

SMOKING, ALCOHOL, and DRUG USE in CORK & KERRY 2004

Dr. T.M.R. Jackson

BA.MB.DCH.DPH.FFPHMI

Specialist Public Health Medicine

CONTENTS

Acknowledgements	2
Foreword	3
Introduction	4
Summary and Main Conclusions of Findings	5
Methodology	7
Results	10
Sections	
1. Smoking	11
2. Alcohol	14
3. Drugs Overall Use	28
4. Cannabis	41
5. Stimulants	49
6. Opiates	54
7. Hallucinogens	62
8. Sedatives	66
9. Solvents	69
10. Non-prescription Codeine	72
11. Community Perceptions of Substance Abuse Issues	74
Perceived Substance Use Problems in Area	74
Source of Awareness of Drug Use in Area	76
Drug Awareness	78
Personal Knowledge of Drug Use Situations	79
Perception of scale of Substance Use Problems	83
Policy and Legislation on Alcohol or Drugs	84
Knowledge of Substance Use Services	87
Leisure Activities	97
12. Alcohol and Drug Use in Family and Friends	100
13. Injecting Drug Use	102
Discussion	103
Smoking	104
Alcohol	106
Drugs	109
Comparison with other Surveys	111
Community Perceptions of Substance Abuse Issues	119
Recommendations	122
Appendices	
1 References	130
2 Range of problems associated with alcohol	135
3 4-Tier Model of Substance Use	136
4 Range of Responses to alcohol and substance use	137
5 Clinical features of opioid and cocaine disorders	138
6 Detailed Drug Classification	140
7 Substance Use Summaries	141
8 Young Adult Population Changes in Cork City	145
9 Detailed Sampling Methodology	147
10 Questionnaire	163

ACKNOWLEDGEMENTS

Many people contributed to the development of this study. It would be impossible to list everyone. However, I would specially like to thank:

Dr Elizabeth Keane Director of Public Health, for her support and advice throughout this study.

My colleagues in the Department of Public Health for their support: especially Dr Margaret O'Sullivan, Dr Fiona Ryan, Dr Mary O'Mahony, Dr Deirdre Murray.

Dr Helena Murray, Specialist Registrar, for proofreading and editing advice.

Ms Joyce Kelly, Research Officer, for her excellent and patient support in processing, and graphing data.

Ms Heather Hegarty, Senior Research Officer, for her consistent and cheerful support in demography, mapping, and literature search.

Ms Judy Cronin, Health Informatics Manager, for her advice on technical issues.

Mr Ian McShane, Director TNS mrbi Ltd for his invaluable help in sampling design, implementing the questionnaire, and data collection.

Support Team of TNS mrbi, who gave valuable advice at key phases of this study:

Ms Sarah Fanagan, Ms Maura Murphy, Ms Marie Hobbs, and Mr Walter Heseltine

Mr William Collins, Coordinator of Services for Substance and Alcohol Use for his continuing support and advice; also his support staff Ms Marwin Jagoe, and Ms Niamh Murphy.

Arbour House Staff, for their patient response to many queries: Mr Declan Roche (Director), Ms Marguerite Lovett, Dr Declan O'Brien, Mr David Baumann.

Directors of Treatment Centres in Cork and Kerry for their support and advice: Mr Michael Devine (Tabor Lodge), Mr Con Cremin (Talbot Grove), Sr Miriam O'Connell (Anchor Centre)

The Secretarial Staff for their patience and help with multiple requests, drafts, and computer and printing problems: Ms Rosalind Condon, Ms Eileen Ryan, Ms Angela Murphy, Ms Dolores Ryan.

Administrative Staff for their support with planning, tendering, financing, and printing this study: Ms Emer O'Shea, Ms Carmel Nixon, Ms Louise Curtin.

Mr Pat Healy Assistant Director of PCCC: for his support.

Ms Gretta Crowley Local Health Office Manager, HSE S Lee PCCC, for her support.

Dr Ann Hope National Alcohol Policy Advisor, for her advice on aspects of the alcohol questionnaire.

Dept Epidemiology and Public Health UCC: Prof Ivan Perry and Dr Tony Fitzgerald for their helpful advice.

Health Promotion Dept Cork for their helpful response to many queries: Ms Sharon McGillicuddy, Ms Denise Cahill, Ms Miriam O'Shea

Dr Alan Kelly for his advice and provision of SAHRU data.

The Health Research Board Drug Misuse Division for response to many queries: Dr Hamish Sinclair, Dr Jean Long, and Librarian Staff.

Ms Mairead Lyons of the National Advisory Committee on Drugs for her advice.

Dr Mai Mannix for her help and advice and permission to quote from her Detoxification study.

T.M.R.Jackson BA.MB.DCH.DPH.FFPHMI
Department of Public Health
Cork

April 2006

FOREWORD

Has the misuse of alcohol and drugs become the plague of 21st century civilisation? A major threat to the health of the Irish population? A catalyst for societal unrest? A spiralling epidemic of violence and crime? Accidents on our roads, violence in our streets and homes?

How effective are our public policies and services for curbing this epidemic? Where should our resources and energies be targeted?

This excellent epidemiological research by Dr Timothy Jackson, analyses the current patterns of drug and alcohol misuse in the Cork and Kerry area. It makes for disturbing reading. The problems are escalating.

This is a report for many interest groups: concerned citizens; policy makers; politicians; planners; provider of health and social care; commentators; victims.

This report must now serve as an impetus to our collective efforts in the control of alcohol and drug misuse, making for a healthier and safer society.

Dr. Elizabeth Keane
Director of Public Health
HSE-South
4th April, 2006.

INTRODUCTION AND BACKGROUND

Substance use continues to be of major concern to our community. Smoking and alcohol use, though legal, have serious public health implications when abused. Illegal use of substances such as cannabis, ecstasy, cocaine, and heroin, has created a drug and crime culture, which have serious implications for many parts of our country.

This study reviews substance use by comparing its findings with an earlier study carried out in 1996, eight years previously. The methodology was similar, and age groups 15-44 years were targeted, allowing study of use from adolescence to adulthood.

This survey was planned in 2003, and carried out in 2004. Analysis has taken place over the remaining time. It has also been a time of great administrative change, when the former Health Boards, including the Southern Health Board (SHB) were disbanded in June 2005, to become part of the new structures of the Health Service Executive (HSE).

SHB is used several times in the text to refer concisely to Cork and Kerry, and reflect the administrative reality at the time of survey. It does not refer to any current organisation within the HSE.

SUMMARY AND MAIN CONCLUSIONS OF FINDINGS

Smoking

Lifetime smoking was reduced by 4% to 58% since 1996. There continues to be a high prevalence of Current Smokers at 37%. Current smoking reached over 40% in age groups 18-34 years, and Social Classes 4-6.

Current smoking in 15 year olds has trebled since 1996, from 10% to 29%. This was especially marked in boys, who showed a ten-fold increase from 3% to 32%.

These findings were consistent with NACD, MWHB, ESPAD, HBSC studies.

Alcohol

81% were current drinkers, with women almost equal to men.

Current drinkers had the following characteristics:

26% of men drank in excess of guidelines, and 22% were Cage Positive, indicating problem/dependent use of alcohol.

17% of women drank in excess of guidelines. This had doubled since 1996, and 11% were Cage Positive.

Men drank a mean of 18 units per week, but women had increased their mean alcohol intake per week by 30% to 9 units since 1996. The pattern of drinking for women showed a doubling of wines and spirits, and a 5 times increase in premix spirits.

50% of men, and 25% of women, binged three or more times in the previous month.

Since 1996, women have shifted alcohol consumption significantly into more damaging categories:

Those in Category 1 (Excessive) doubled to 13%.

Those in Category 2 (Problem drinking) trebled to 3%.

Those in Category 3 (Problem and Dependent drinking) increased by 5 to 1%.

Men did not significantly change their alcohol categories, although these were higher than women, with Category 1: 17%, Category 2: 8%, and Category 3: 4%.

In the Under 18 years group:

41% were current drinkers – 47% boys and 32% girls.

87% had been drunk, an increase of 15% since 1996.

These findings were consistent with NACD, MWHB, ESPAD, HBSC studies.

Drug Use

(*Lifetime*: Ever Taken; *Recent*: Taken in Last Year; *Current*: Taken in last month)

Cannabis has doubled in all forms, with Lifetime use now 32%, and Recent use 14%.

Stimulants use has doubled to 10% Lifetime use, and 4% Recent use.

Ecstasy has doubled for Lifetime (7%) and Recent use (3%).

Cocaine Lifetime use has increased by five times to 6%, and Recent use has increased by three times to 2.5%. Crack has increased by eight times for lifetime use to 2%. While the actual prevalence's are still low, the increases show a serious trend.

Lifetime use of opiates has doubled to 2%, and Recent use has increased by eight to almost 1%. Heroin itself has increased by eight times for Lifetime use (1.8%), and by five times for Recent use (0.5%), but these prevalence's are still low. Lifetime Heroin use was highest, in larger towns of 10,000+ population at 4.4%.

Overall, This 2004 study shows much higher Drug use than the NACD study, but is comparable to many School Studies, and other population lifestyle studies. The difference from the NACD study, may be due the use of confidential self-reporting for drug use in this study.

Increases shown in this Survey are also reflected by increases in Treated Problem Drug Use data.

Comparison of Regions:

Cork City was highest for all modes of drug use.

Lifetime use was 41% compared to 30% elsewhere.

Recent use in Cork City was 18% compared to 11% in Cork Co and 14% in Kerry.

All regions showed significant increases since 1996, especially Cork Co and Kerry, which doubled or tripled drug use in all categories.

Some City Wards/Electoral Areas showed only small increases or actual decreases since 1996, which could reflect Local Drugs Task Force efforts in the City.

Attitudes

Cannabis was perceived as the least harmful and most used drug. There was widespread knowledge and contact with situations where drugs were being taken, with 50% claiming to know someone who had been offered or taken Cannabis or Ecstasy. Knowledge of Cannabis, Cocaine, and Heroin use showed a marked increase.

There was reluctance to agree with increasing tax on alcohol or tobacco. 33% agreed to some legalisation for cannabis.

GPs, Arbour House and Community Counselling Services, and Psychiatrists were well recognised as sources of help.

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

Alcohol was perceived to be the dominant problem-use substance.

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. Drug Use is mainly "soft drugs" but is widely available. Cocaine and Heroin use are still low, but there have been marked increases in these drugs since 1996.

METHODOLOGY

This research was a repeat of the 1996 SHB Substance Use Survey¹. The methodology was similar to that used in 1996.

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 Former Southern Health Board (SHB): Cork City, Cork Co, and Co. Kerry as identified by the Census²⁻⁴. The sample was structured into two groups:

1. The Main Sample totalled 1512, age groups 15-44 years, with approx 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, by selecting populations considered to be at higher risk for illegal substance use. This was done by choosing a younger age group (i.e. those aged 15-25 years), from Deprived Urban areas of Cork City, and towns in Cork County and Kerry.

The Booster Sample totalled 900, age groups 15-24. This was increased from 600 since the last survey to increase statistical robustness. These were taken from Local Authority Housing in the most deprived Urban Areas of each region. In contrast to the 1996 Survey, areas identified as most deprived were based on the Small Area Research Health Unit (SAHRU) index⁵. The maximum deprivation index of 10 was chosen. These are referred to in the text as Young Urban Deprived.

Detailed structure of population sampling is described in Appendix 9. After exclusions, the final analysis was based on 1508 for the Main sample, and 909 for the Booster sample.

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 a separate confidential self-completion booklet)

A dummy drug semeron was included in the list of drugs to check false entries. This drug was excluded from analysis.

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^{6,7}. 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.

Drugs were categorised into Cannabis, Stimulants, Opiates, Hallucinogens, Sedatives, and Solvents (see detailed classification in Appendix 6).

The frequency of drug use was classified as follows:

Lifetime Use: Drug Ever Taken;

Recent Use: Drug Taken in last year;

Current Use: Drug taken in last month.

Social Class

The Central Statistics Office⁸ 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

These were grouped into classes 1-3 and 4-6 for analysis. The Socio-economic Class Groupings in the questionnaire (Appendix 10, Part F Classification) were converted to Social Class groups as above.

The draft questionnaire and proposed survey structure were tendered to several survey companies, and TNS mrbi was chosen to carry out the field interviewing. Several meetings were held to decide on changes to the original questionnaire, and finalise the details of survey structure. The survey was piloted in June 2004, and finally carried out during the autumn of 2004.

Data Analysis

The data was coded in SPSS version 12.0.1, and after piloting the survey, the draft Data Set was sent to this Dept Public Health. 800 variables had to be re-coded into readable variables, and mistakes checked and corrected. After the survey was carried out during the autumn, the Main Data Set was sent in December 2004, for final analysis. As stated, the final analysis was based on 1508, and 909 for the Main and Booster samples.

Statistical Methods

Statistical analysis was carried out using SPSS versions 12 and 13. Varied statistical tests were used.

The following tests (with their abbreviations) were used. These are listed below, with main reason for the test:

Chi-squared test (χ^2)

Categorical analysis

Fishers Exact test (Fx)

Categorical analysis 2x2 table

where expected counts are less than 5.

The Mann-Whitney test (M-W)

non-parametric data, 2 samples

Kruskal-Wallis test (K-W)

non-parametric data, more than 2 samples

T test (T test)

parametric data, 2 samples

Anova test (Anova)

parametric data, more than 2 samples

P values are given either as actual values, when significant at the 5% level eg: (p=0.03), or as (p<0.05). In cases where p values are less than 0.1%, they are described as (p<0.001).

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 showed more resistance than the last time. However, most were willing to co-operate. It is estimated that about 5% actually refused interview, which is the same as in 1996.

Ethics

This study was carried out under the guidelines and codes of the European Society for Opinion and Market Research (ESOMAR)^{9 10}.

RESULTS

SECTIONS

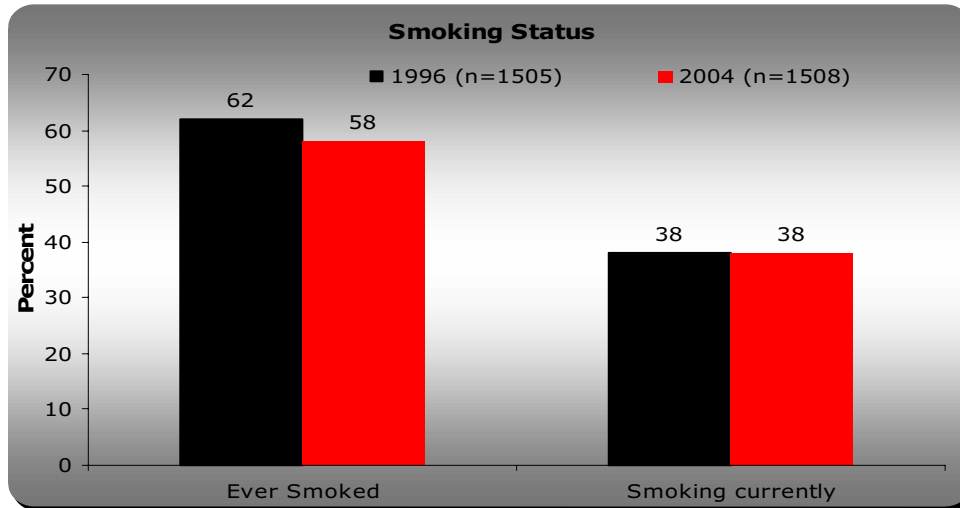
- 1. Smoking**
- 2. Alcohol**
- 3. Drugs Overall Use**
- 4. Cannabis**
- 5. Stimulants**
- 6. Opiates**
- 7. Hallucinogens**
- 8. Sedatives**
- 9. Solvents**
- 10. Non-prescription Codeine**
- 11. Community Perceptions of Substance Abuse Issues**
 - Perceived Substance Use Problems in Area**
 - Source of Awareness of Drug Use in Area**
 - Drug Awareness**
 - Personal Knowledge of Drug Use Situations**
 - Perception of scale of Substance Use Problems**
 - Policy and Legislation on Alcohol or Drugs**
 - Knowledge of Substance Use Services**
 - Leisure Activities**
- 12. Alcohol and Drug Use in Family and Friends**
- 13. Injecting Drug Use**

1. SMOKING

Smoking Main Sample (Fig 1)

In 2004, 58% have “ever smoked”, and 38% currently smoke (Fig1). Lifetime smoking was almost 4% less than in 1996 (χ^2 : $p < 0.05$), but there was no significant change in current smoking since 1996.

Fig 1



Gender (Fig 2)

Slightly more men smoked (40%) than women (35%).

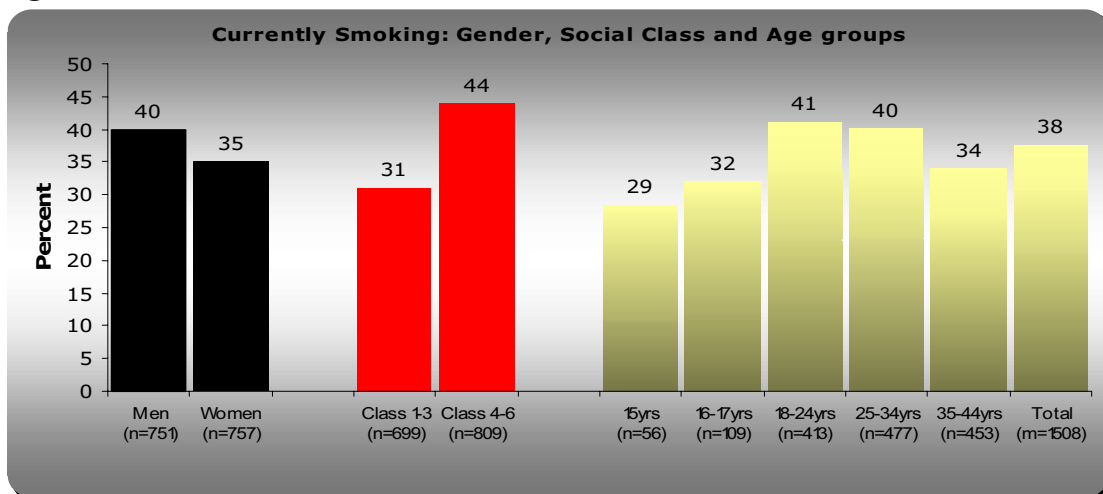
Social Class (Fig 2)

Significantly more were current smokers in Social Class 4-6 (44%), compared with Social Class 1-3 (31%) (χ^2 : $P < 0.001$). Those who were Young Urban Deprived, showed no significant difference.

Age Groups (Fig 2)

Current smoking was highest in age-groups 18-34 at about 40%, dropping to 34% at 35-44 years. Smoking rapidly increased from 29% at 15 years to 32% at 16-17 years, and 41% at 18-24 years.

Fig 2

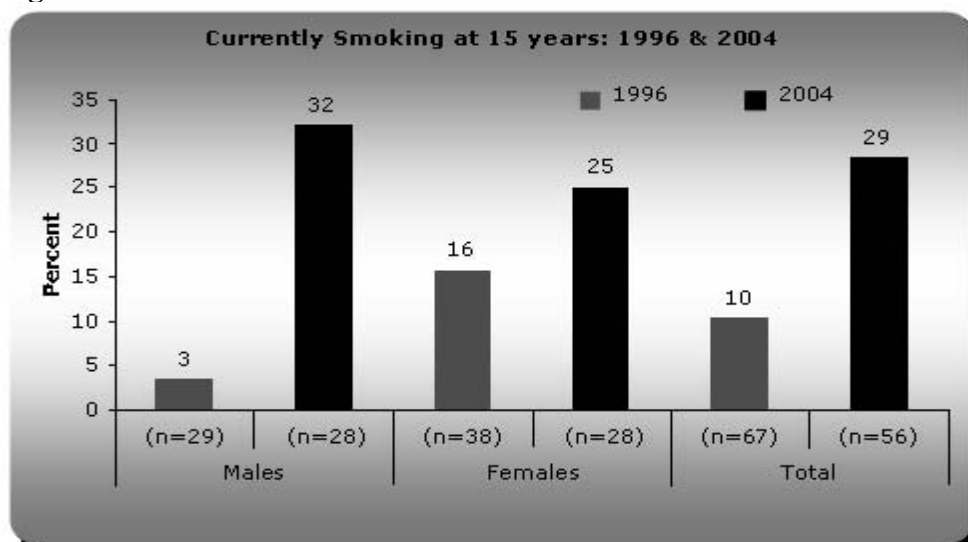


Smoking at 15 years - Changes Since 1996 (Fig 3)

Current Smoking at 15 years almost trebled from 10% to 29% from 1996 to 2004 (χ^2 : $p=0.01$). There was no significant change for other age groups.

Boys showed a 10-fold increase from 3% to 32% (Fishers Exact Test: $p=0.005$). Smoking in girls rose from 16% to 25%, although this was not statistically significant.

Fig 3



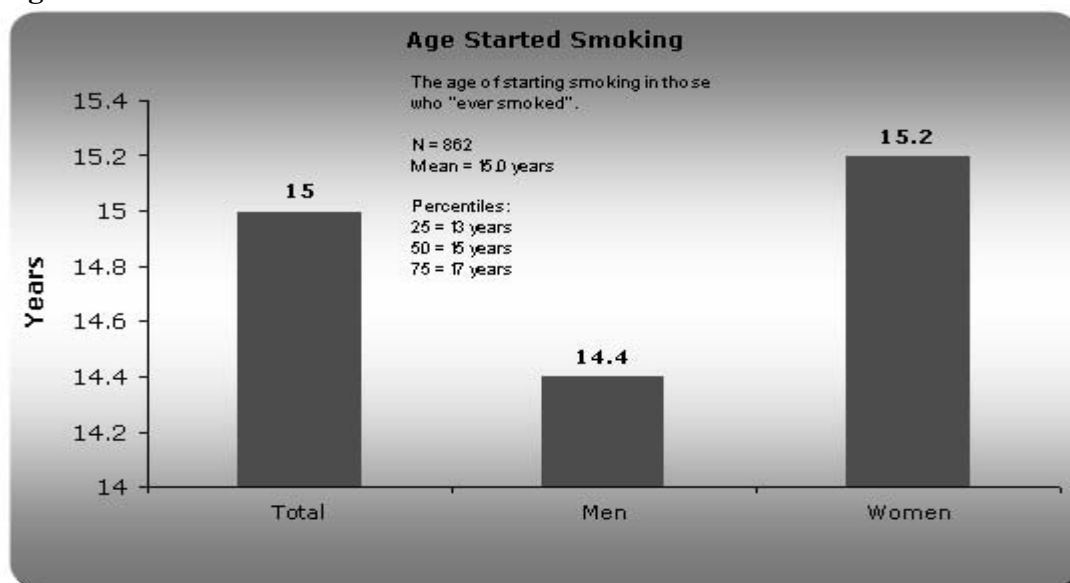
Age First Started Smoking (Fig 4)

In those who had Ever Smoked, the mean age of first smoking was 15 yrs. 25% had tried smoking by 13 years. A similar pattern was shown for Current Smokers.

Current Smokers (Fig 4)

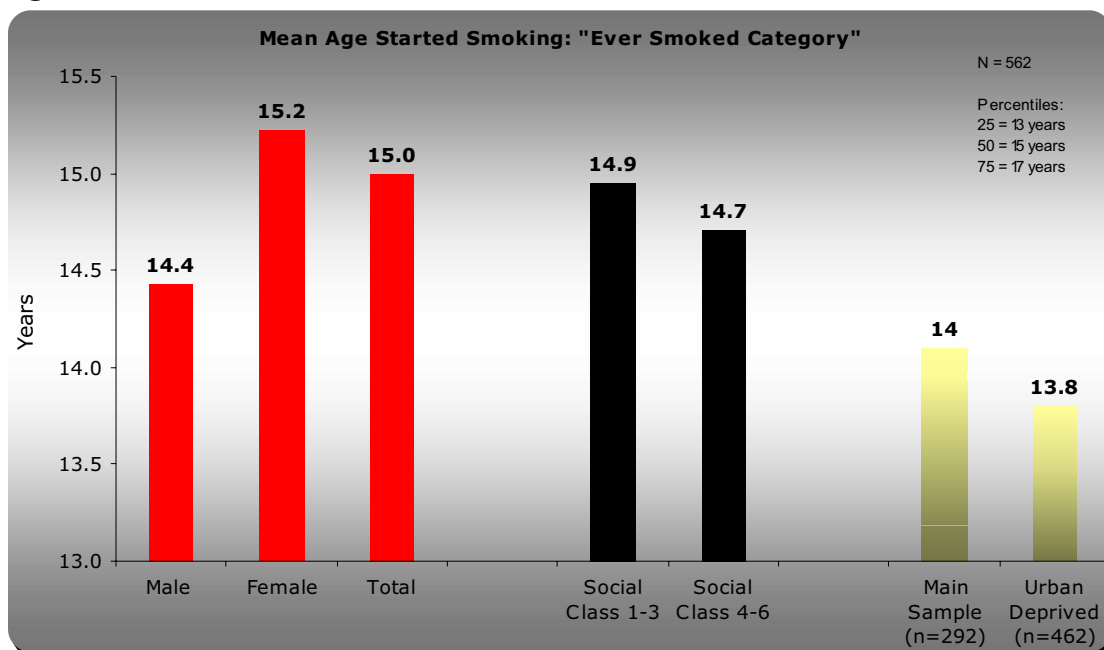
Mean Age of first smoking in men (14.4 years) was about 9 months less than in women (15.2 years) (T test: $p=0.001$)

Fig 4



Mean age of first smoking group was little different for social class or urban deprivation (Fig 5).

Fig 5

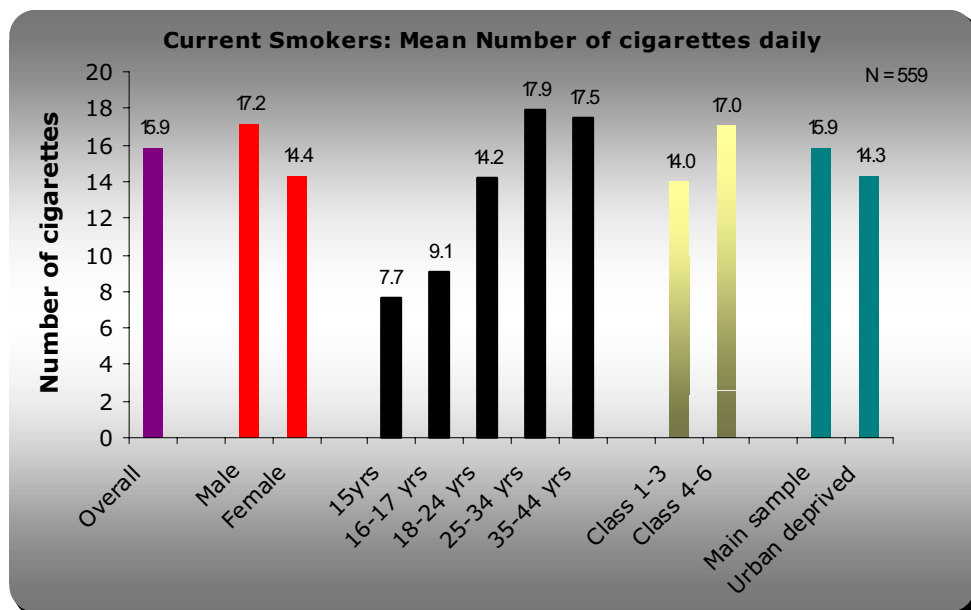


Amount of Smoking (Fig 6)

In Current Smokers, the mean number of cigarettes smoked daily was 16.

Men smoked a mean of 3 more cigarettes than women (T test: $P < 0.001$), Social Class Groups 4-6 smoked more, but Urban Deprived smoked less (T test: $p < 0.05$). For the different age groups, the highest mean cigarettes smoked was 18 daily for 25-34 years, this was significantly more than those at younger age groups (Anova: $p = 0.001$).

Fig 6

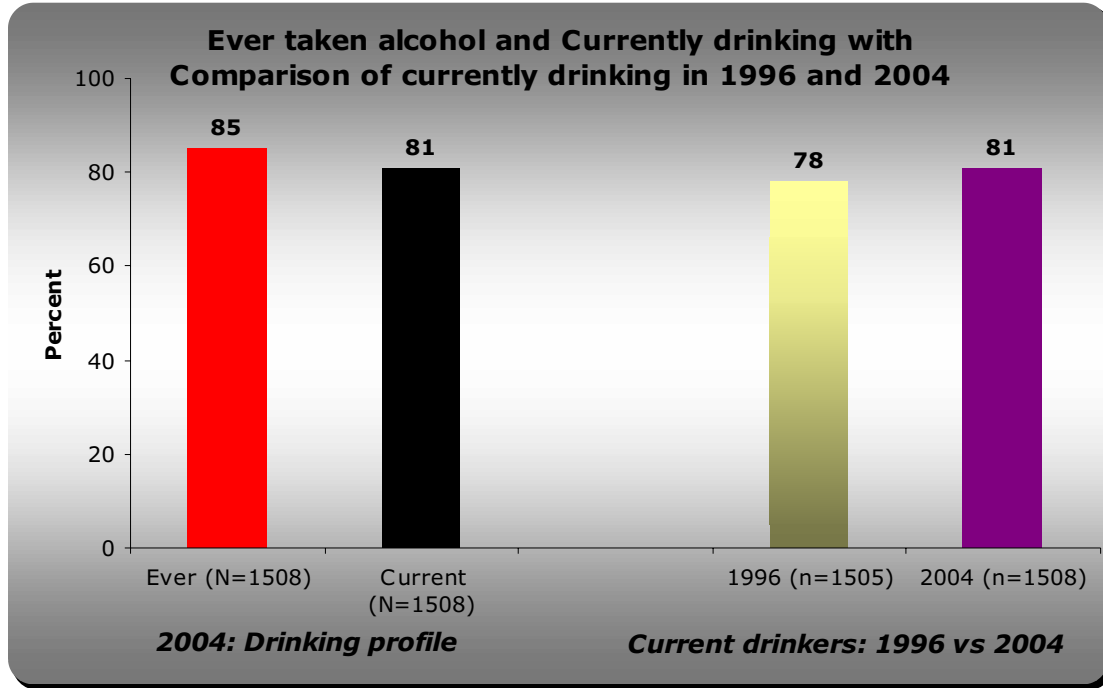


2. ALCOHOL

Alcohol (Fig 7)

85% had ever taken alcohol, and 81% were Current drinkers. Current drinking has increased by 3% since 1996 (χ^2 : $p < 0.05$).

Fig 7

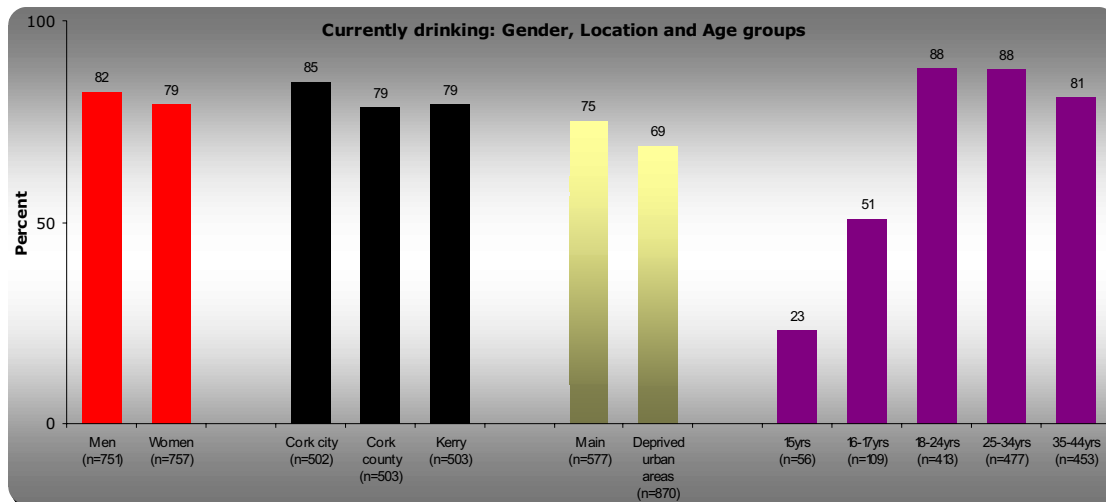


Current drinking was almost equal between the sexes - men 82%, and women 79%. Current drinking was highest for Cork City at almost 85% (χ^2 : $p < 0.05$). There was no difference between Social Class Groups, but Deprived Urban areas showed 6% less current drinking than the main sample (χ^2 : $p < 0.005$) (Fig 8)

Age Groups (Fig 8)

The proportion of current drinkers rapidly increased from 23% at 15 years, to 51% at 16-17 years, and peaked at 88% for 18-34 years (χ^2 : $P < 0.001$).

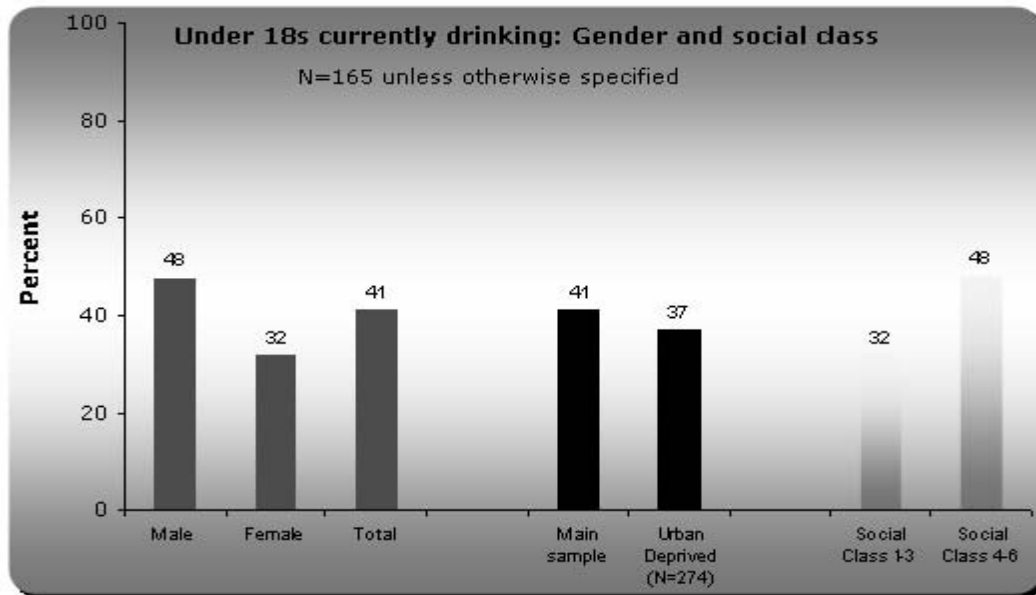
Fig 8



Under 18 years

41% of those under 18 years were current drinkers. More men (48%) drank than women (32%), (χ^2 : $p < 0.05$). Social class group 4-6 showed 16% more current drinkers (χ^2 : $p < 0.05$). (Fig 9)

Fig 9



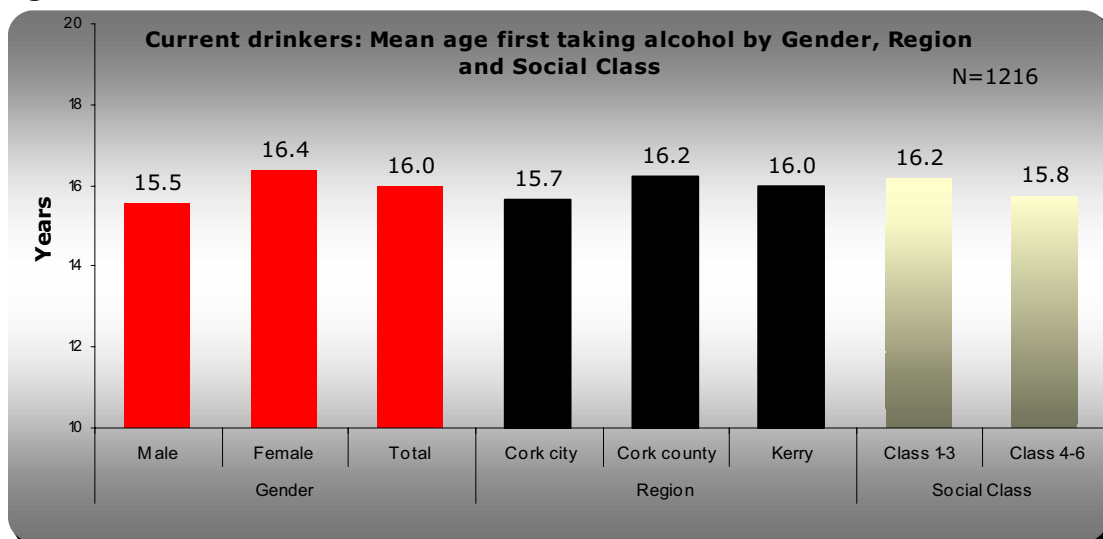
Age First Taking Alcohol (Fig 10)

The mean age of first taking alcohol in current drinkers was 16 years. One quarter had taken alcohol by 14 years. Men first took alcohol about 9 months earlier than women (χ^2 : $P < 0.001$).

People in Cork City first took alcohol about 6 months earlier than those in Cork County or Kerry (Anova: $p = 0.007$).

People in Social Class 4-6 first took alcohol about 5 months earlier than classes 1-3 (T test: $p = 0.007$).

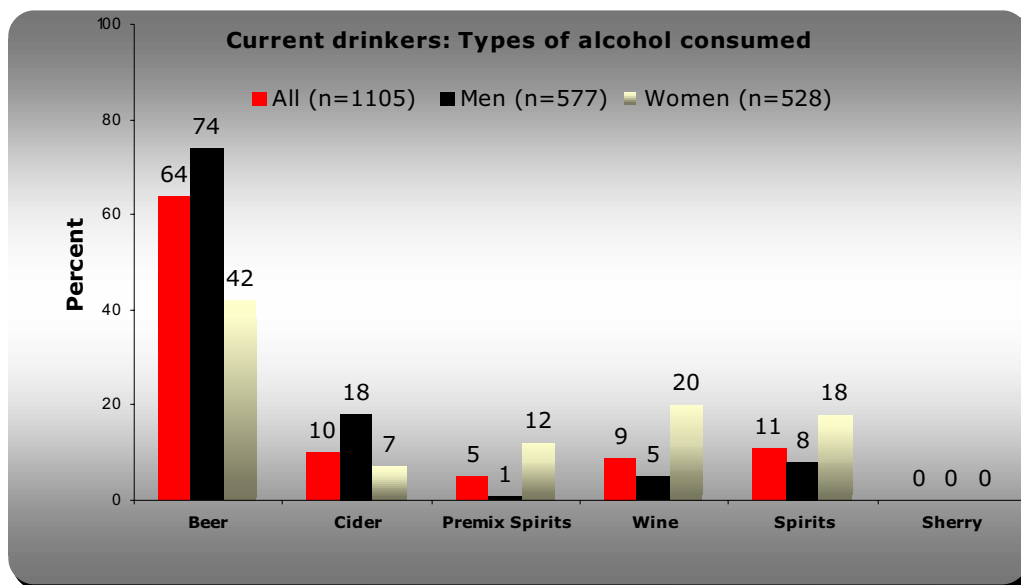
Fig 10



Types of Alcohol Consumed (Fig 11)

Beer is the most frequently consumed drink overall at 64%. Men mostly consumed beer and cider, whereas women drank beer, wine, spirits, premix spirits, and cider.

Fig 11

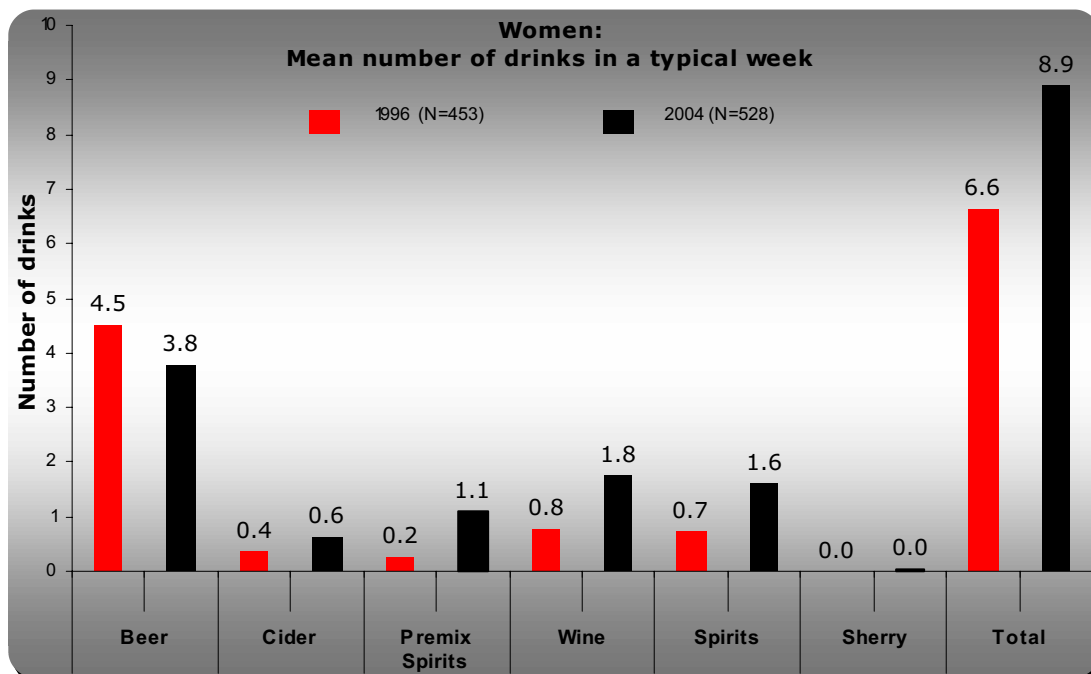


Current drinkers: changes since 1996 (Fig 12)

Women

Women increased their total weekly alcohol consumption by 30% to 9 units (Anova: $P < 0.001$). Beer was the drink with highest consumption. They decreased their beer intake by 16% ($p = 0.04$), and increased their premix spirits by 5 times ($P < 0.001$), and their wine and spirit consumption by twice ($P < 0.001$).

Fig 12



Men (Fig 13)

Men did not change their total intake of alcohol from 18 units per week, mostly beer. They decreased their beer intake by 13% (Anova: $p=0.01$), but increased their cider by 68% ($p=0.01$), their wine by 84% ($p=0.004$), and spirits by almost 3 times ($P<0.001$).

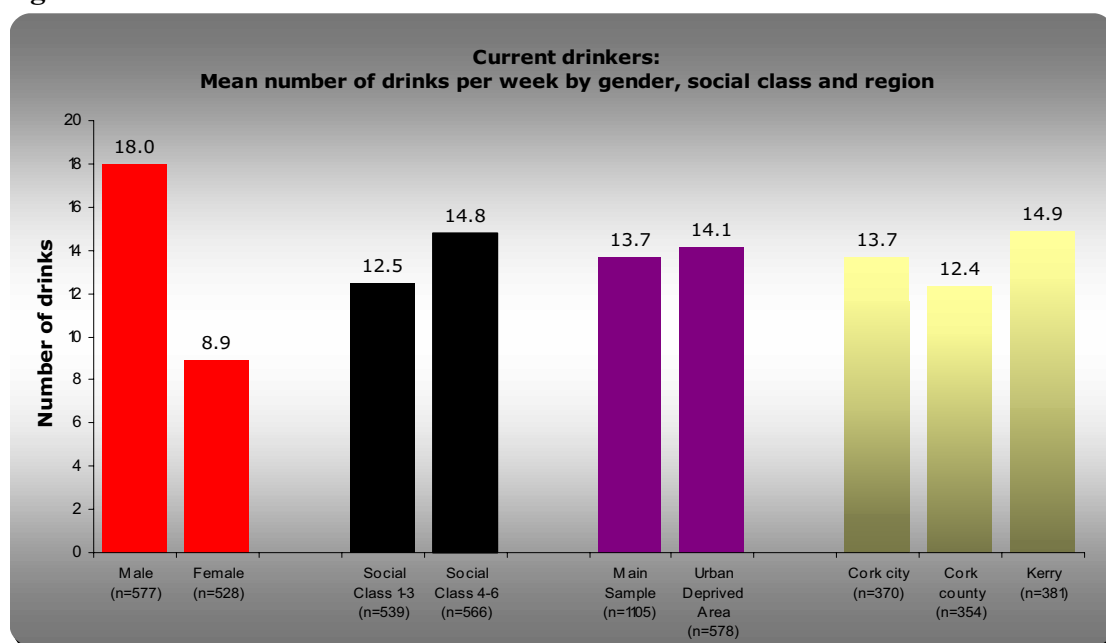
Fig 13

Current drinkers: amount consumed (Fig 14)

In current drinkers the mean amount of alcohol taken was 14 units per week.

Men took a mean of 18 units per week, twice as much as women (9 units) (T test: $P<0.001$). Social Class Group 4-6 took 18% more than Group 1-3 ($p=0.004$). Kerry took 20% more than Cork County (Anova: $p=0.03$), but little more than Cork City. There was minimal difference for Urban deprivation.

Fig 14



Alcohol: Current Drinkers Taking Amounts greater than recommended. (Fig 15)

It is recommended that men take less than 21 units of alcohol per week, and women less than 14 units.

26% of men took more than recommended amounts. These had started to take alcohol 1 year earlier than those who took less (T test: $P < 0.001$). (Fig 16)

17% of women took more than recommended amounts. These had started to take alcohol 1.8 years (almost 2 years) earlier than those who took less (T test: $P < 0.001$).

(Fig 16)

Changes since 1996 (Fig 15)

Women showed a significant rise in the percentage drinking more than recommended since 1996, doubling from 8% to 17% (χ^2 : $P < 0.001$). Men did not show any change, reducing slightly from 29% to 27%.

