Adults	6	6
Other (Code and write in)	7	7
Everyone	8	8
Don't know	0	0

Q.19 **SHOW CARD O** Which organisations do you think should be responsible for providing such education?
PROMPT: Who else?
IF MORE THAN ONE ASK: Who should be mostly responsible?

	ALL MENTIONED	MOST RESPONSIBLE (ONE ONLY
The Government	1	1
Local Council	2	2
Schools/ Colleges	3	3
Doctors/The Medical Profession	4	4
Chemist/Pharmacist	5	5
Health Boards	6	6
Police	7	7
Other (Code and write in)		
Everyone	8	8
Don't Know	0	0

ASK ALL

Q.20 Do you think that education should aim mainly at trying to prevent people starting to take drugs, or at drug users on how to avoid the worst effects of drugs, such as overdoses and the danger of catching AIDS? **CODE ONE ONLY**

Education should mainly be prevention from starting drugs	1
Education should mainly help those already taking drugs	2
Both	3
Don't Know	0

12

Q. 21 What organisations are you aware of locally working to increase people's awareness about drugs or to provide advice, information or help? **PROMPT:** What others?

……
……
…… 13

READ: The Southern Health Board Freephone Alcohol and Drugs Helpline has been available since November 1995 to provide confidential advice on service available for persons with alcohol and drugs problem.

Q.22 Have you heard anything about this Helpline?

YES 1
NO 2 14

ASK ALL

Q.23 Where can people go for advice and help about alcohol or drugs in (QUOTE TOWN)? PROMPT "Where else?"

FOR EACH SERVICE AWARE OF AT q.23 ASK Q.24.

IF NONE KNOWN, SKIP TO Q.25 (a).

Q.24 Do you know anyone who has ever approached ...(NAME PLACE) for help?"

ASK Q. 25 FOR EACH MENTION AT Q.24.
IF NONE, SKIP TO Q.25 (a).

Q.25 **SHOW CARD T**
How helpful or otherwise did they find the advice or information?

Services Available	Q.23	Q.24		Q.25				
		Yes	No	Very Helpful	Fairly Helpfu1	Not Very Helpful	Not at all Helpful	Don't know
GP	01	1	2	1	2	3	4	0
Chemist/Pharmacist	02	1	2	1	2	3	4	0
Psychiatric Clinic/Hospital	03	1	2	1	2	3	4	0
Arbour House(Cork)	04	1	2	1	2	3	4	0
Tabor Lodge (Cork)	05	1	2	1	2	3	4	0
St. Helen's Convent (Blarney)	06	1	2	1	2	3	4	0
Talbot Grove (Kerry)	07	1	2	1	2	3	4	0
Ashairi Centre	08	1	2	1	2	3	4	0
(Cahir/Wexford)	09	1	2	1	2	3	4	0
Coolmine Centre (Dublin)	10	1	2	1	2	3	4	0
SHB Freephone Alcohol and Drugs Helpline	11	1	2	1	2	3	4	0
Social Worker	12	1	2	1	2	3	4	0
Police	13		2	1	2	3	4	0
Church	14	1	2	1	2	3	4	0
Youth Club	15	1	2	1	2	3	4	0
Narcotics Anonymous	16	1	2		2	3	4	0
Other Voluntary Advice Agency	17	1	2	1	2	3	4	0
Other (Code and Write in)	18	1	2	1	2	3	4	0
La Patriarche Centre (Skibbereen)	19							
None	00							
Don't Know								

ASK ALL

Q.25 (a) How many people do you personally know who have received professional advice or help for**..... (READ OUT EACH OPTION AND WRITE NUMBER IN BOX PROVIDED.)**

Alcohol related problems.....	
Drugs related problems	
Both alcohol and drugs related problems	

Q.26 **SHOW CARD U**

Which organisations do you think *should* be helping people who wish to stop taking drugs? **PROMPT:** Who else?

IF MORE THAN ONE, ASK: Who should be mostly responsible?

	ALL MENTIONS	MOST RESPONSIBLE (ONE ONLY)
GP	1	1
CHEMIST / PHARMACIST	2	2
CLINIC/HOSPITAL	3	3
HEALTH BOARD	4	4
POLICE	5	6
VOLUNTARY ADVICE	6	6
OTHER (CODE AND WRITE IN) ……	7	7
DON'T KNOW	0	0

E. GENERAL

Finally, it will be useful for us to look at people's replies in the light of the type of people they are and the things that they do.