Fig 15

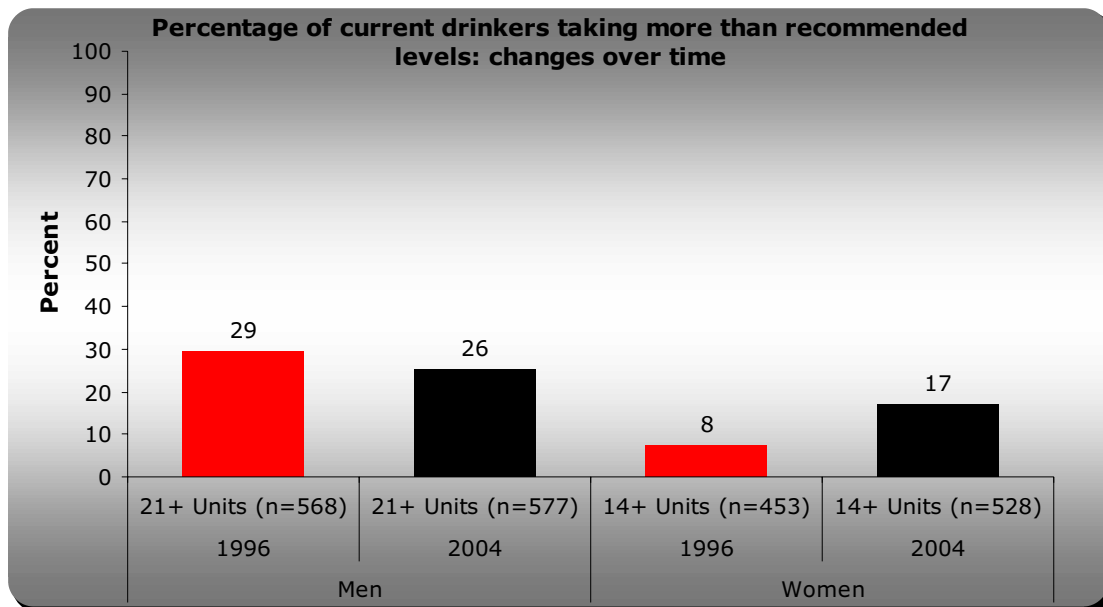
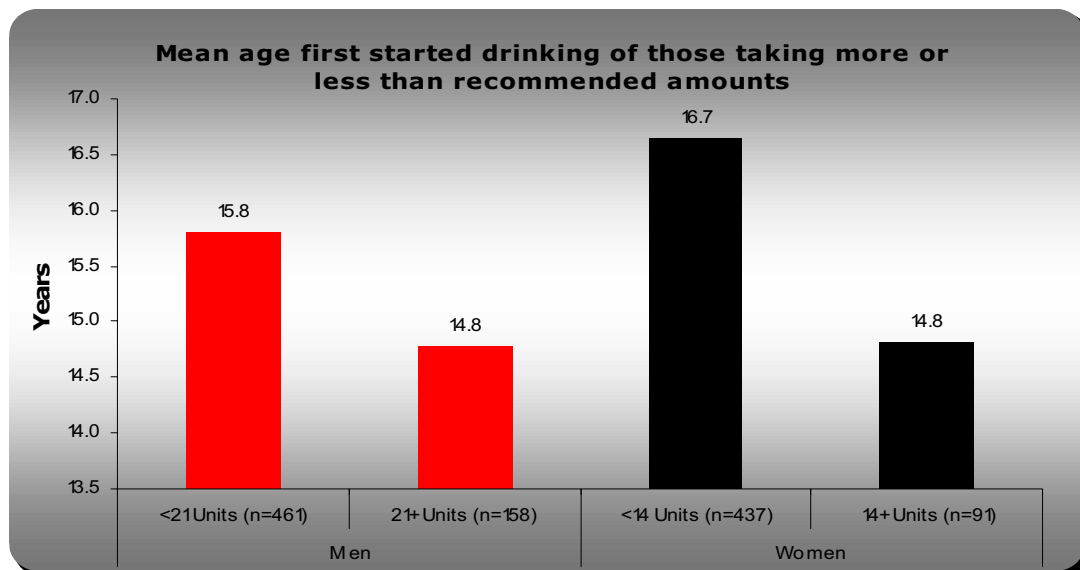


Fig 16



Detailed analysis of excessive drinking: Category changes since 1996

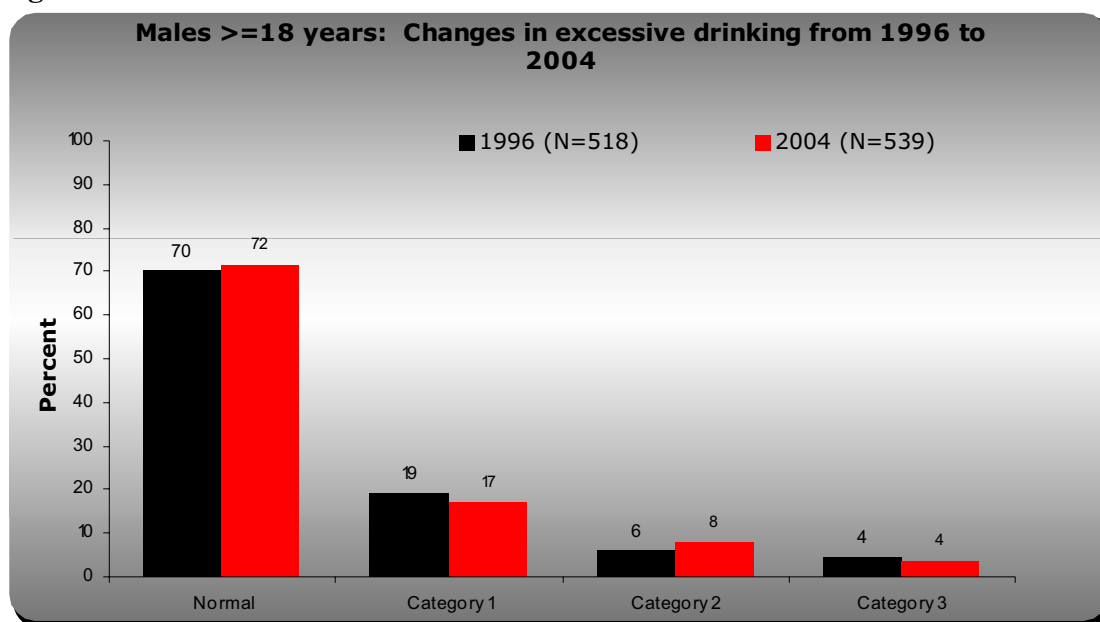
Edwards and Unnithal¹¹ attempt to correlate categories of problem use, with quantities of alcohol consumed per week, as determined by the OPCS survey 1996. The following table shows these categories for men and women who are currently drinking:

<u>Problem Level</u>	<u>Level of Consumption:</u> <u>Alcohol Units per Week</u>	
	M	F
Normal	<i>Normal</i> <21	<14
Category 1: Excessive drinking without problems or dependence	<i>Fairly High</i> 22-35	15-25
Category 2: Excessive drinking with problems but no dependence	<i>High</i> 36-50	26-35
Category 3: Excessive drinking with problems and dependence	<i>Very High</i> 51 or more	36 or more

Men 18 year or Over (Fig 17)

It can be seen that for men, there was no significant changes in alcohol categories since 1996. 17% showed excess drinking, 8% problem drinking, and 4% problem and dependent drinking.

Fig 17



Women 18 year or Over (Fig 18)

In women, however, there were significant changes in category of drinking since 1996 (χ^2 : $p=0.001$).

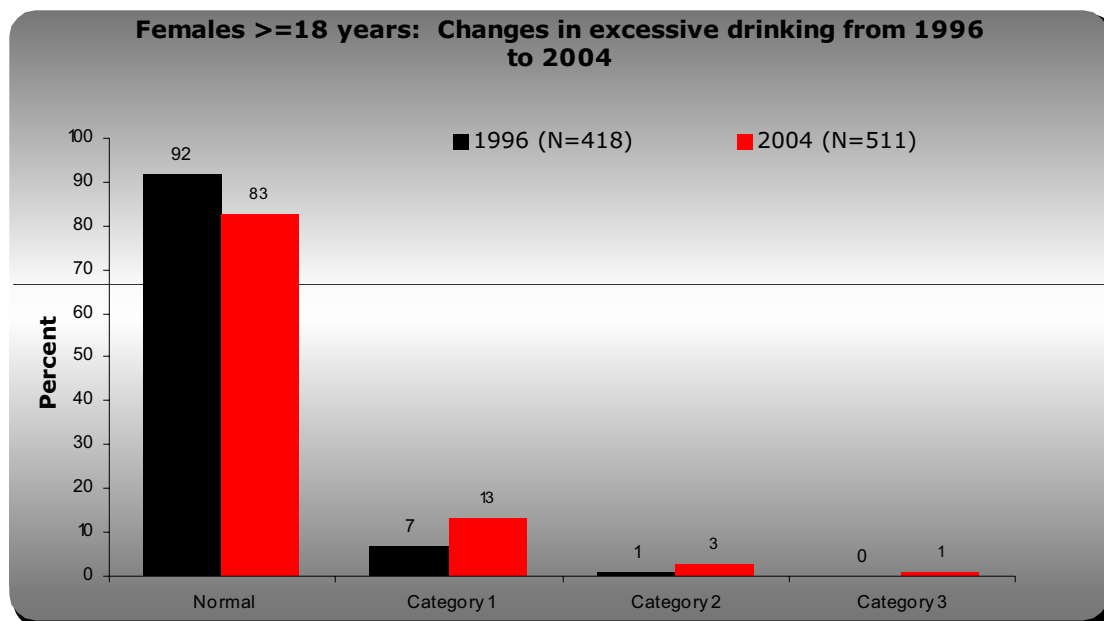
Those in the normal category – decreased.

Those in the excessive drinking category 1 – doubled to 13%.

Those in the problem drinking category 2, trebled to 3%

Those in the problem and dependent drinking category 3, increased by 5 times to 1%

Fig 18



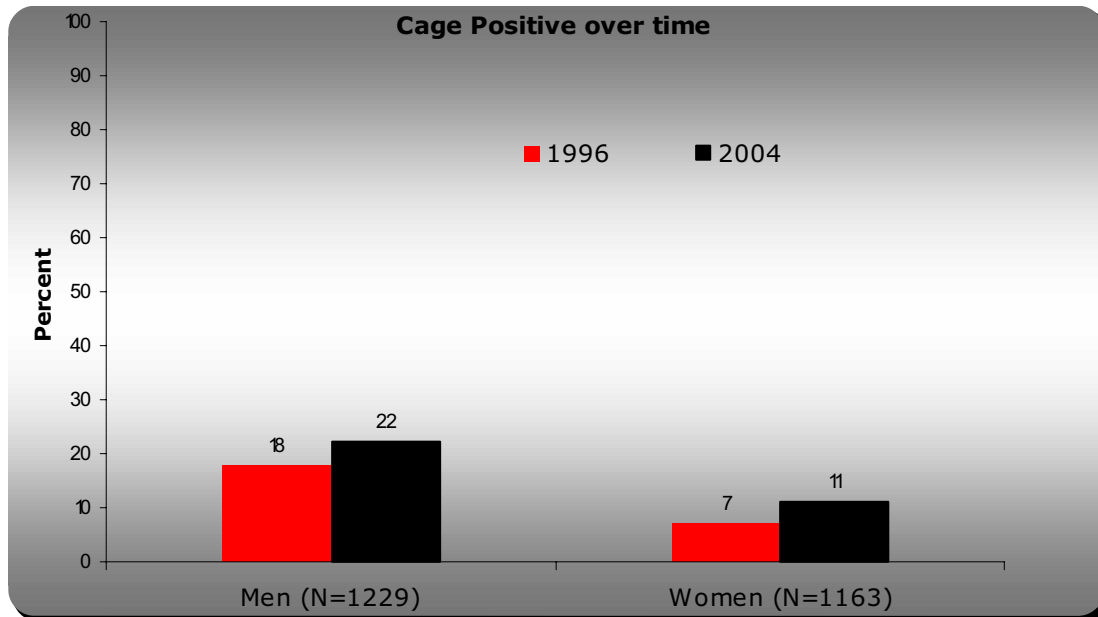
Cage Scoring (Fig 19)

Cage Positive scoring was 22% in men, twice that of women (11%), (χ^2 : $P < 0.001$).

Changes in Cage Status since 1996 (Fig 19)

Women showed a 50% rise in Cage Positivity since 1996 to 11% (χ^2 : $p = 0.021$). Men did not show any significant rise at 22%.

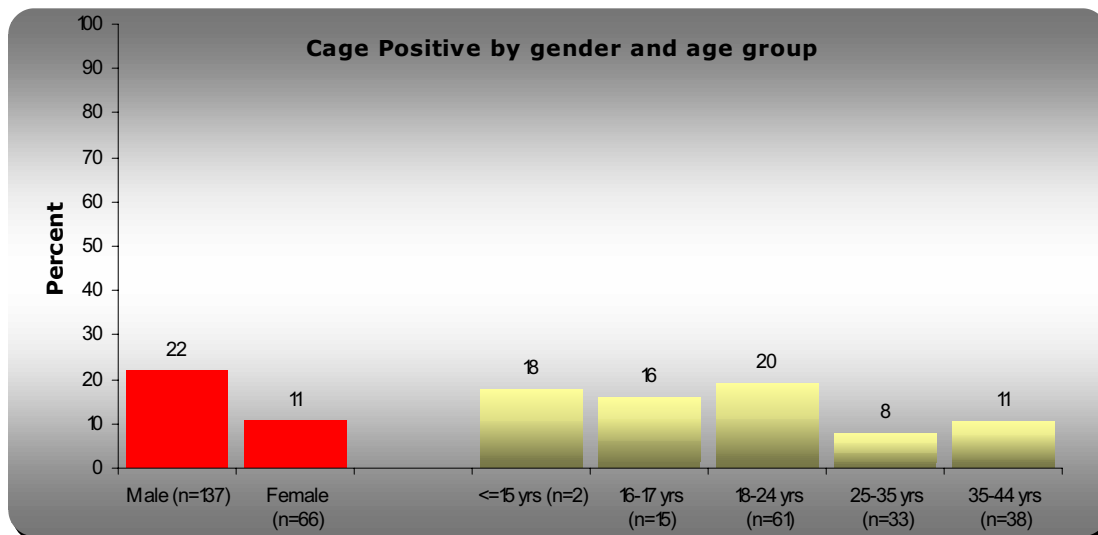
Fig 19



Changes by Age Group (Fig 20a)

Cage Positive was highest in ages 18-24 years, at 20%, but halved in older age groups (χ^2 : $P < 0.001$).

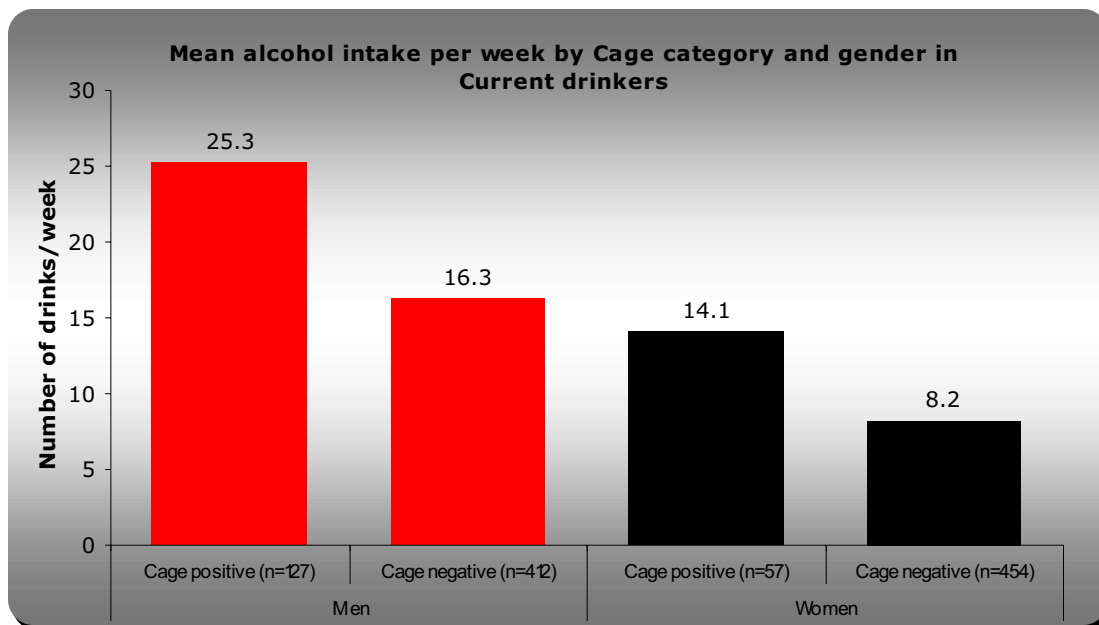
Fig 20a



Mean Alcohol Intake in Cage Positive, 18 years and over. (Fig 20b)

Men, who were Cage Positive took a mean of 25 units per week, 9 units more than those who were Cage Negative (T test: $P < 0.001$). Cage Positive Women took a mean of 14 units per week, 6 units more than those who were Cage Negative (T test: $P < 0.001$).

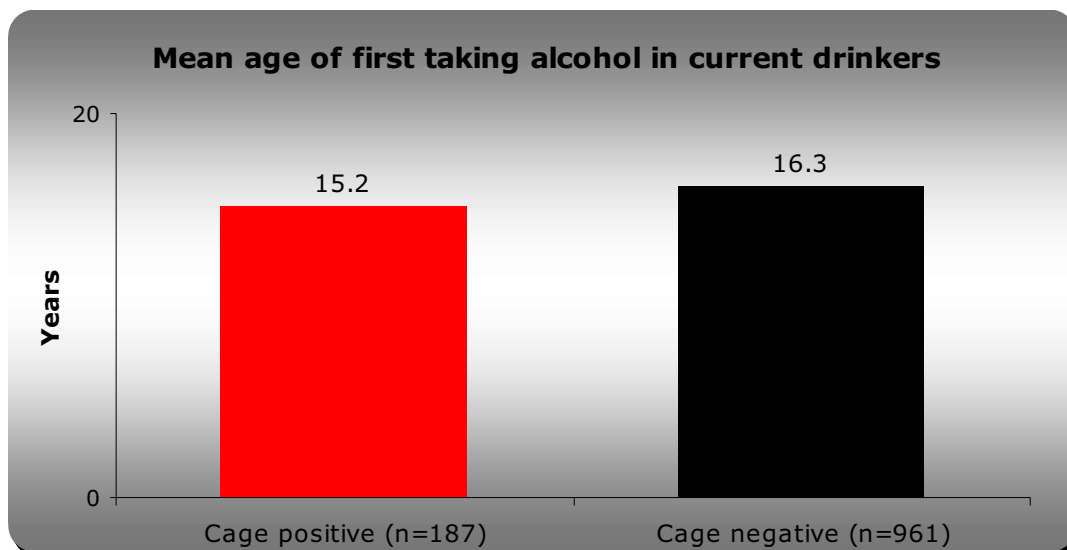
Fig 20b



Age difference in starting drinking for Cage Positive, 18 years and over (Fig 21)

In Cage Positive cases, the mean age of first taking alcohol was 1 year younger than Cage Negatives (T test: $P < 0.001$).

Fig 21



Under 18 years (Fig 22)

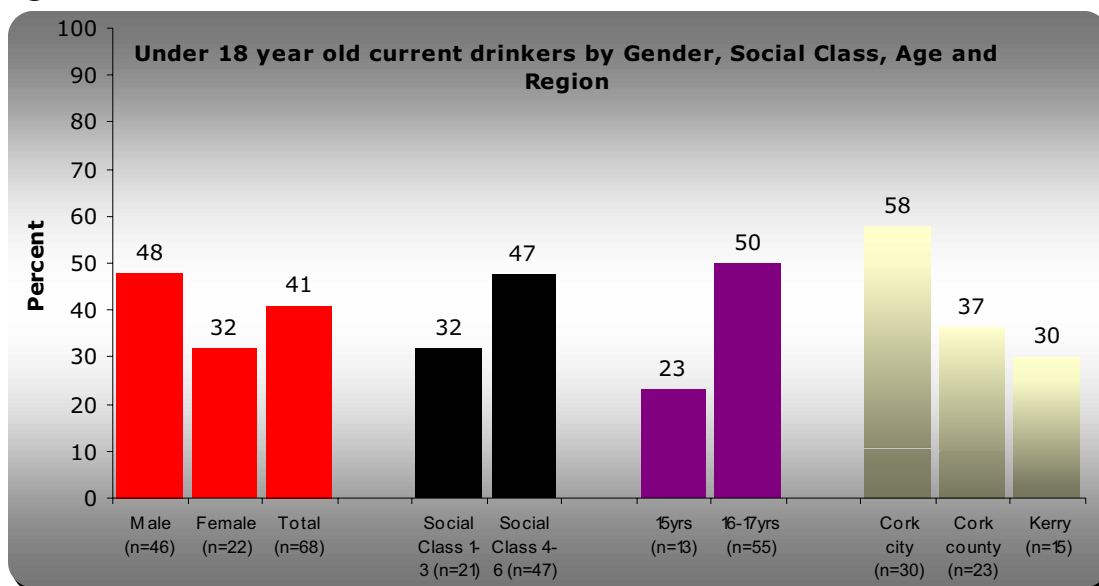
41% of those under the legal age for sale of alcohol, state that they are currently drinking. 48% were men, 16% more than women (32%) (χ^2 : $p=0.04$). There was little change from 1996.

In under 18s, Social Class Group 4-6 (47%) showed 15% more current drinking than Social Class Group 1-3 (32%), (χ^2 : $p=0.045$), but there was no difference for Urban Deprivation.

Age 16-17yrs showed a rapid increase to 50% current drinking, compared with 15 years (23%) (χ^2 : $p=0.01$).

Cork City (58%) showed at least 20% more current drinking in under 18 year olds, than in Cork County or Kerry.

Fig 22

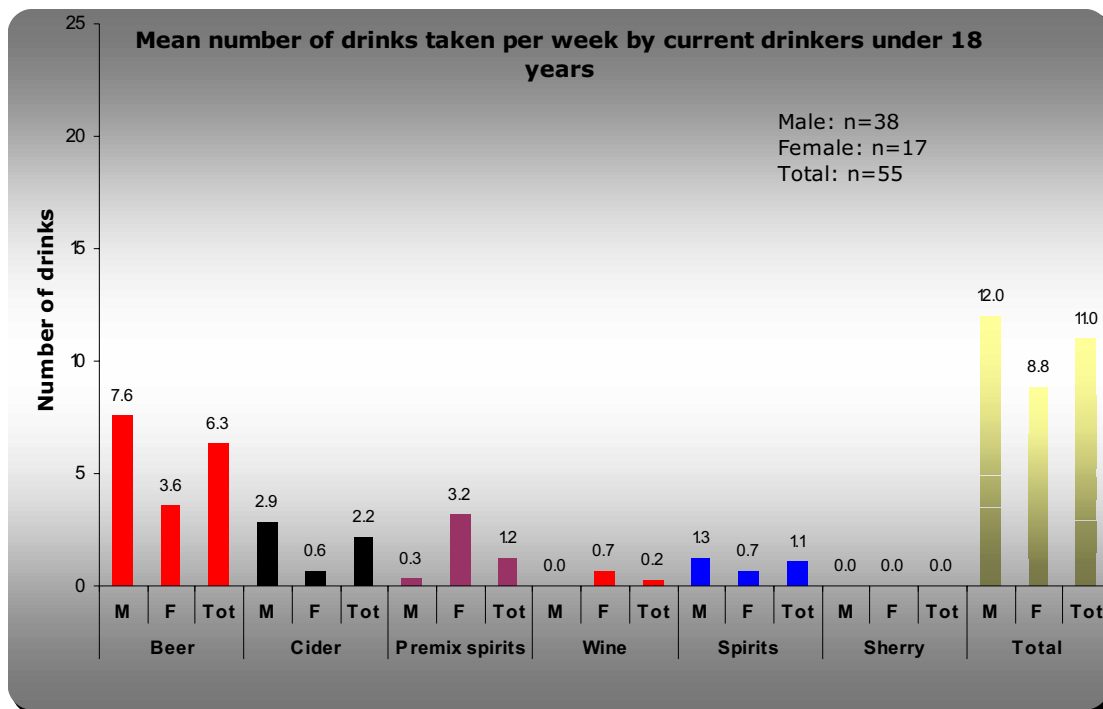


Types of Alcohol Taken in Under 18s (Fig 23)

Current Drinkers in under 18 years drank a mean of 11 units per week. Men drank a total of 3 units more than women, although this was not significantly different.

Under-18 women drank significantly more premix spirits and wine than men (Anova: $p=0.01$). They also drank 3 times more premix spirits, than older women (Anova: $p=0.01$).

Fig 23



Binge Drinking (Fig 24)

Binge drinking was defined as 6 or more drinks taken per occasion³².

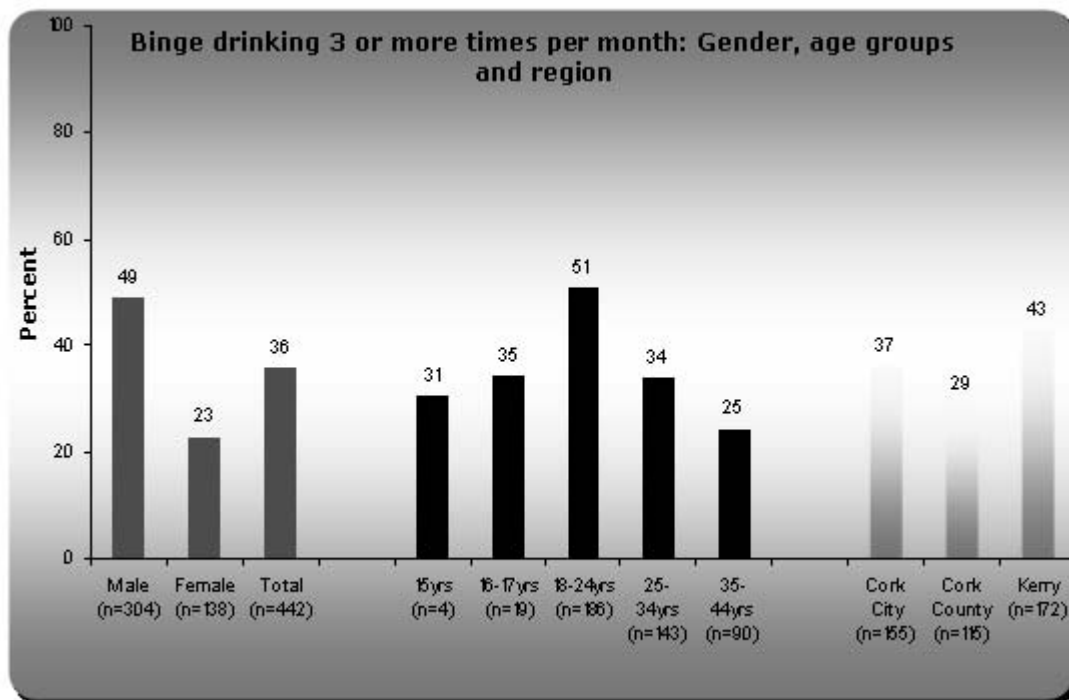
In Current Drinkers, more than one third binge 3 or more times per month; almost half of men (49%) and a quarter of women (23%) (χ^2 : $P<0.001$).

Differences were not significant for Social Class or Urban Deprivation.

Binge drinking 3 or more times per month, increased from about one third for under 18 years, to peak at 51% for ages 18-24 years. It decreased to 25% at 35-44 years (χ^2 : $P<0.001$).

Bingeing 3/+ per month was highest in Co Kerry at 43% (χ^2 : $P<0.001$) in contrast to Cork City (37%), and Cork Co (29%).

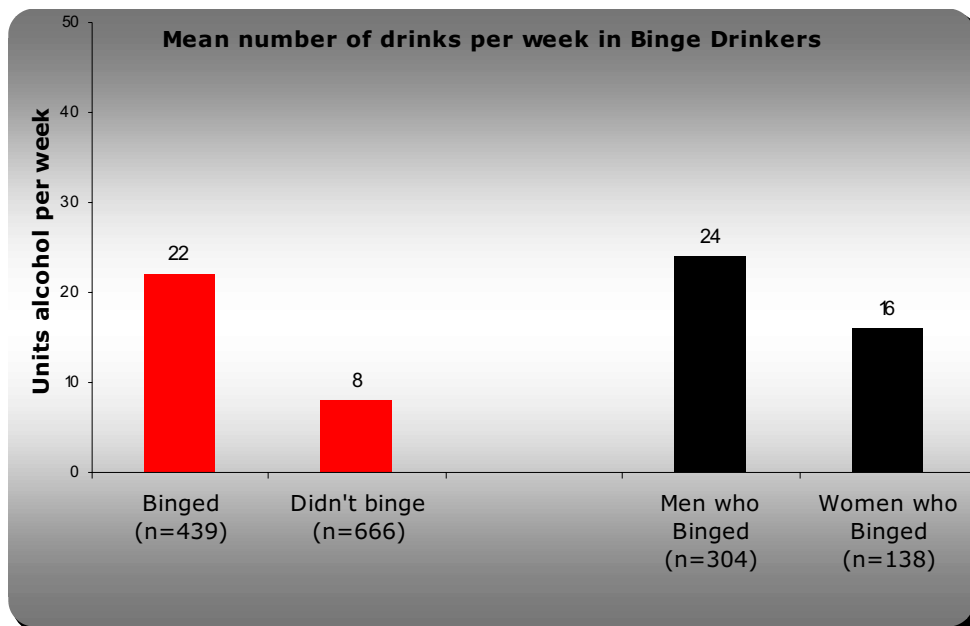
Fig 24



Amount consumed by Binge drinkers (Fig 25)

Those who binged 3/+ per month, drank a mean of 22 units per week, 14 units more than those who did not binge (χ^2 : $P<0.001$). Men took 24 units, and women 16 units.

Fig 25



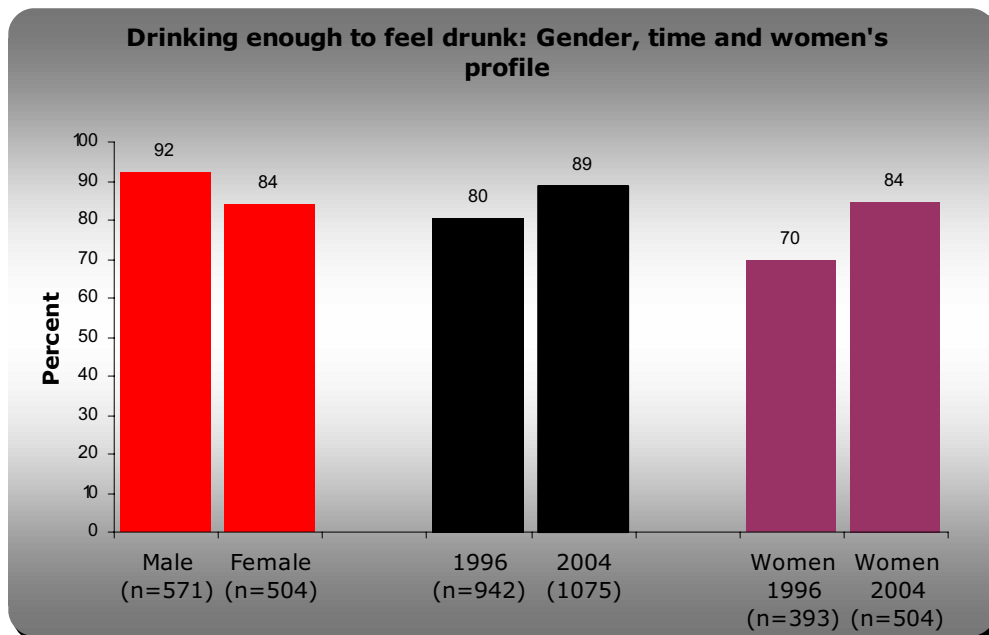
Current Drinkers: Drunkenness (Fig 26)

92% of Men and 84% of women admitted to experiencing drunkenness (χ^2 : $P<0.001$).

Overall there was a 9% rise in drunkenness since 1996, from 80% to 89% (χ^2 : $P<0.001$).

Men did not show a significant increase, but drunkenness in women increased by 14%, from 70% to 84% since 1996 (χ^2 : $P<0.001$).

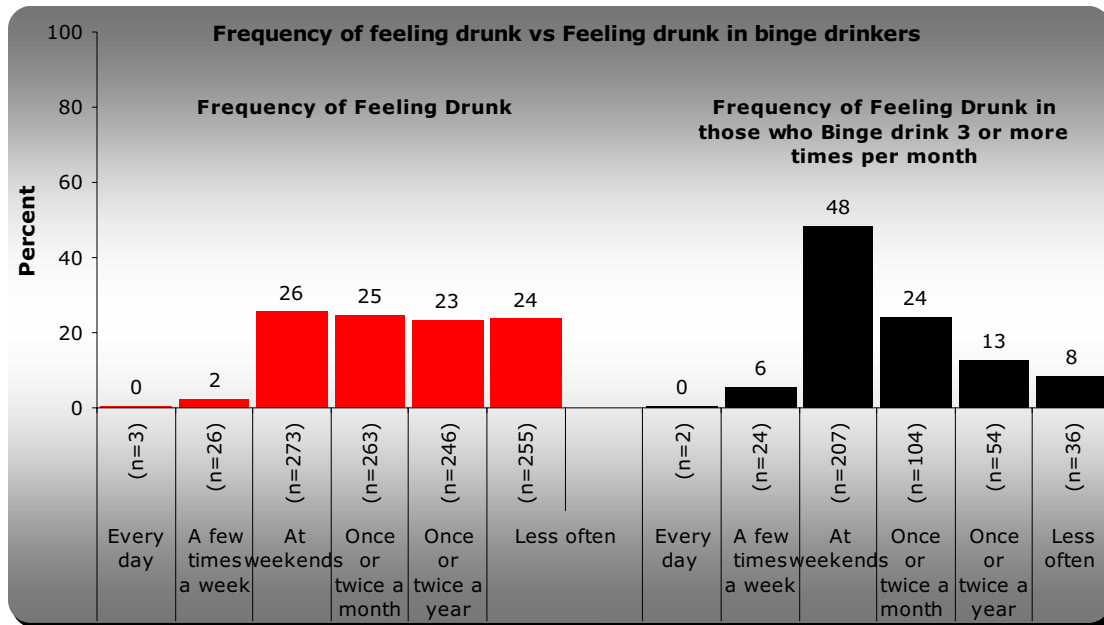
Fig 26



About half were drunk at weekends or once or twice a month (χ^2 : $P < 0.001$). (Fig 27)

Bingeing 3 or more times per month peaked with drunkenness at weekends at almost 50% (χ^2 : $P < 0.001$).

Fig 27

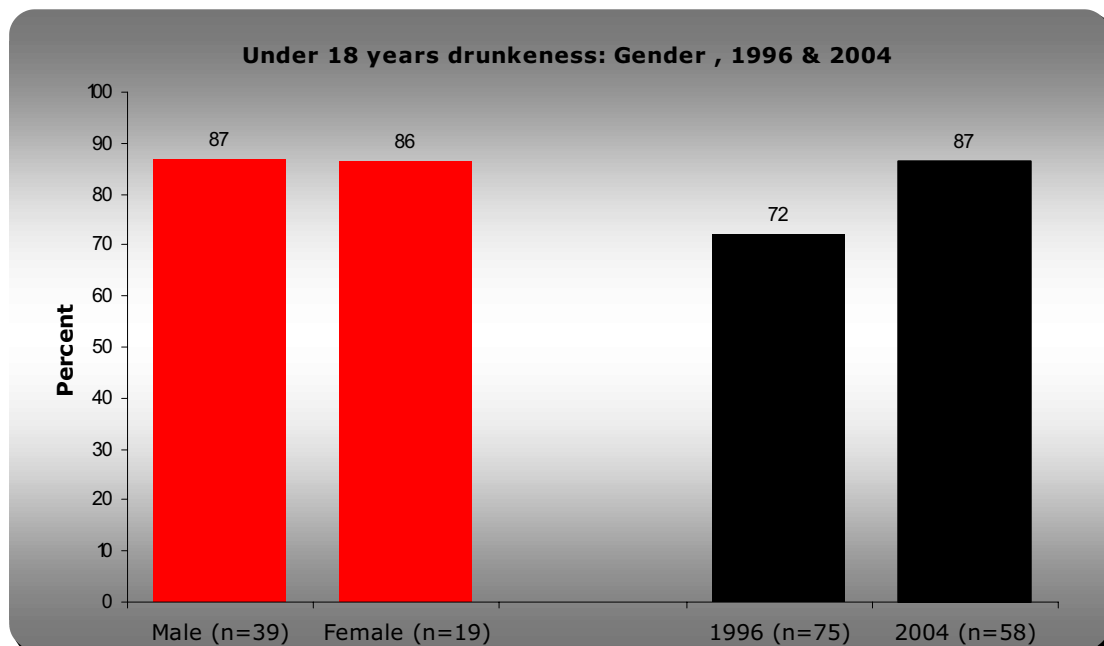


Under 18s and Drunkenness (Fig 28)

87% of Current Drinkers under 18s had been drunk, with no difference between sexes.

Drunkenness in under 18 year-old current drinkers increased by 15% since 1996, from 72% to 87%. (χ^2 : $P < 0.001$).

Fig 28



3. DRUGS OVERALL USE

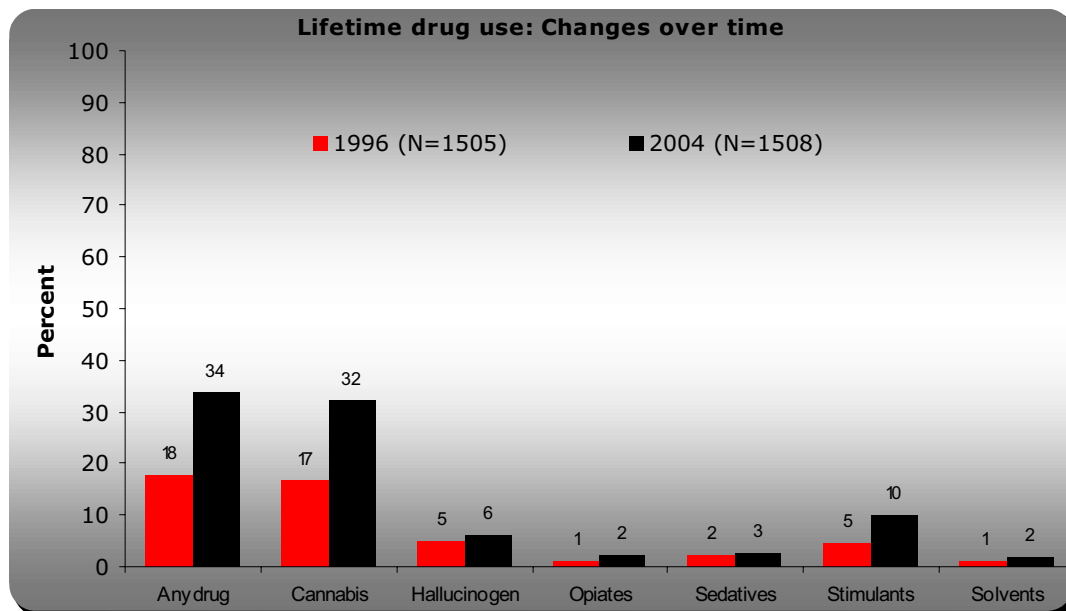
Lifetime Use (Fig 29)

34% admitted to ever taking an illegal drug in their life. The main drug groups used were Cannabis 32%, Stimulants 10%, and Hallucinogens 6%. Sedatives (3%), Solvents (2%), and Opiates (2%) showed lesser use.

Changes since 1996

Lifetime use of Any Drug, Cannabis, and Stimulants doubled (χ^2 : $P < 0.001$). Opiates doubled from a small base of 1% (χ^2 : $p = 0.009$). Other drugs showed little change.

Fig 29



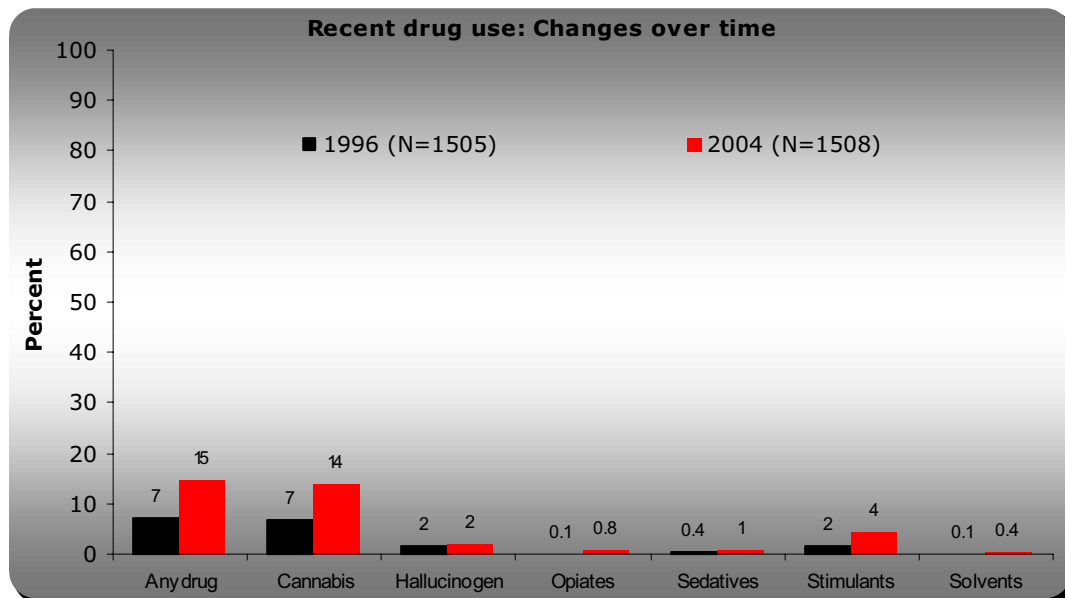
Recent Use (Fig 30)

15% had taken Any Drug in the last year, and 14% had taken Cannabis. 4% had taken Stimulants, and 2% Hallucinogens. Sedatives (1%), Opiates (1%), and Solvents (0.4%) showed lesser prevalence.

Changes since 1996

Recent use of Any Drug, Cannabis, and Stimulants doubled (χ^2 : $P < 0.001$). Opiates increased by eight times from a very small base of 0.1% (χ^2 : $p = 0.002$). Other drugs showed no significant change, although sedatives did increase from 0.4% to 0.9%.

Fig 30



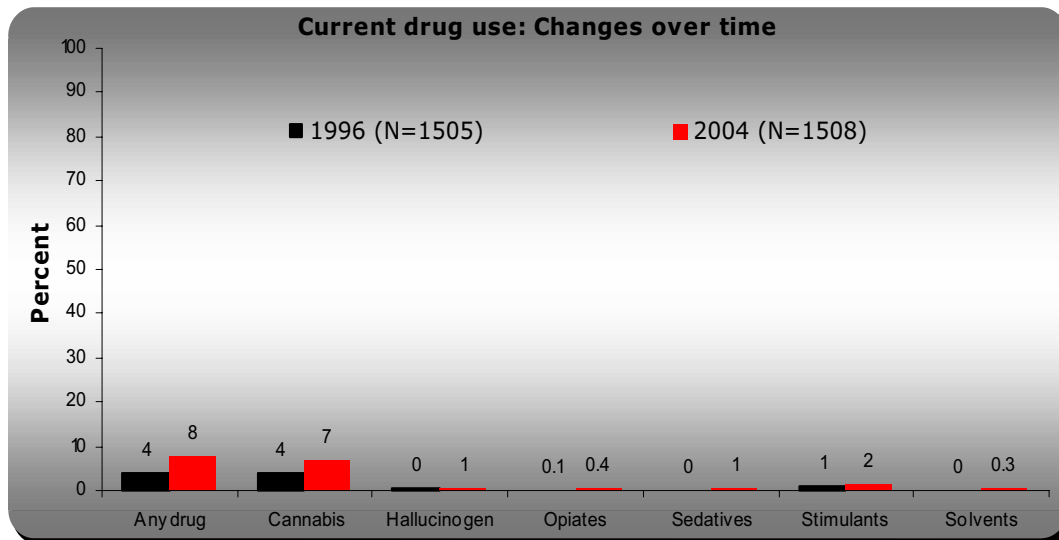
Current Use (Fig 31)

8% took Any Drug in the previous month, and 7% took Cannabis. 2% took Stimulants, but less than 1% took other drugs.

Changes Since 1996

Current use of Any Drug, and Cannabis doubled (χ^2 : $P < 0.001$). Other drugs showed no significant change, although Opiates and Stimulants did increase from very low bases.

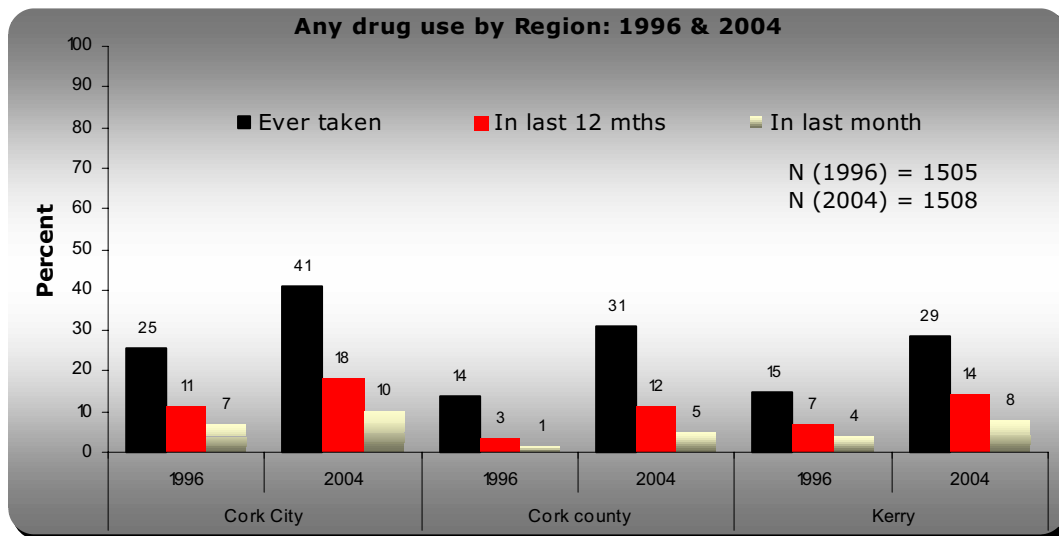
Fig 31



Changes in Regions since 1996 (Fig 32)

All regions showed significant increases for Any Drug use, since 1996; particularly Cork Co and Kerry, which doubled or trebled drug use in all categories (χ^2 : $P < 0.001$).

Fig 32



Main and Booster Samples

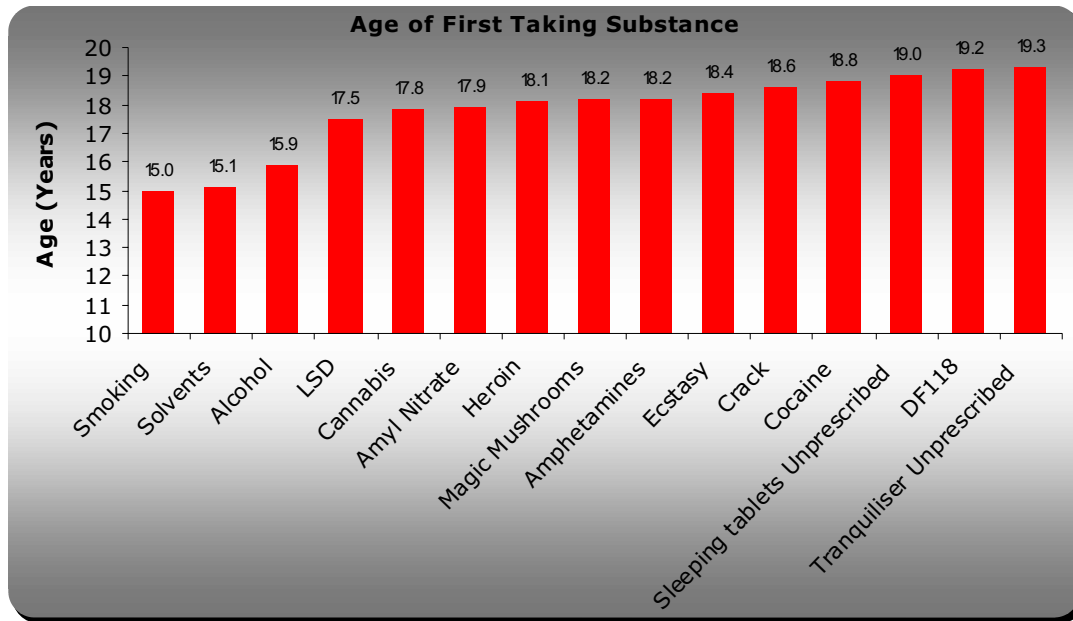
In 2004, despite enlarging the booster sample, there were no significant differences between Young Urban Deprived and the General Sample under 25 years, for Lifetime, Recent, and Current use for Any Drug.

Age of First Taking Substance (Fig 33)

Substances, which were taken by at least 1% of those surveyed, were analysed for the mean age at which they were first taken. This gives an indication of the general sequence in which drugs are taken.

Smoking, solvents, and alcohol were all taken in earlier years before illegal drugs.

Fig 33

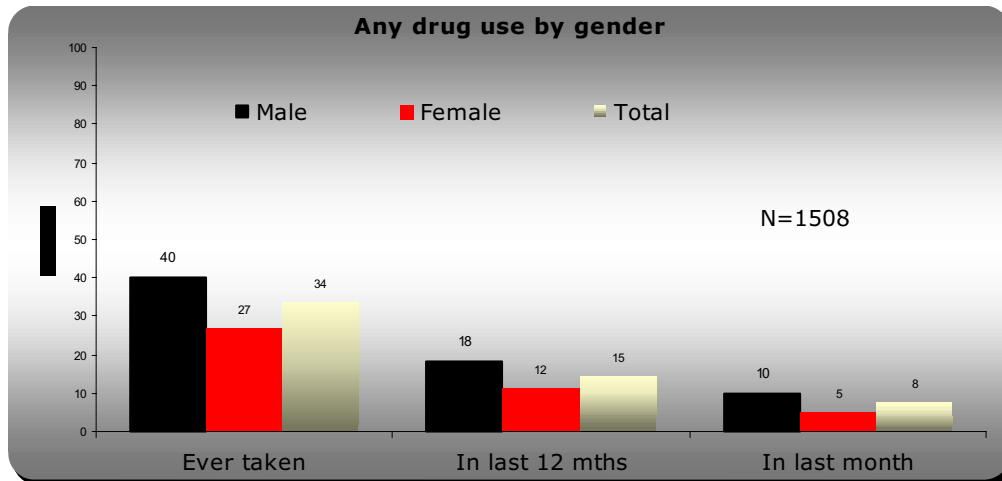


Any Drug Use (Fig 34)

Lifetime use was 34%, Recent use 15%, and Current use 8%, roughly halving for each phase of use.

Men (10%) were twice women (5%) for Current use, but only 50% greater for Lifetime (40%) and Recent (18%) use (χ^2 : $P < 0.001$).

Fig 34



Regions (Fig 35)

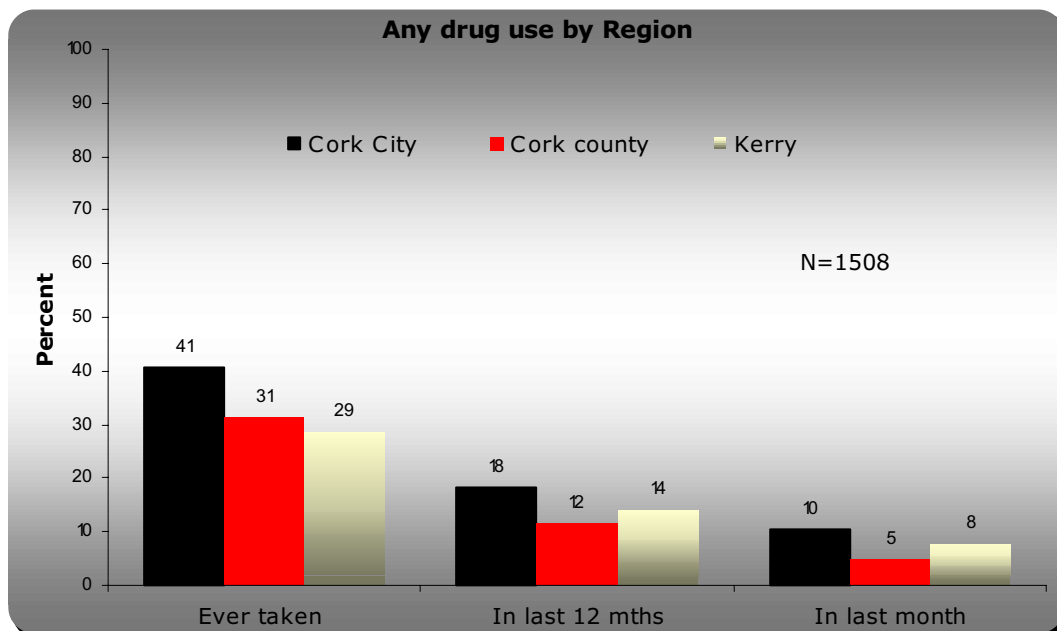
Cork City was highest for all modes of drug use (χ^2 : $p < 0.01$).

Lifetime use was 41% for Cork City, compared to about 30% elsewhere.

Recent use was 18% for Cork City, compared to 12% in Cork Co, and 14% in Kerry.

Current use was 10% for Cork City, compared to 5% in Cork Co, and 8% in Kerry.

Fig 35



Cork City Wards/Electoral Areas (Fig 36)

The detailed composition of City Wards has changed slightly since 1996. It was decided to make the 2004 wards identical to those in 1996 for accurate comparison.

Lifetime Drug Use (overall 34%)

Cork South East showed the highest prevalence for Any Drugs Lifetime at 50%, Cork N West, Cork S Central were over 40%, and Cork N Central was 30%, and Cork S West was lowest at 23%. Cork Suburbs was 46%.

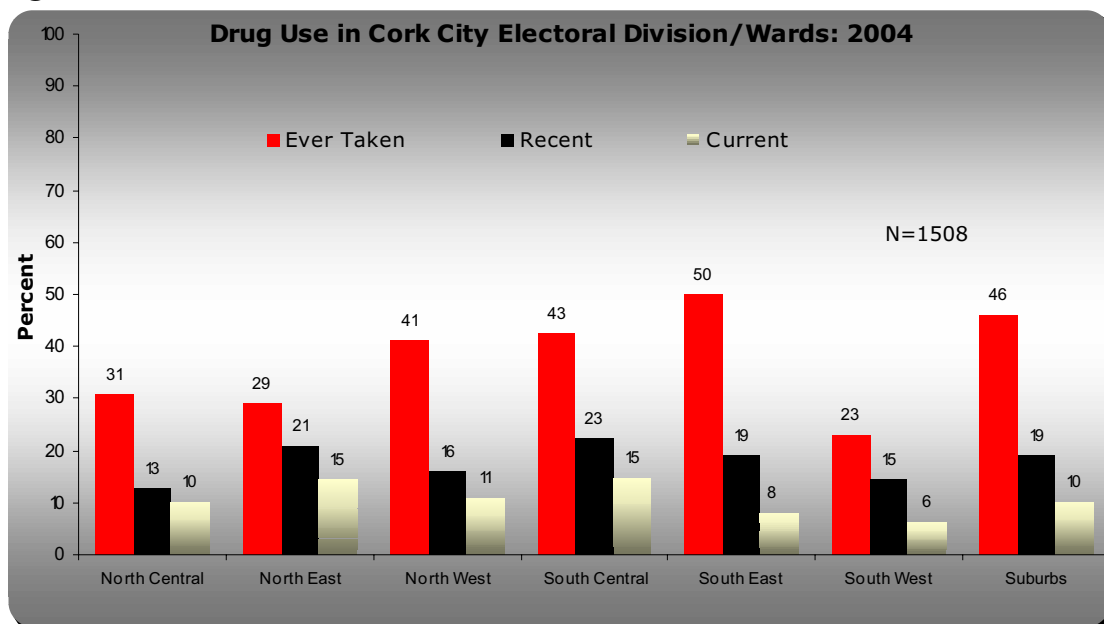
Recent Drug Use (overall 15%)

Recent drug use was about half that of lifetime use. Cork S Central, Cork Eastern areas were all about 20%, and Cork Western areas were about 15%, and Cork N Central was least at 13%. Cork Suburbs were 19%.

Current Drug Use (overall 8%)

Cork S Central and Cork N East were highest at about 15%, and Cork S East and West were least at about 7%. Cork Suburbs were 10%

Fig 36



Changes since 1996. (Fig 37-38)

In contrast to other areas, Cork N Central and Cork S West areas showed a decrease in prevalence for Lifetime, Recent, and Current drugs. Other City areas showed only a 7% increase for Recent Drug use. Suburbs showed a marked increase.

Fig 37

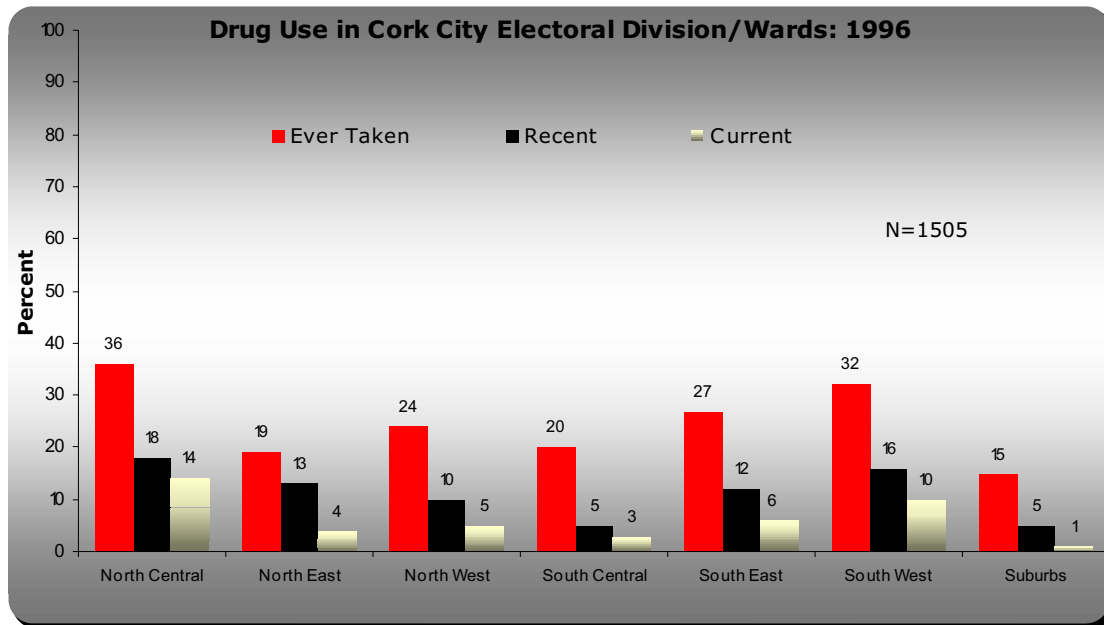
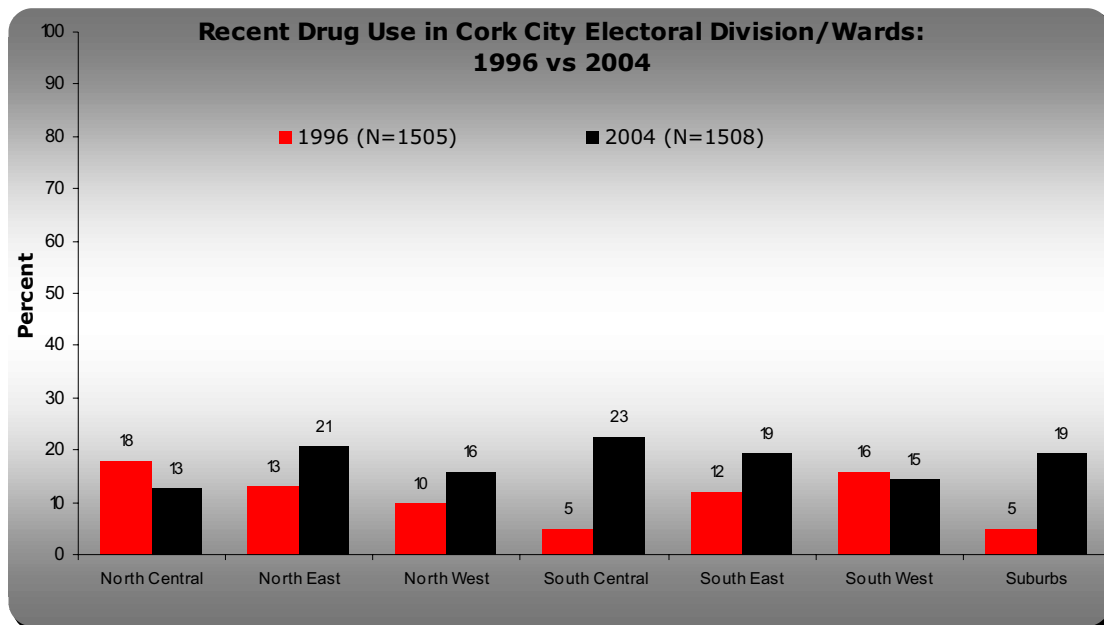


Fig 38

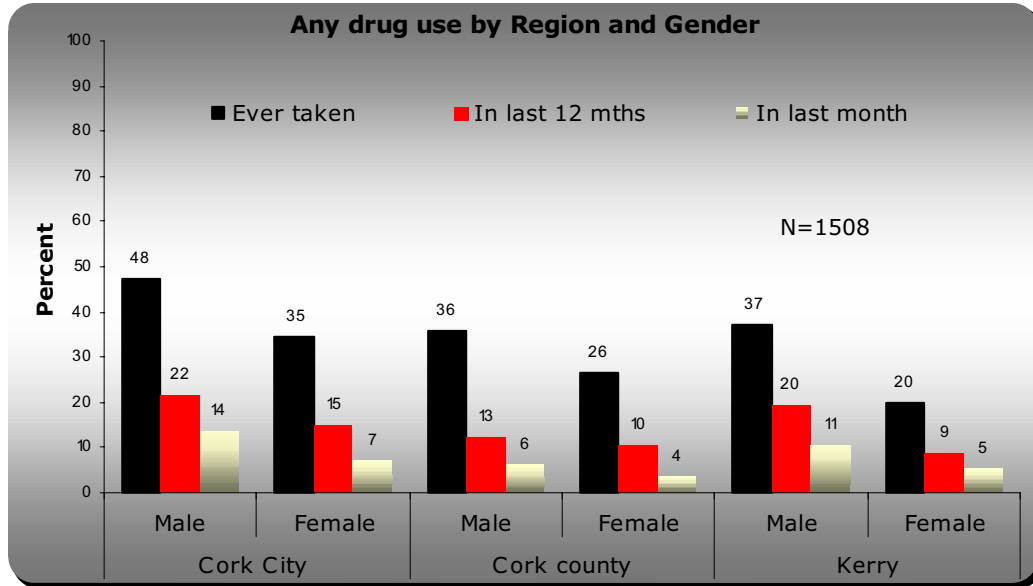


Gender and Region (Fig 39)

Men (48%) and women (35%) showed highest lifetime use in Cork City.

In men, Recent (22%) and Current (14%) use in Cork City, were almost twice that for Cork Co, but only slightly less for Kerry.

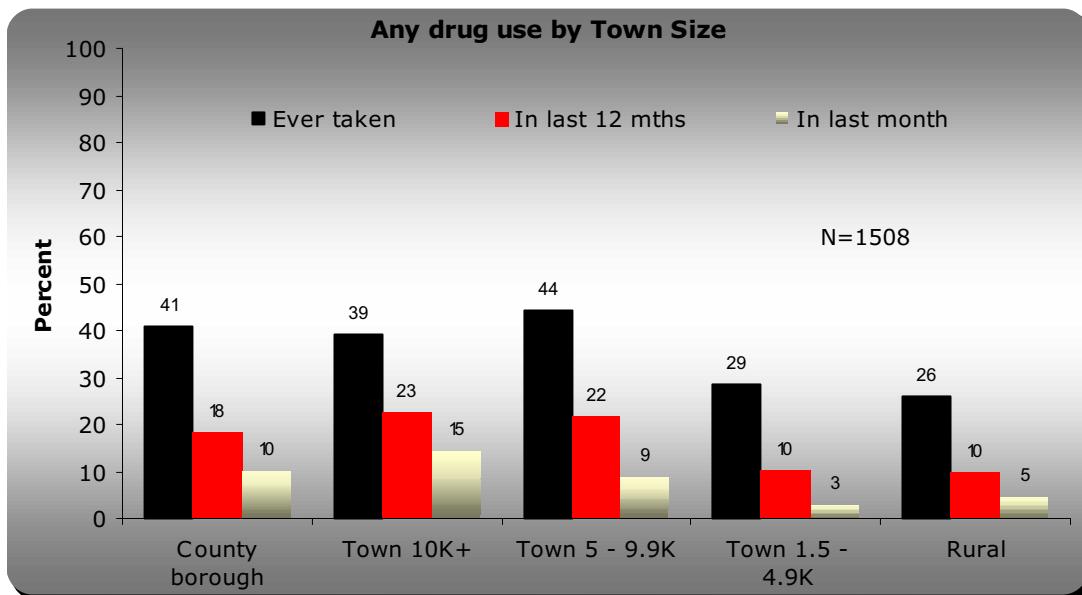
Fig 39



Town Size (Fig 40)

Any drug use was highest for communities with greater than 5,000 population (χ^2 : $P < 0.001$).

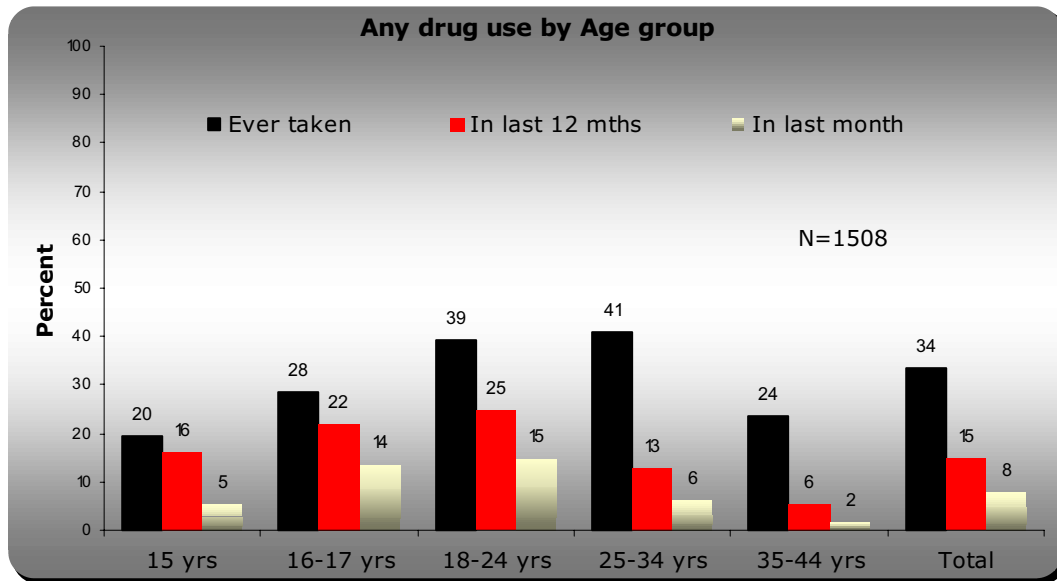
Fig 40



Age Group (Fig 41)

Lifetime drug use peaked at about 40% for 18-34 years. Recent drug use was highest at 25% for 18-24 years. Current use (15%) was also highest at 18-24 years (χ^2 : $P < 0.001$).

Fig 41



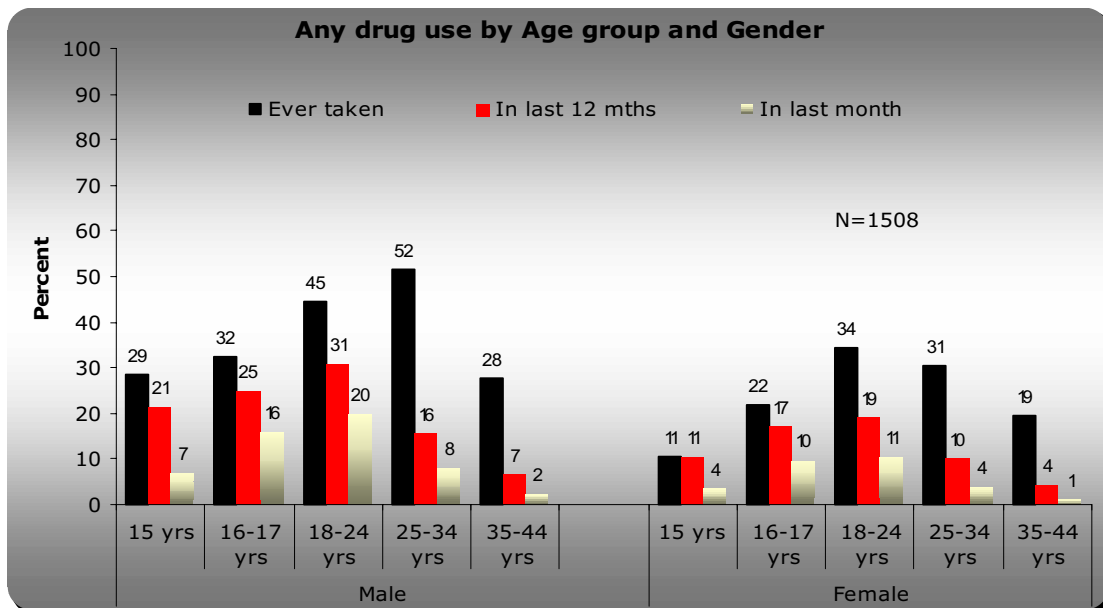
Gender and Age Group (Fig 42)

About a quarter of men at 15 years had taken Lifetime or Recent Drugs, twice as many as women (11%).

For Men, Lifetime drug use peaked at 52% at 25-34 years. Recent (31%) and Current (20%) drug use were highest at 18-24 years (χ^2 : $P < 0.001$).

For Women, Lifetime drug use peaked earlier than men at 34% for 18-24 years. Recent (19%), and Current Use (10%) were highest earlier than men from 16-24 years (χ^2 : $P < 0.001$).

Fig 42



Association with Smoking and Drinking (Fig 43-5)

Current Smokers, Current Drinkers, and those who Drink & Smoke; all showed almost twice the amount using drugs, over those who did not smoke or drink (χ^2 : $P < 0.001$). This was especially shown for Recent and Current Drug use.

Fig 43

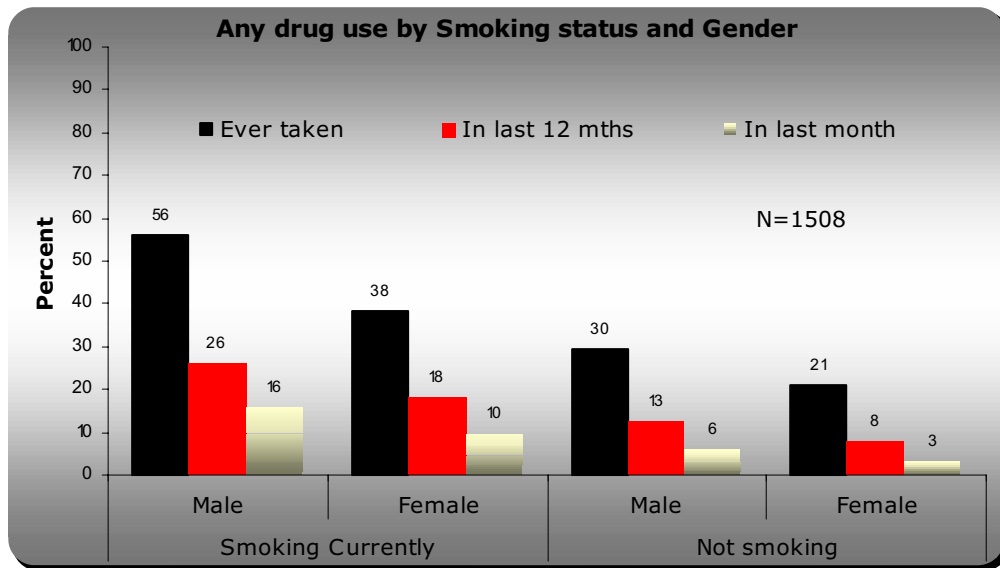


Fig 44

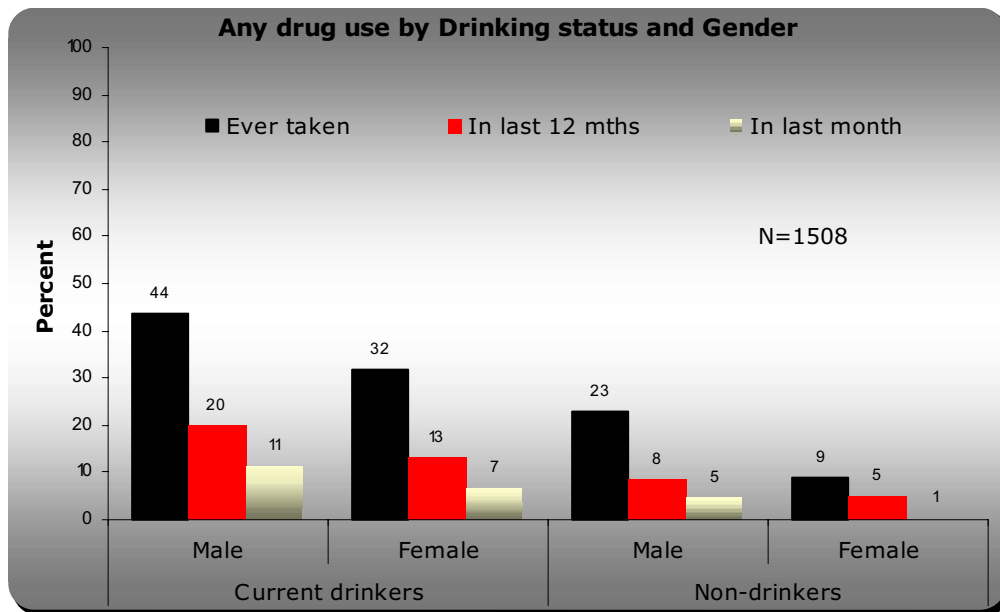
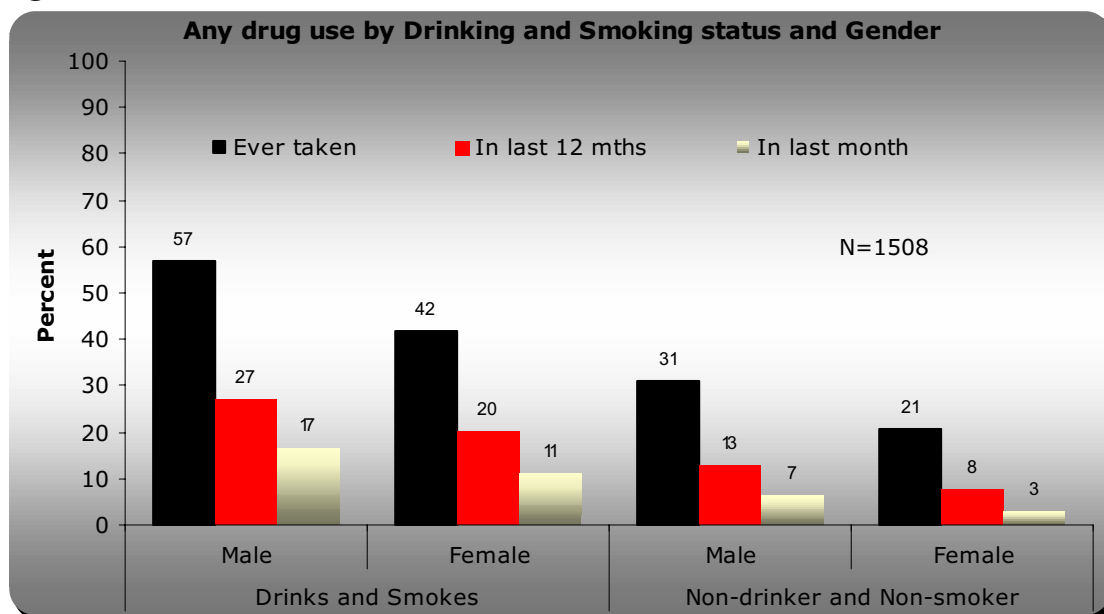


Fig 45

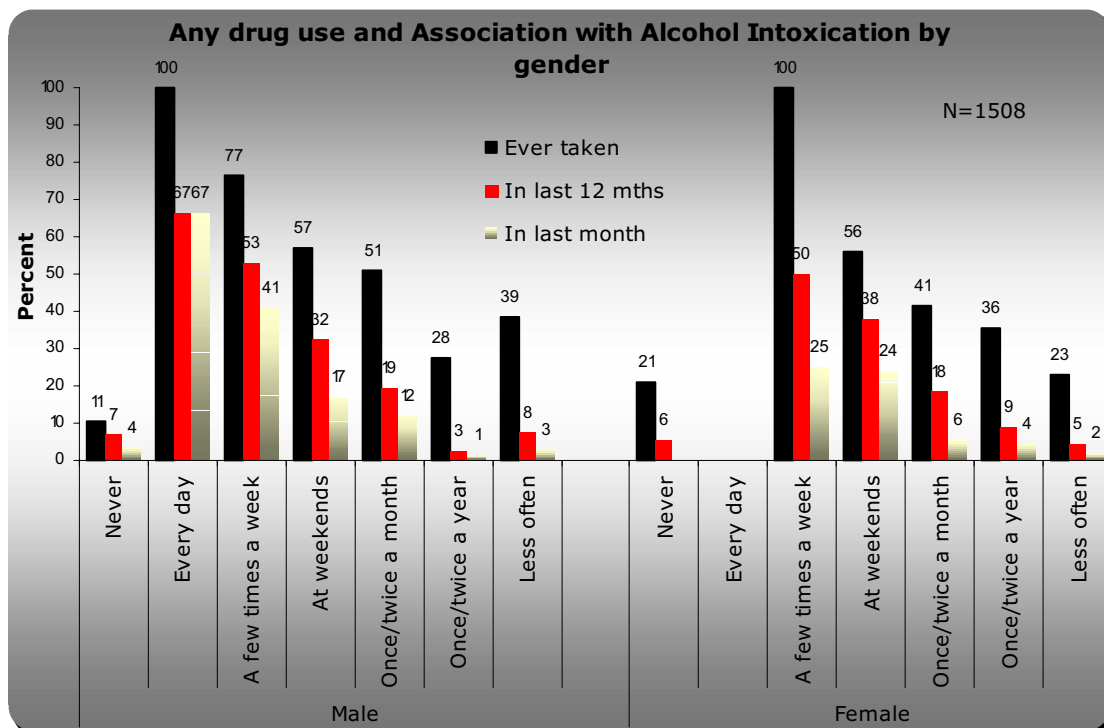


Association with Alcohol Intoxication (Fig 46)

Those who get drunk, at least once or twice a month, show at least twice the rate of Recent or Current drug use, than those who get less frequently intoxicated. (χ^2 : $P < 0.001$). 20% of those who got drunk at weekends admitted Current drug use. This pattern is the same for both sexes.

Those who get drunk a few times a week showed very high drug use.

Fig 46



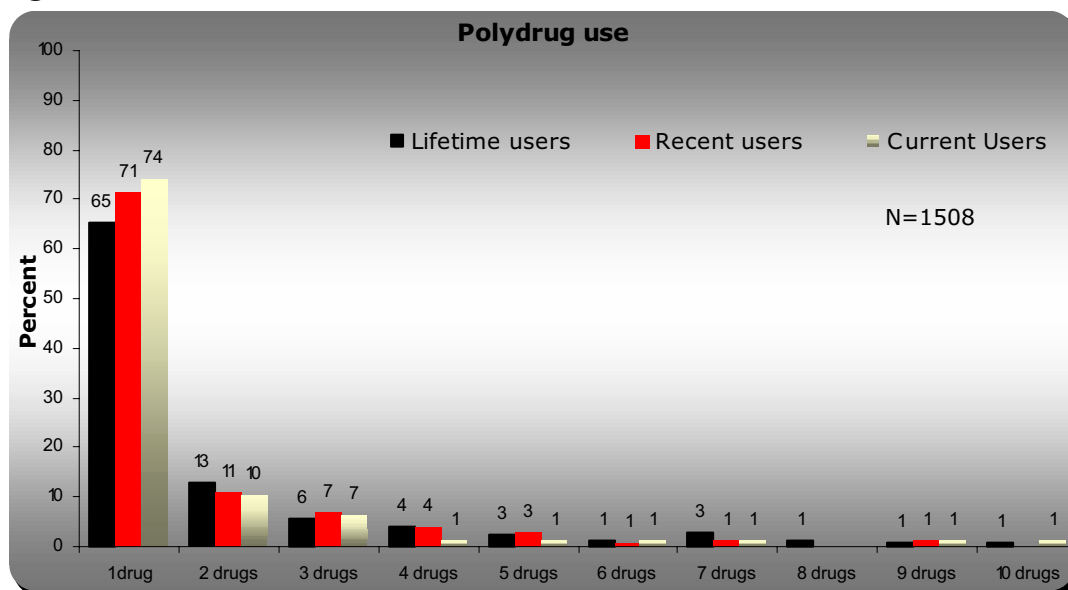
Polydrug Use (Fig 47)

Lifetime users reported up to 18 drugs used, with a mean of 2.27. 65% had used one drug. 35% used more than one drug. 13% used two drugs. 6% used 3 drugs. The remaining 16% used 4 or more drugs.

Recent Users had used up to 17 drugs with a mean of 1.9. 71% used one drug. 29% used more than one drug. 11% used 2 drugs; 7 % used 3 drugs. The remaining 11% used 4 or more drugs.

Current Users took up to 13 drugs with a mean of 1.8. 74% took one drug. 10% took 2 drugs, and 7% took 3 drugs. 9% took 4 or more drugs.

Fig 47



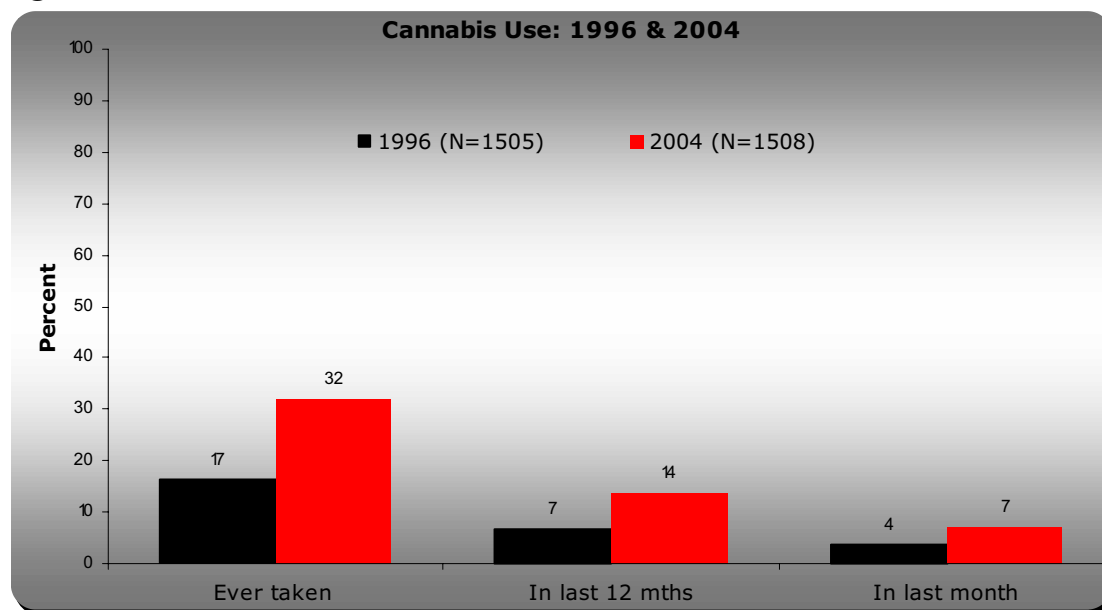
4. CANNABIS

Overall Lifetime use for Cannabis was 32%, Recent use 14% and Current use 7%. This pattern closely reflects Any Drug use, since Cannabis is the main drug used. (Fig 48)

Changes since 1996 (Fig 48)

Lifetime, Recent, and Current use of Cannabis doubled since 1996 (χ^2 : $P < 0.001$).

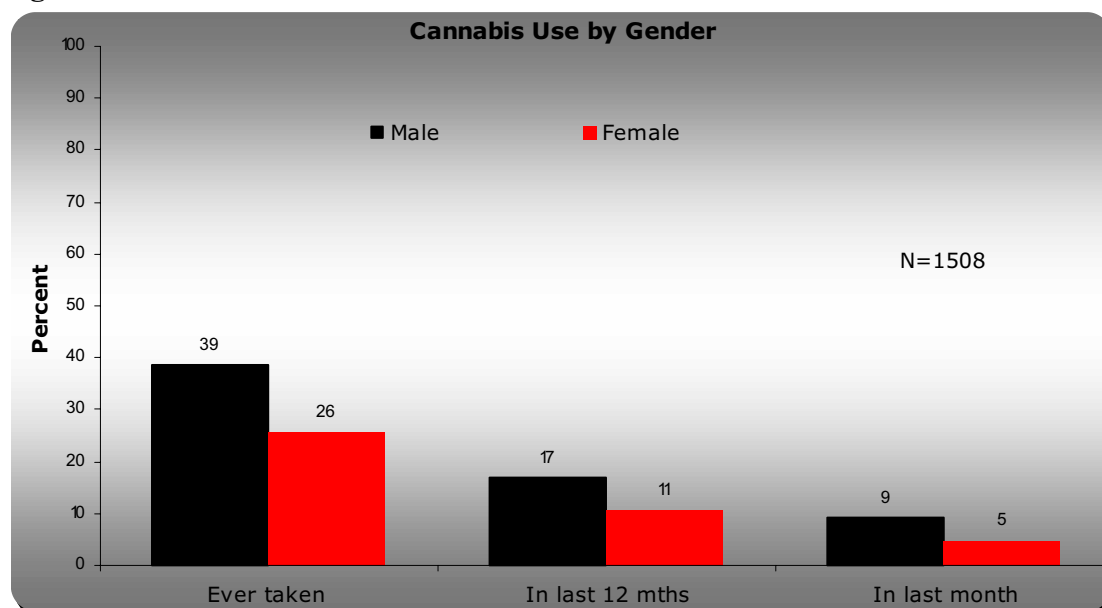
Fig 48



Gender (Fig 49)

Males use cannabis 50% more than females for Lifetime and Recent use, and twice as much for Current use (χ^2 : $P < 0.001$).

Fig 49



Regions (Fig 50)

Cork City was highest for all modes of Cannabis use (χ^2 : $p < 0.01$).

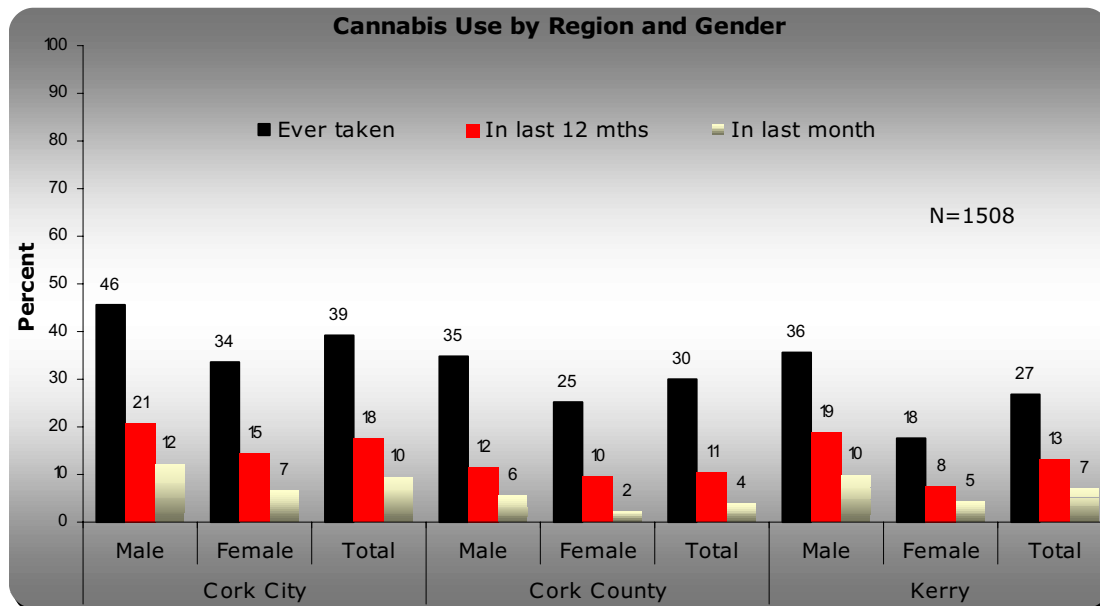
Lifetime use was 39% for Cork City, compared to 30% in Cork Co and 14% in Kerry.

Recent use was 18% for Cork City, compared to 11% in Cork Co, and 13% in Kerry.

Current use was 10% for Cork City, compared to 4% in Cork Co, and 7% in Kerry.

Men (46%) and women (34%) showed highest lifetime use in Cork City. Recent (21%) and Current (12%) use for men in Cork City, were almost twice that for Cork Co, but only slightly less for Kerry.

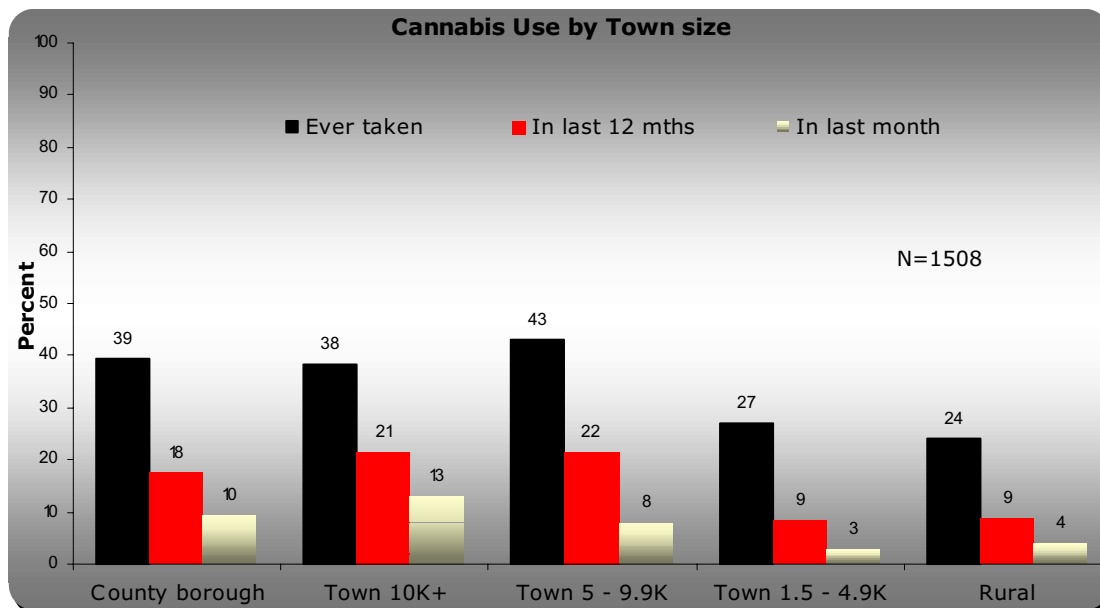
Fig 50



Town Size (Fig 51)

Town size reflected these figures, showing Cannabis use highest for towns with greater than 5,000 population (χ^2 : $P < 0.001$).

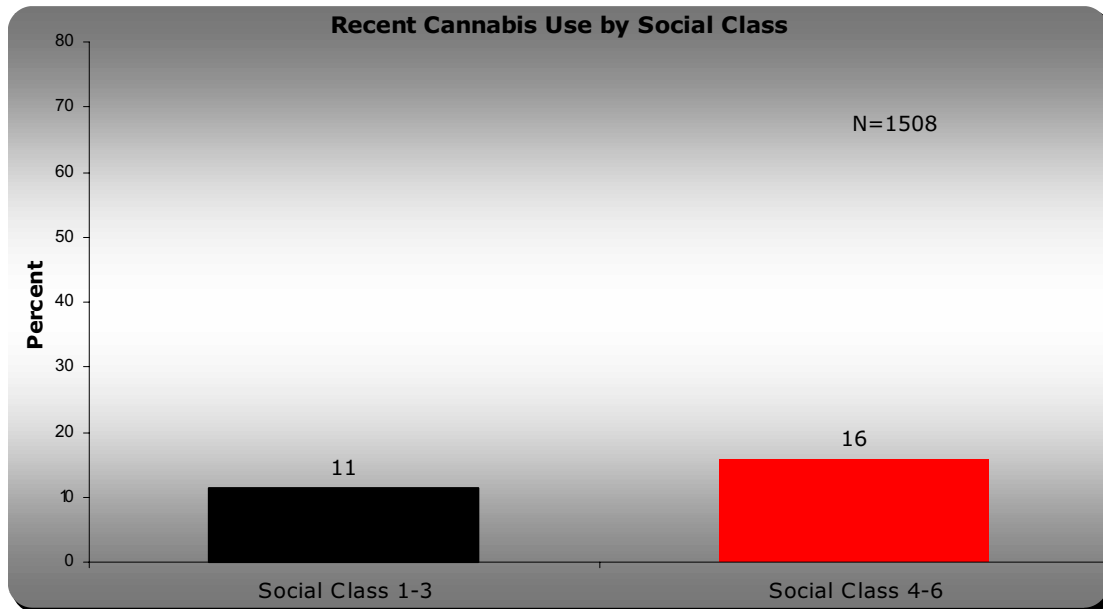
Fig 51



Social Class and Deprivation (Fig 52)

There was no significant difference for deprivation, but Recent Cannabis use was higher for Social Class Group 4-6 (χ^2 : $p < 0.01$).

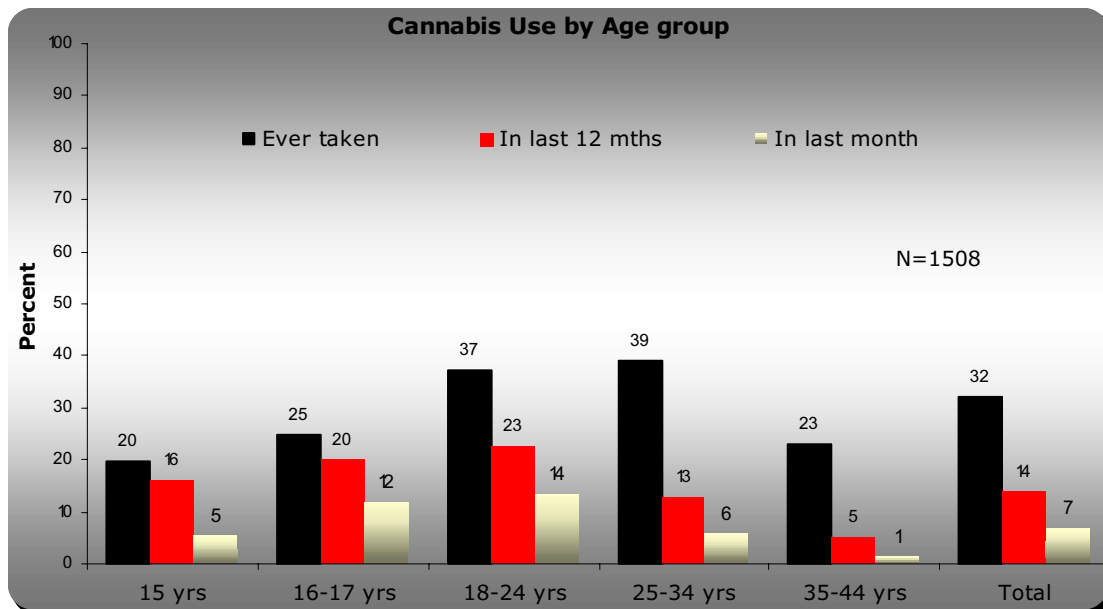
Fig 52



Age Group (Fig 53)

Lifetime Cannabis use peaked at about 38% for 18-34 years. Recent drug use was highest at 23% for 18-24 years. Current use (14%) was also highest at 18-24 years (χ^2 : $P < 0.001$).

Fig 53



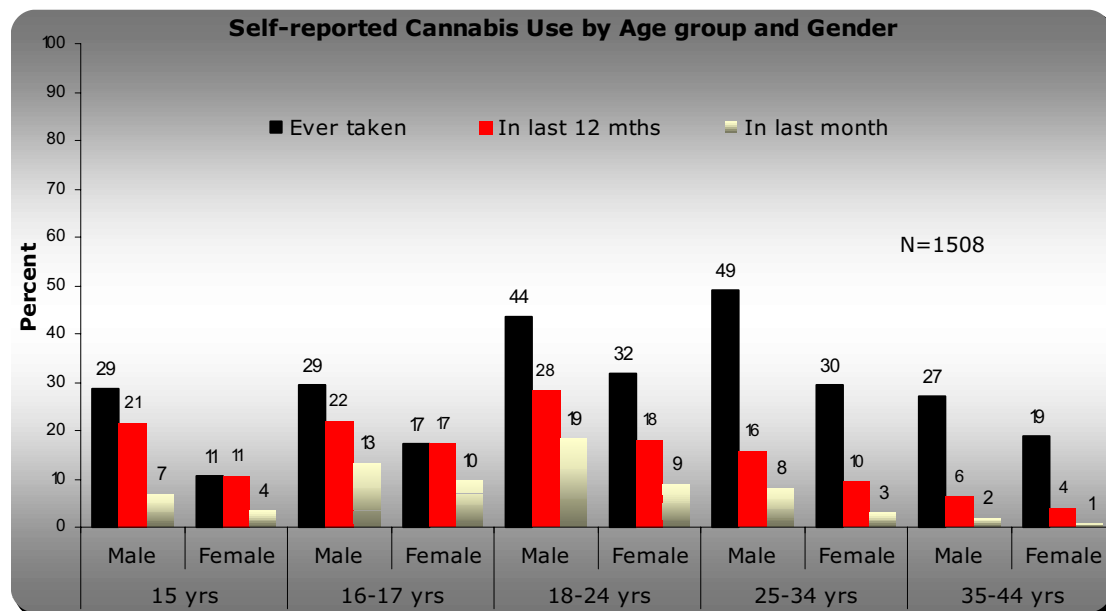
Sex and Age Group (Fig 54)

About a quarter of men at 15 years had taken Lifetime or Recent Cannabis; twice that of women (11%).