Q.27 SHOW CARD W

Which of these places do you ever go to?
PROMPT: Which others?

ASK 0.28 FOR ALL MENTIONS AT 0.27. IF NONE. SKIP TO 0.29

Q.28 SHOW CARD X

How often, on average, do you go to...?

	Q27	Q28 Frequency							
	Ever Do	Daily	2/3 Times a Week	Once a Week	Several Times a Month	Once a Month	Less Often	Never	Don't Know
Relatives Home	1	2	3	4	5	6	7	8	0
Friends Home	1	2	3	4	5	6	7	8	0
Pub	1	2	3	4	5	6	7	8	0
Cafe/ Restaurant	1	2	3	4	5	6	7	8	0
Dance/-Disco/Club	1	2	3	4	5	6	7	8	0
Party	1	2	3	4	5	6	7	8	0
Rave Dance/Club	1	2	3	4	5	6	7	8	0
Church/ Place of Worship	1	2	3	4	5	6	7	8	0
Evening Class	1	2	3	4	5	6	7	8	0
Sports Centre	1	2	3	4	5	6	7	8	0
Participation in Sports Event: e.g.- self/club., jog, cycle, train, aerobics	1	2	3	4	5	6	7	8	0
Watched Sports Event	1	2	3	4	5	6	7	8	0
Cinema/Theatre	1	2	3	4	5	6	7	8	0
Bingo	1	2	3	4	5	6	7	8	0
Other (Code and Write in) ……..	1	2	3	4	5	6	7	8	0
None of the above									
	1								

DRINKING

Q.29 Have you ever had an alcoholic drink?

Yes	1 **Continue**
No	2 **Go to Q.36**

Q.30 How old were you when you had your first alcoholic drink? **WRITE AGE IN BOX PROVIDED.**

Q.30 (a) Where **were you first introduced to alcohol?**

At home 1	In school 5
At a party 2	Outdoors 6
In a pub or hotel 3	None of the above 7
In a disco or club 4	

Q.30 (b) On the first occasion you drank alcohol, what was the reason for starting?

My parents gave me a drink 1	Curiosity 5
A close relative gave me a drink 2	I was depressed or anxious 6
My friends encouraged me 3	None of the above 7
I was celebrating a success 4	

Q.30 (c) Do you drink now, even occasionally?

Yes. 1 **CONTINUE**
No 2 **GO TO Q 36**

Q.31 How regularly would you drink any of the following drinks? **SHOW CARD V**

	Daily	A few times a week	At week-ends	About once a month	Less than once a month	Never
Beer (Stout, Ale, Lager)	1	2	3	4	5	7
Cider	1	2	3	4	5	7
Alcoholic Lemonade (e.g. Woody's Grog, Hooch, Mug Shot etc.)	1	2	3	4	5	7
Wine	1	2	3	4	5	7
Sherry	1	2	3	4	5	7
Spirits (e.g. Whiskey, Gin, Vodka)	1	2	3	4	5	7

Q.32 In a typical week (i.e. Monday to Sunday), how many pints/glasses/measures **(INTERVIEWER: SEE INSTRUCTION BELOW)** of the following drinks would you usually drink?

INTERVIEWER NOTE:	One drink =	1/2 pint of beer 1/2 pint of cider 1/2 pint of alcoholic lemonade A glass of wine A glass of sherry A measure of spirits

	No. of drinks in a typical week	
	no of drinks	
Beer (Stout, Ale, Lager)		20
Cider		21
Alcoholic Lemonade		22
Wine		23
Sherry		24
Spirits (Whiskey, Gin etc.)		

Q.33 Have you ever had enough of any alcoholic drink to feel drunk? 25

Yes .....1 No.....2 26
if No go to Q. 36

Q.34 How old were you the first time you ever felt drunk from an alcoholic drink? **WRITE AGE IN BOX PROVIDED.**

[ ] 27

Q 35 And how often would you have enough of any alcoholic drink to feel drunk?