For men, Lifetime Cannabis use peaked at 49% at 25-34 years. Recent (28%) and Current (19%) use were highest at 18-24 years (χ^2 : $P < 0.001$).

For women, Lifetime Cannabis use peaked earlier than men at 32% for 18-24 years. Recent (18%), and Current Use (10%) were highest earlier than men, between 16 and 24 years (χ^2 : $P < 0.001$).

Fig 54



Association with Smoking and Drinking (Fig 55-7)

Current Smokers, Current Drinkers, and those who Drink & Smoke, all showed marked increases in Cannabis use over those who did not smoke or drink; almost twice as many using Cannabis (χ^2 : $P < 0.001$). This was especially for Recent and Current Drug use.

Fig 55

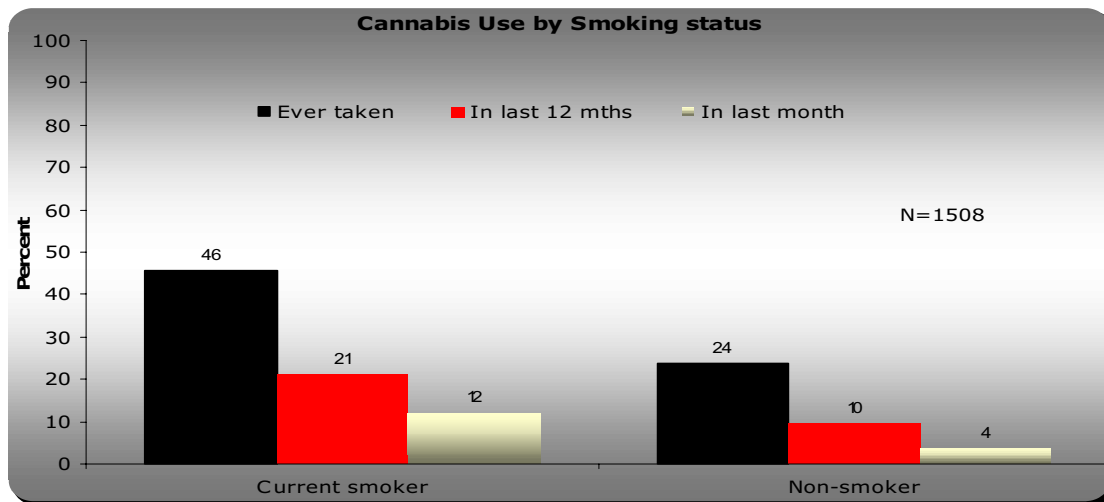


Fig 56

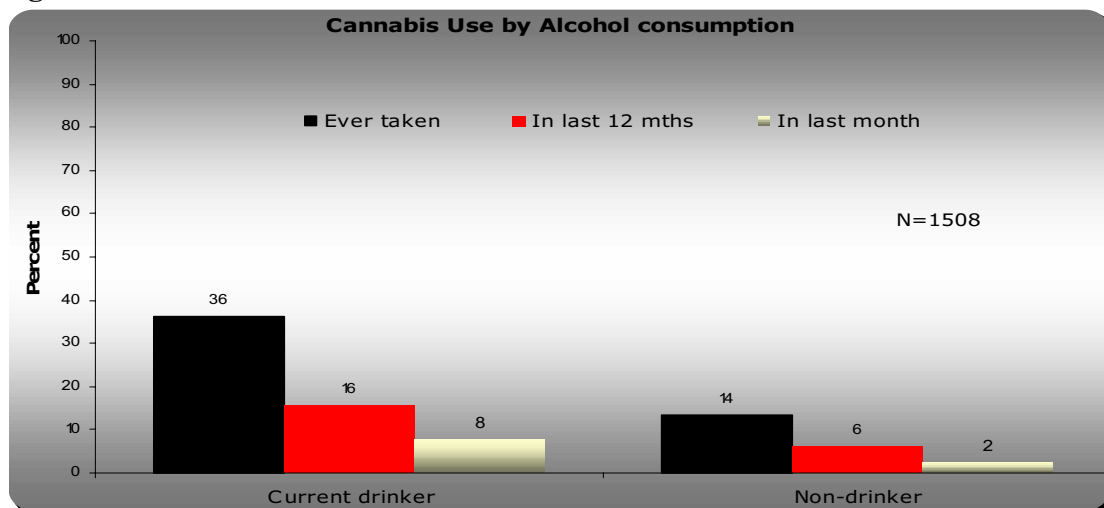
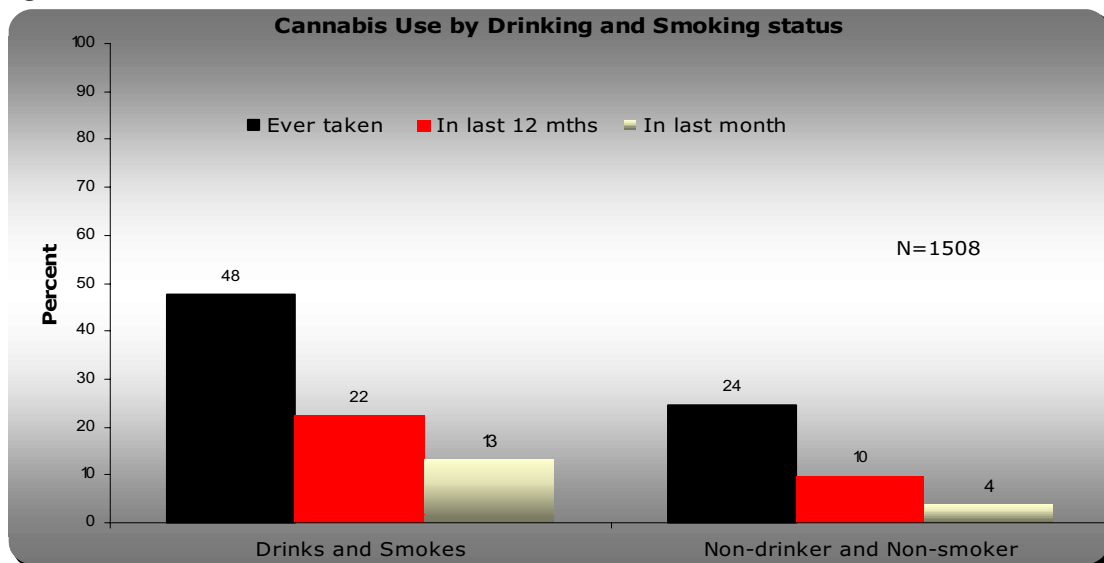


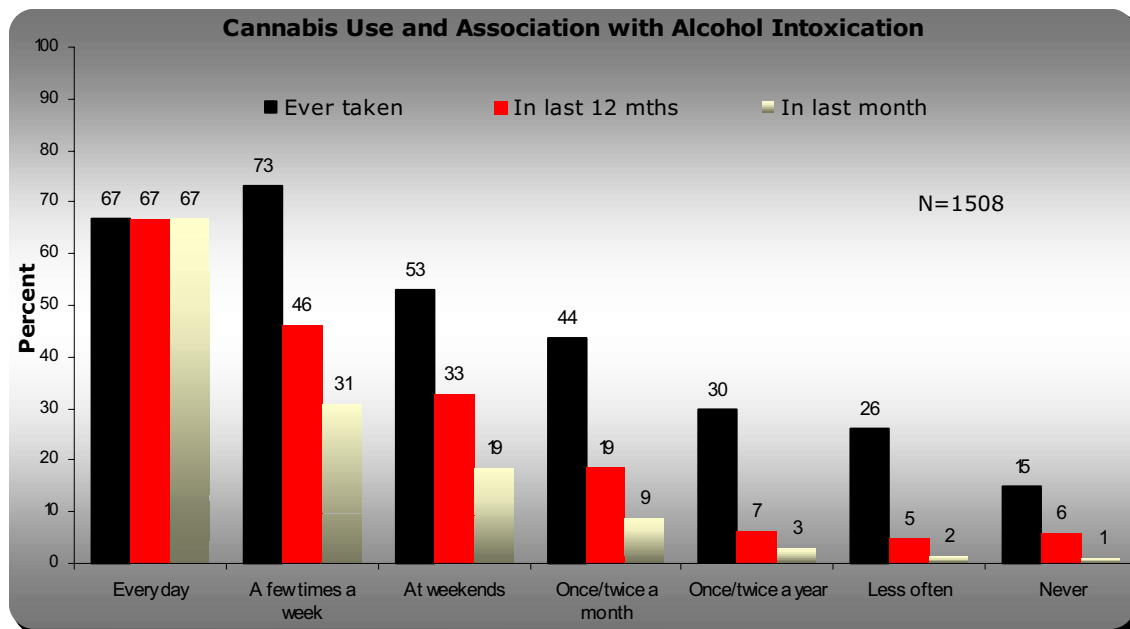
Fig 57



Association with Alcohol Intoxication (Fig 58)

Those who get drunk, at least once or twice a month, show at least twice the rate of Recent or Current Cannabis use, than those who get less frequently intoxicated. (χ^2 : $P < 0.001$). One third of those who got drunk at weekends admitted Recent use. Those who get drunk a few times a week had even higher use of Cannabis.

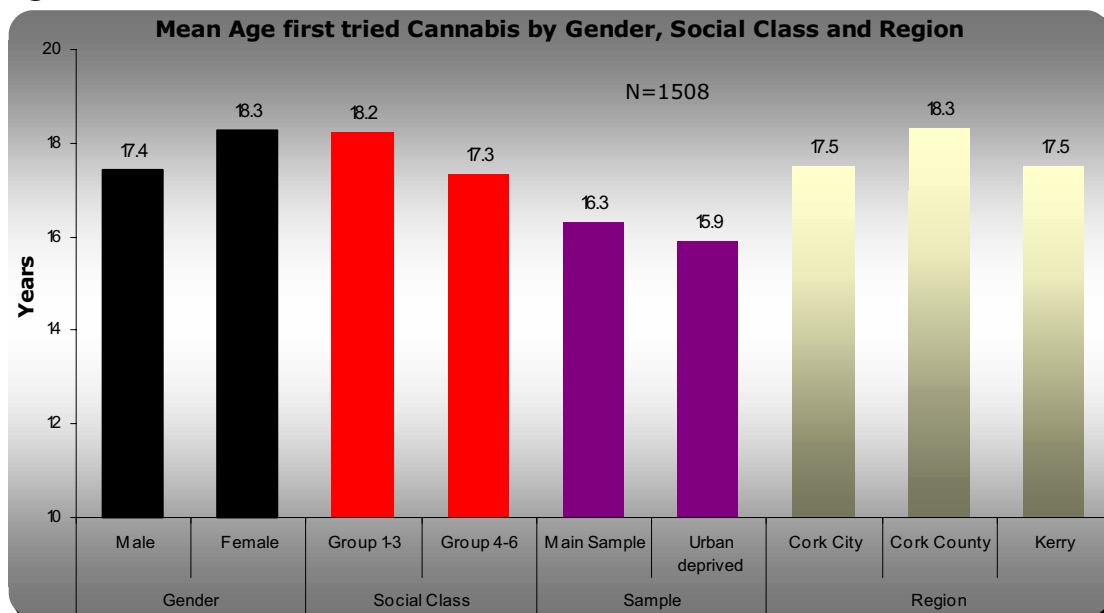
Fig 58



Age First Taking Cannabis (Fig 59)

The mean age of first taking Cannabis was 17.8 years. A quarter had taken Cannabis by 16 years. Men started taking Cannabis about 10 months earlier than women (T test $p = 0.005$). Those in Social Class groups 4-6, also took it about 10 months earlier than those in groups 1-3 (T test $p = 0.003$). There was minimal difference in first taking Cannabis for regions, or Urban Deprived.

Fig 59



Age of First Smoking and Drinking in Cannabis Users (Fig 60-1)

The mean age of first smoking was almost a year earlier in those who took Cannabis, and 1.5 years earlier for age of first taking alcohol.

Fig 60

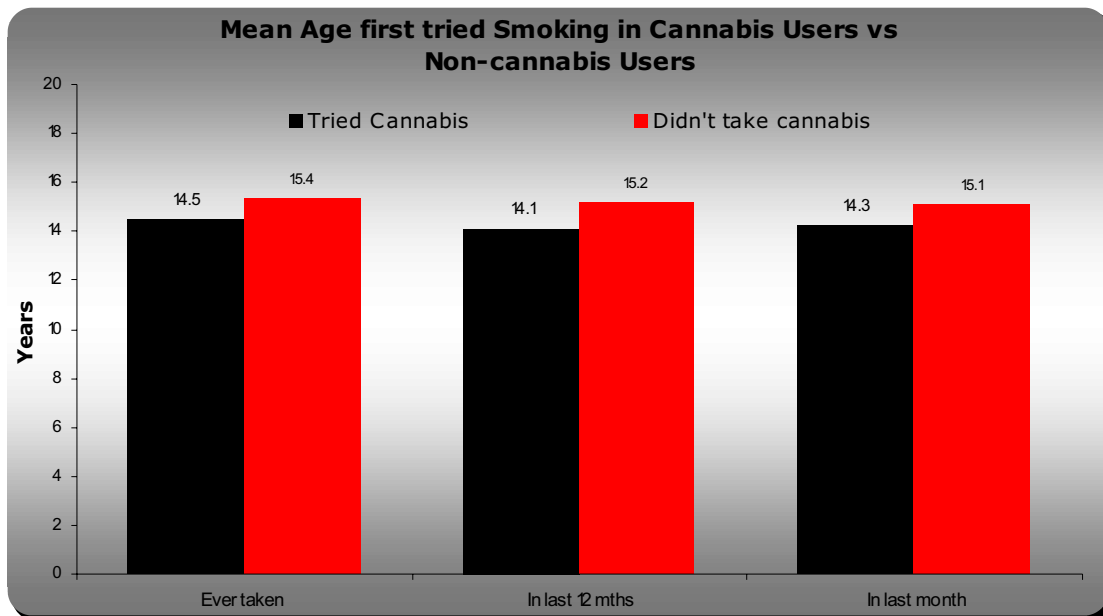
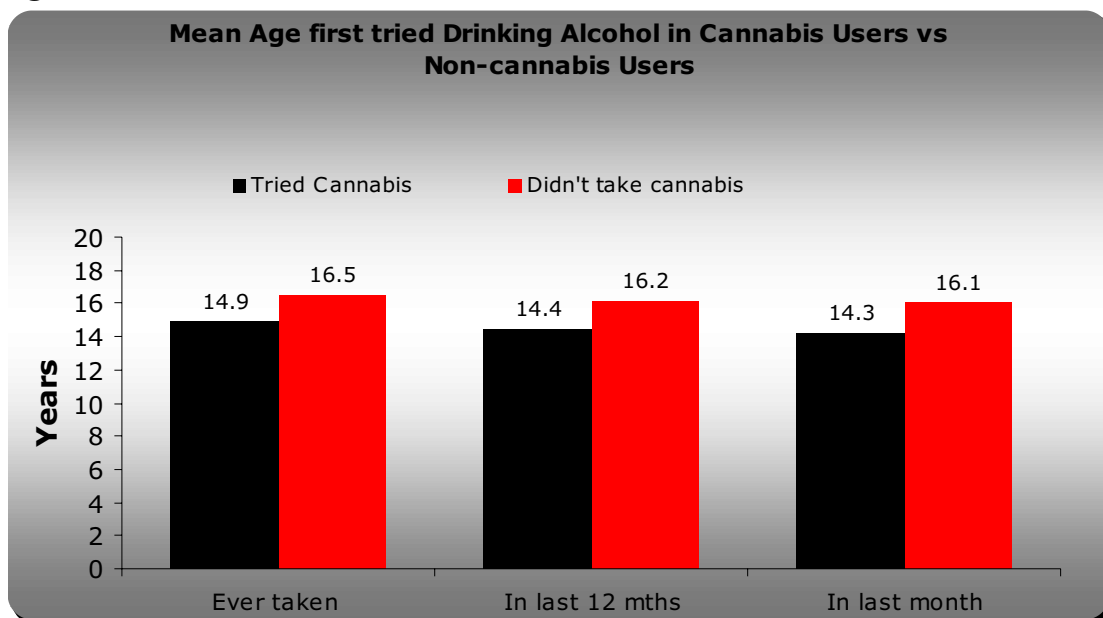


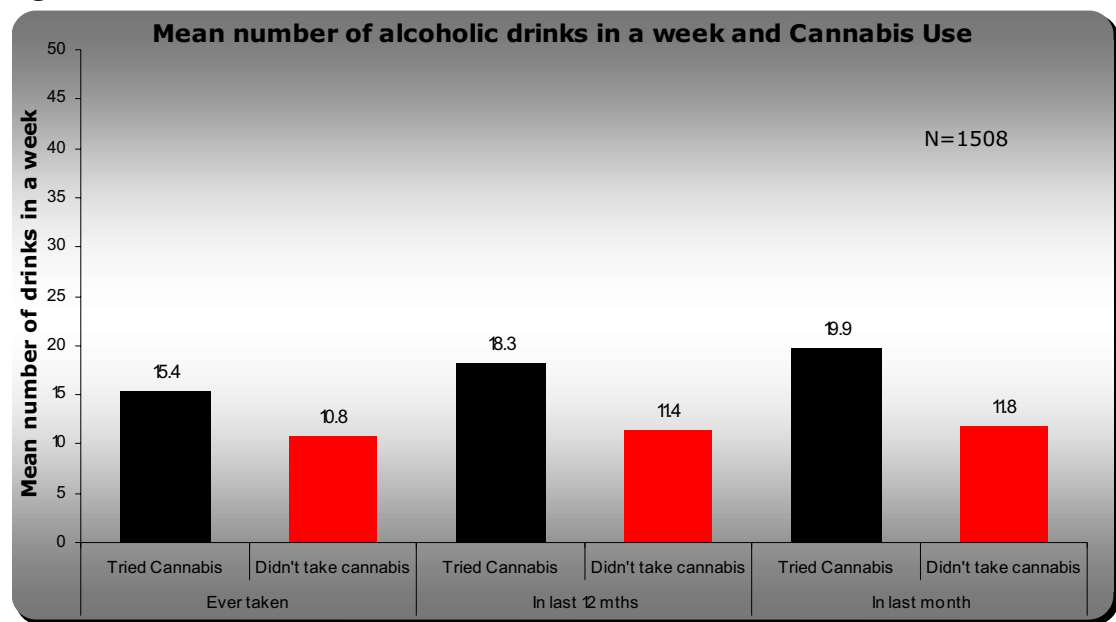
Fig 61



Alcohol Intake in Cannabis Users (Fig 62)

Mean alcohol taken per week was increased in those who took Cannabis (T test $P<0.001$). Recent and Current Cannabis users drank 7 units more per week, than those who did not take Cannabis.

Fig 62

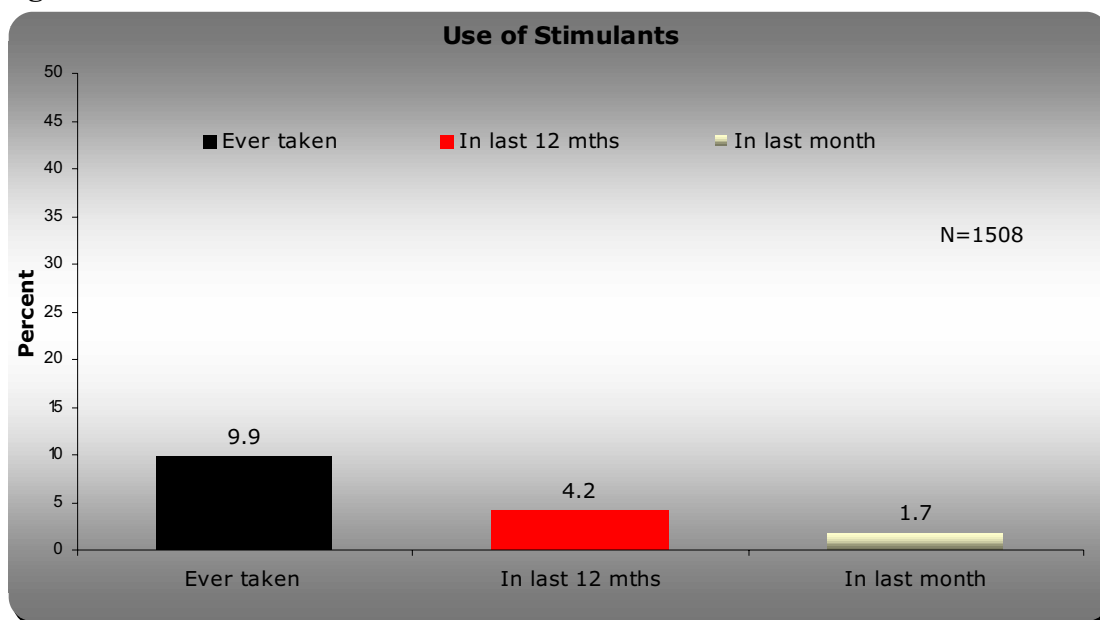


5. STIMULANTS

Amphetamines
Amyl Nitrate
Cocaine
Crack
Ecstasy

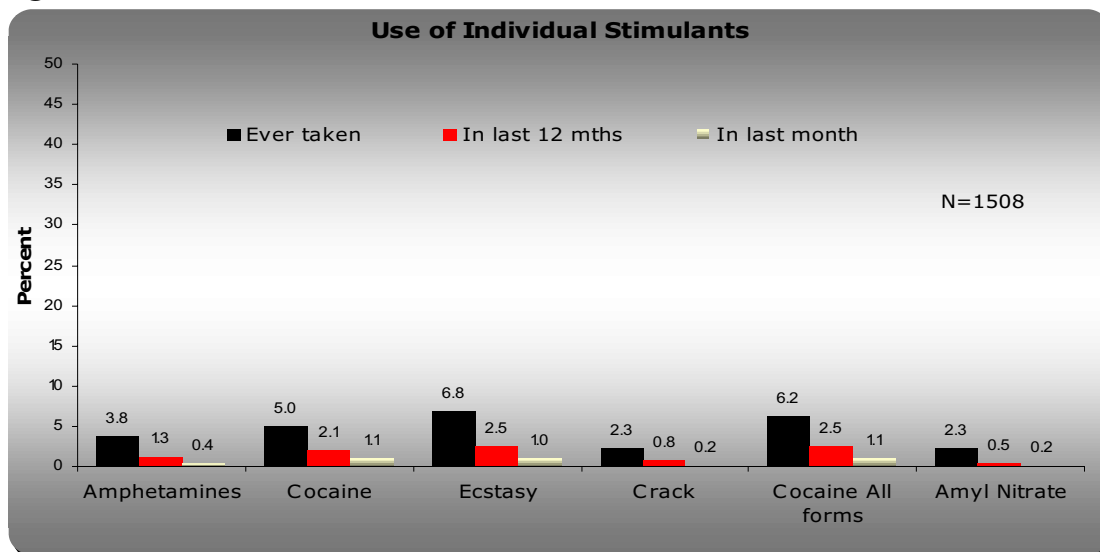
Overall Lifetime use for Stimulants was 10%, Recent use 4%, and Current use 2%. (Fig 63)

Fig 63



Ecstasy (7%), Cocaine-all forms (6%), and Cocaine were the commonest Lifetime stimulants used, with less use of Amphetamines (4%) and Amyl Nitrate (2%). (Fig 64) Cocaine-all forms, Cocaine, and Ecstasy were the most frequent Recent drugs used at 2-2.5%, with other stimulants at 1% or less. Cocaine-all forms, Ecstasy, and Cocaine were the most frequent Current stimulants used at 1%, with other stimulants at 0.4% or less.

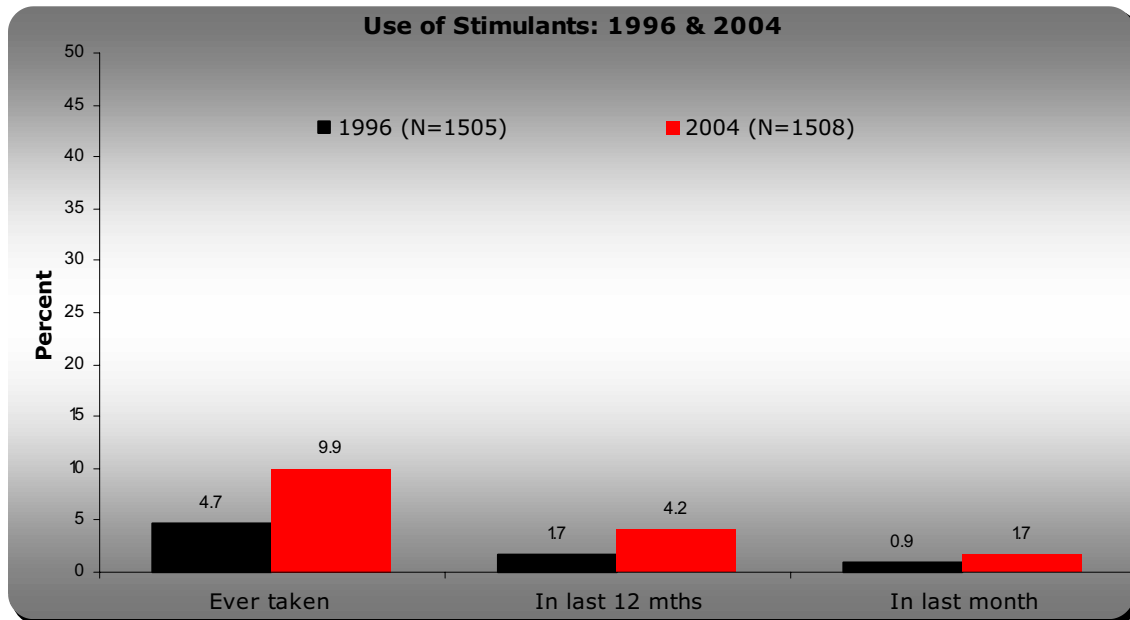
Fig 64



Changes since 1996 (Fig 65)

Lifetime and Recent use of Stimulants doubled since 1996 (χ^2 : $P<0.001$). Current use also doubled, but was just short of statistical significance.

Fig 65



Changes in individual stimulant drugs since 1996 (Fig 66)

Lifetime and Recent use of Cocaine, Crack, and Ecstasy significantly increased since 1996. Only Cocaine increase was significant among Current users of stimulants.

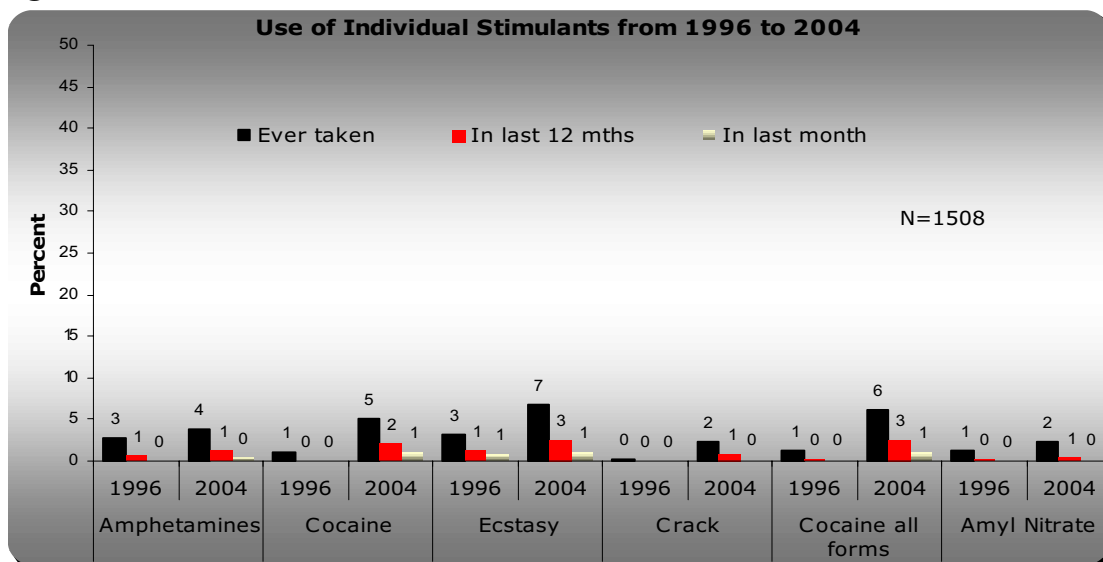
Ecstasy doubled for Lifetime (7%) (χ^2 : $P<0.001$), and Recent (2.5%) use (χ^2 : $p=0.02$).

Lifetime use of Cocaine all forms, increased by almost 5 times to 6% (χ^2 : $P<0.001$).

Recent use of Cocaine all forms increased by 3 times to 2.5%; Cocaine increased by 21 times from almost nil (χ^2 : $P<0.001$); and Crack increased by 8 times (χ^2 : $p=0.017$).

Current use of Cocaine increased by 11 times to 1% from almost nil (χ^2 : $P<0.001$).

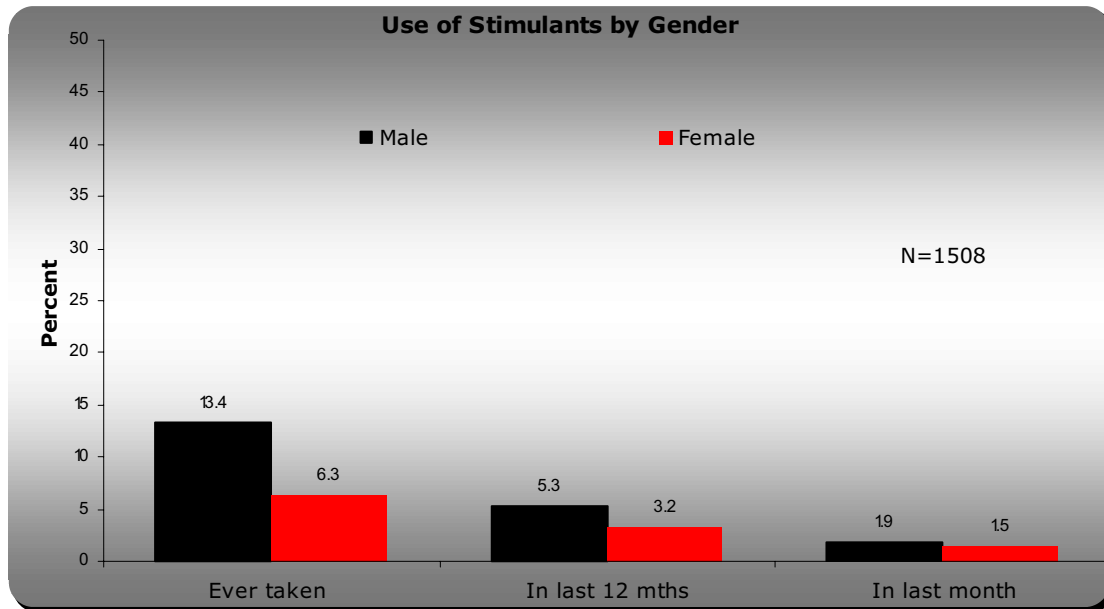
Fig 66



Gender (Fig 67)

Twice as many males use Stimulants than females for Lifetime (χ^2 : $P < 0.001$), and Recent use (χ^2 : $p = 0.04$).

Fig 67



Regions (Fig 68-69)

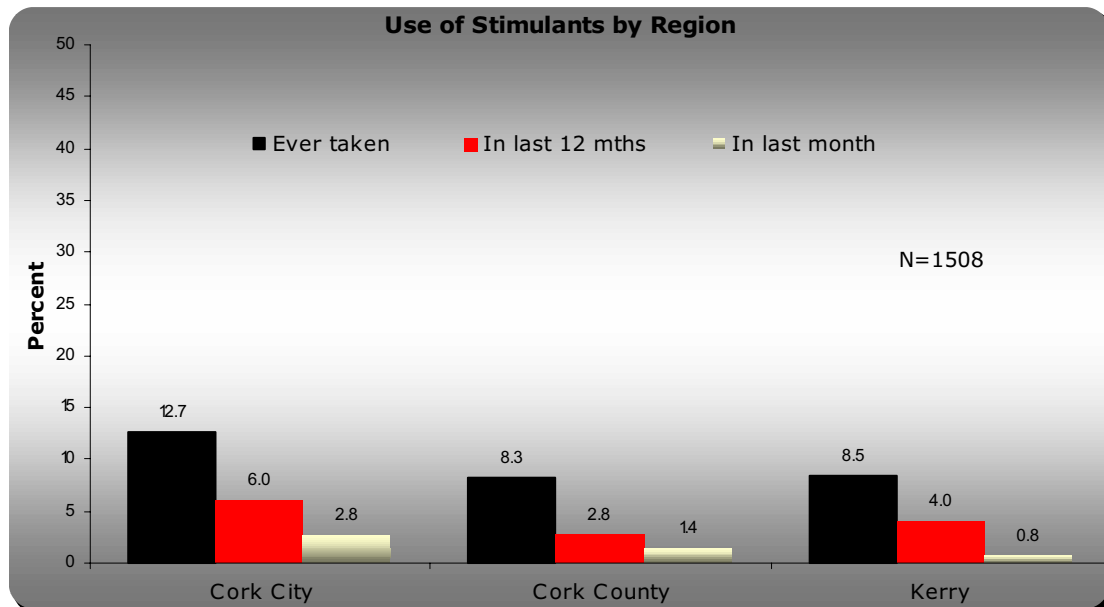
Cork City was highest for all modes of Stimulant use (χ^2 : $p = 0.031$).

Lifetime use was 13% for Cork City, compared to 8% in Cork Co and Kerry.

Recent use was 6% for Cork City, compared to 3% in Cork Co, and 4% in Kerry.

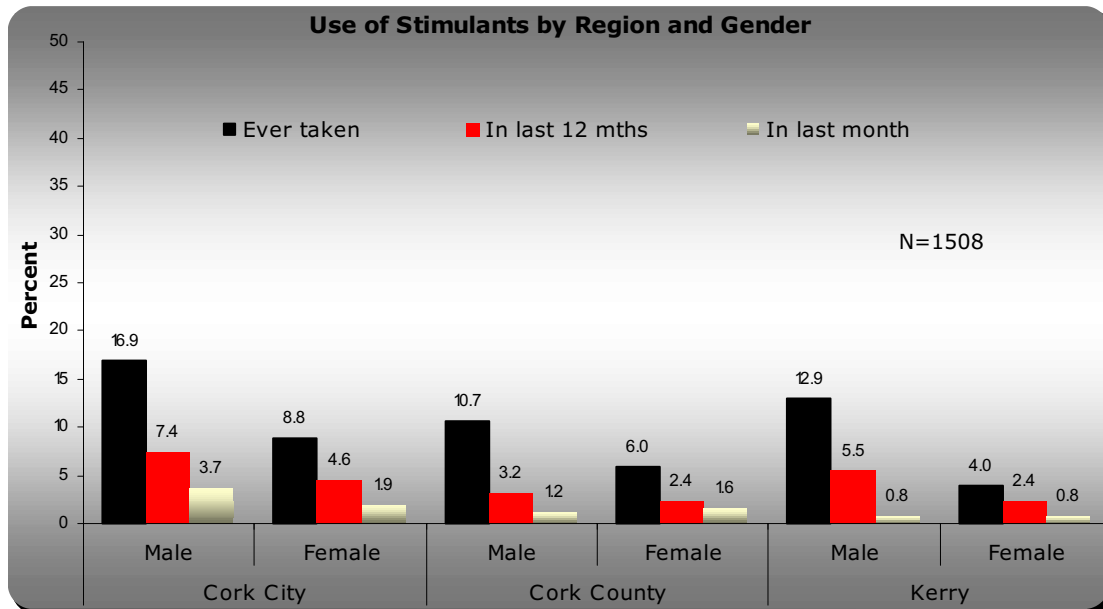
Current use was 3% for Cork City, compared to 1% in Cork Co, and Kerry.

Fig 68



Men (17%) and women (9%) showed highest Lifetime use in Cork City. Recent (7%) and Current (4%) use for men in Cork City were almost twice that for Cork Co, and Kerry

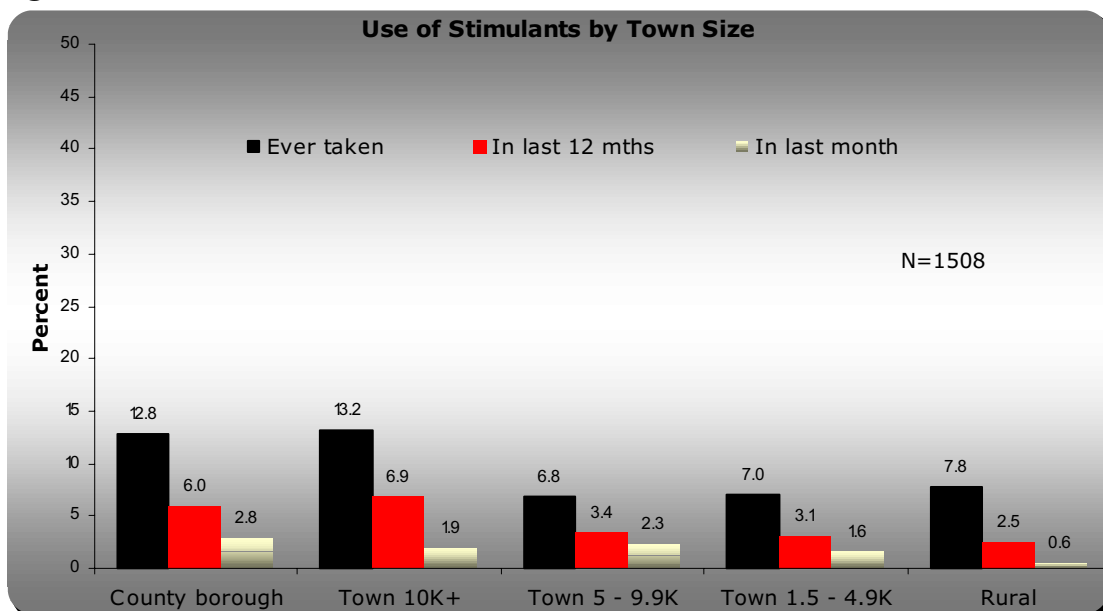
Fig 69



Town Size (Fig 70)

Town size reflected these figures showing Lifetime and Recent Stimulant use highest for communities with greater than 10,000 population, with smaller populations having half the prevalence (χ^2 : $p < 0.05$).

Fig 70



Social Class and Deprivation

Stimulants showed no significant difference for Social Class Group or Deprivation.

Age Group (Fig 71-2)

Lifetime Stimulant use peaked at about 14% for 18-24 years. Recent use was highest at 10% for 16-17 years. Current use (6%) was also highest at 16-17 years (χ^2 : $P < 0.001$). Males showed higher use than females, in all age groups except at 15 years.

Fig 71

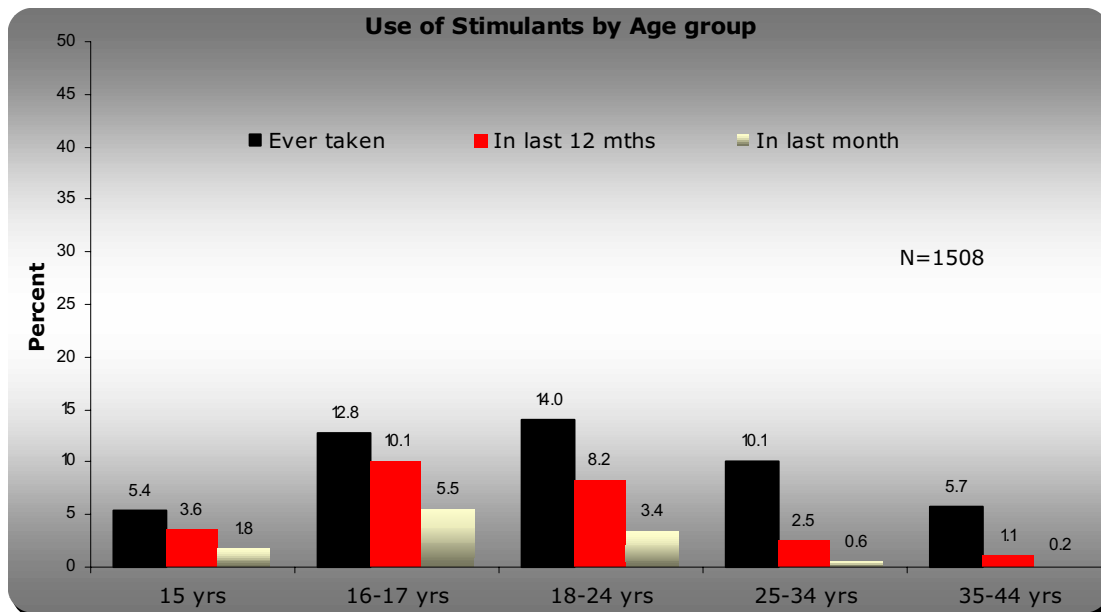
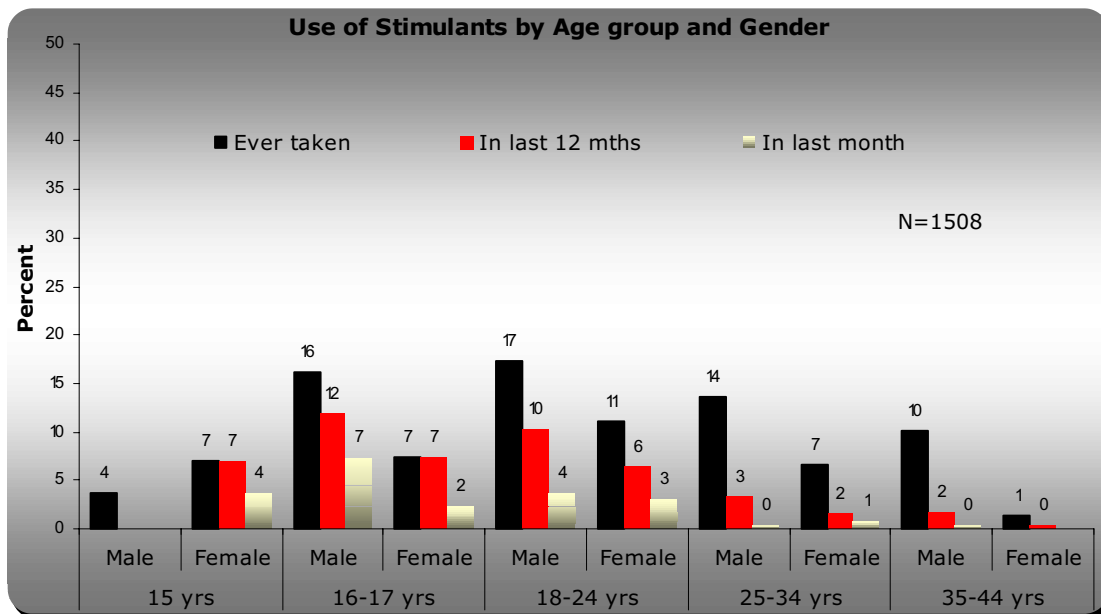


Fig 72



6. OPIATES

Diconal
DF118
Heroin
Methadone

Overall Lifetime use for Opiates was 2.2%, Recent use 0.8%, and Current use 0.4%. (Fig 73)

Heroin (1.6%) and DF118 (1.1%) were the commonest Lifetime opiates used. Smaller numbers used Methadone (0.5%) and Diconal (0.4%). (Fig 74)

Recent and Current use Opiates were 0.5% or less, and too small in number for stable analysis.

Fig 73

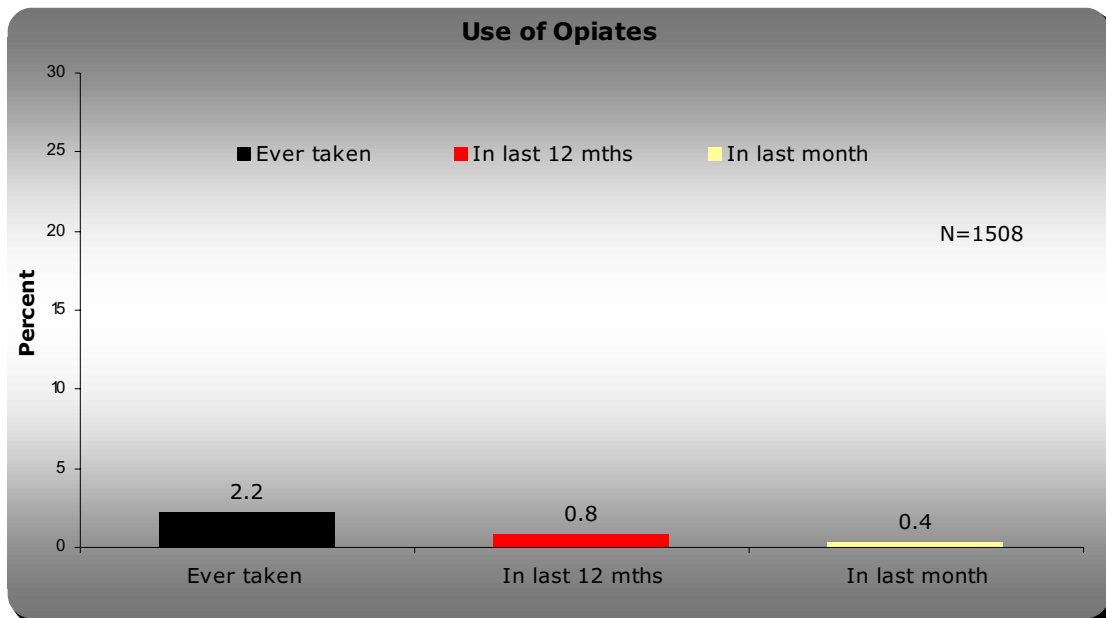
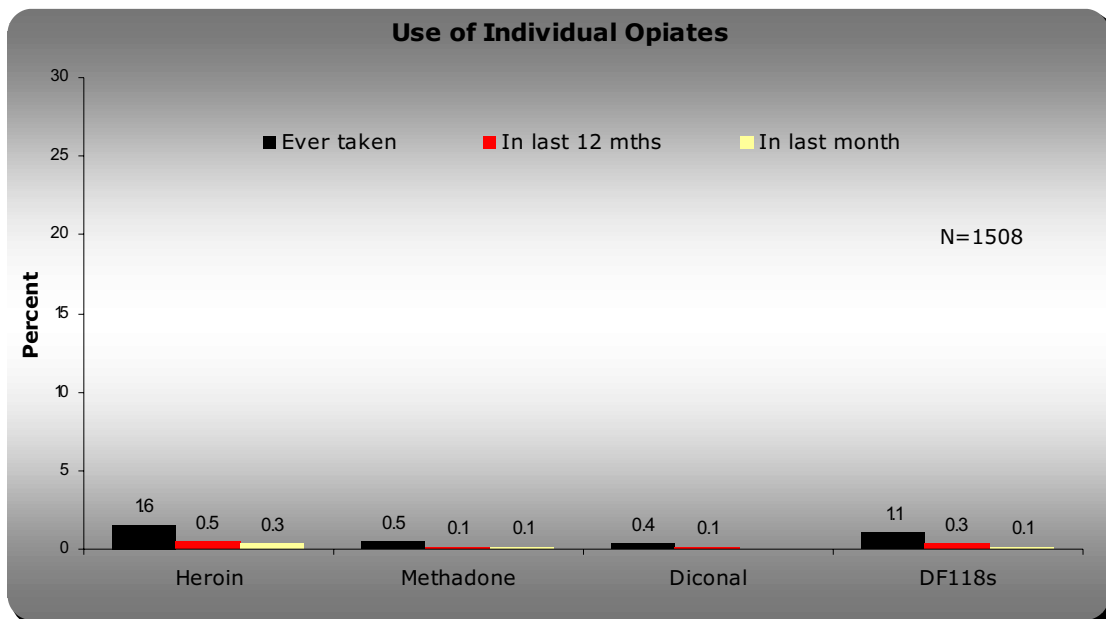


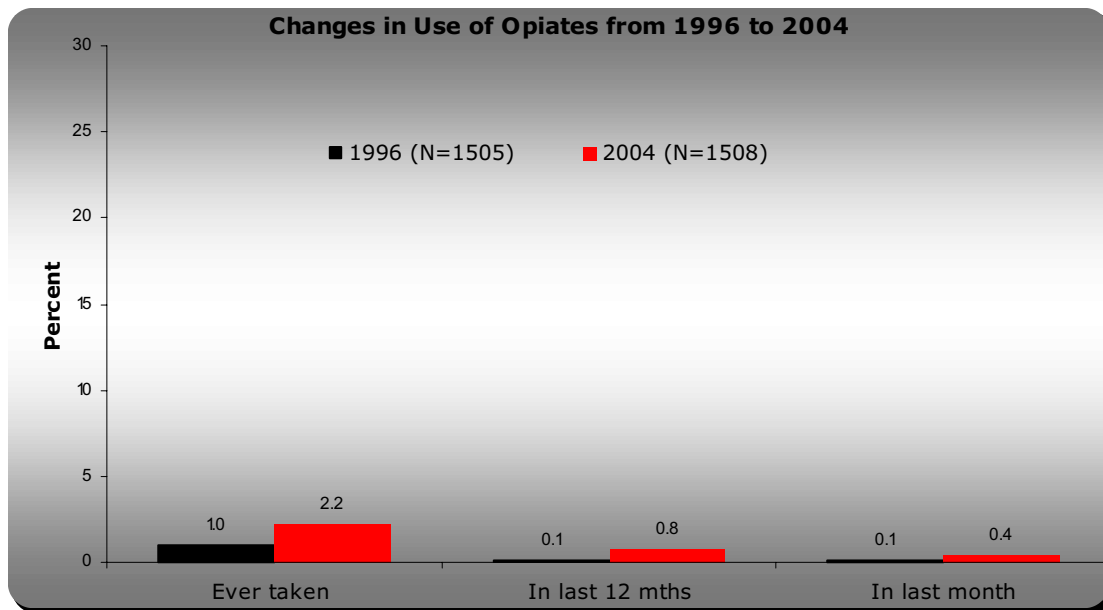
Fig 74



Changes since 1996 (Fig 75)

Lifetime use of Opiates doubled since 1996 (χ^2 : $p=0.009$). Recent use increased by eight to 0.8% (χ^2 : $p=0.002$). Current use also increased, but was not statistically significant.