Every day.....1
A few times a week 2
At weekends.....3
Once or twice a month 4
Once or twice a year.....5 28
Less often.....6

SMOKING

Q.36 Have you ever smoked?

Yes 1
No
2 **GO TO CLASSIFICATION** 29

Q.37 How old were you the first time you ever smoked a cigarette?

[ ][ ] Years Old 30

Q. 38 And do you smoke now, even occasionally? 31

1 **ASK Q.39**
Yes
No

Q.39 Overall, how many cigarettes do you smoke daily?

[ ][ ][ ] 32

ALL
HAND RESPONDENT SELF COMPLETION BOOKLET- ALLOW TIME
READ INTRODUCTION AND ASK QUESTIONS - YOU MAY OFFER TO HELP THEM COMPLETE IT IF THEY SO REQUEST

F. CLASSIFICATION

NAME: _____

ADDRESS: _____

_____

AGE: WRITE EXACT AGE IN BOX PROVIDED AND CODE BELOW: [ ][ ] 33 34

15-19.....1 20-24 .....2 25-34 ..... 3 35-44 .....4 35

SEX: Male..... 1 Female..... 2

STATUS: Married... 1 Widowed... 2 Separated... 3 Divorced...4 Single...5 36

OCCUPATION OF HEAD OF HOUSEHOLD: _____

If Employer/Manager - write in No. of Employees responsible for: _____

If Fanner/Farm Manager - write in No. of Acres:_____

If occupation given as "Widow" - write in former occupation of husband here: _____

If occupation given as "Retired" - write in former occupation here: _____

If occupation given as "Unemployed" - write in former occupation here: _____

SOCIAL CLASS: A ...1 B.....2 C1.....3 C2.....4 D.....5 E.....6

[7]

F1 (Fanner 50+ acres)..... F2 (Fanner -50 acres/farm labourer) ..... [8]

IN FARMING HOUSEHOLDS. ASK:

Are you the person responsible for running the farm - either solely responsible or responsible jointly with somebody else?

Yes..... 1 No..... 2 37

RESPONDENT

Has respondent: a full-time occupation/paid job of 30+ hours per week? 1 38

a part-time occupation/paid job of 18-29 hours per week? 2

a part-time occupation/paid job of 17 or less hours per week? 3

no paid job 4 39

HOUSEHOLD

* No. of persons in household (including respondent)?

1-2 persons ..... 1 3-4 persons ..... 2 5-6 persons ..... 3 7+ persons..... 4

*are there children (under 15) living in the household? Yes ..... 1 No 2

Would you be prepared to be interviewed again on this subject? 42

[1]

Do you have a telephone here in your home?

Yes..... 1 No..... 2 Refused No….3 43

[1]

Phone Number: _____

At what level did you finish your full-time education?

Still at 2nd level..... 1 Still at 3rd level..... 2

Finished at Primary level…. 3 Finished at 2nd level.....….. 4

Finished at 3rd level..... 5 No formal education 6

I certify that I have interviewed the above named respondent in accordance with survey instructions 44 45 46 47

Signed_____ Date_____

Ass No_____ **Quest No. _____** **MRBI/4368/96**

SELF COMPLETION BOOKLET

CONFIDENTIAL

- We promise that your answers are totally confidential and will not be seen by the interviewer if you hand back this booklet sealed in the envelope provided.
- The person who opens the envelope (and hundreds are being collected) will never know who you are and all answers will be added together by computer. No names or addresses will be entered on the computer.
- Please answer honestly. It is important that we should have the complete picture on the way people behave. » Please ignore the numbers next to the boxes. These are for office use.

To answer these questions. Just tick the answers in the boxes which apply to you. If there is anything that Is unclear, please ask the interviewer.

These are questions about drugs which people are not supposed to take unless they have a doctor's prescription.

Just tick the answers which apply in the boxes at each question.

Question 1.