Fig 75

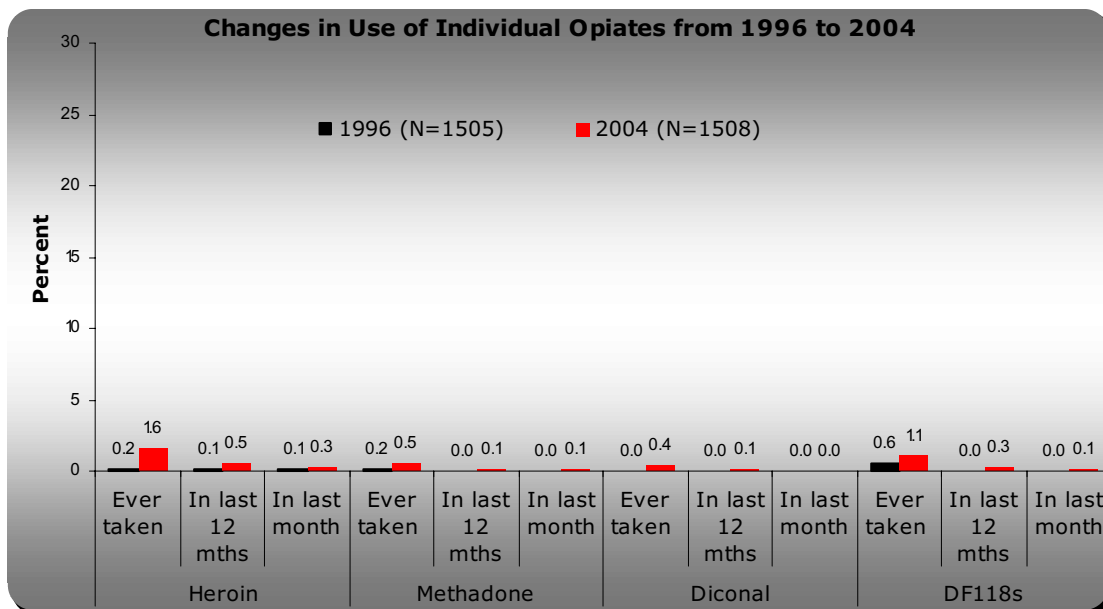


Changes in individual Opiates since 1996 (Fig 76)

Lifetime and Recent use of Heroin, significantly increased since 1996. Increases for other opiates were not significant, or were small increases from a zero base.

Heroin increased by 8 for Lifetime use to 1.6% (χ^2 : $P<0.001$), and by 5 for Recent use to 0.5% (F_x: $p=0.04$).

Fig 76



Gender (Fig 77)

Males (3.2%) use Opiates twice as much as females (1.2%) for Lifetime use (χ^2 : $P<0.008$).

Heroin showed 5 times more Lifetime use in males (2.7%) than females (0.5%) (χ^2 : $P<0.001$). (Fig 78)

Gender differences for Recent or Current opiates were not significant, or were small increases from a zero base.

Fig 77

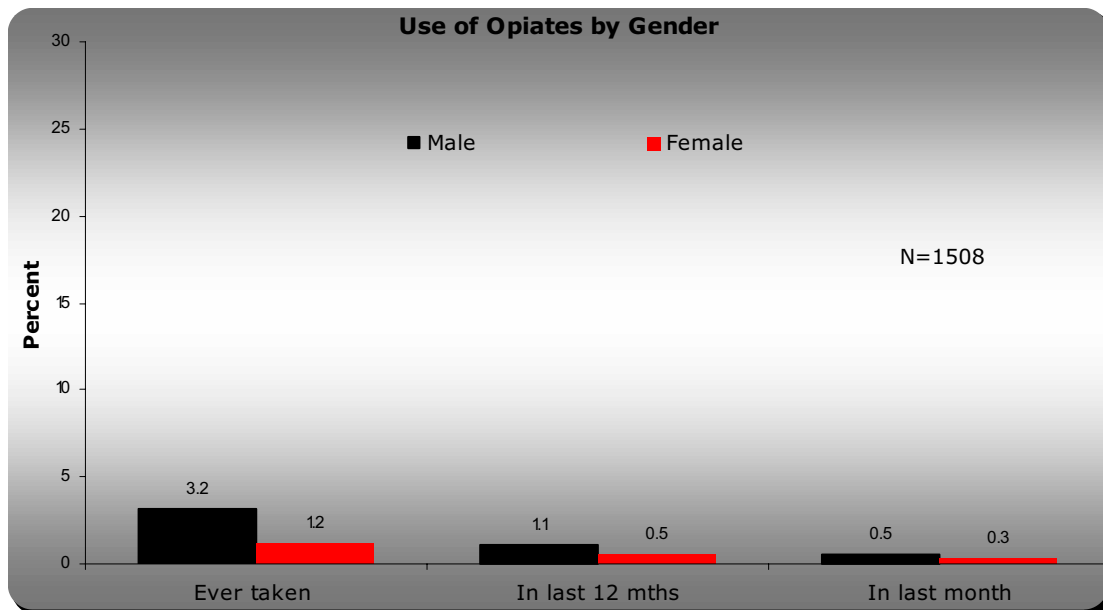
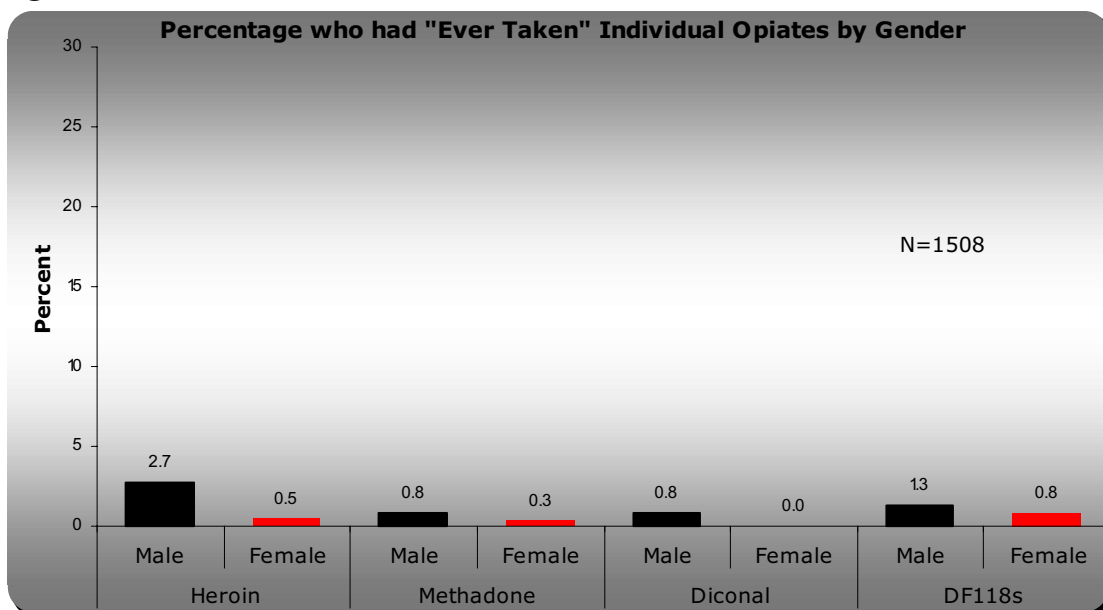


Fig 78



Regions (Fig 79)

There was no significant difference between regions for Opiate use, although Cork City was highest for Lifetime use at 3%.

For individual Opiates, only Lifetime DF118 showed significantly higher use in Cork City at 2% (χ^2 : p=0.037). (Fig 80)

Fig 79

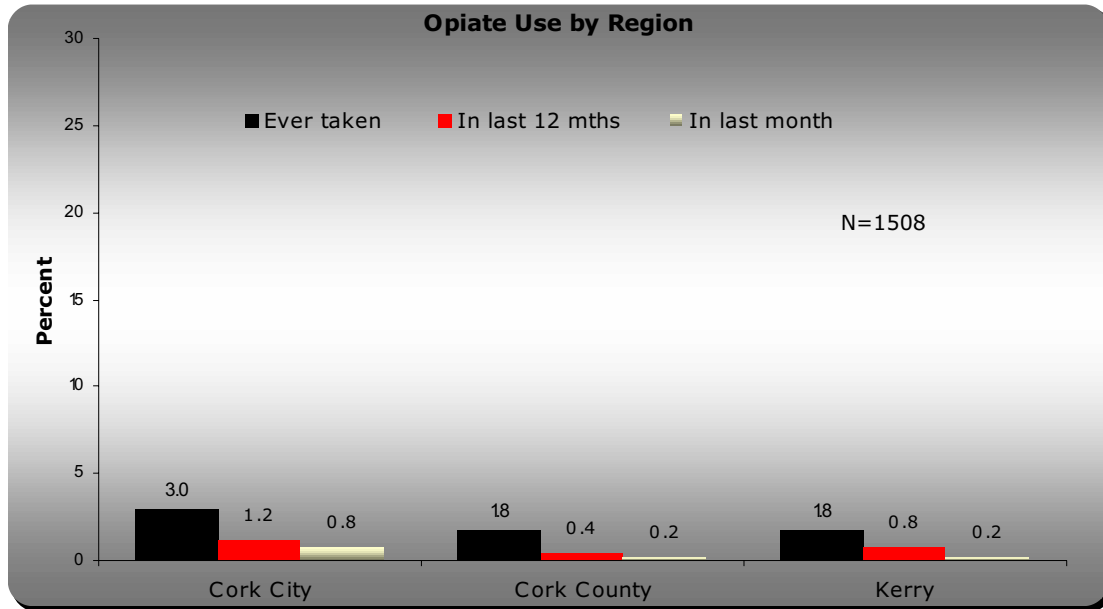
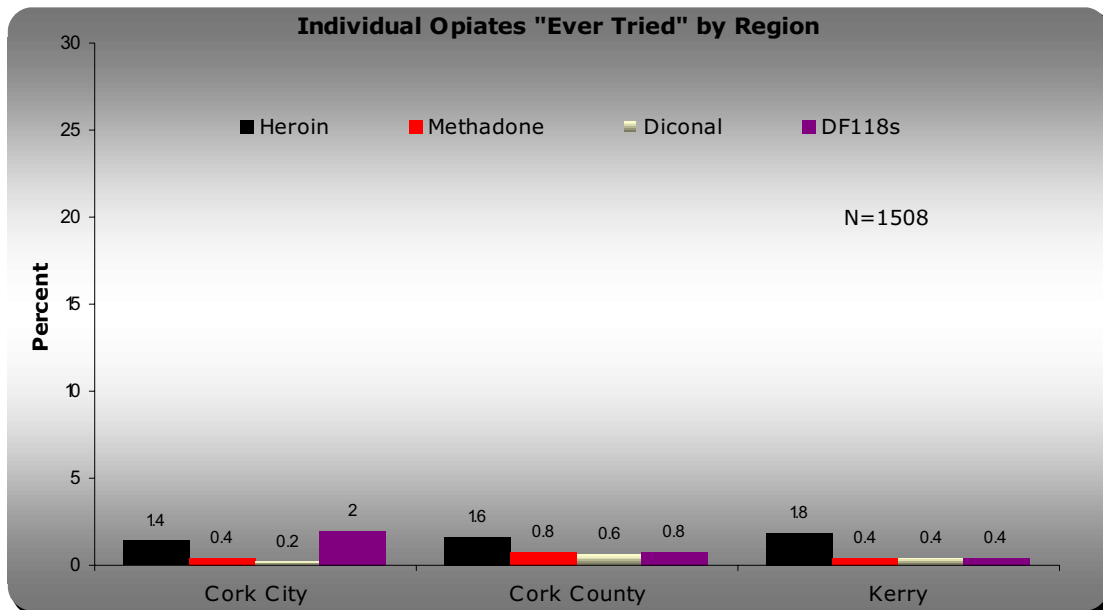


Fig 80



Town Size (Fig 81-2)

Recent Opiate use was significantly higher in larger towns outside Cork City at 2.5% (χ^2 : P=0.03). Lifetime use was high in both City and larger towns.

Lifetime Heroin use was significantly higher at 4.4% in larger towns, in contrast to 1.4% in Cork City (χ^2 : p=0.03).

Fig 81

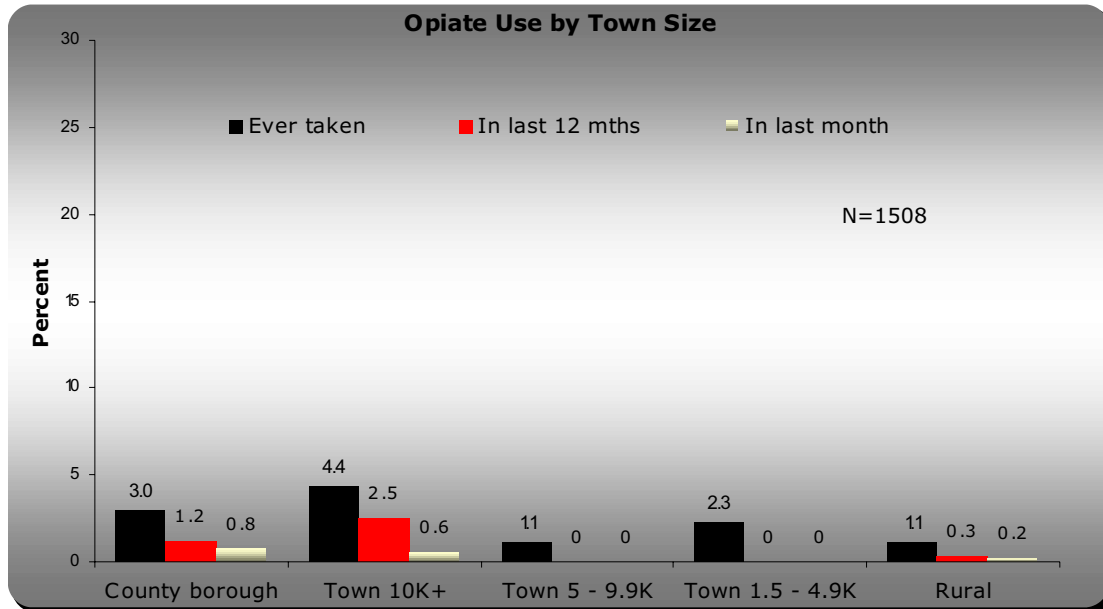
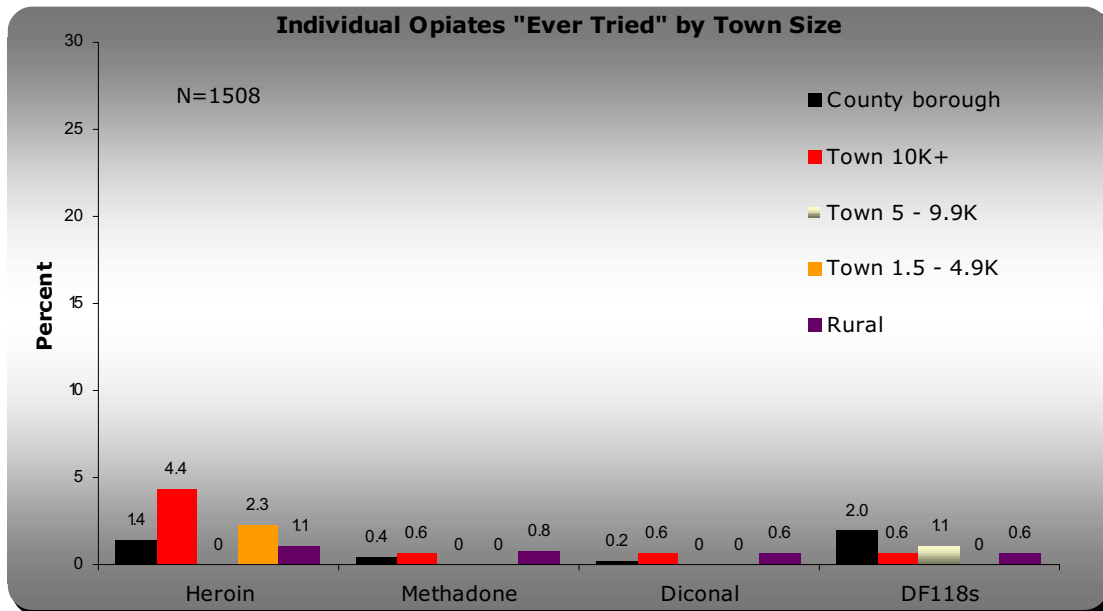


Fig 82



Social Class and Deprivation (Fig 83-4)

Opiates showed no significant difference for Deprivation. Social Class group 4-6 showed higher prevalence for Opiates, which was significant for Recent and Current use despite small figures (Fx: $P=0.033$).

Recent Heroin use was highest in Social Class 4-6 at 1% (Fx: $p=0.008$).

Fig 83

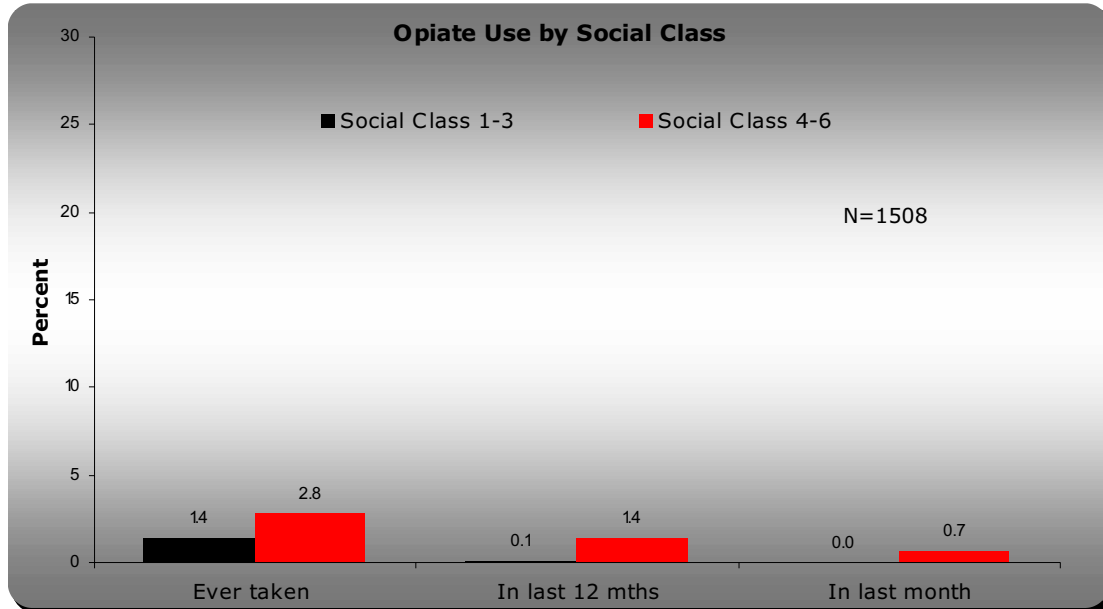
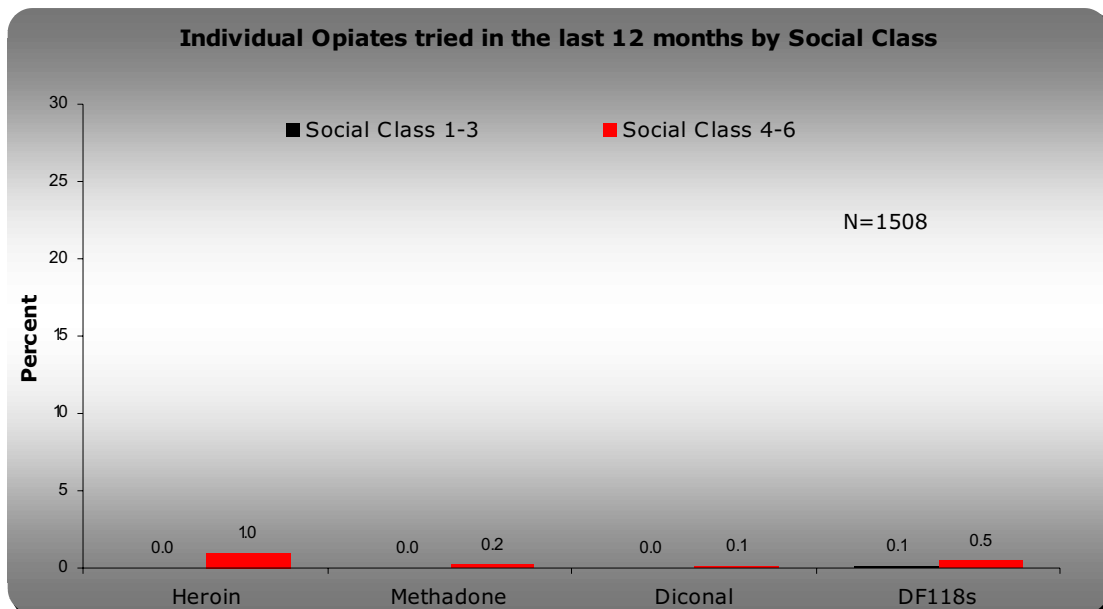


Fig 84



Age Group (Fig 85)

Opiate use was highest at 16-24 years, especially for Recent and Current use (χ^2 : $p < 0.05$).

Individual Opiates reflected this pattern, although only Lifetime DF118 was significant (χ^2 : $p < 0.05$). (Fig 86)

Fig 85

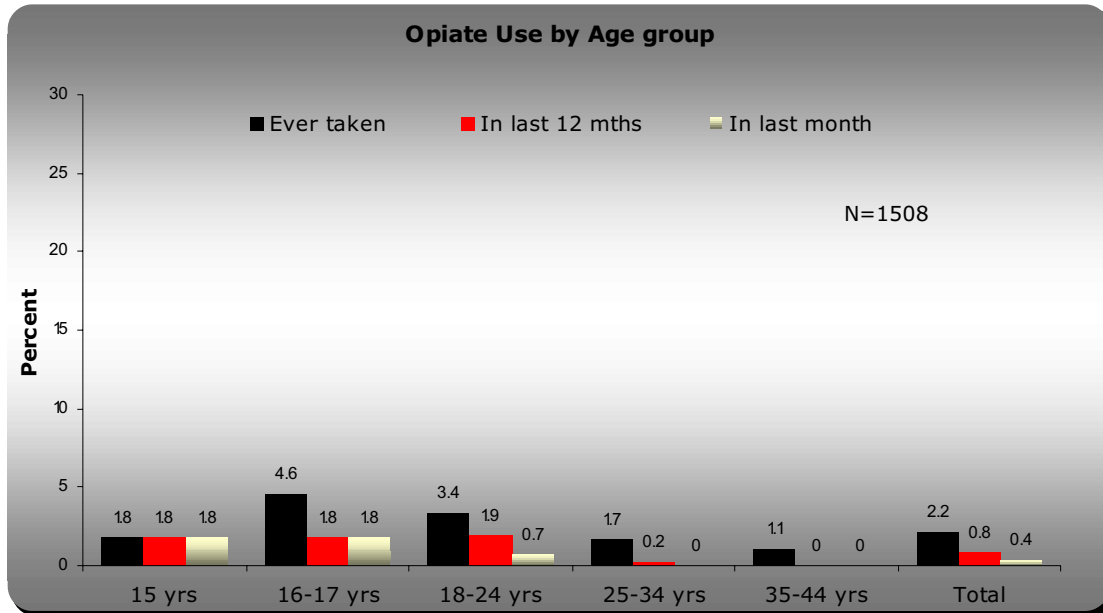
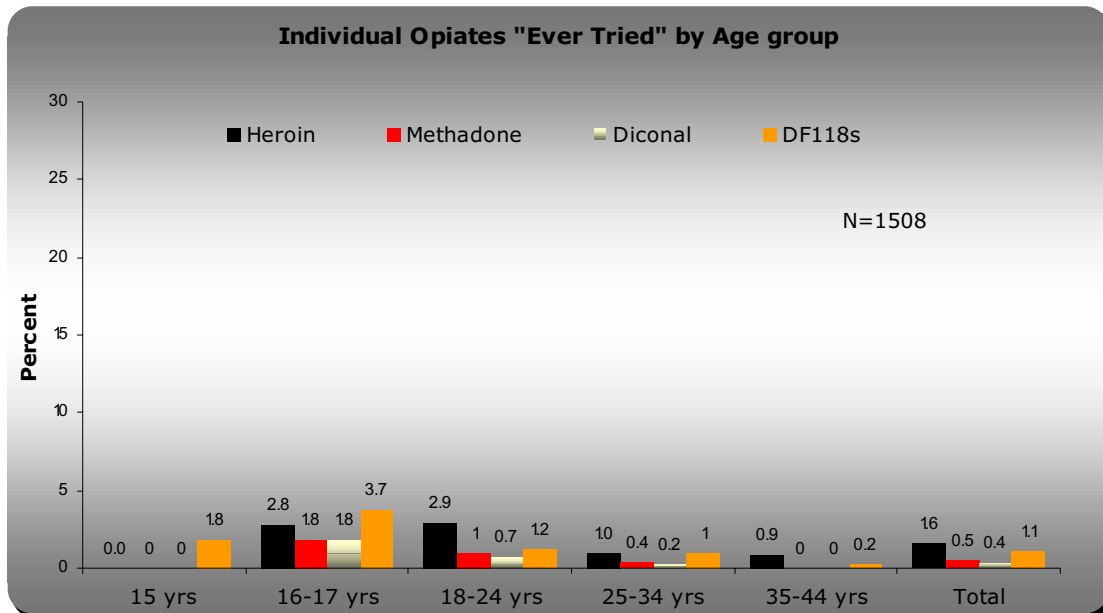


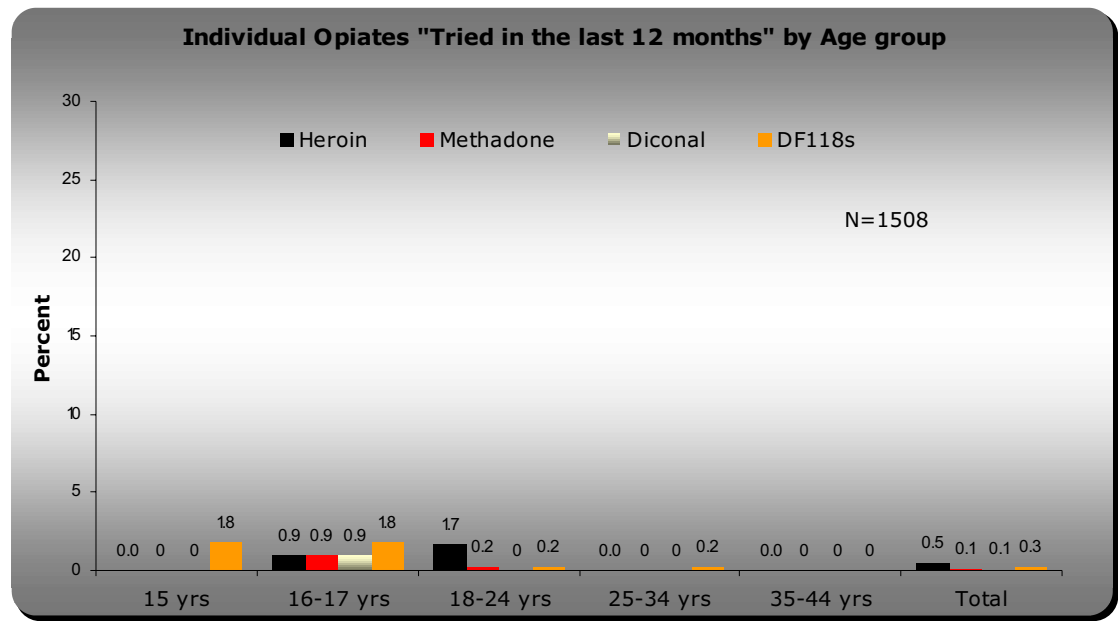
Fig 86



Recent use of Heroin was highest at 1.7% for Age 18-24 (χ^2 : p=0.003). (Fig 87)

Recent DF118 was highest at 15-17 years at 1.8% (χ^2 : p=0.012).

Fig 87



7. HALLUCINOGENS

LSD

Magic Mushrooms

Overall Lifetime use for Hallucinogens was 6.3%, Recent use 1.8%, and Current use 0.7%. (Fig 88)

Magic Mushrooms use was more frequent in Lifetime (5.1%) and Recent use (1.4%) compared to LSD (3.6% and 0.9%). (Fig 89)

Current use Hallucinogens were 0.5% or less, and too small in number for stable analysis.

Fig 88

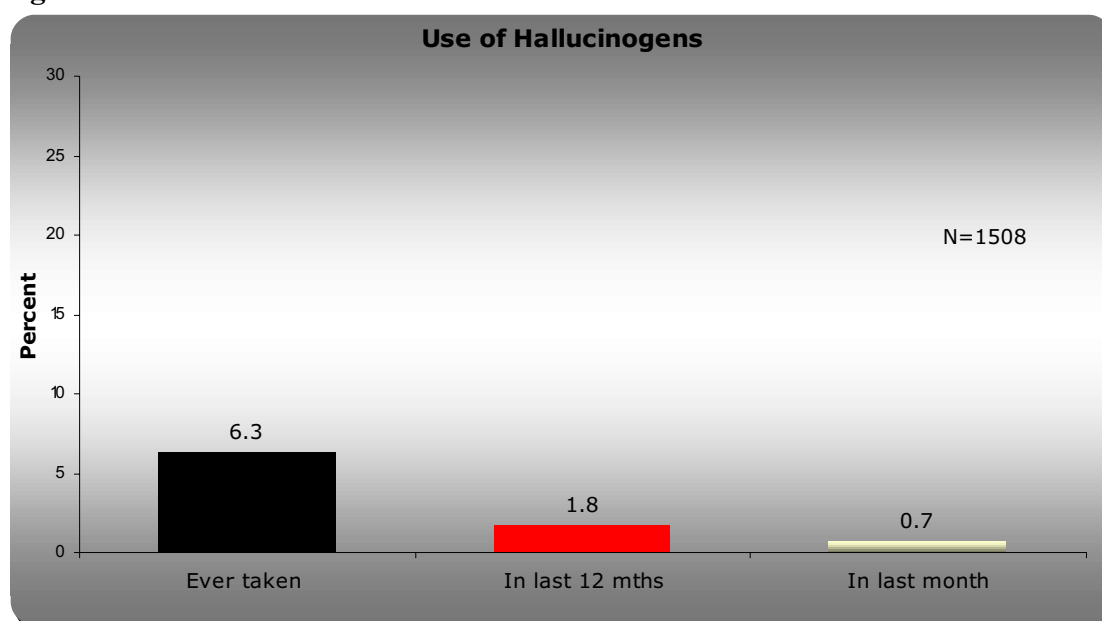
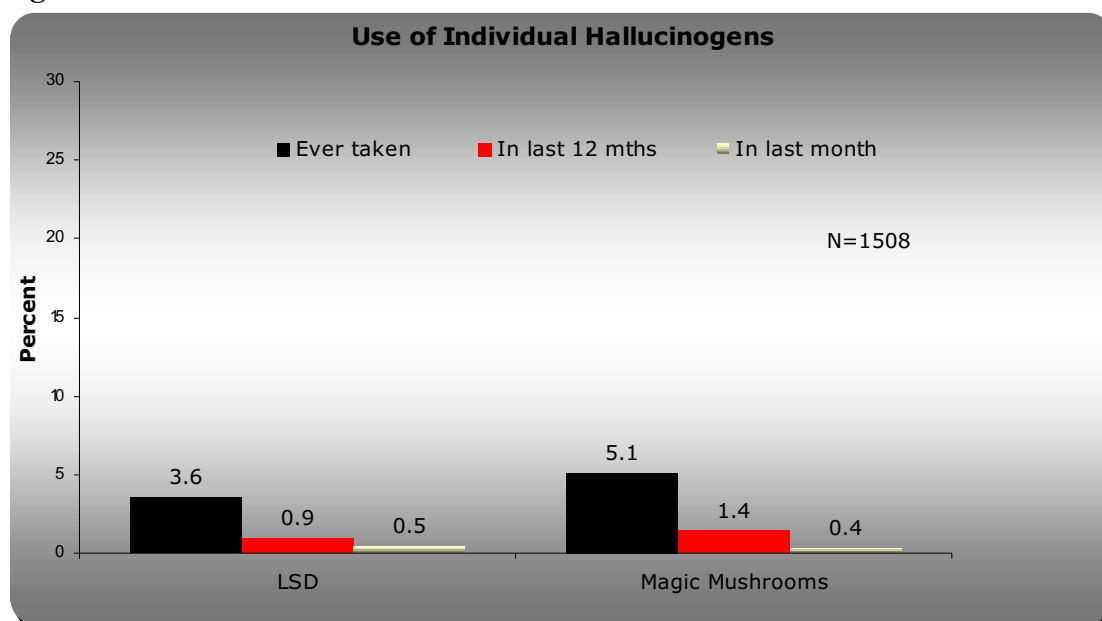


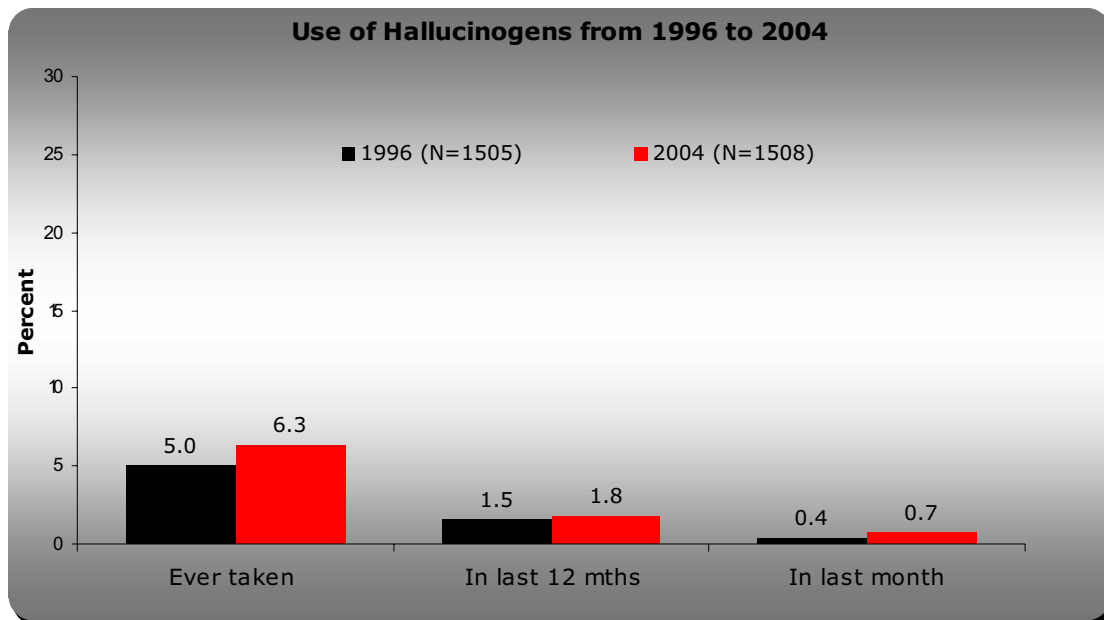
Fig 89



Changes in individual Hallucinogens since 1996 (Fig 90)

There was no significant change in any category of Hallucinogens or individual drugs since 1996.

Fig 90

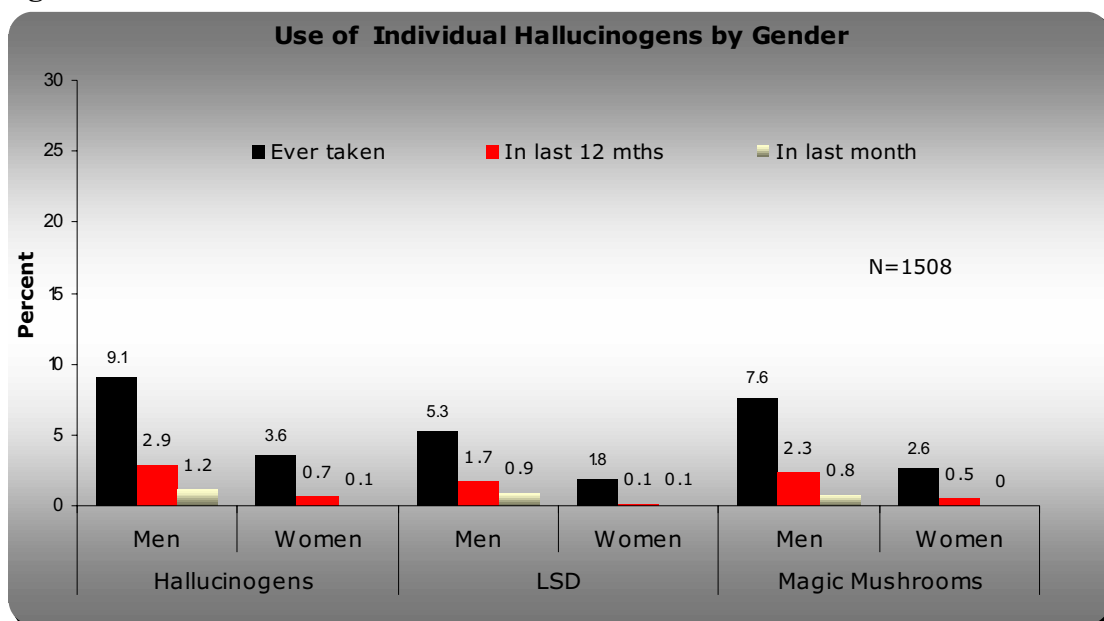


Gender (Fig 91)

Males (9.1%) use Hallucinogens more than twice as much as females (3.6%) for Lifetime use (χ^2 : $P < 0.001$), and four or more times as much for Recent and Current use (χ^2 : $p \leq 0.01$)

Significant Gender differences for individual Hallucinogens reflected the overall group patterns, with Magic Mushrooms being more frequently used than LSD for Lifetime and Recent use.

Fig 91

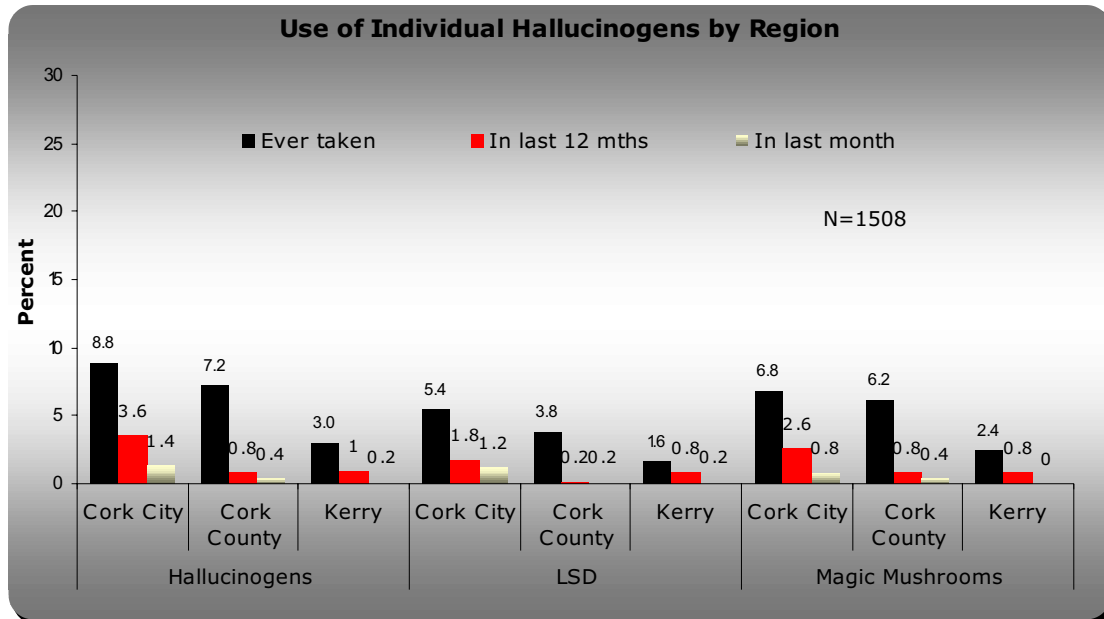


Regions (Fig 92)

Cork City (9%) and County (7%) were significantly higher than Kerry (3%) for Lifetime use of hallucinogens (χ^2 : $p=0.001$). Recent (3.6%) and Current (1.4%) use was highest for Cork City (χ^2 : $p<0.05$).

Individual hallucinogens reflected this pattern, with Magic Mushrooms being slightly more used than LSD.

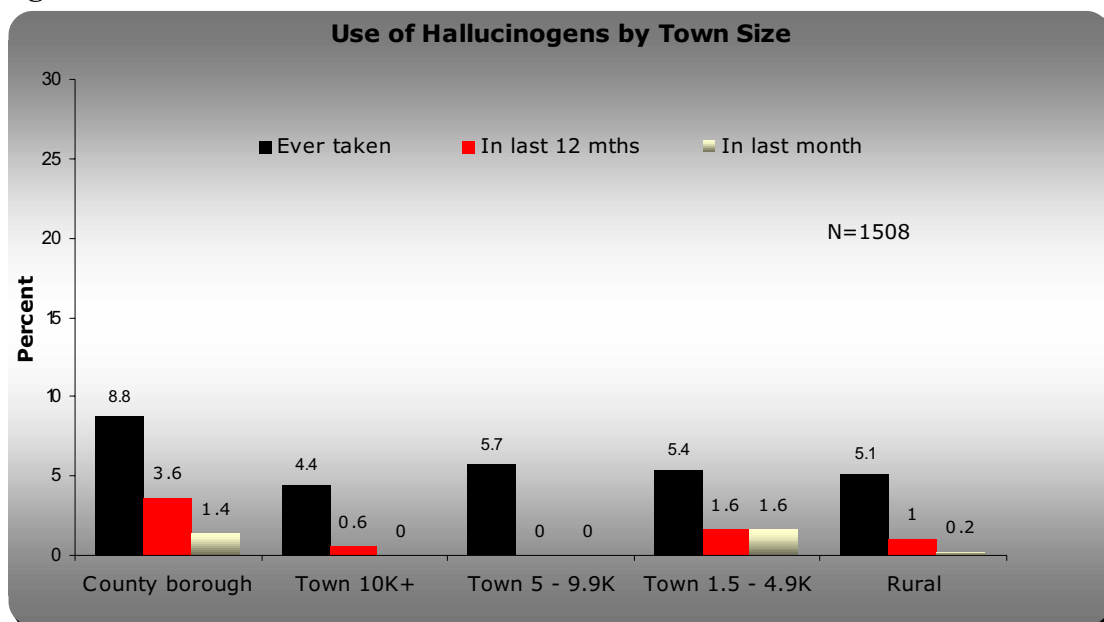
Fig 92



Town Size (Fig 93)

This reflected Regional figures with Recent (3.6%), and Current (1.4%) Hallucinogens, being almost mainly in city populations, but also in small towns (χ^2 : $p < 0.05$). Individual hallucinogens showed a similar pattern.

Fig 93



Social Class and Deprivation

Hallucinogens showed no significant differences for Social Class Group or Deprivation.

Age Group (Fig 94-5)

Lifetime use of Hallucinogens showed little variation for age from 16 years onwards. Recent (4.6%) and Current (3.7%) use were highest at age 16-17ys (χ^2 : $p < 0.01$). This pattern was also shown for individual hallucinogens.