Assuming you are at a party or festival where drugs are available. How likely

DRUG	very likely	Likely	unlikely	very unlikely
Unprescribed use of sleeping tablets (e.g. Rohypnol, Mogadon)	1	2	3	4
Unprescribed use of Tranquilisers (e.g. Valium, Librium, Ativan, Diazepam. Roche, D5s)	1	2	3	4
Cannabis (also called Marijuana, Grass, Pot, Hash, Draw, Dope, Ganja, Nudge, Nine Bar, Soaps)	1	2	3	4
Heroin (also called Smack, Junk, Skag, Tackle, Gear, H.)	1	2	3	4
Amphetamines (also called Speed, Whizz, Uppers, Sulph, Sulphate, Billy, Buzz)	1	2	3	4
LSD (also called Acid, Tabs, Trips)	1	2	3	4
Cocaine (also called Coke, Ice, Rocks, Snow, Base)	1	2	3	4
Ecstasy (also called E, MDMA, XTC, Disco Biscuits, Love Doves, Shamrock, Champagne, Chiefs)	1	2	3	4
Crack (also called Rock, Ice, Crack Cocaine)	1	2	3	4
Magic Mushrooms (also called Mushies)	1	2	3	4
Methadone (also called MST, Physeptone)	1	2	3	4
Diconal	1	2	3	4
Arnyl Nitrate (also called Poppers, Liquid Gold, Rush)	1	2	3	4
Temazepam (also called Jellies, Eggs, Beans)	1	2	3	4
Temgesic (also called Terns, Midget Gems)	1	2	3	4
Semeron	1	2	3	4
Barbiturates (also called Downers, Barbies, Reds, Blues, Sekkies)	1	2	3	4
DF118s (also called Dfs, Hydra, Scratchers)	1	2	3	4
Triazelam (also called Upjohns)	1	2	3	4
Sniffing Glue, Gas, Aerosols	1	2	3	4
Other Drug Please write in…….	1	2	3	4
NONE/NONE of the Drugs Listed	1	2	3	4

These are questions about drugs which people are not supposed to take unless they have a doctor's prescription.

Just tick the answers which apply in the boxes at each question.

DRUG	Question 2. Which, if any, of these have you ever tried.even if it was a long time ago. (except on a doctor's prescription)	Question 3. If you ever tried drugs. What age were you when you first tried? Write age in years next to drug	Question 3(a) If you ever tried drugs, Where did you first by them? Home; Party; Pub; Disco/club; Rave dance/club; Outdoors; School; WRITE IN	Question 4. Which, if any, of these have you tried, in the last 12 months (except on a doctor's prescription)	Question 5. Which, if any, of these have you tried, in the last month (except on a doctor's prescription)
Unprescribed use of **sleeping tablets** (e.g. Rohypnol, Mogadon)	01	age		01	01
Unprescribed use **of Tranquilisers** (e.g. Valium, Librium, Ativan, Diazepam, Roche, D5s)	02	age		02	02
Cannabis (also called Marijuana, Grass, Pot, Hash, Draw, Dope, Ganja, Nudge, Nine Bar, Soaps)	03	age		03	03
Heroin (also called Smack, Junk, Gear, H, Skag)	04	age		04	04
Amphetamines (also called Speed, Whizz, Uppers, Sulph, Sulphate, Billy, Buzz)	05	age		05	05
LSD (also called Acid, Tabs, Trips)	06	age		06	06
Cocaine (also called Coke, Ice, Rocks, Snow, Base)	07	age		07	07
Ecstasy (also called E, MDMA, XTC, Disco Biscuits, Love Doves, Shamrock, Champagne, Chiefs)	08	age		08	08
Crack (also called Rock, Ice, Crack Cocaine)	09	age		09	09
Magic Mushrooms (also called Mushies)	10	age		10	10
Methadone (also called MST, Physeptone)	11	age		11	11
Diconal	12	age		12	12
Amyl Nitrate (also called Poppers, Liquid Gold, Rush)	13	age		13	13
Temazepam (also called Jellies, Eggs, Beans)	14	age		14	14
Temgesic (also called Terns, Midget Gems)	15	age		15	15
Semeron	16	age		16	16
Barbiturates (Also called Downers, Barbies, Reds, Blues, Sekkies)	17	age		17	17
DF118s (also called Dfs, Hydra, Scratchers)	18	age		18	18
Triazelam (also called Upjohns)	19	age		19	19
Sniffing Glue, Gas, Aerosols	20	age		20	20
Other Drug Please write in ……	21	age		21	21
NONE/NONE of the Drugs Listed	00			00	00

Q.6 Do you sometimes drink alcohol together with:
Prescribed Legal Medical Drugs Yes.....1 No.....2 48

If yes, which drugs _____ 49

Q.7 Do you sometimes drink alcohol together with:
Unprescribed/Illegal Drugs Yes .....1 No 2 50

If yes, which drugs _____ 51

Q.8 Have you ever felt that you should cut down on your drinking?
Yes.....1 No.....2

Q.9 Have people annoyed you by criticising your drinking?
Yes.....1 No.....2

Q.10 Have you ever felt bad or guilty about your drinking?
Yes .....1 No 2

Q.11 Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (*eye-opener*)
Yes.....1 No.....2

Please answer Questions 12, 13 and 14 about each of the Drugs you have tried in the last 12 months
Just tick the answers which apply in the boxes at each question.
If you have not tried any drugs in the last 12 months, then please seal this booklet in the envelope provided and return it to the interviewer.

Question 12. On average, how often do you take the following DRUGs?	Daily	Several times a week	Once a week	Once a fortnight	Once a month	Less Often	Only tried once
Unprescribed use of **sleeping tablets** (e.g. Rohypnol, Mogadon)	1	2	3	4	5	6	7
Unprescribed use of Tranquilisers (e.g. Valium, Librium, Ativan, Diazepam, Roche, D5s)	1	2	3	4	5	6	7
Cannabis (also called Marijuana, Grass, Pot, Hash, Draw, Dope, Ganja, Nudge, Nine Bar, Soaps)	1	2	3	4	5	6	7
Heroin (also called Smack, Junk, Gear, H. Skag)	1	2	3	4	5	6	7
Amphetamines (also called Speed, Whizz, Uppers, Sulph, Sulphate, Billy, Buzz)	1	2	3	4	5	6	7
LSD (also called Acid, Tabs, Trips)	1	2	3	4	5	6	7
Cocaine (also called Coke, Ice, Rocks, Snow, Base)	1	2	3	4	5	6	7
Ecstasy (also called E, MDMA, XTC, Disco Biscuits, Love Doves, Shamrock, Champagne, Chiefs)	1	2	3	4	5	6	7
Crack (also called Rock, Ice, Crack Cocaine)	1	2	3	4	5	6	7
Magic Mushrooms (also called Mushies)	1	2	3	4	5	6	7
Methadone (also called MST, Physeptone)	1	2	3	4	5	6	7
Diconal	1	2	3	4	5	6	7
Amyl Nitrate(also called Poppers, Liquid Gold, Rush)	1	2	3	4	5	6	7
Temazepam (also called Jellies, Eggs, Beans)	1	2	3	4	5	6	7
Temgesic (also called Terns, Midget, Gems)	1	2	3	4	5	6	7
Semeron	1	2	3	4	5	6	7
Barbiturates (also called Downers, Barbies, Reds, Blues, Sekkies)	1	2	3	4	5	6	7
DF118s (also called Dfs, Hydra, Scratchers)	1	2	3	4	5	6	7
Triazelam (also called Upjohns)	I	2	3	4	5	6	7
Sniffing Glue, Gas, Aerosols	1	2	3	4	5	6	7
Other Drug Please write in …….	1	2	3	4	5	6	7
NONE/NONE of the Drugs Listed	1	2	3	4	5	6	7