Fig 94

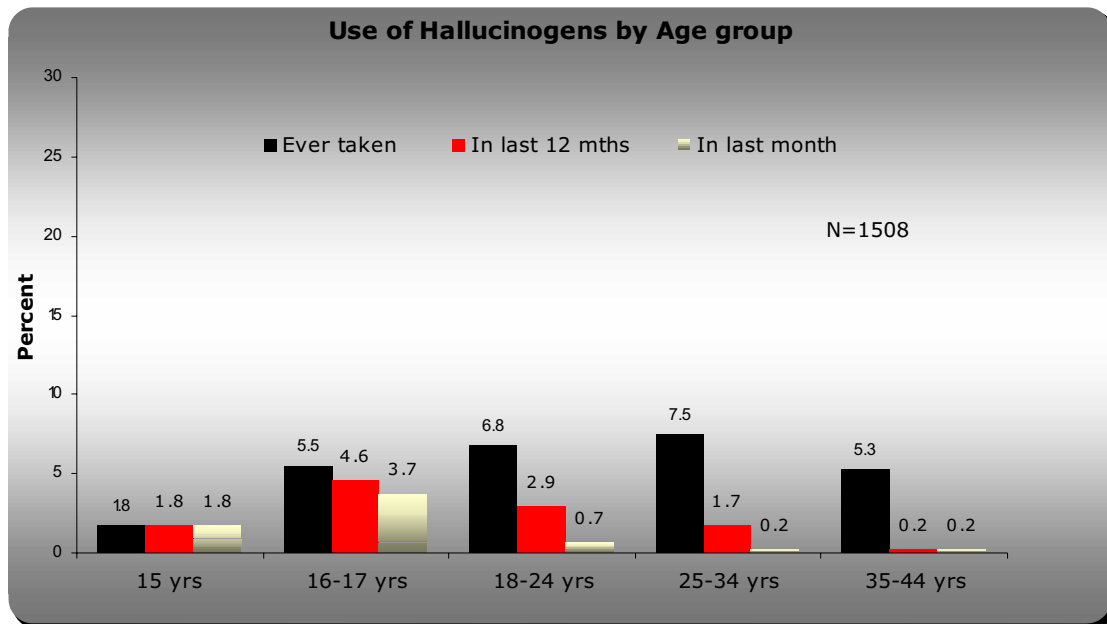
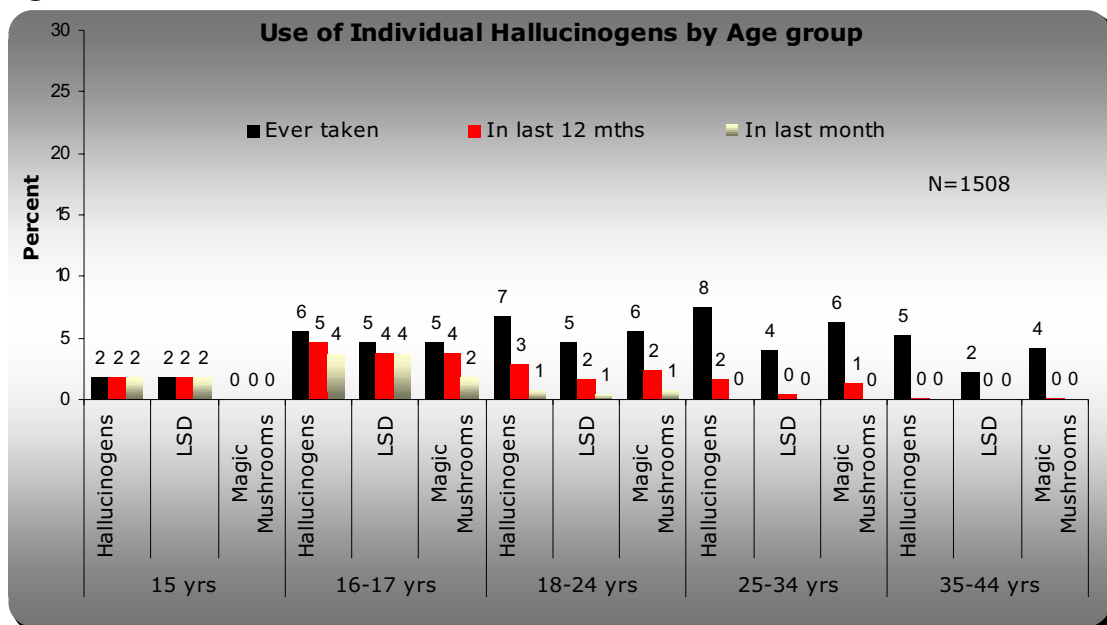


Fig 95



8. SEDATIVES

Barbiturates
Sleeping Tablets
Temazepan
Tranquillisers
Temgesic
Triazolam

Overall Lifetime use for Sedatives was 2.9%, Recent use 0.9%, and Current use 0.6% (Fig 96-7). Unprescribed Tranquilisers (2.1%) and Unprescribed Sleeping Tablets (1.5%) were the commonest Lifetime Sedatives used. Other individual Sedatives were less than 1%. Recent and Current individual Sedatives were less than 0.7%.

Fig 96

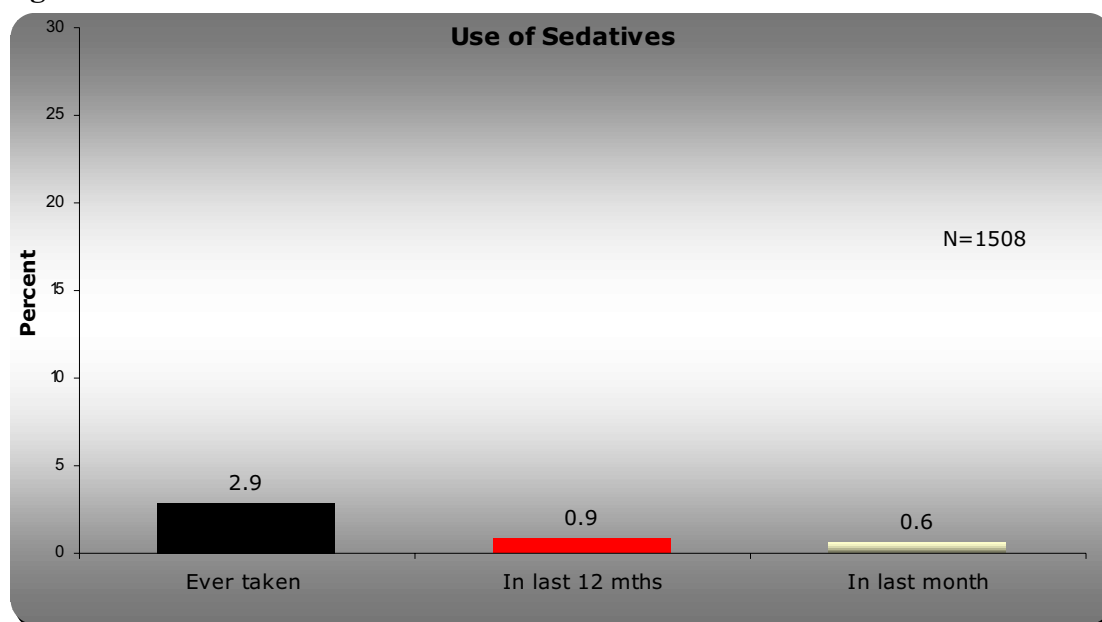
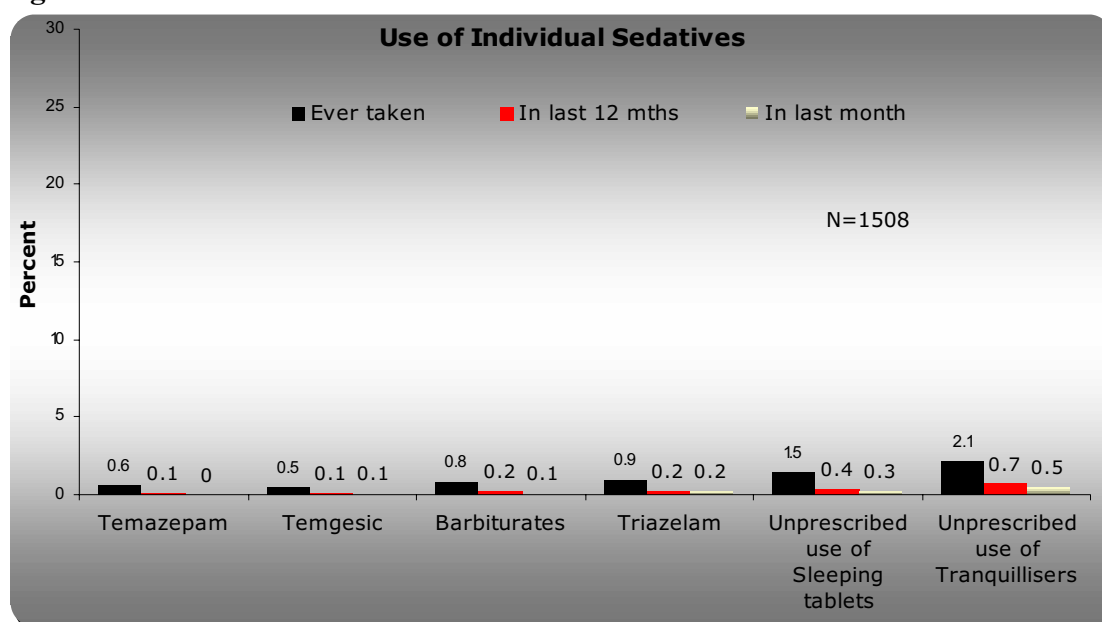


Fig 97



Changes since 1996

Lifetime Temgesic use, and Current Tranquiliser use, increased from 0.1% to 0.5% (Fx: $p < 0.05$).

There was no other significant change in any other category of Sedatives or individual drugs since 1996.

Gender

There was no significant differences for Sedative use by gender.

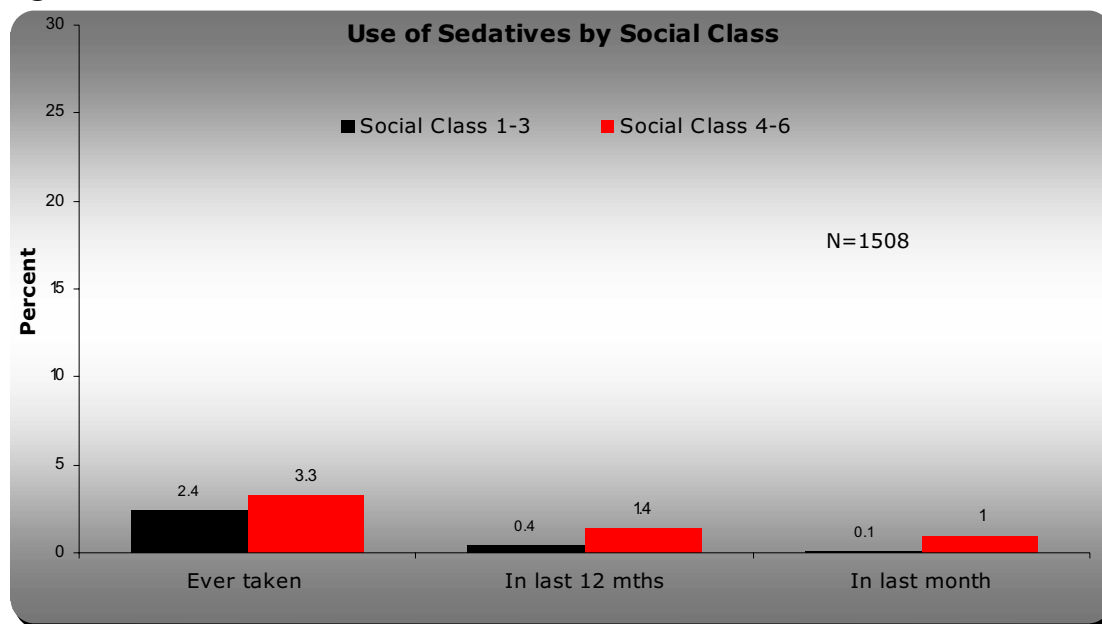
Regions

There were no significant differences for Sedative use by Region or Community Size.

Social Class Group and Deprivation (Fig 98)

Current Sedative use showed an increase for Social Class 4-6 (1%), but this was not reflected in any individual drugs. Deprivation showed no difference.

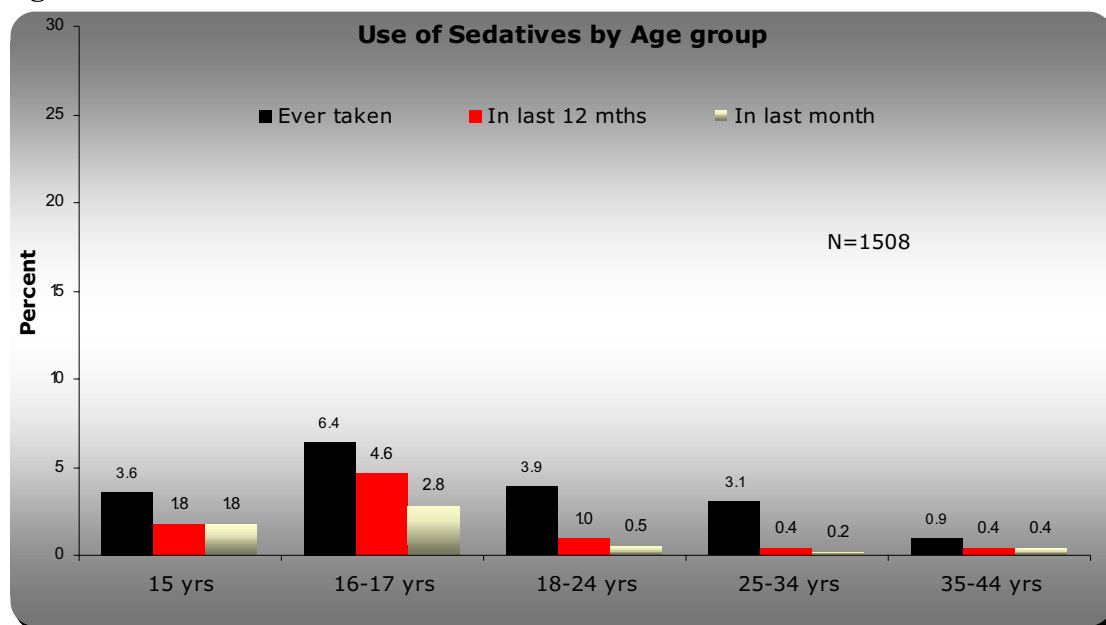
Fig 98



Age Group (Fig 99)

Lifetime (6.4%), Recent (4.6%) and Current (2.8%) use of Sedatives were highest at age 16-17ys (χ^2 : $p < 0.05$). This pattern was also shown for individual Sedatives, although numbers were small.

Fig 99

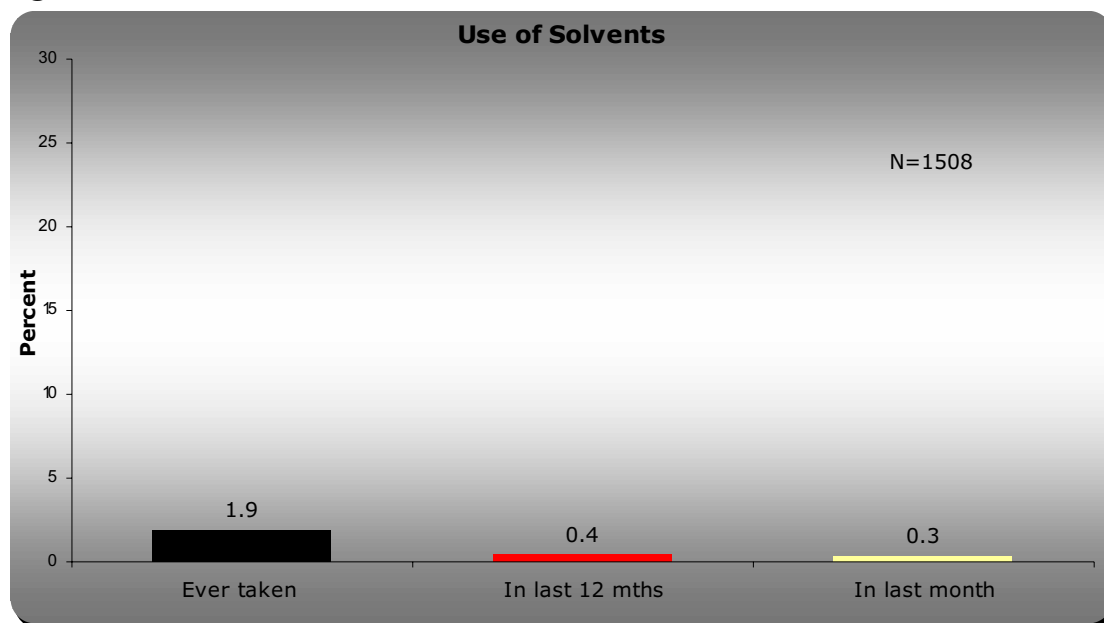


9. SOLVENTS

Glue
Aerosols
Gas

Overall, Lifetime use for Solvents was 1.9%, Recent use 0.4%, and Current use 0.3% (Fig 100).

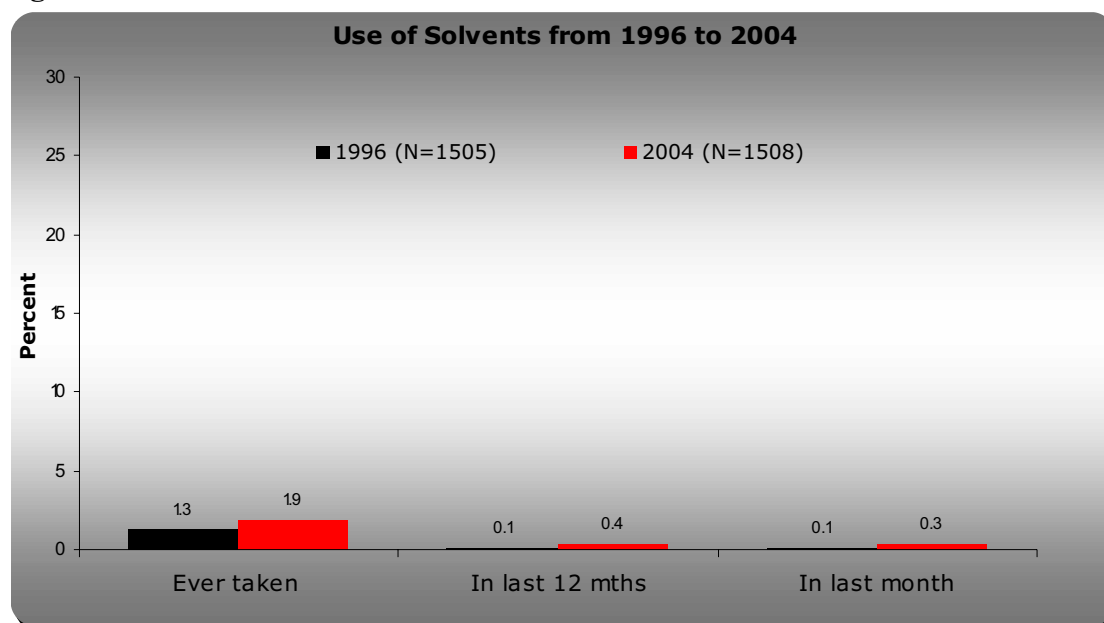
Fig 100



Changes since 1996 (Fig 101)

There was no significant change in any category of Solvents since 1996.

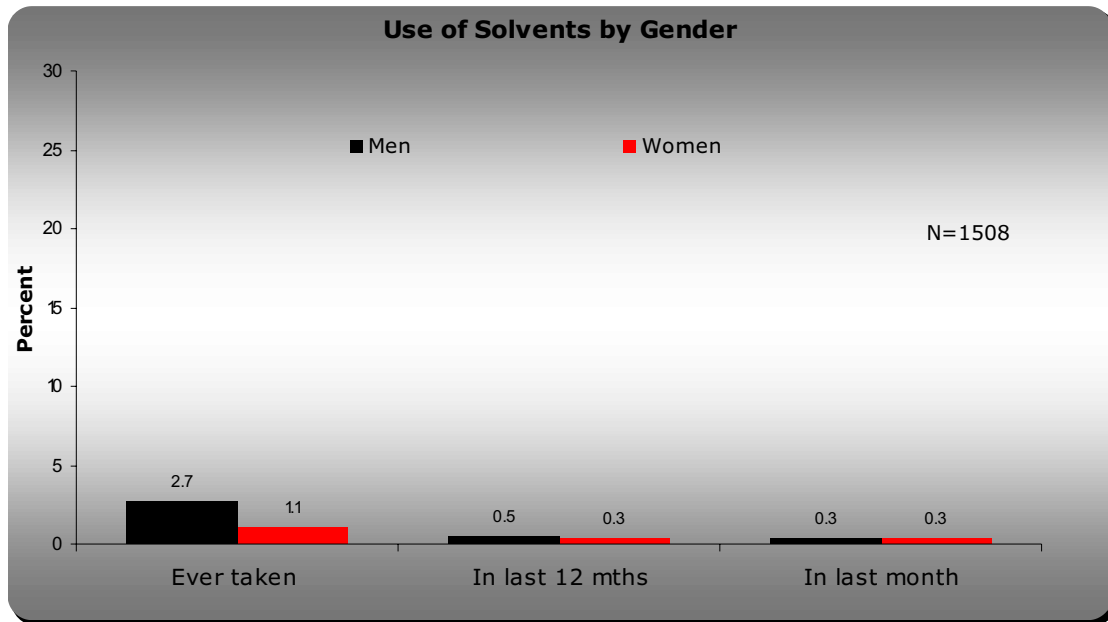
Fig 101



Gender (Fig 102)

Lifetime use of Solvents was higher in males (2.7%) than females (1.1%) (χ^2 : $p = 0.02$). Other categories showed no significant difference.

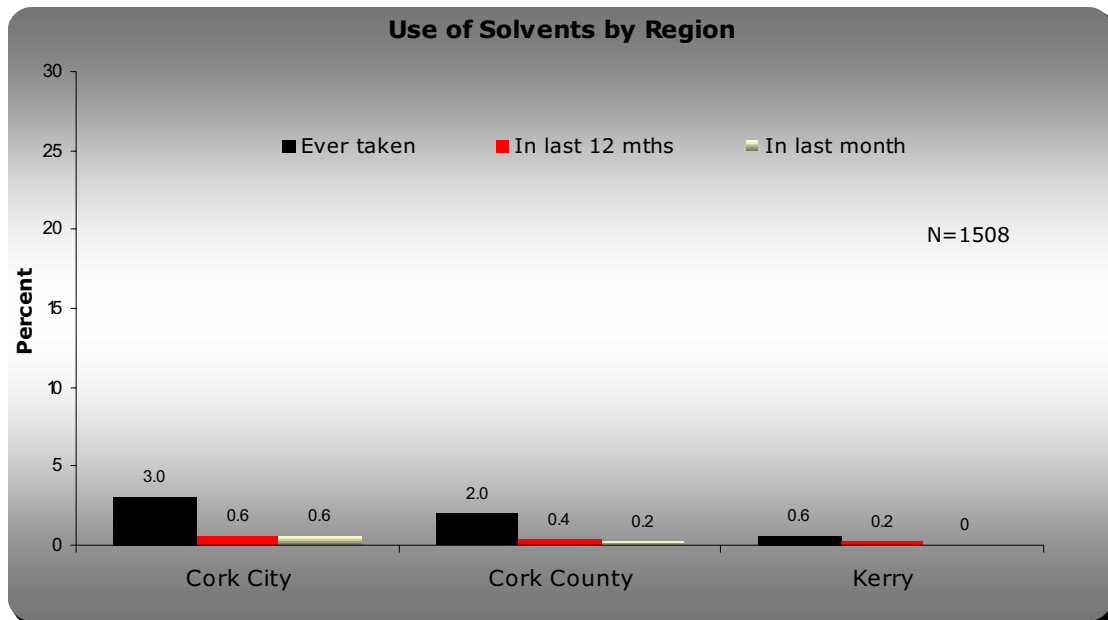
Fig 102



Regions and Community Size (Fig 103)

Lifetime use of Solvents was highest in Cork City (3.0%) in contrast to Cork Co (2%) or Kerry (0.6%) (χ^2 : $p = 0.02$). Recent and Current use showed no difference. Community Size showed no significant differences.

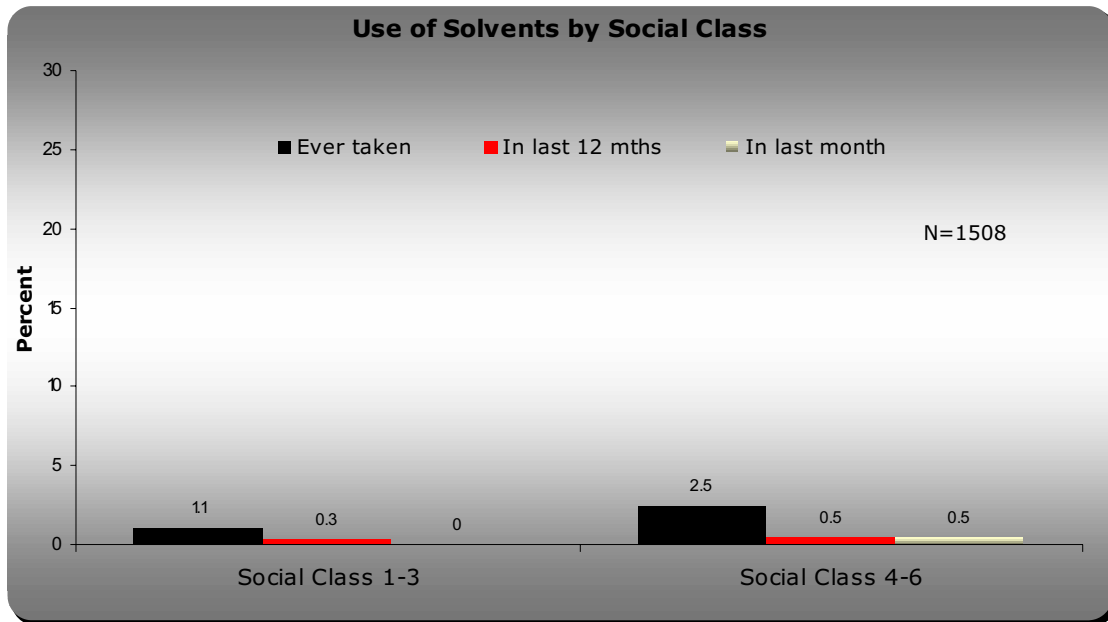
Fig 103



Social Class and Deprivation (Fig 104)

Solvents did not show significant difference for Social Class or Deprivation, although Lifetime use in Social Class Group 4-6 (2.5%) was twice that of Group 1-3 (1.1%).

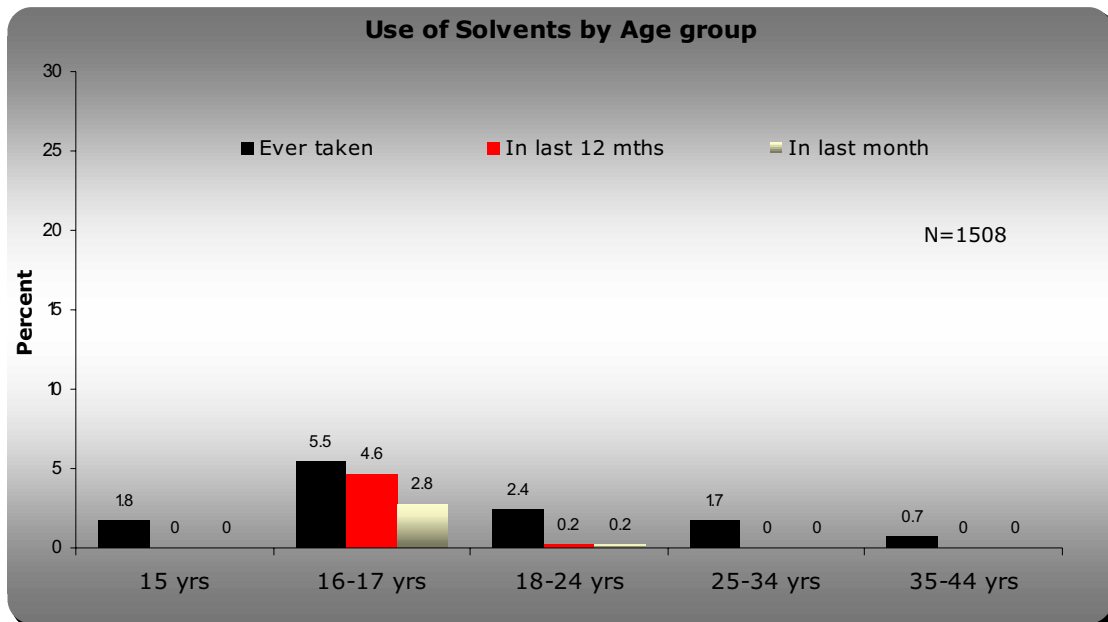
Fig 104



Age Group (Fig 105)

Lifetime (5.5%), Recent (4.6%) and Current (2.8%) use of Solvents were highest at age 16-17ys (χ^2 : $p < 0.02$).

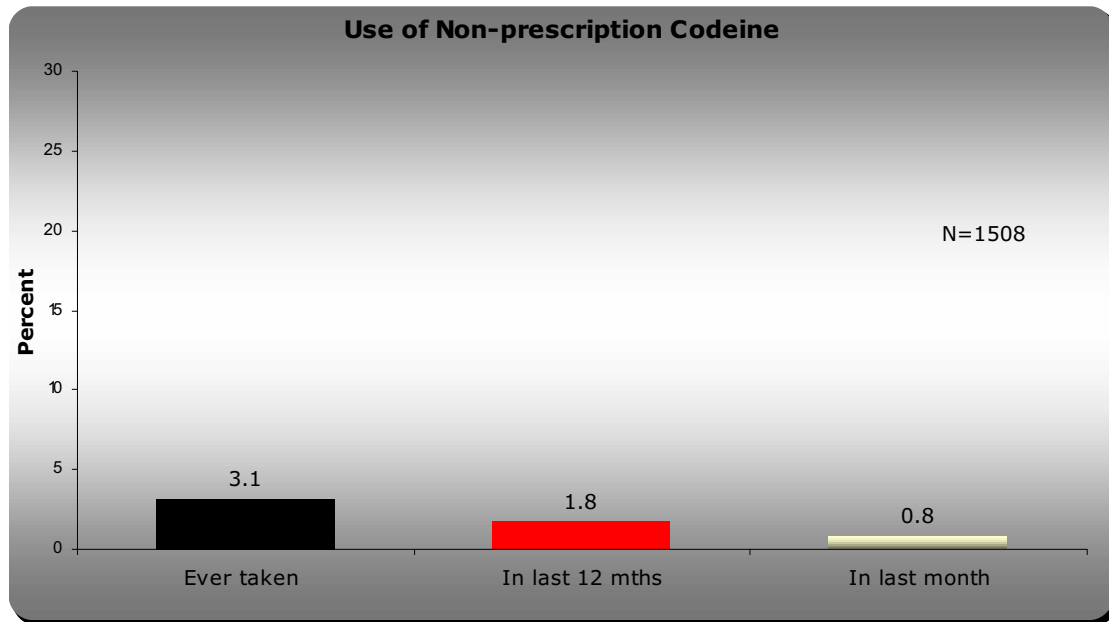
Fig 105



10. NON-PRESCRIPTION CODEINE

Overall Lifetime use for Codeine was 3.1%, Recent use 1.8%, and Current use 0.8%.

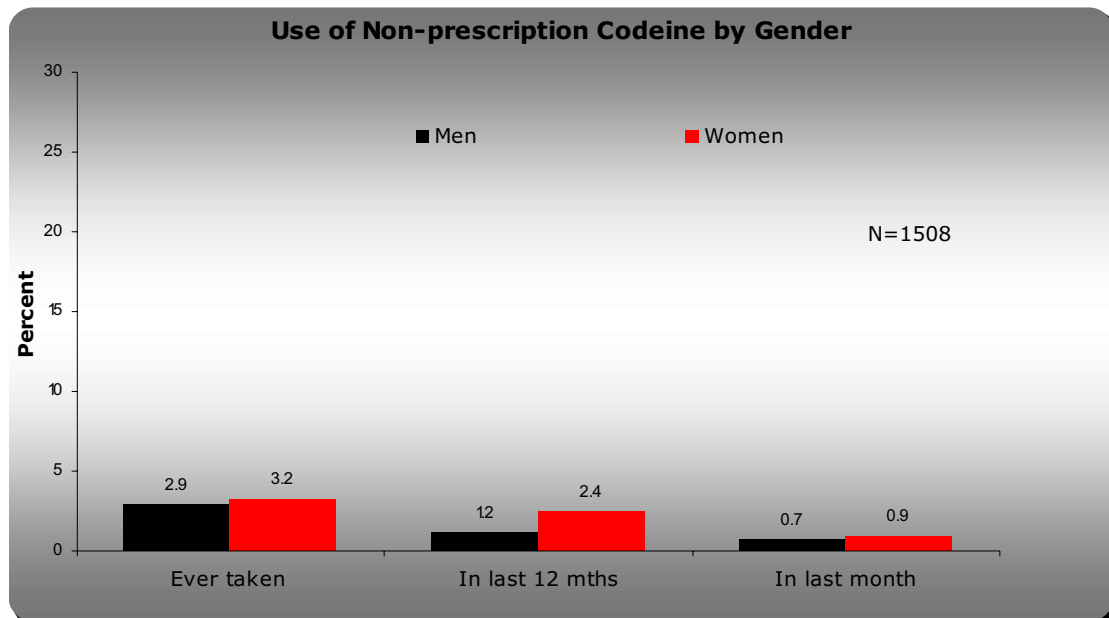
Fig 106



Gender (Fig 107)

There was a tendency for Recent use of Codeine to be higher in females (2.4%) than males (1.2%), but differences were not significant.

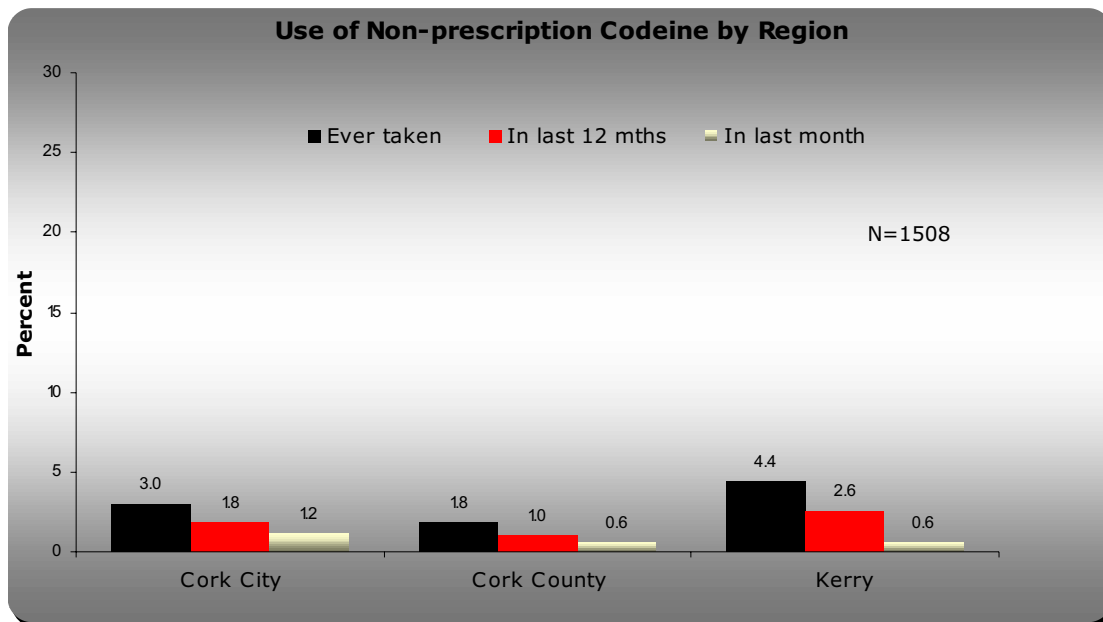
Fig 107



Regions and Community Size (Fig 108)

Use of Codeine was similar across all regions, and Communities with no significant differences.

Fig 108



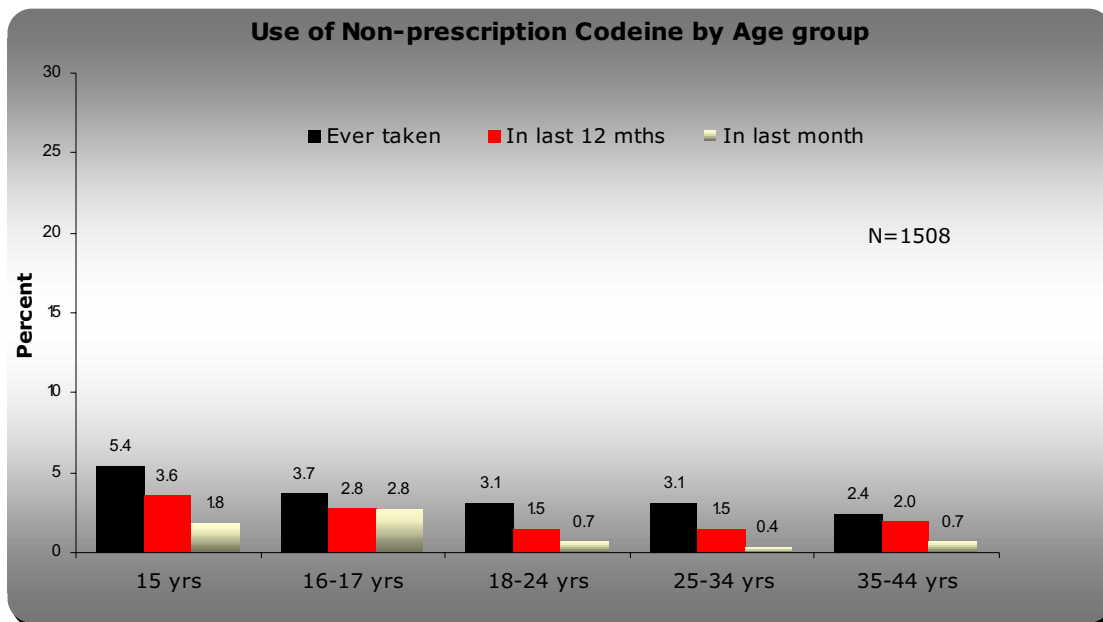
Social Class and Deprivation

Codeine did not show significant difference for Social Class or Deprivation.

Age Group (Fig 109)

Use of Codeine was similar across all age groups with no significant differences, although Lifetime and Recent use were highest at 15 to 17 years.

Fig 109



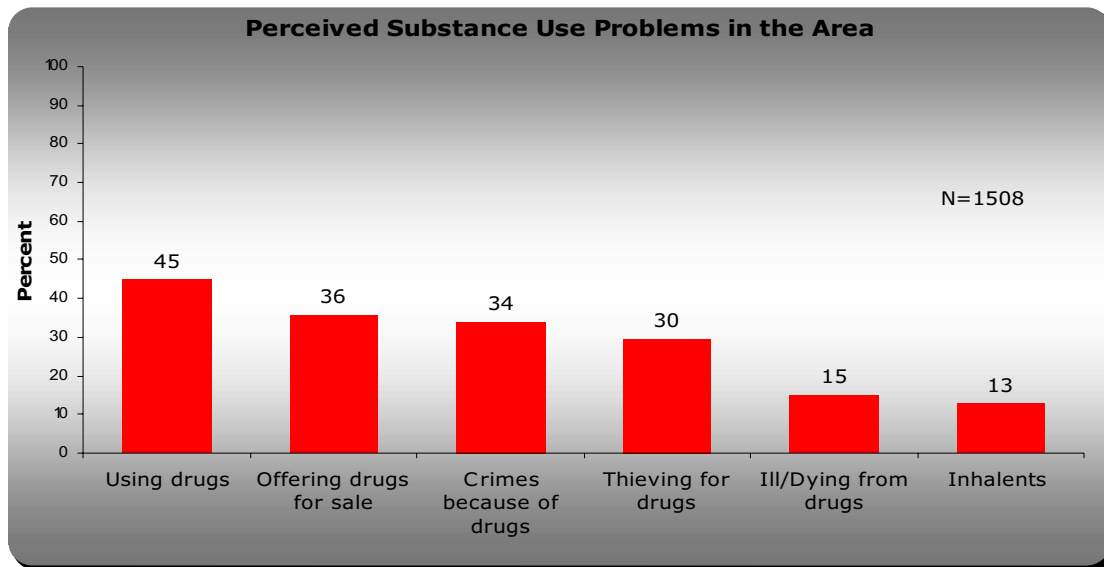
11. COMMUNITY PERCEPTIONS OF SUBSTANCE ABUSE ISSUES

Perceived Substance use Problems in Area (Fig 110)

People were asked about varying types of problems related to drug use in their areas. Those who perceived a problem as Very big or Fairly big were classified as seeing that there was a problem. All other categories including don't know, were classified as not having a problem.

Using Drug (45%), Offering Drugs for sale (36%), and Crimes related to Drugs (34%) were the main problems perceived in the community.

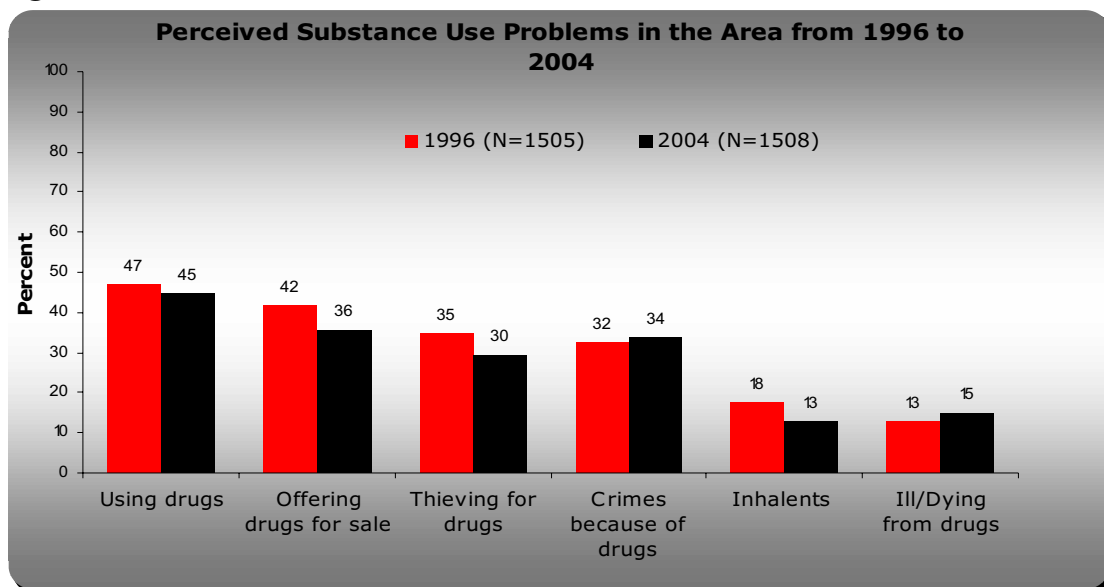
Fig 110



Changes since 1996 (Fig 111)

Offering Drugs for sale, Thieving for Drugs, and Inhalants were slightly but significantly lower since 1996, with reductions of 3-5% (χ^2 : $P < 0.005$).

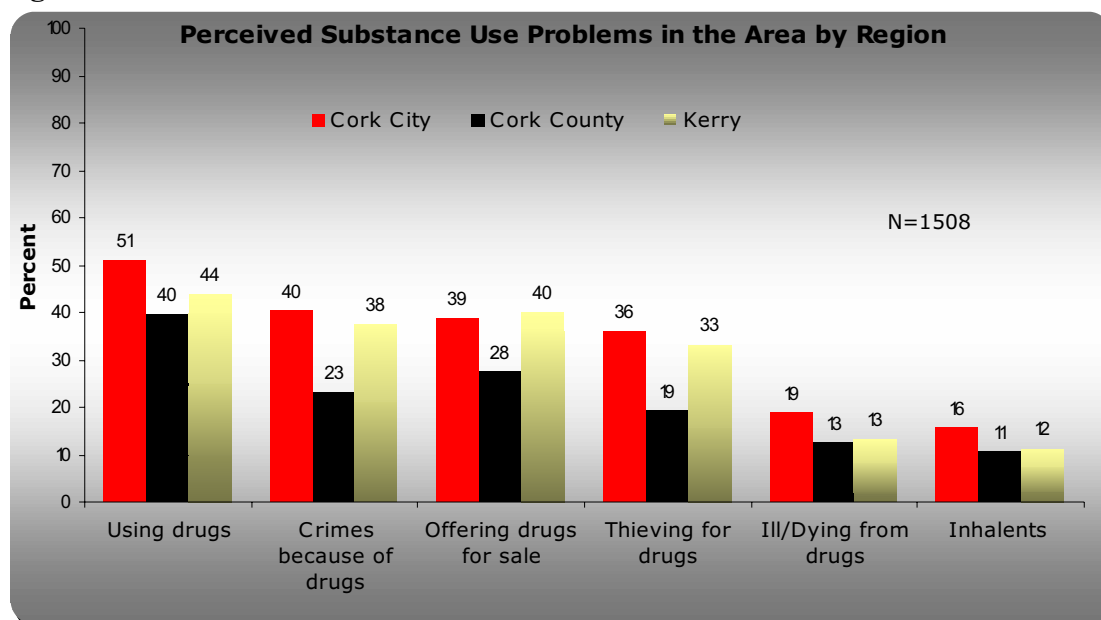
Fig 111



Regions (Fig 112)

Cork City had highest level for all problems, but was closely matched by Kerry (χ^2 : $P<0.05$).

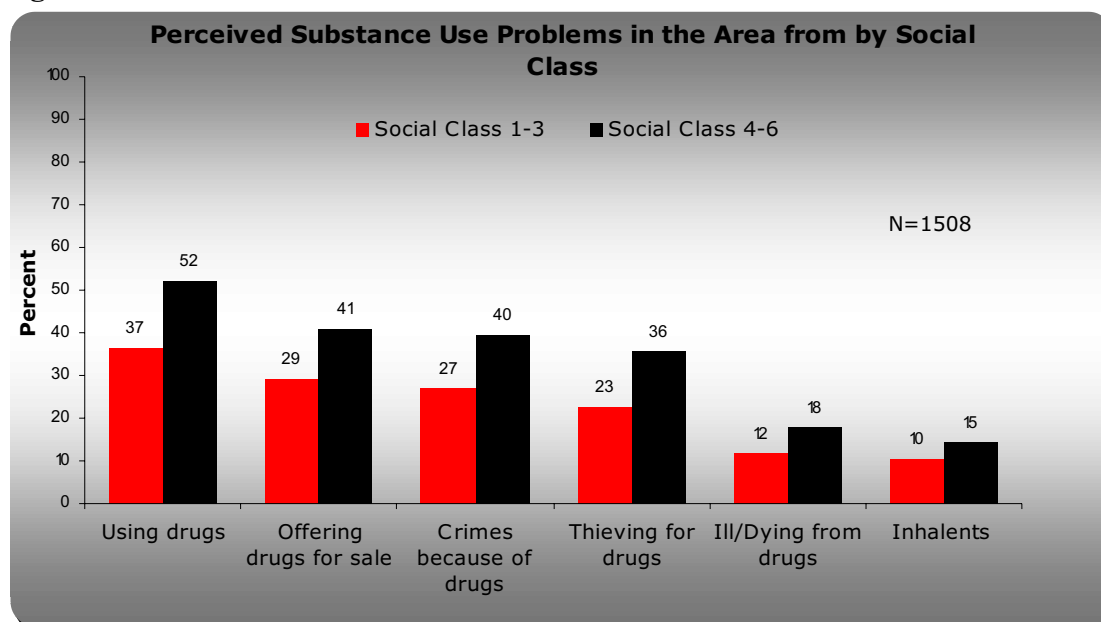
Fig 112



Social Class Group and Deprivation (Fig 113)

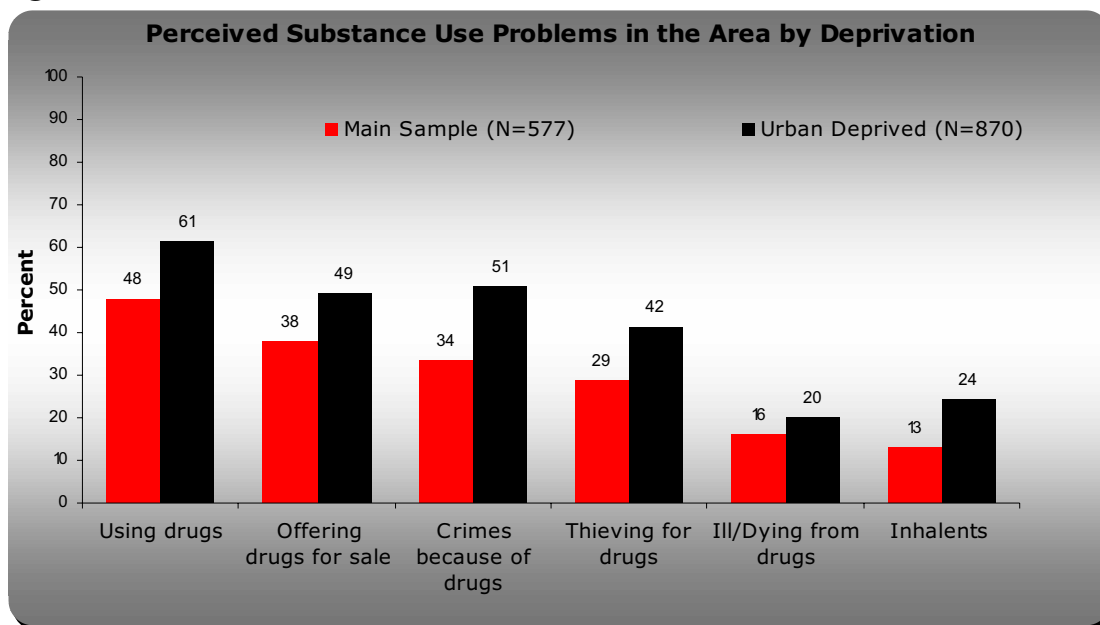
Perception of Problems in Social Class Group 4-6, were significantly higher, by up to 50% (χ^2 : $P<0.02$); especially for Drug use, Drugs Offered, and Thieving, and Crime.