	Question 13. Have you ever injected this drug?		**Question 14.** Is this drug usually available in your City/ Town/Area?			**Question l4 (a)** If you do take drugs, Where do you usually take them e.g. Home; Party; Pub; Disco/Club; Rave dance/Club; School; Outdoors; Other (Write answer in box next to corresponding drug(s))
DRUG	YES	N0	YES	N0	Don't know	
Unprescribed use of **sleeping tablets** (e.g. Rohypnol, Mogadon)	1	2	1	2	0	
Unprescribed use of Tranquilisers(e.g. Valium, Librium, Ativan, Diazepam, Roche, D5s)	1	2		2	0	
Cannabis (also called Marijuana, Grass, Pot, Hash, Draw, Dope, Ganja, Nudge, Nine Bar, Soaps)	1	2	1	2	0	
Heroin (also called Smack, Junk, Gear, H, Skag)	1	2	1	2	0	
Amphetamines (also called Speed, Whizz, Uppers, Sulph, Sulphate, Billy, Buzz)	1	2	'	2	0	
LSD (also called Acid, Tabs, Trips)	1	2	1	2	0	
Cocaine (also called Coke, Ice, Rocks, Snow, Base)	1	2	1	2	0	
Ecstasy (also called E, MDMA, XTC, Disco Biscuits, Love Doves, Shamrock, Champagne, Chiefs)	1	2	1	2	0	
Crack (also called Rock, Ice, Crack Cocaine)	1	2	1	2	0	
Magic Mushrooms (also called Mushies)	1	2	1	2	0	
Methadone (also called MST, Physeptone)	1	2	1	2	0	
Diconal	1	2	1	2	0	
Amyl Nitrate (also called Poppers, Liquid Gold, Rush)	1	2	1	2	0	
Temazepam (also called Jellies, Eggs, Beans)	1	2	1	2	0	
Temgesic (also called Terns, Midget, Gems)	1	2	1	2	0	
Semeron	1	2	1	2	0	
Barbiturates (Also called Downers, Barbies, Reds, Blues, Sekkies)	1	2	1	2	0	
DF118s (also called Dfs, Hydra, Scratchers)	1	2	1	2	0	
Triazelam (also called Upjohns)	1	2	1	2	0	
Sniffing Glue, Gas, Aerosols	1	2	1	2	0	
Other Drug Please write in ……	1	2	1	2	0	
NONE/NONE of the Drugs Listed	1	2	1	2	0	
Thank you for answering these questions. Now please seal the booklet in the envelope provided and return it to the interviewer.						

APPENDIX 3

DETAILED DRUG CLASSIFICATION

Classification of Drugs

CANNABIS
Cannabis (also called Marijuana, Grass, Hash, Draw, Dope, Ganja)

OPIATES
Methadone (also called MST, Physeptone)
Diconal
Heroin (also called Smack, Junk, Tackle, Gear, H, Skag)
DF118s (also called Dfs, Hydra, Scratchers)

STIMULANTS
Amphetamines (also called Speed, Whizz, Uppers, Sulph, Sulphate, Billy, Buzz)
Cocaine (also called Coke, Ice, Rocks, Snow , Base)
Ecstasy (also called E, MDMA, XTC, Disco Biscuits, Love Doves , Shamrock;
Amyl Nitrate (also called Poppers, Liquid Gold, Rush)
Crack (also called Rock, Ice)

Caffeine
Nicotine

HALLUCINOGEN
LSD (also called Acid, Tabs, Trips)
Magic Mushrooms

SEDATIVES/HYPNOTICS
Temazepam (also called Jellies, Eggs, Beans)
Temgesic (also called Terns, Midget, Gems)
Barbiturates (also called Downers, Barbies, Blues, Reds, Sekkies)
Triazelam (also called Upjohns)
Unprescribed use of **Sleeping Tablets**
Unprescribed use of **Tranquillizers** (e.g. Valium, Librium, Ativan)

Alcohol

SOLVENTS
Sniffing Glue, Gas, Aerosol

APPENDIX 4

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APPENDIX 5

DRUGS EFFECTS

DSM-IV Substance-Related Diagnoses

Table 1. Diagnoses associated with class of substances.

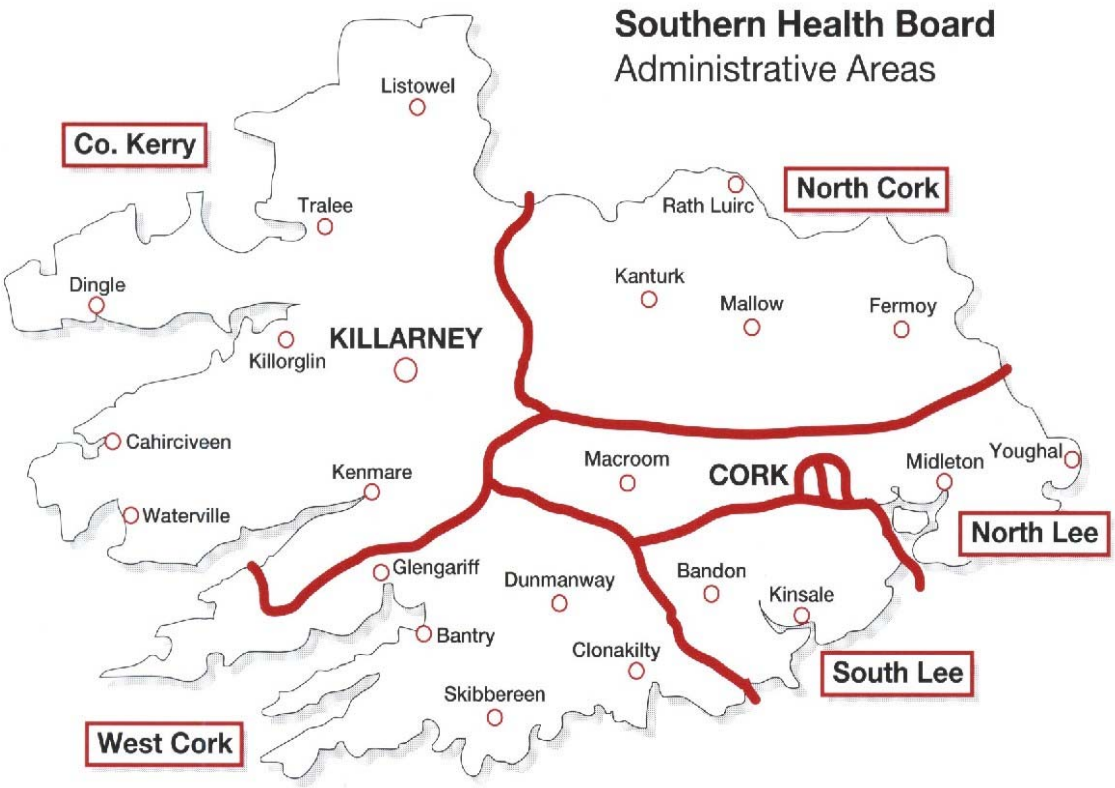
	Dependence	Abuse	Intoxication	Withdrawal	Intoxication Delirium	Withdrawal Delirium	Dementia	Amnestic Disorder	Psychotic Disorders	Mood Disorders	Anxiety Disorders	Sexual Dysfunctions	Sleep Disorders
Alcohol	**x**	**x**	**x**	**x**	**1**	**W**	**P**	**P**	**1/W**	**1/W**	**1/W**	**1**	**1/W**
Amphetamines	**x**	**x**	**x**	**x**	**1**				**1**	**1/W**	**1**	**1**	**1/W**
Caffeine			**x**								**1**		**1**
Cannabis	**x**	**x**	**x**		**1**				**1**		**1**		
Cocaine	**x**	**x**	**x**	**x**	**1**				**1**	**1/W**	**1/W**	**1**	**1/W**
Hallucinogens	**x**	**x**	**x**		**1**				**1**	**1**	**1**		
Inhalants	**x**	**x**	**x**		**1**		**P**		**1**	**1**	**1**		
Nicotine	**x**			**x**									
Opioids	**x**	**x**	**x**	**x**	**1**				**1**	**1**		**1**	**1/W**
Phencyclidine	**x**	**x**	**x**		**1**				**1**	**1**	**1**		
Sedatives, hypnotics, or anxiolytics	**x**	**x**	**x**	**x**	**‘**	**W**	**P**	**P**	**1/W**	**1/W**	**W**	**‘**	**1/W**
Polysubstance	**x**												
Other	**x**	**x**	**x**	**x**	**1**	**W**	**P**	**P**	**1/W**	**1/W**	**1/W**	**1**	**1/W**

- Also Hallucinogen Persisting Perception Disorder (Flashbacks).

Note: **X, I, W, 1/W,** or **P** indicates that the category is recognised in DSM-IV. In addition, **I** indicates that the specifier With Onset During Intoxication may be noted for the category (except for Intoxication Delirium); **W** indicates that the specifier With Onset During Withdrawal may be noted for the category (except for Withdrawal Delirium); and **1/W** indicates that either With Onset During Intoxication or With Onset During Withdrawal may be noted for the category. **P** indicates that the disorder is Persisting.