Fig 113



This was also reflected for Deprivation, which showed even higher increases of up to 57% for most problems in urban deprived areas. All differences were significant (χ^2 : $P<0.001$), except for People Ill or Dying from Drugs. (Fig 114)

Fig 114



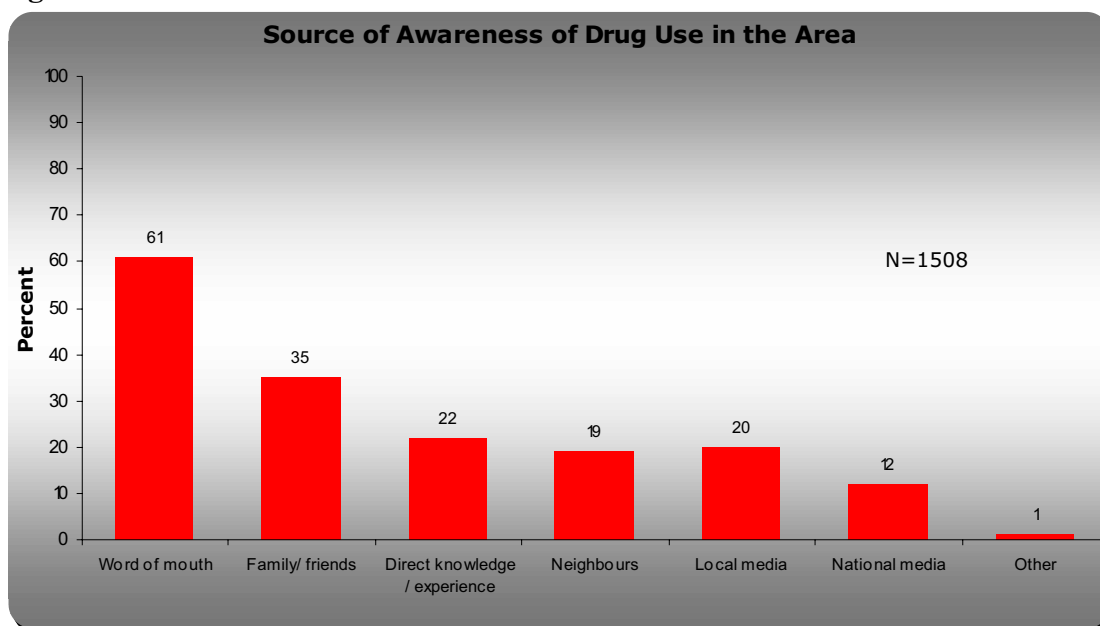
Age Group

There was no difference in perception of problems for age-groups.

Source of Awareness of Drug Use in Area (Fig 115)

As before, the major sources of awareness of drug use were all due to personal contact systems, with Word of Mouth (61%), Family/Friends (35%) and Direct Experience (22%) being the most frequent sources. Local Press (13%) was highest for the media groups.

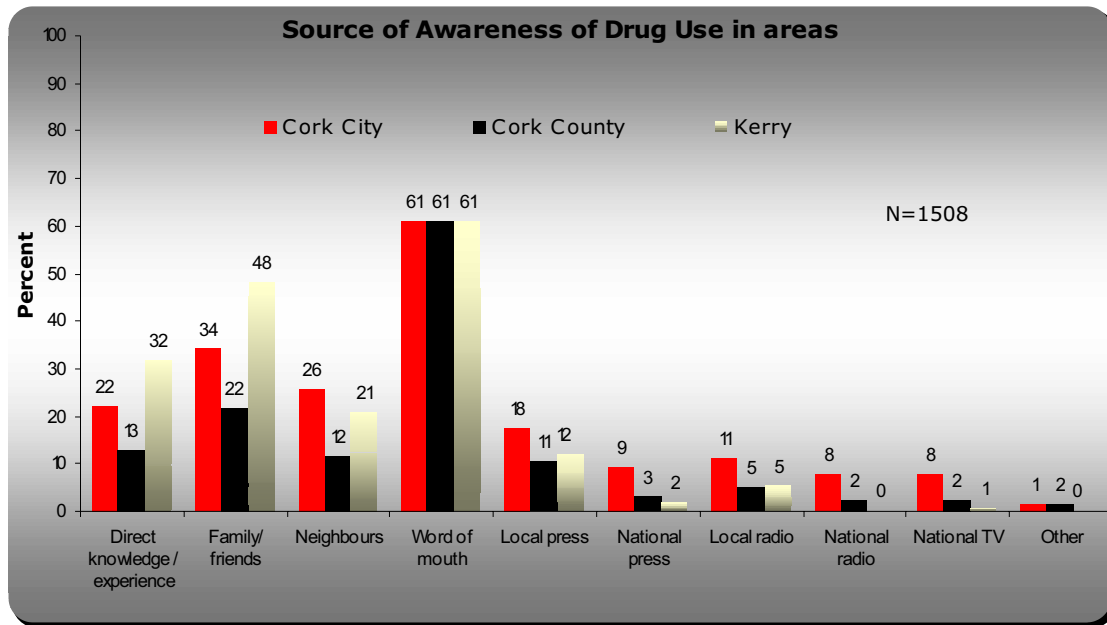
Fig 115



Regional Differences for Sources Awareness (Fig 116)

Kerry was highest for Family and Friends (48%), and Direct Experience (32%) (χ^2 : $P < 0.001$). All regions were equally high for General Word of Mouth (65%). Cork City was highest for all other Sources of Awareness (K-W: $P < 0.001$).

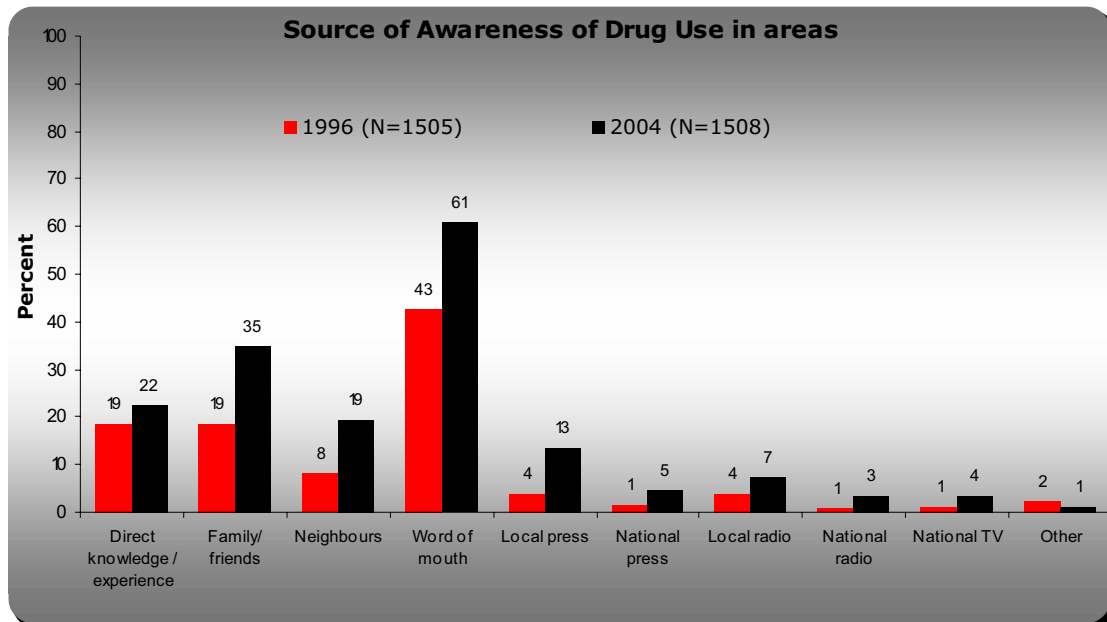
Fig 116



Changes Since 1996 (Fig 117)

All sources of awareness for drugs showed an increase, especially personal contact systems (χ^2 : $p < 0.001$).

Fig 117

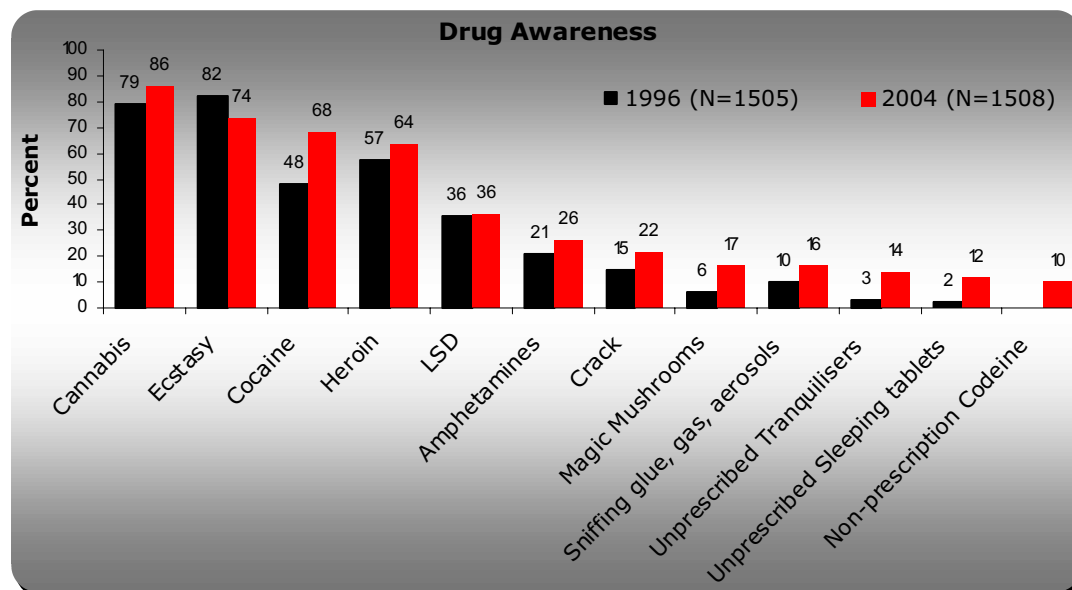


Drug Awareness (Fig 118)

When respondents were asked what drugs they could name, the commonest were Cannabis, Ecstasy, Cocaine, Heroin, which were named by more than 60%. LSD, Amphetamines, Crack, Magic Mushrooms, Solvents, Tranquilisers, Sleeping Tablets, Codeine were mentioned by 10-36%. Other drugs were less than 10%.

Magic Mushrooms, Tranquilisers, Sleeping Tablets, and Codeine were all above 10% awareness, compared with 1996, and almost all drug awareness had increased.

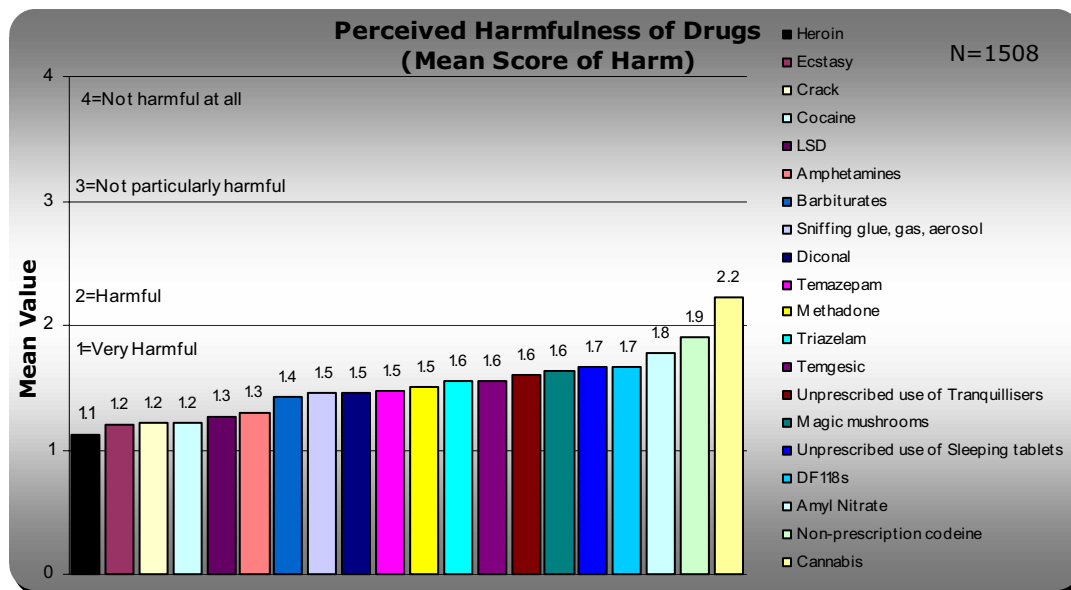
Fig 118



Perceived Harmfulness of Drugs (Fig 119)

People were asked about how harmful they thought particular drugs were. This was coded on a scale of one to four, from most harmful (1) to not harmful at all (4). Heroin, Ecstasy, Crack, Cocaine, and LSD are seen as the most harmful of drugs. Cannabis is seen as the least harmful. Those who regard Cannabis as not harmful take it most (70%), compared to those who consider it harmful (30%) (χ^2 : P = 0.000).

Fig 119



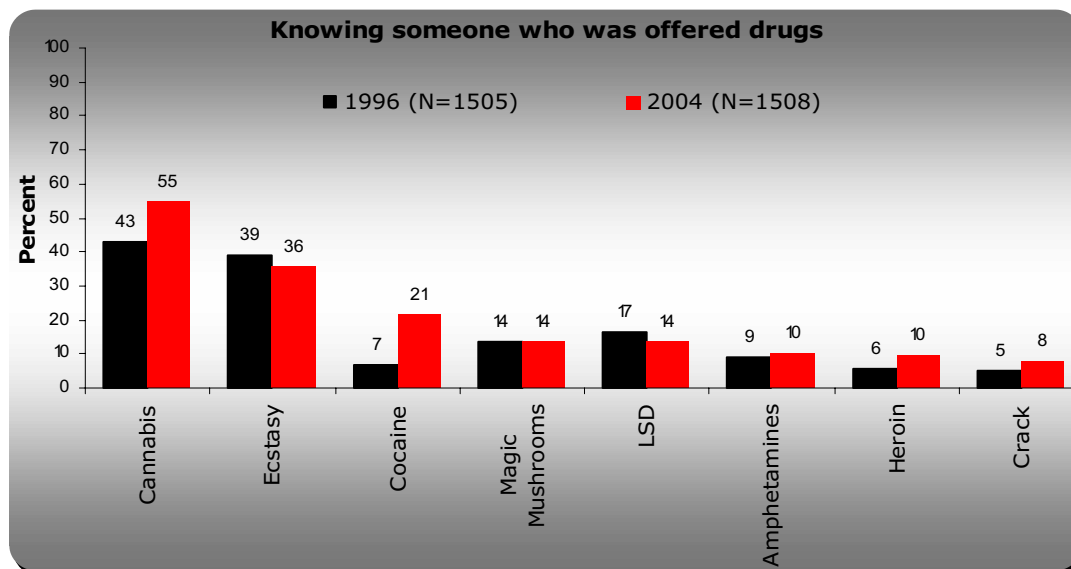
Personal Knowledge of Drug Use Situations

Knowing someone who was Offered Drugs: (Fig 120)

55% knew someone who was offered Cannabis, 36% Ecstasy, 21% Cocaine, 14% Magic Mushrooms or LSD, 10% Amphetamines or Heroin, and 8% Crack. Other drug situations were less than 5%.

In most cases, there was a significant increase since 1996 especially for Cannabis, Heroin, Cocaine, Crack, and Methadone (χ^2 : P= 0.000)

Fig 120

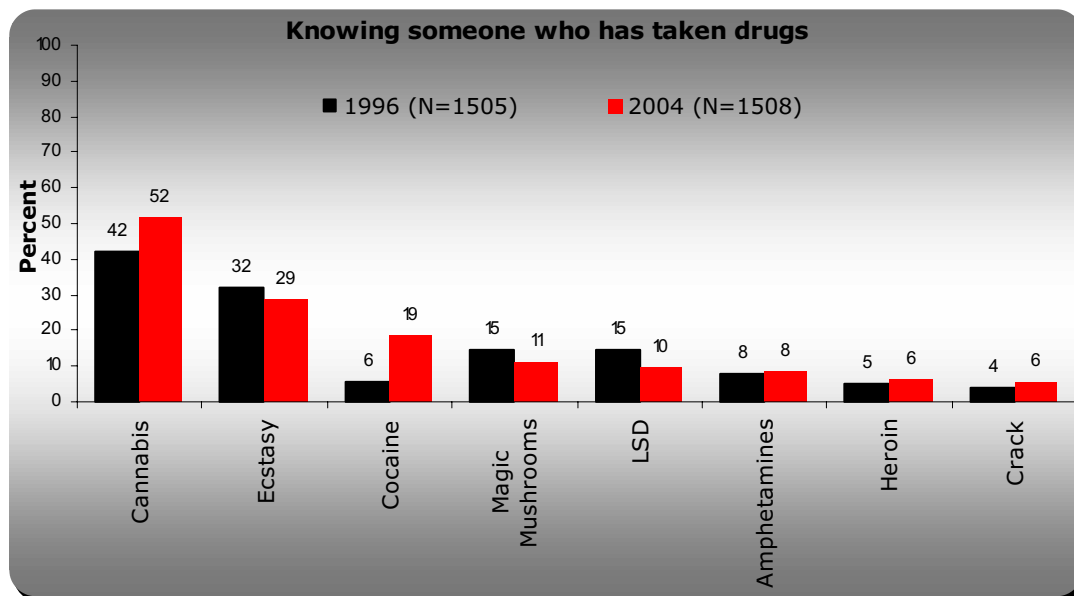


Knowing someone who has **Taken Drugs**: (Fig 121)

52% knew someone who had taken Cannabis, 29% Ecstasy, 19% Cocaine, 11% Magic Mushrooms, 10% LSD, 8% Amphetamines, 6% Heroin or Crack. Other drug situations were less than 5%.

Cannabis and Cocaine situations were significantly increased since 1996, and LSD decreased (χ^2 : $P < 0.001$).

Fig 121

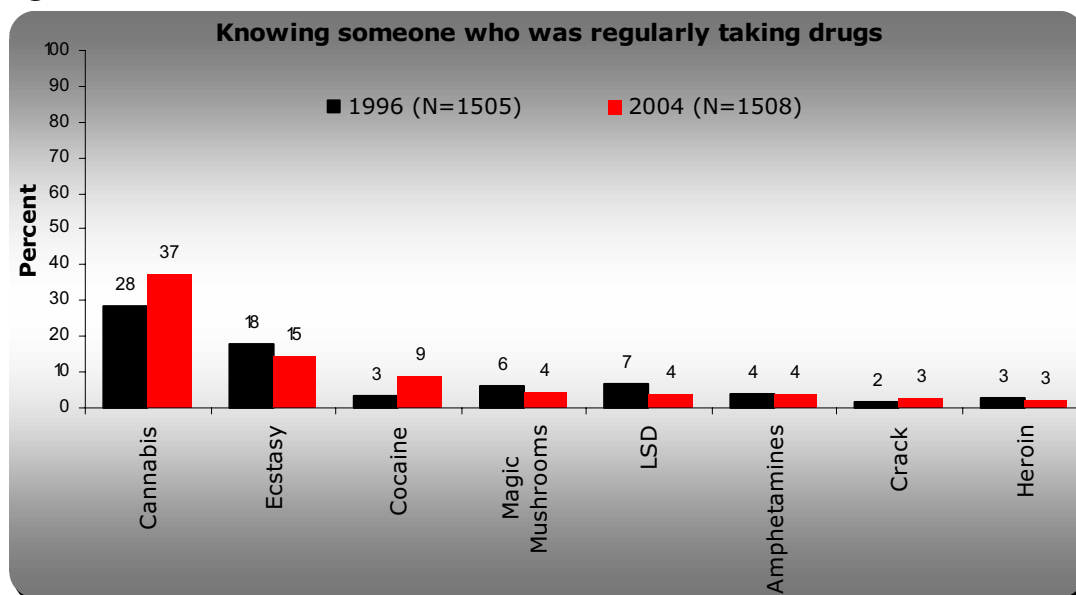


Knowing someone who was **Regularly Taking Drugs** (Fig 122)

37% knew someone who regularly took Cannabis, 15% Ecstasy, and 9% Cocaine. Other drug situations were less than 5%.

Cannabis and Cocaine situations were significantly increased since 1996 (χ^2 : $P < 0.001$), and LSD and Magic Mushrooms decreased.

Fig 122

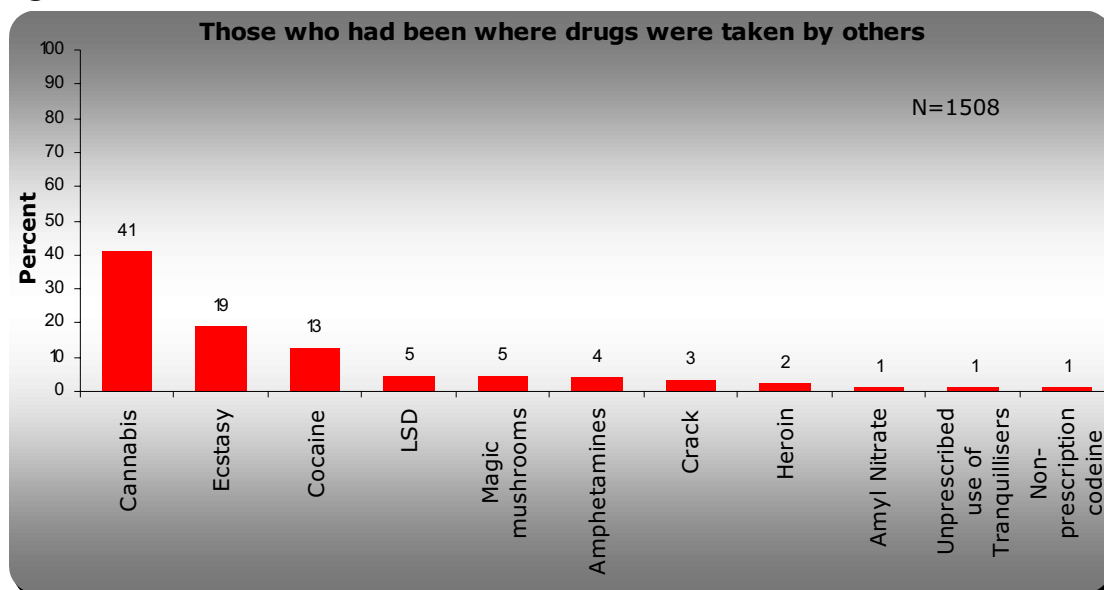


Those who had **Been where Drugs were Taken by Others:** (Fig 123)

41% had been where Cannabis was taken, 19% Ecstasy, and 13% Cocaine. Other drug situations were 5% or less.

Cannabis and Cocaine situations were significantly increased since 1996 (χ^2 : $P < 0.001$), and LSD decreased.

Fig 123



Perception of Scale of Substance Use Problems posed by Alcohol or Drugs

67% considered Alcohol to be an equal or greater problem than drugs. (Fig 124)

This pattern had significantly changed since 1996, when drugs were seen as the main problem (χ^2 : $P < 0.001$). (Fig 125)

Fig 124

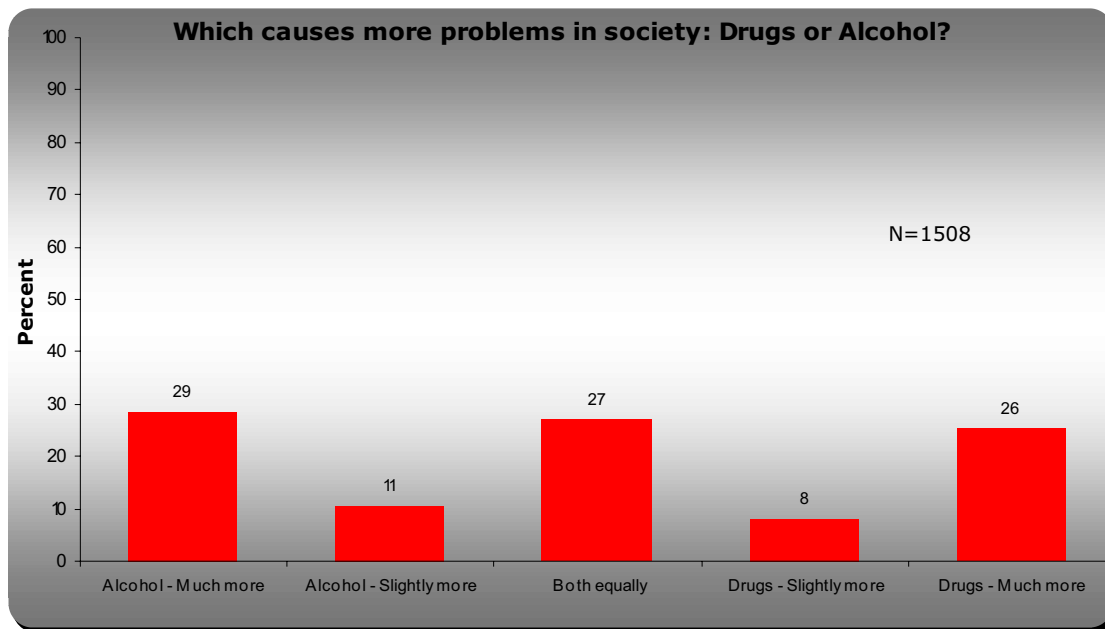
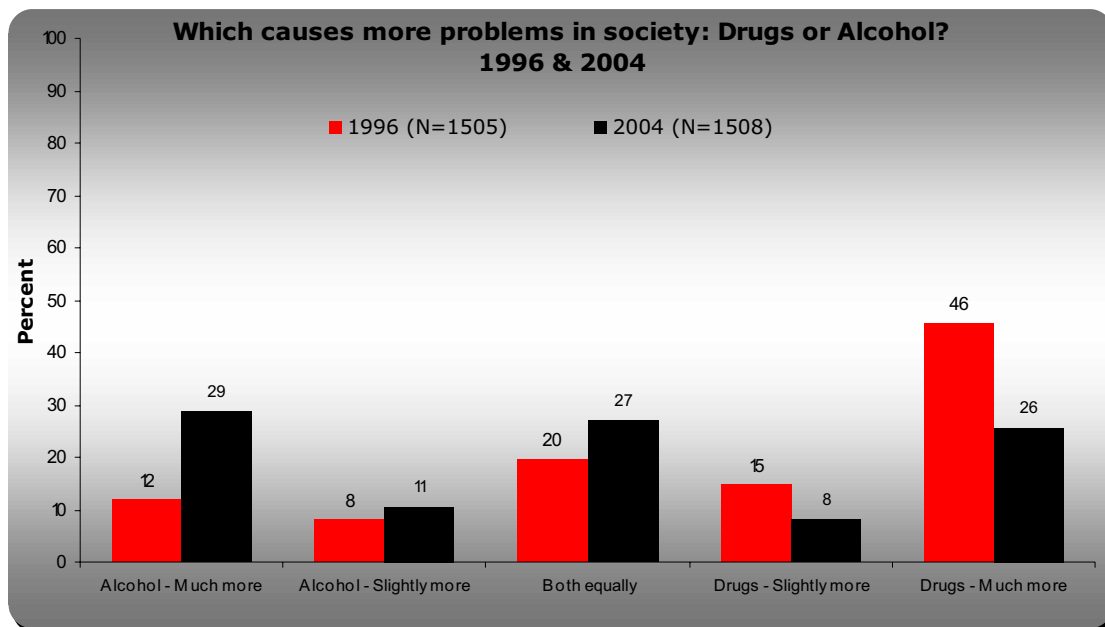


Fig 125

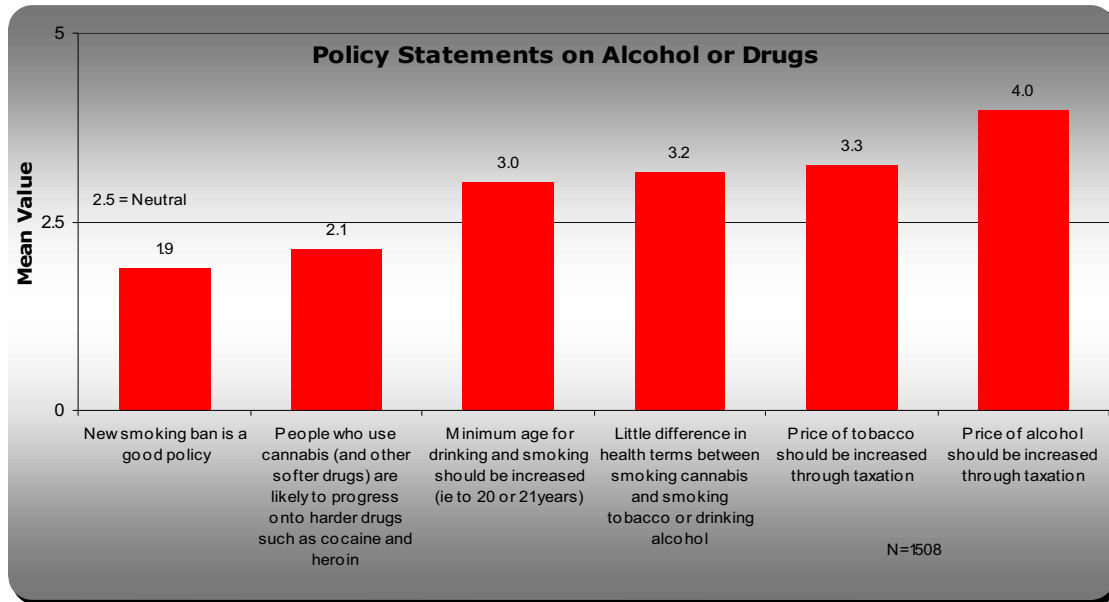


Policy and Legislation on Alcohol and Drugs

Respondents were asked how much they agreed or disagreed with several statements on Alcohol or Drug issues. A mean of 2.5 was neutral. A mean score of 1 showed strong agreement, and 5 strong disagreement.

There was agreement that the Smoking Ban was a good policy, and some agreement that cannabis could be a gateway drug leading to progression to harder drugs (Fig 126). There was disagreement on all the remaining statements, especially for raising the price of alcohol or smoking further.

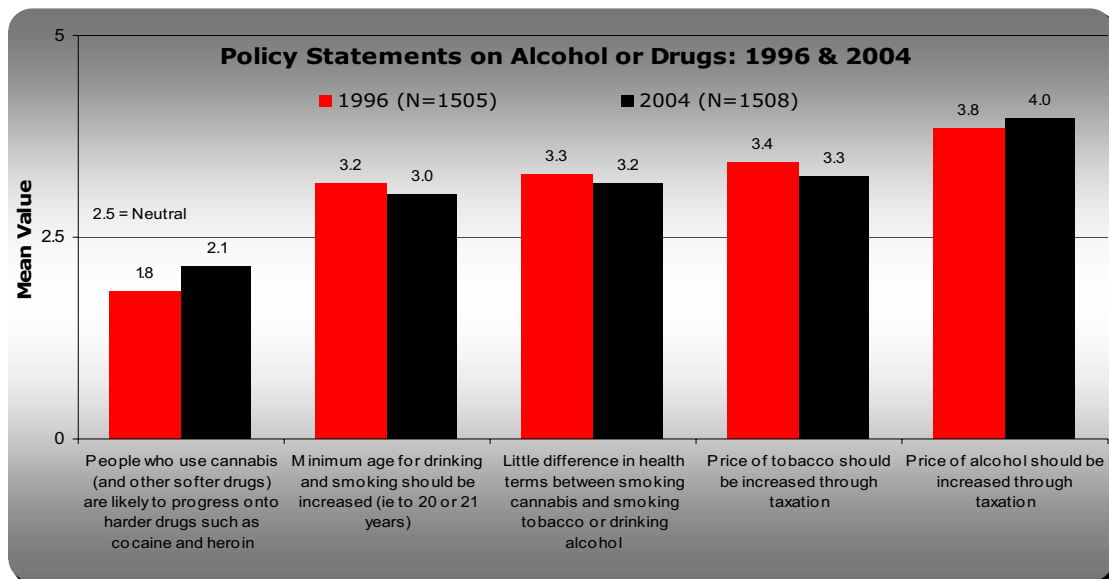
Fig 126



Changes since 1996 (Fig 127)

Relevant mean scores were all significantly changed since 1996 (χ^2 : $P < 0.05$). Disagreement for Cannabis being little different from tobacco or alcohol was reduced. Agreement that Cannabis was a gateway drug was reduced. There was increased disagreement on increasing alcohol pricing, but decreased disagreement on increasing tobacco pricing.

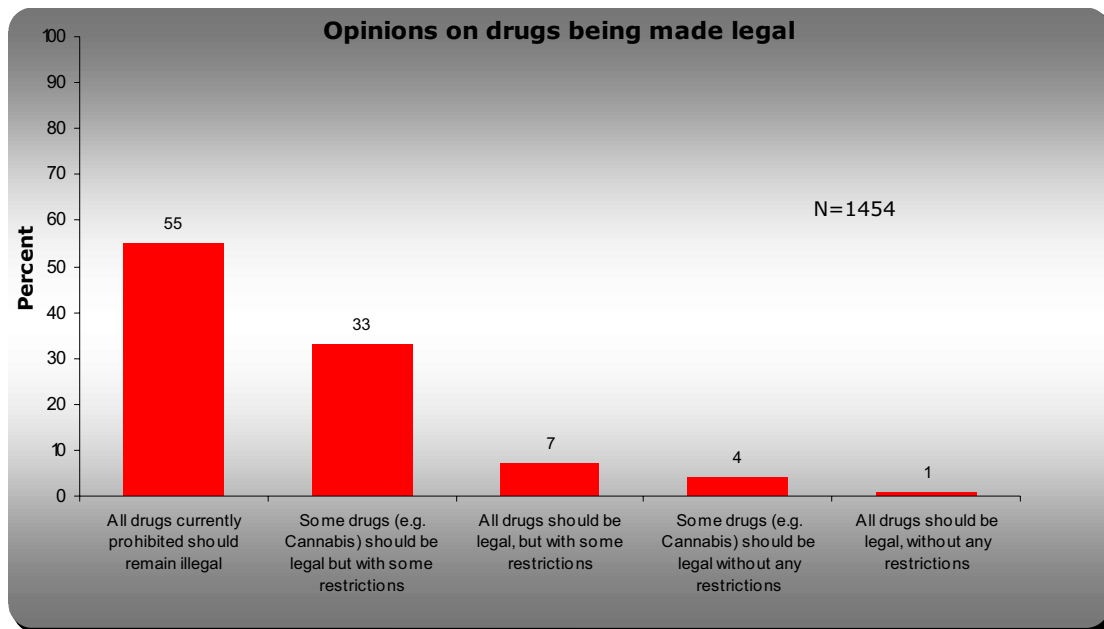
Fig 127



Attitudes Towards Legalising Drugs (Fig 128)

55% supported current prohibitions on drug use. However 33% thought that Cannabis should be legalised with restrictions. 7% agreed all drugs should be legal with restrictions. Relaxing other restrictions on drug use was supported by only 5%.

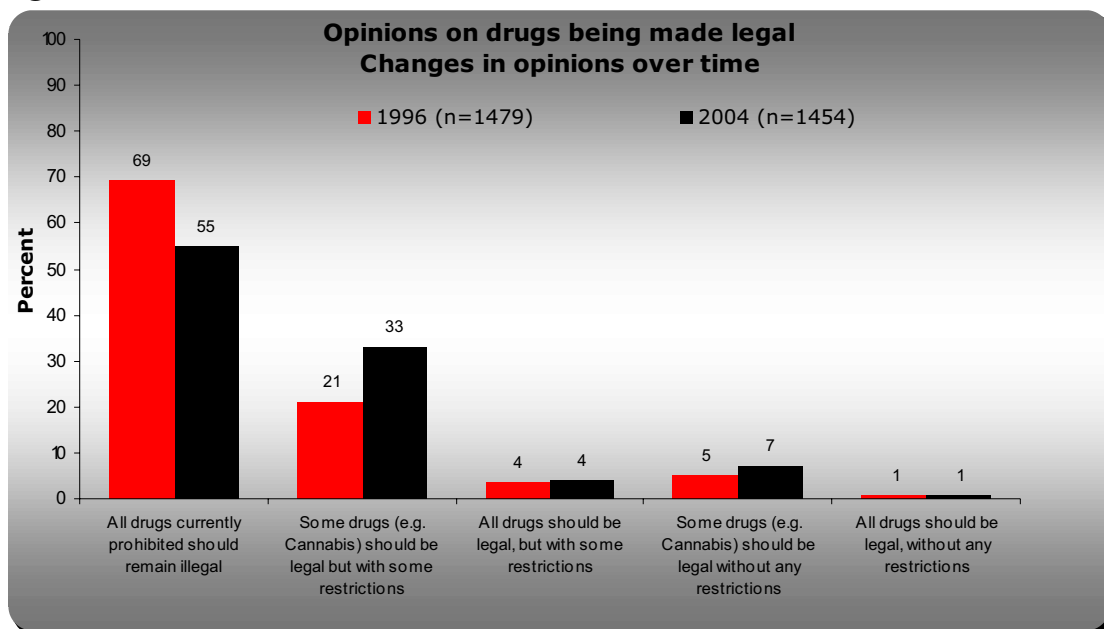
Fig 128



Changes since 1996 (Fig 129)

There was a 13% increase in support for legalisation of Cannabis, and a corresponding drop (14%) in support for continuing prohibition of all currently illegal drugs (χ^2 : $P < 0.05$). Other drug legalisation statements did not change.

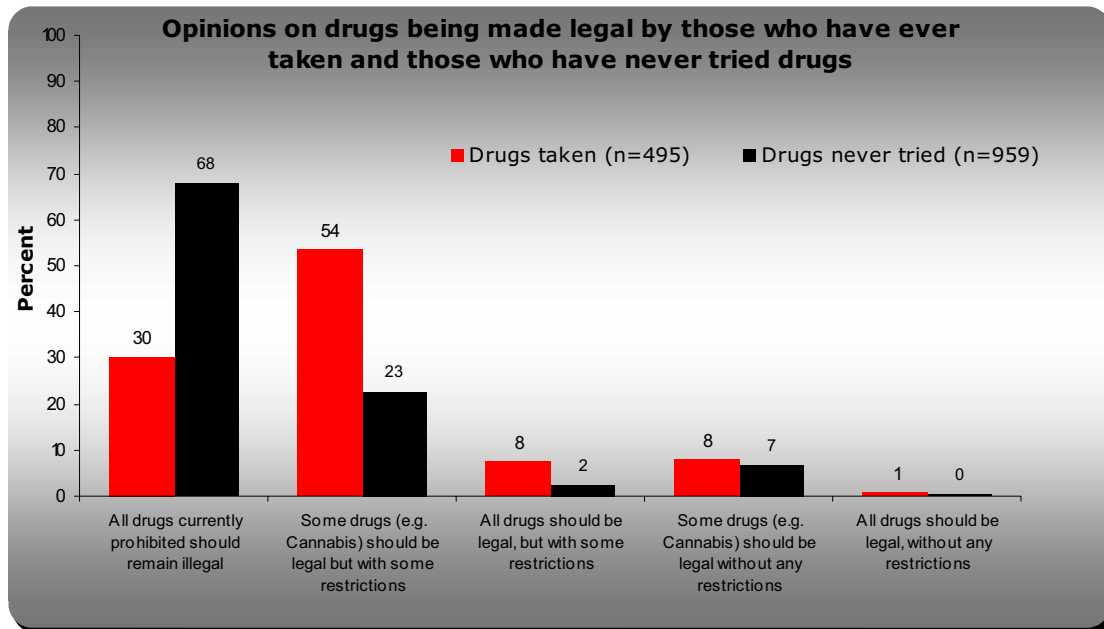
Fig 129



Effect of Drug-Taking on opinions on Drug Legislation (Fig 130)

Those who had ever taken drugs, showed markedly greater agreement to legalisation of Cannabis (55%), and freeing of prohibition on drugs (30%), compared to those who had never taken drugs (χ^2 : $P < 0.001$).

Fig 130

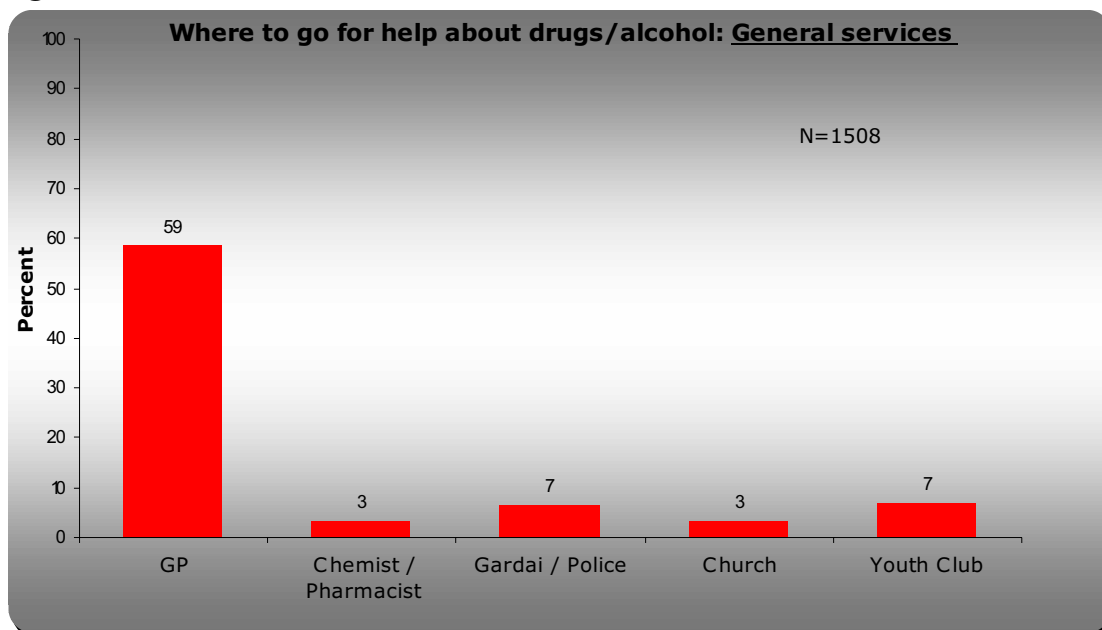


Knowledge of Substance Use Services offering advice and help for Alcohol and Drugs

General Services (Fig 131-3)

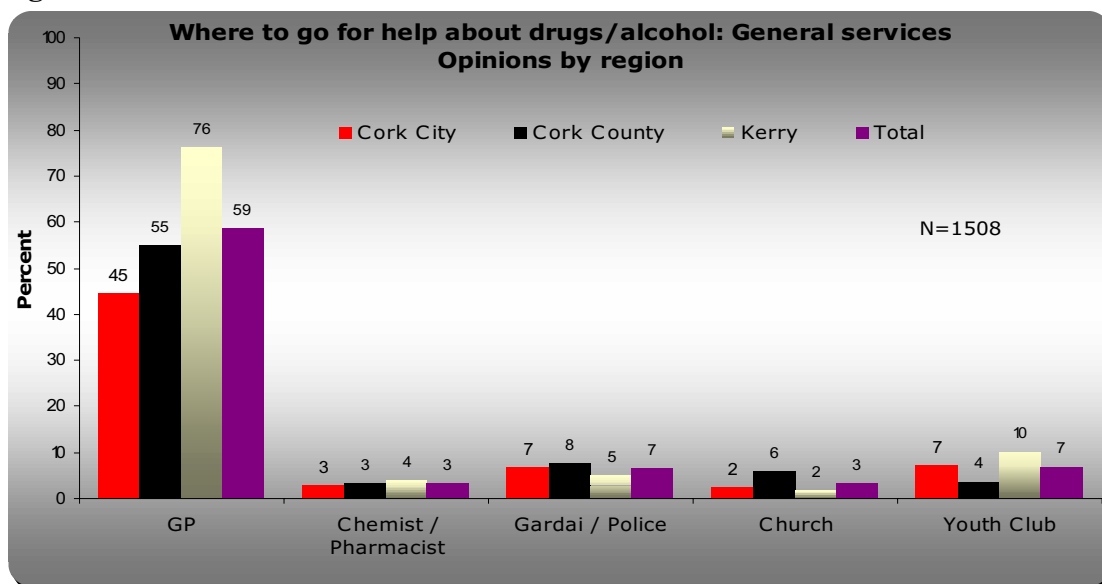
GP services were the commonest service mentioned for help at 59%. Other general services were much less at 7% (Gardai and Youth Clubs), and 3% (Chemist and Church).

Fig 131



GP as a source of help was highest in Kerry at 76% and lowest in Cork City at 45%. Youth Services were also highest in Kerry (10%) (χ^2 : P= 0.000).

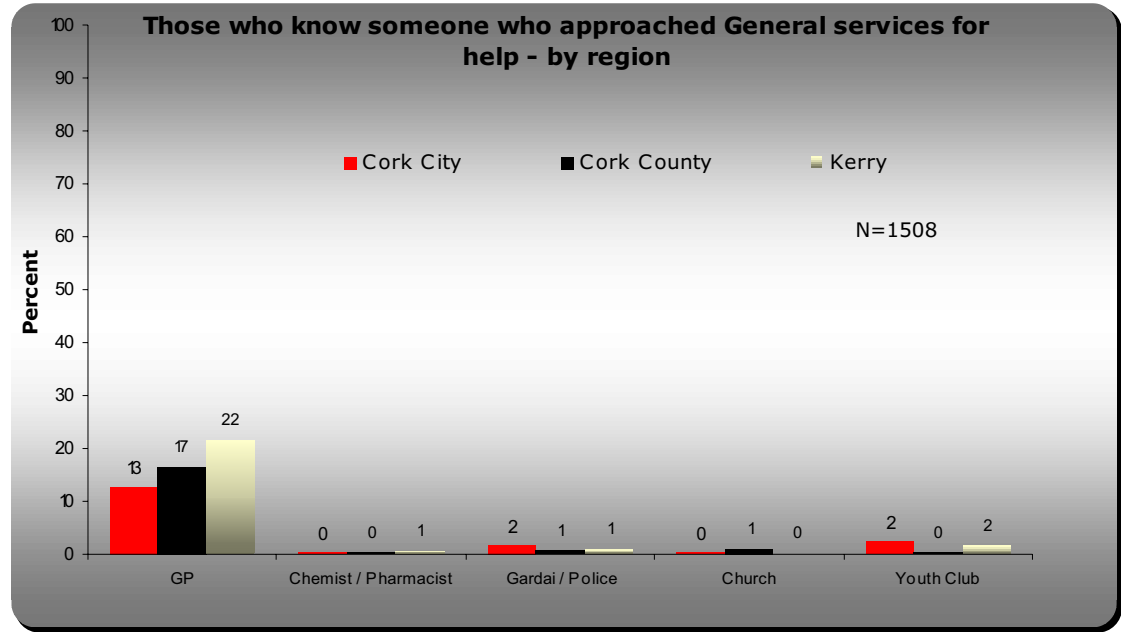
Fig 132



17% knew someone who had gone to a GP for help. This was highest in Kerry at 22% almost double Cork City (13%) (χ^2 : P= 0.000). Other services were 1% or less.

In those reporting, 80-100% said that the service was helpful to the person.