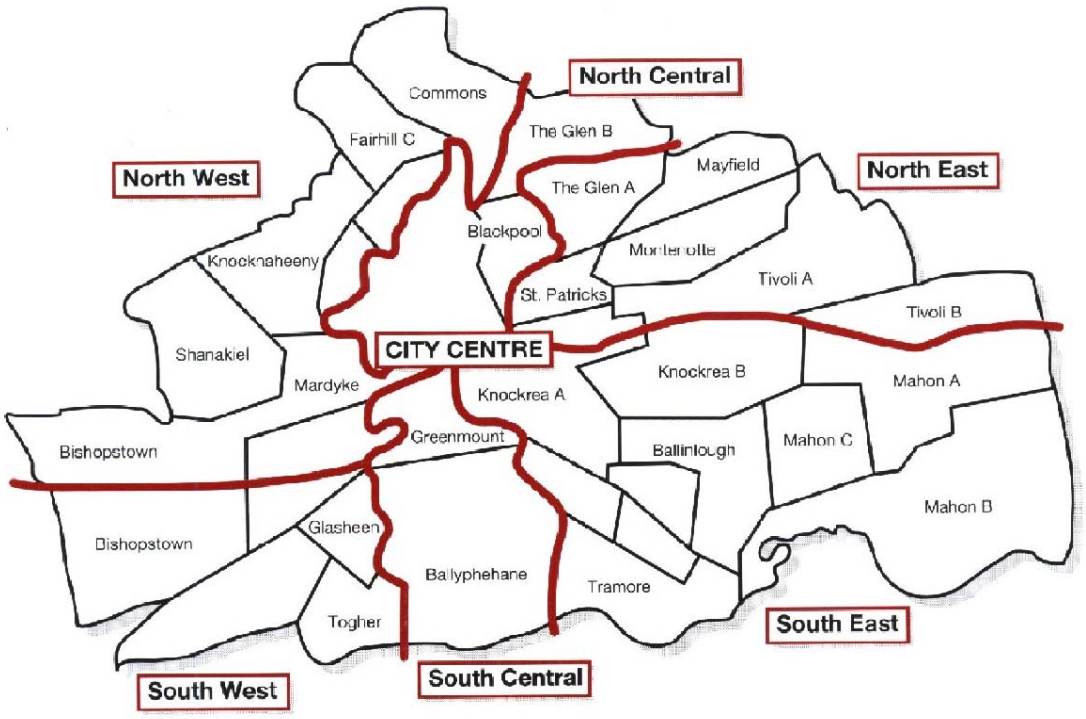
APPENDIX 6

SOUTHERN HEALTH BOARD MAP



APPENDIX 7

CORK CITY WARDS



Cork City Electoral Areas:
Listing of Wards/DEDs in each area

Cork South East	Cork South Central	Cork South West	Cork North West	Cork North Central	Cork North East
Ballinlough A	Ballypnehane A	Bishopstown B	Bishopstown A	Blackpool A	Mayfield
Ballinlough B	Ballyphehane B	Bishopstown C	Churchfield	Blackpool B	Montenotte A
Ballinlough C	Evergreen	Bishopstown D	Commons	Centre B	Montenotte B
Browningstown	Gillabbey A	Bishopstown E	Fair Hill B	Fairhill A	St. Patrick's A
Centre A	Greenmount	Glasheen A	Fair Hill C	Farranferris A	St. Patrick's B
City Hall A	Pouladuff A	Glasheen B	Farranferris B	Farranferris C	St. Patrick's C
City Hall B	Pouladuff B	Glasheen C	Gilabbey B	Gurranebraher A	The Glen A
Knockrea A	South Gate B	Togher A	Gillabbey C	Gurranebraher B	Tivoli A
Knockrea B	The Lough		Knocknaheeny	Gurranebraher C	Tivoli B
Mahon A	Togher B		Mardyke	Gurranebraher D	
Mahon B	Turners Cross B		Shanakiel	Gurranebraher E	
Mahon C	Turners Cross C		Sunday's Well A	Shandon A	
South Gate A	Turners Cross D			Shandon B	
Tramore A				Sunday's Well B	
Tramore B				The Glen B	
Tramore C					
Turners Cross A					