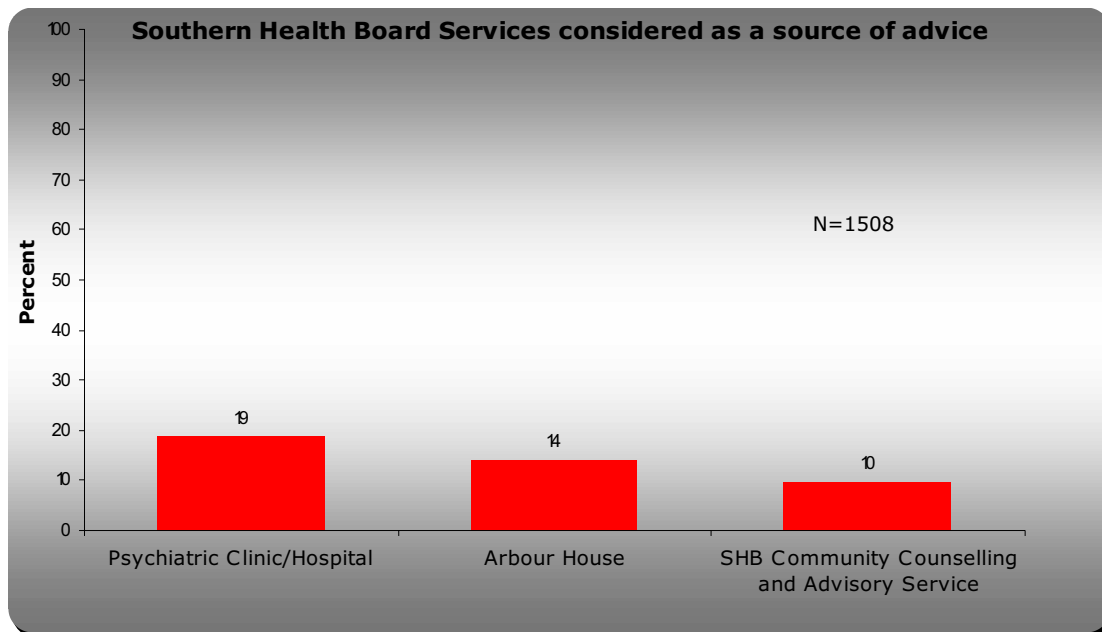
Fig 133



Southern Health Board Services (Fig 134-6)

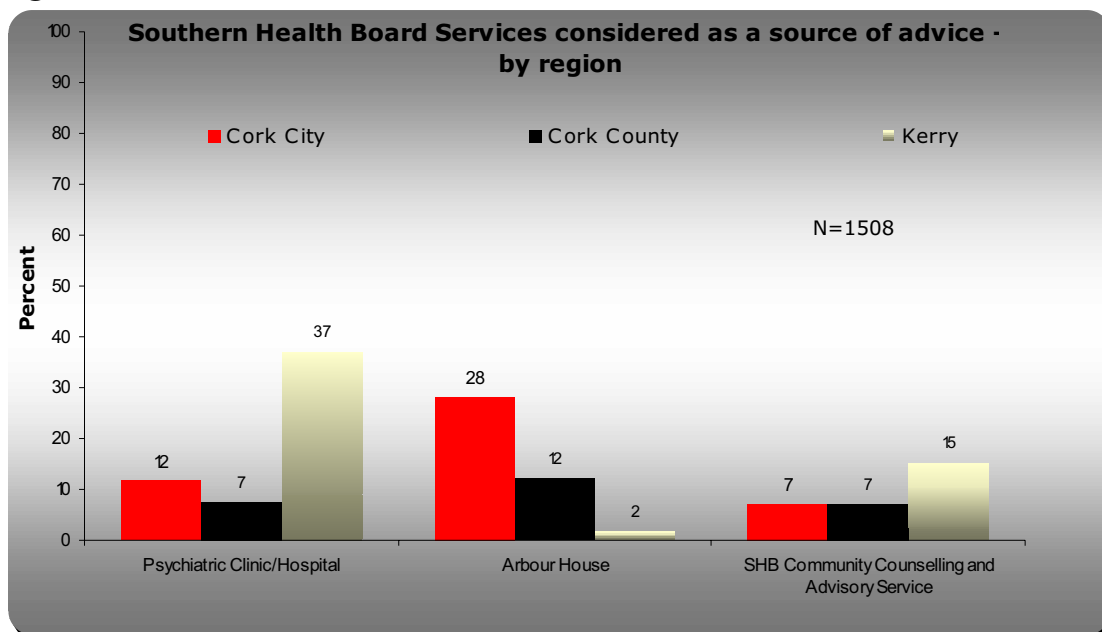
Arbour House with its Community Counselling Service was seen as a source of advice for 24%, and Psychiatric Clinics were mentioned by 19%.

Fig 134



Psychiatry was the commonest source of help in Kerry at 37%, and Counselling was also highest in Kerry at 15%. Arbour House was greatest in Cork City at 28% (χ^2 : $P < 0.001$).

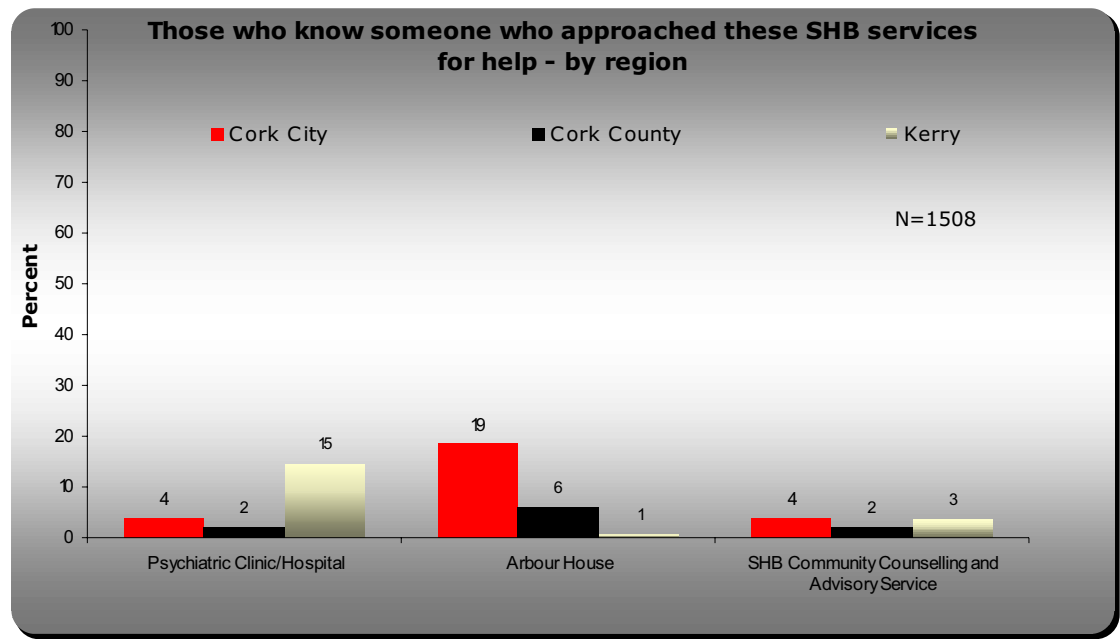
Fig 135



12% knew of someone attending Arbour House or Community Counselling – especially in Cork City (23%) (χ^2 : P= 0.000); 7% Psychiatry – especially in Kerry (15%) (χ^2 : P< 0.001).

In those reporting, 70-80% said that the service was helpful to the person.

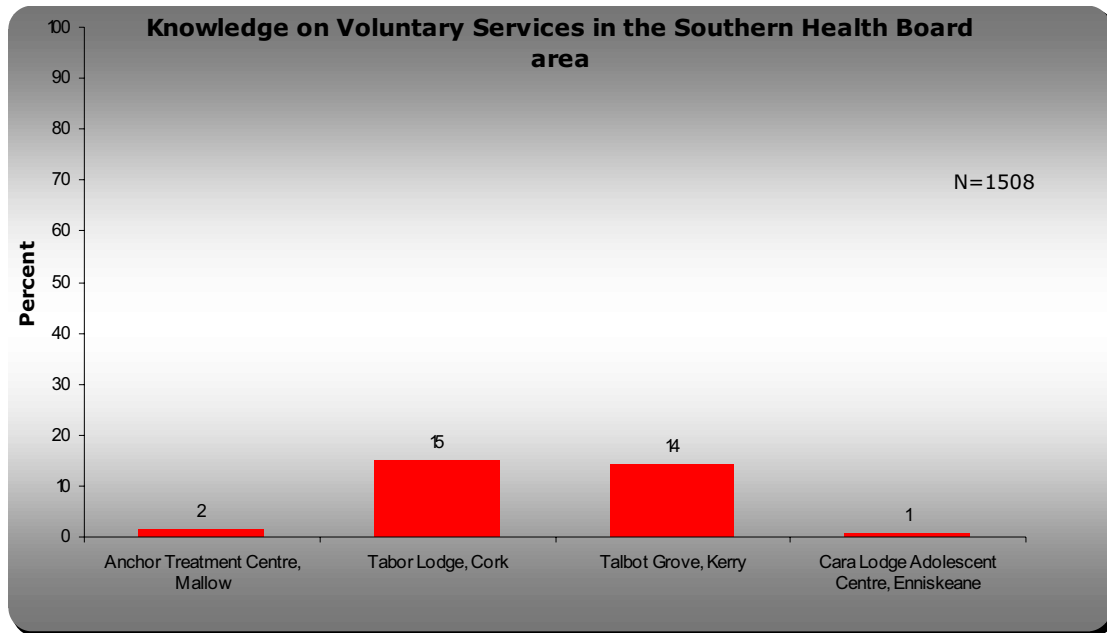
Fig 136



Voluntary Services SHB area (Fig 137-9)

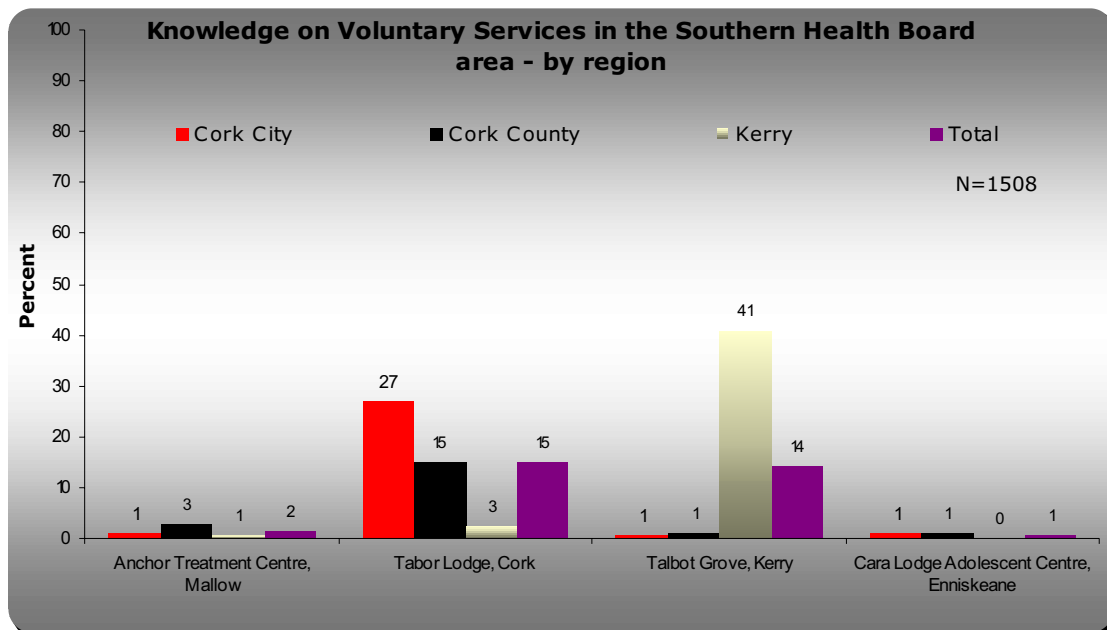
Tabor lodge (15%) and Talbot Grove (14%) were the most frequently mentioned sources of help.

Fig 137



Knowledge of Tabor Lodge increased to 27% in Cork City, and knowledge of Talbot Grove increased to 41% in Kerry (χ^2 : $P < 0.001$).

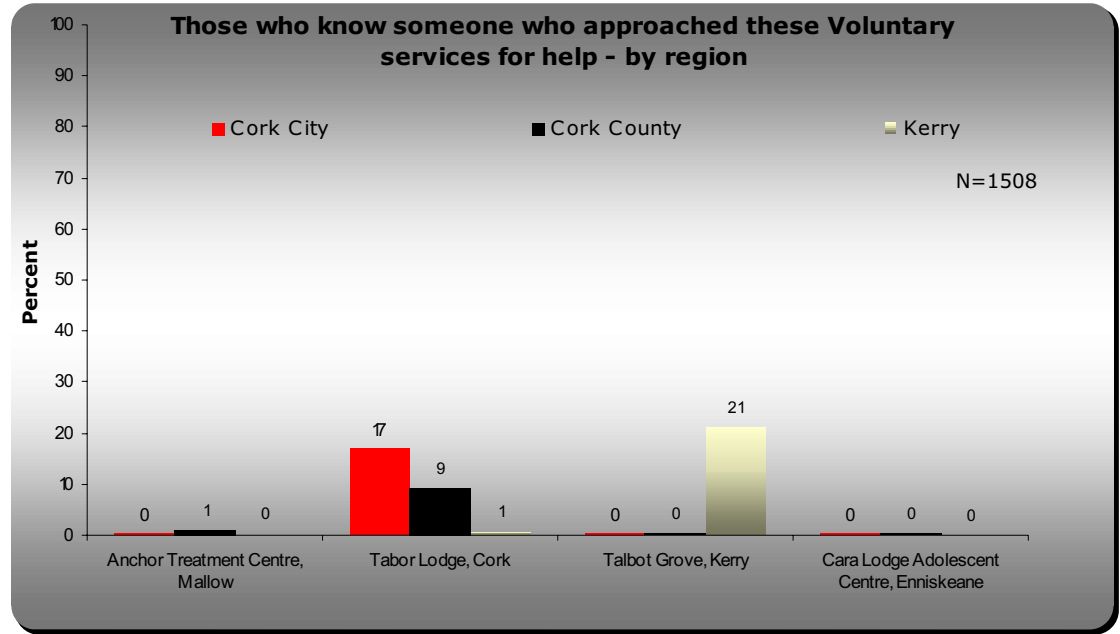
Fig 138



9% knew of someone attending Tabor Lodge – especially in Cork City (17%) (χ^2 : P< 0.001). 7% Talbot Grove – especially Kerry (21%) (χ^2 : P< 0.001).

In those reporting, 75-100% said that the service was helpful to the person.

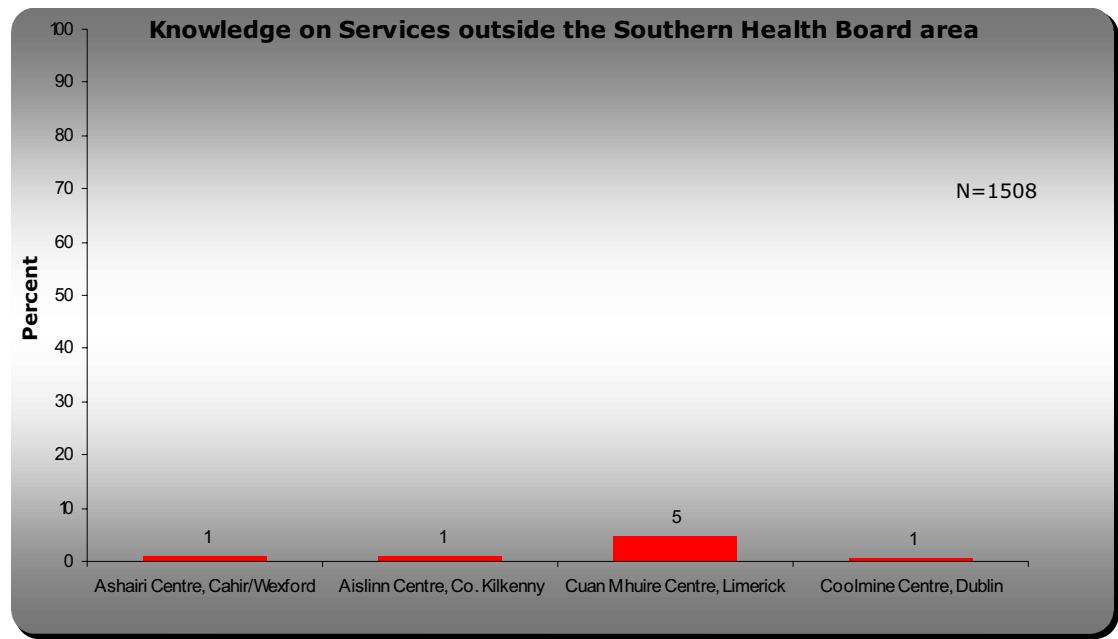
Fig 139



Centres Outside SHB area (Fig 140-2)

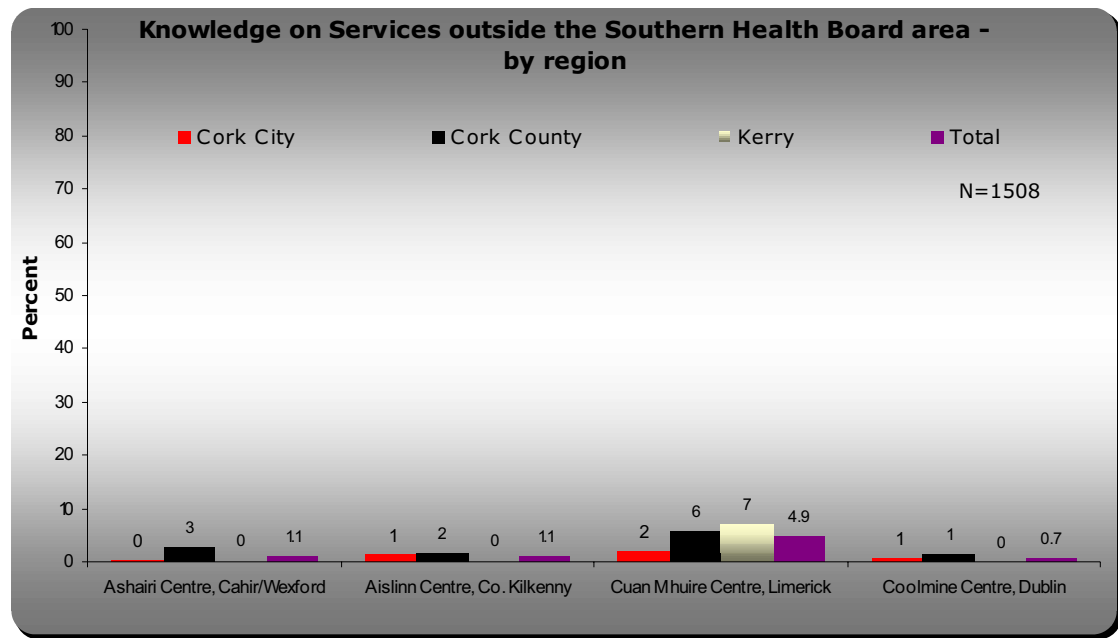
Only Cuan Mhuire Limerick was recognised by 5%, the rest were 1% or less.

Fig 140



Regionally, Ashairi Centre was mentioned by 3% in Cork Co, and Cuan Mhuire Centre by 6-7% in Cork Co and Kerry (χ^2 : $P < 0.001$).

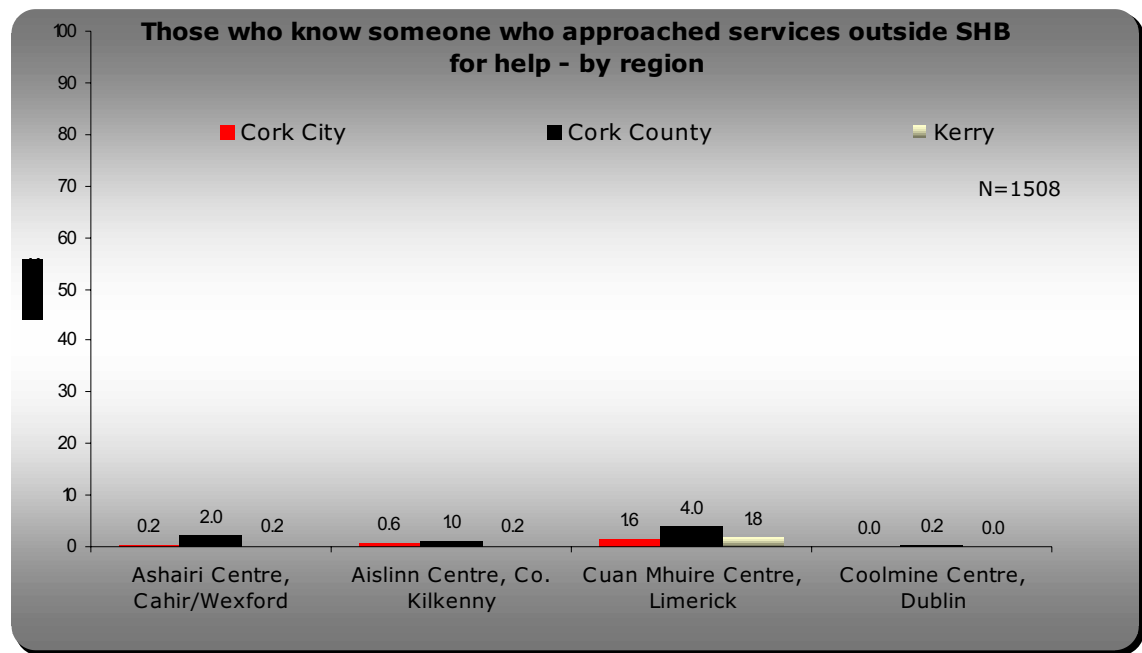
Fig 141



3% knew of someone attending Cuan Mhuire – slightly more in Cork County (4%) (χ^2 : P= 0.002). Knowledge of attendance at other centres was less.

In those reporting, 75-100% said that the service was helpful to the person.

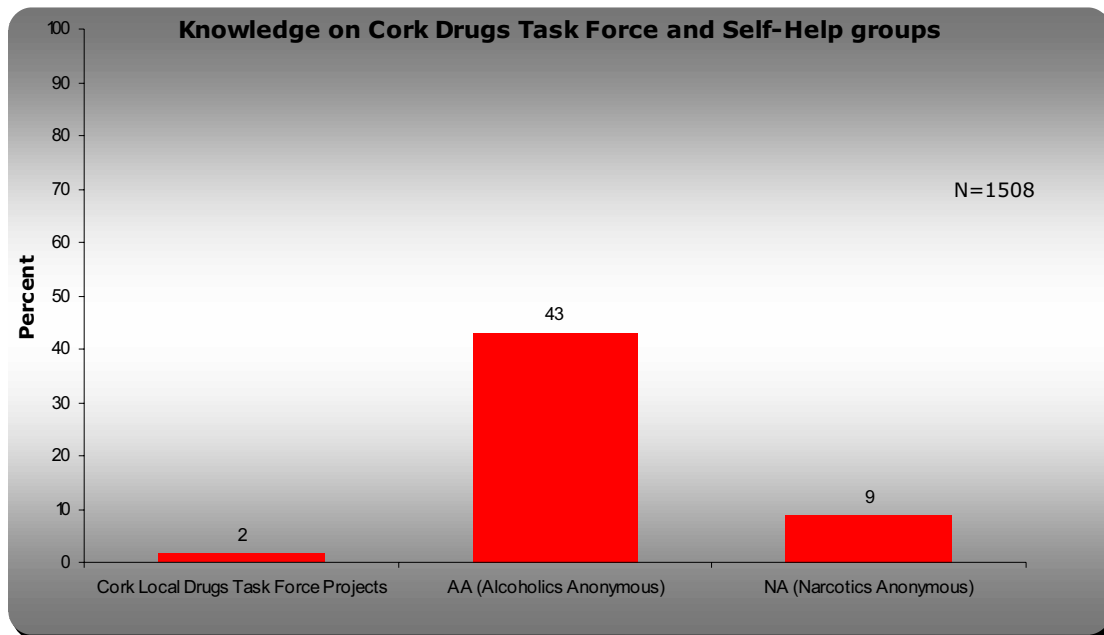
Fig 142



Cork Drugs Task Force and Self-Help Groups (Fig 143-5)

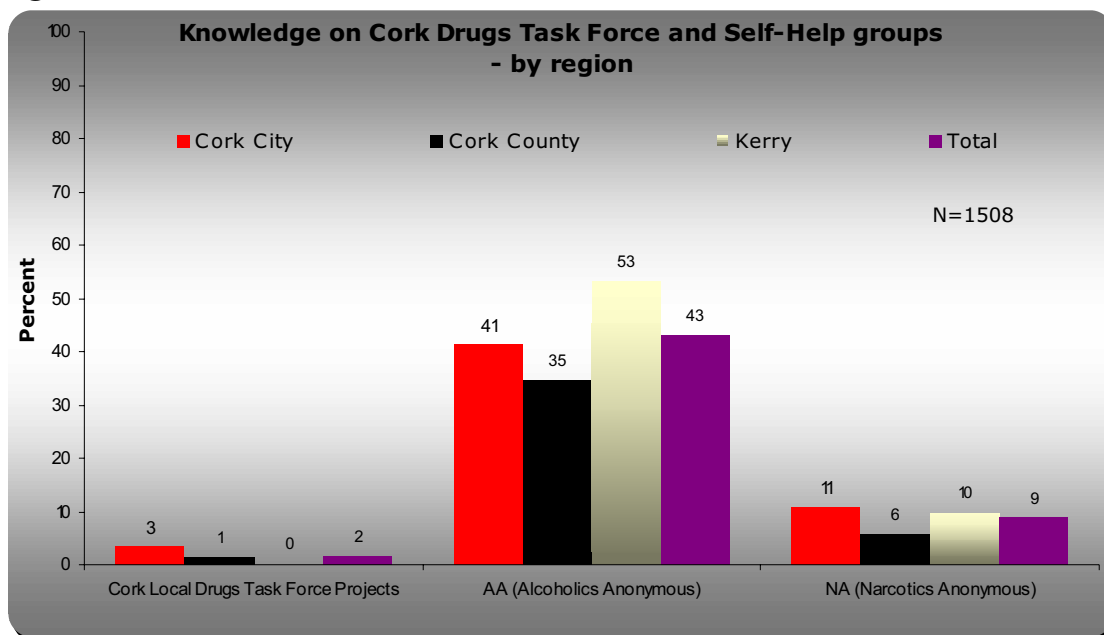
AA, Alcoholics Anonymous, (43%) was the most known service; with NA, Narcotics Anonymous, known by 9%.

Fig 143



Regionally, knowledge of AA was widespread but highest in Kerry (53%) and Cork City (41%). NA was highest in Cork City (11%) and Kerry (10%). Local Drugs Task Force was known to 3% in Cork City.

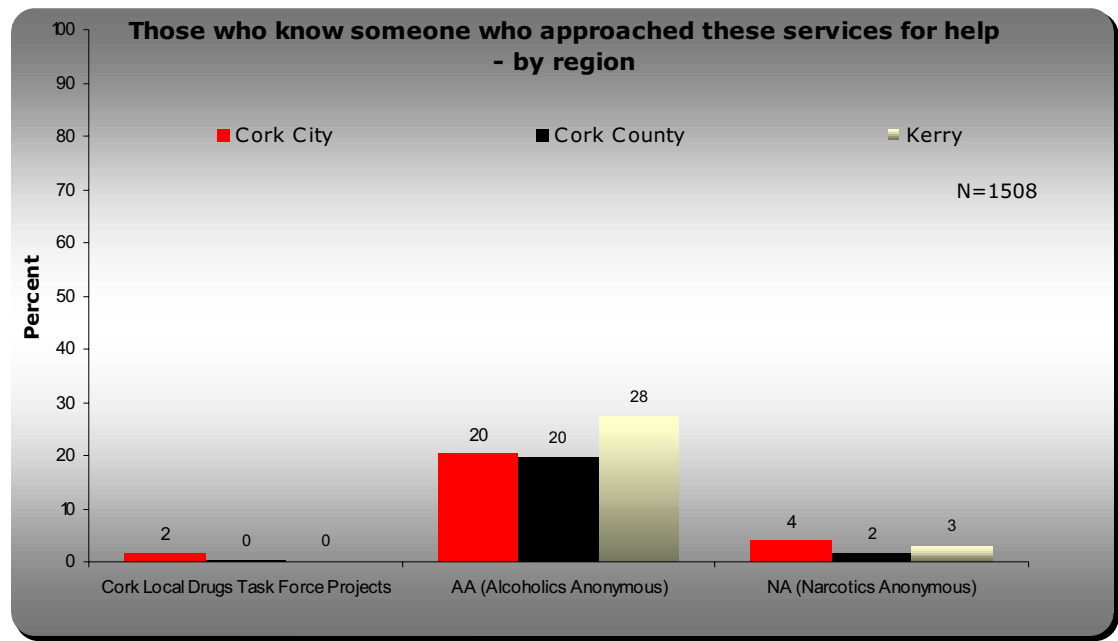
Fig 144



23% knew of someone attending AA – Highest in Kerry (28%) (χ^2 : P< 0.001); 3% NA – 4% in Cork City. Task Force was 2% in Cork City.

In those reporting, 82-100% said that the service was helpful to the person.

Fig 145

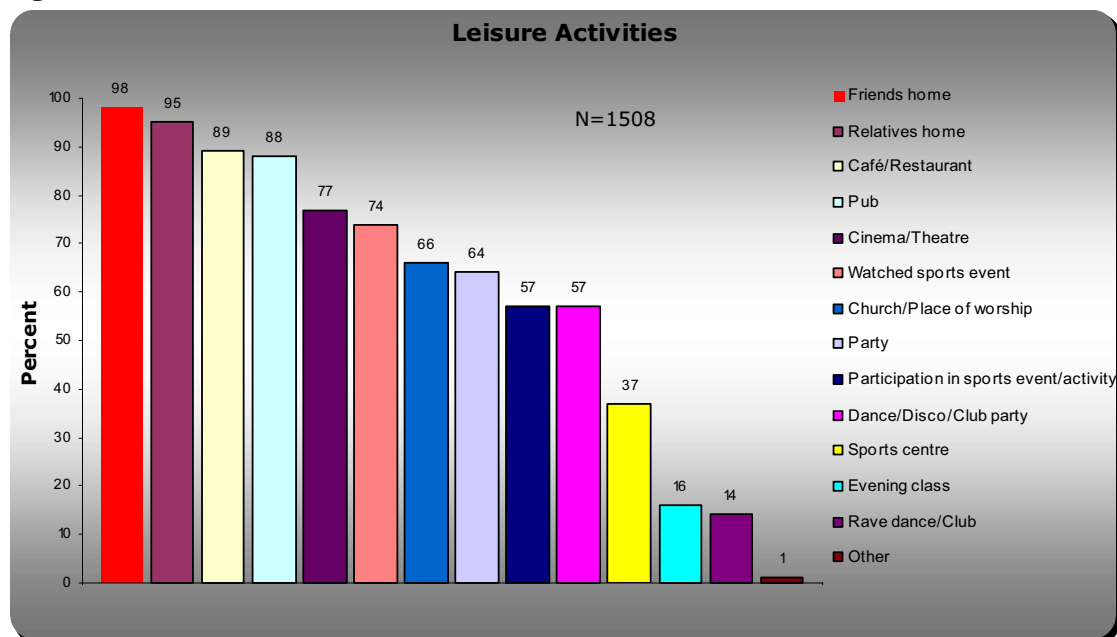


Leisure Activities (146-9)

The most frequent leisure activities were Friends home, Relatives Home, Café/Restaurant, Pub, (88-98%). 37-77% went to Cinema/Theatre, Watch Sports Event, Church, Party, Sport's participation, Party/Disco, or Sports Centre

Other activities were 16% or less.

Fig 146

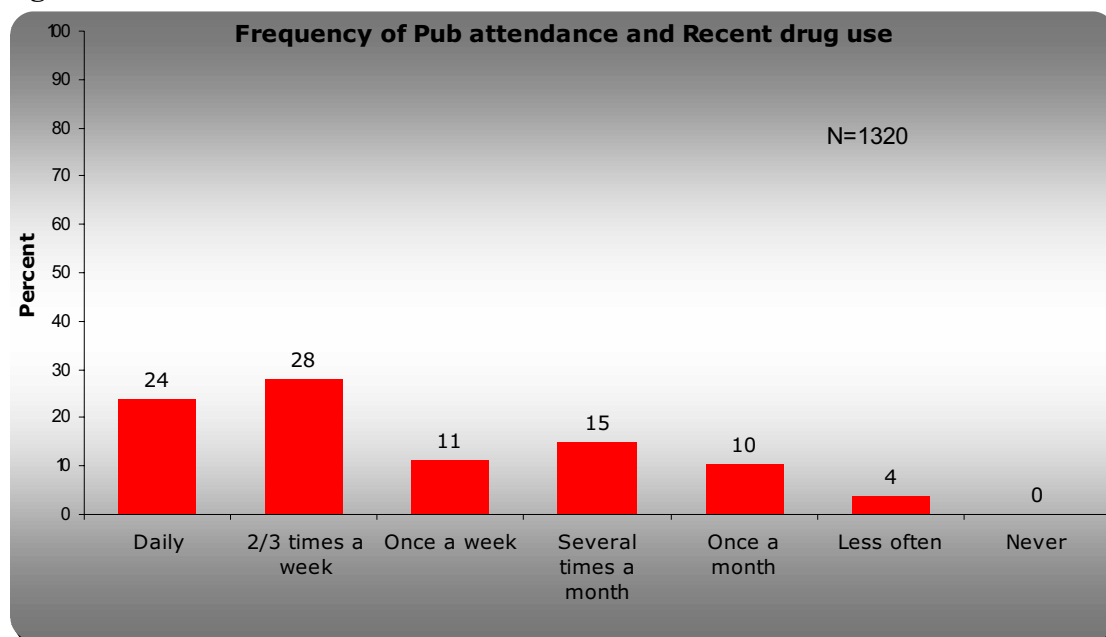


Any Drug Lifetime Use was higher in those attending Pub, Disco/Party, Party, Rave dance, and in those with decreased attendance at church (χ^2 : $P < 0.05$).

This was further explored by frequency of use of these leisure activities in relation to Recent Any Drug use in last 12 months. There was a clear link to frequency of attendance at Pub, Dance/Disco/Party, and decreased frequency of Church attendance.

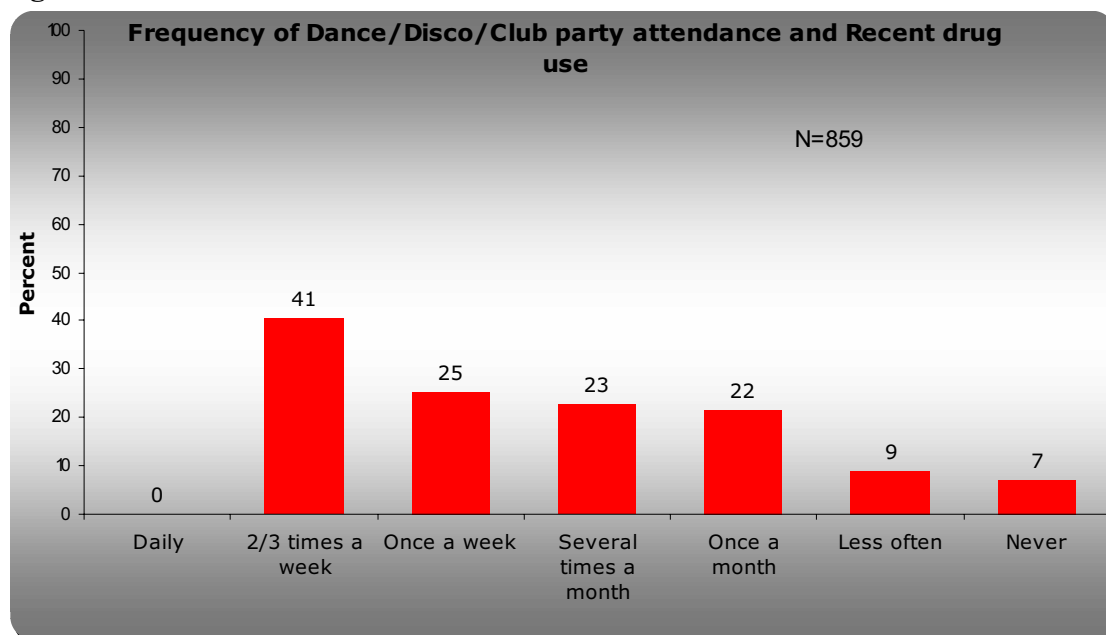
10% of those who attended a pub once a month, compared to 4% of those who attended less; and 28% of those who attended a pub 2/3 times a week had taken Any drug in the past year (χ^2 : $p < 0.001$). (Fig 147)

Fig 147



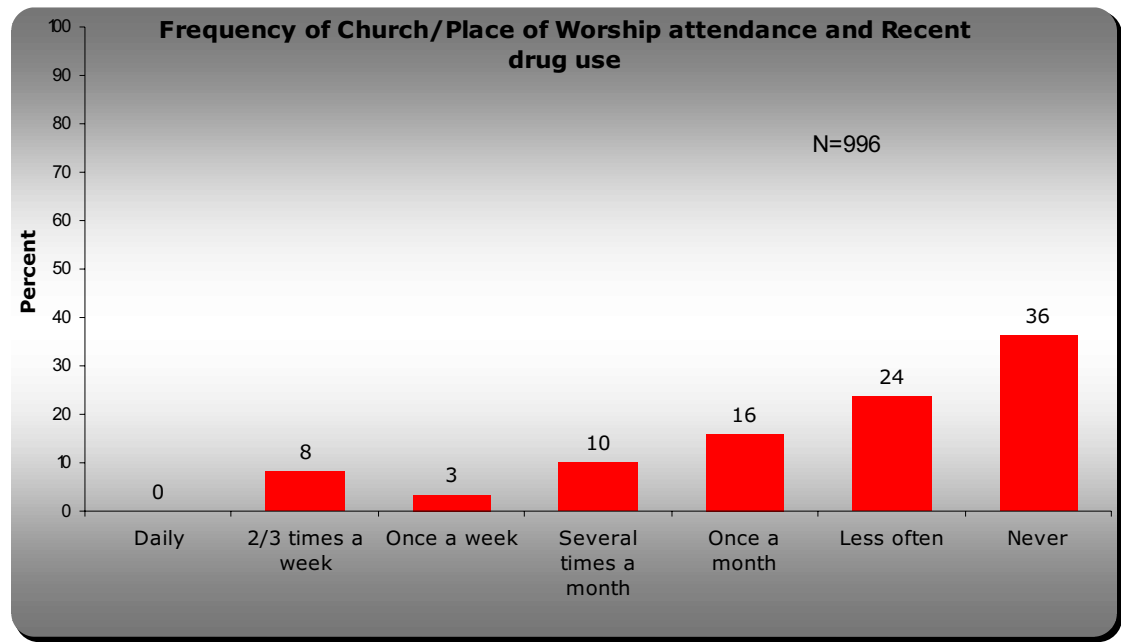
22% of those who attended Dance/Disco/Club/Party once a month or more frequently had taken Recent drugs, compared to 9% who attended less; and 41% of those who attended Party/Disco 2/3 times a week took recent drugs (χ^2 : $p < 0.001$). (Fig 148)

Fig 148



24% of those attending Church less than once a month took Recent drugs, compared to 10% of those who attended Church more frequently than once a month (χ^2 : $p < 0.001$). (Fig 149)

Fig 149



These patterns were further enhanced for Lifetime use of Any Drug.

12. ALCOHOL AND DRUG USE IN FAMILY AND FRIENDS

When asked how many did they know who had received help for Alcohol-Related Problems, 19% knew at least one family member, 22% knew a friend, and 7% knew someone at work (Fig 150).

When asked if they knew someone who needed help for Alcohol, 13% knew at least one family member, 18% knew a friend, and 4% knew someone at work (Fig 151).

On average each person knew 1.3 people who had received help for alcohol, and 0.98 who needed help.

Drug-related situations were less, with 5% knowing someone in the family who had received help, 12% knew friends, and 2% knew someone at work.

Those knowing someone needing help for drug-related problems were 3% in family and 9% among friends.

On average each person knew 0.5 people who had received help for drugs, and 0.46 who needed help.

The numbers known for those receiving or needing help for both alcohol and drugs were small.

Fig 150

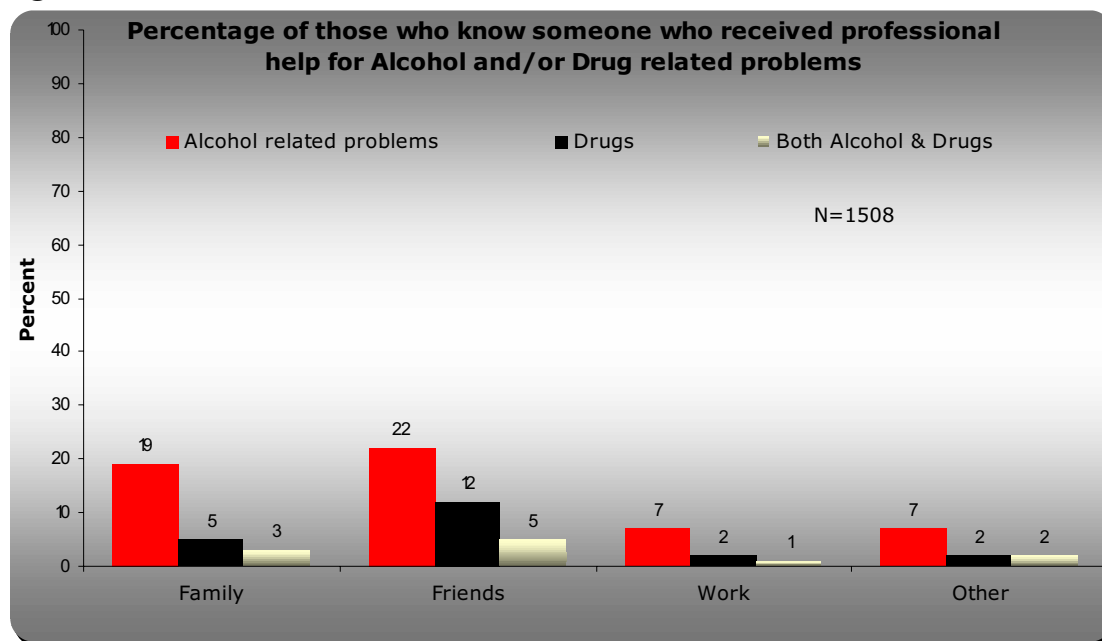
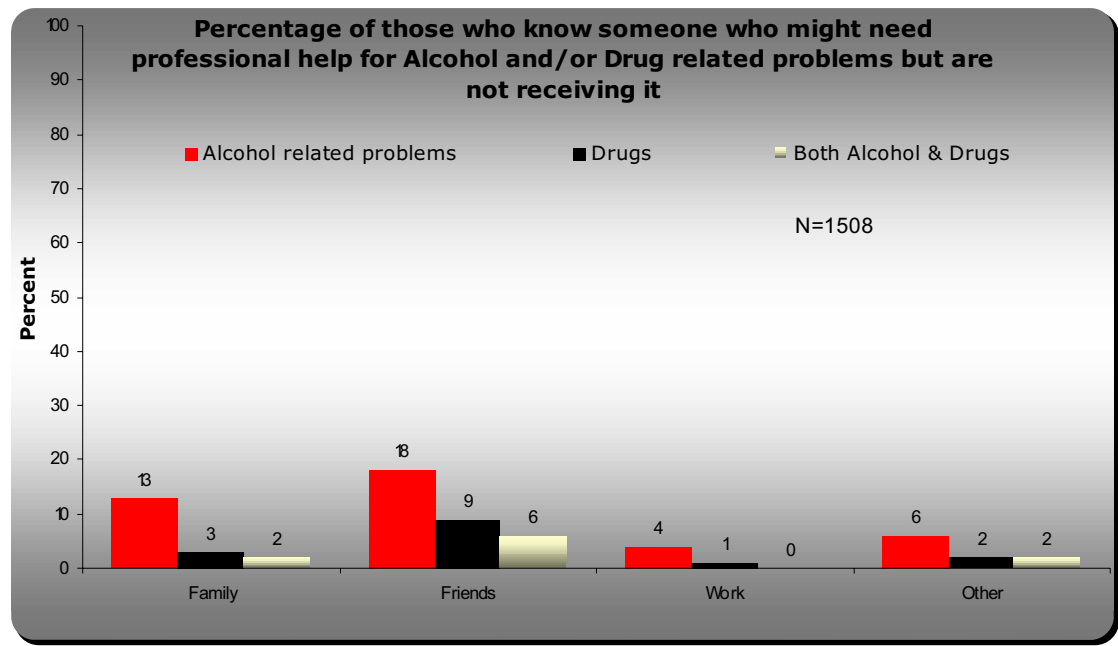


Fig 151



13. INJECTING DRUG USE

Only 25 (0.6) in the whole sample had ever injected.

When the under 25 years were examined, the Urban deprived areas showed twice as many injecting as in the main sample (χ^2 : $P < 0.001$).

One third of those injecting had injected within the last year.

5 had injected Heroin, and 8 had injected Cocaine.

DISCUSSION

SMOKING

ALCOHOL

DRUGS

COMPARISONS WITH OTHER SURVEYS

COMMUNITY PERCEPTIONS OF SUBSTANCE ABUSE ISSUES

SMOKING

In this 2004 survey Lifetime experience of smoking was 58%. This was 4% less than in 1996. 38% smoked currently, with men 5% more than women. Current Smoking was significantly higher in social classes 4-6. It was also highest in age group 18-34 years at over 40%. About 30% of those aged 15-17 years were current smokers. 15 year olds showed 29% current smokers, which was a marked increase from 10% in 1996.

It was encouraging to see the slight 4% drop in Lifetime smoking, but Current smoking overall had not significantly changed. It is also worrying to see a trebling of Current smokers in 15 year olds, especially in boys where the increase was ten-fold.

Overall these findings were almost identical to the National Advisory Committee on Drugs (NACD) 2003 survey, SHB sub-set, for ages 15-34 years^{12 13}, showing 39% Current Smoking. Examination of matching sub-sets, for studies from the Mid-Western Health Board (MWHB) 2002¹⁴, Health Behaviour in School Children (HBSC) 2002¹⁵ and European School Survey Project on Alcohol and Other Drugs (ESPAD) 2003¹⁶, showed similar prevalence's of about 30% Current Smoking for school children. Only the North Eastern Health Board (NEHB) 2002¹⁷ school children survey 13-18 years, showed a lower prevalence of 18%, which probably reflects the younger age spectrum chosen. Detailed graphical comparisons are made with these surveys later in this discussion section.

This survey showed no significant change overall in current smoking since 1996, in contrast to the Survey of Lifestyle, Attitudes and Nutrition (SLAN) studies 2002^{18 19}, which showed a drop of 5% in the 18-34 age-group to 34%.

In a wider context, ESPAD¹⁶ noted that Ireland was slightly less than average for Europe, for current smokers with 33%. This is certainly an improvement since ESPAD 1999²⁰, when Ireland was the highest for current smokers for girls, in the ESPAD countries, and third equal for boys.

As stated, these findings for school age are similar to other recent surveys, and show the same worrying pattern of sex equality, and increasing use with age. Smoking prevalence at 15 years has markedly increased, especially in boys, and young adults in the 18-34 year age group still show such high current use at 40%. Current smokers also tend to increase their doses over time, as shown by the increasing average number of cigarettes smoked daily with increasing age groups.

The Irish Towards a Tobacco Free Society Report²¹ has researched the Public Health impact of smoking extensively. It states that nicotine is ranked by WHO²¹ as more addictive than heroin, cocaine, alcohol, caffeine, or cannabis. It is therefore a notoriously difficult addiction to break. Smoking causes chronic obstructive pulmonary disease (COPD), cardiovascular disease, and several forms of cancer, especially lung cancer²¹.

Since 1996, important measures have been introduced to Irish Legislation to improve Public Health control of smoking. The legal age for tobacco sale was increased to 18 years in August 2001. An independent Office of Tobacco Control was created.

Tobacco Advertising has been banned. The price of tobacco has risen markedly in successive budgets, and the Smoke-Free Workplace Law was introduced in March 2004²². Ireland has been justly recognised for these, especially for the latter initiative²³.

Such legal provisions are reinforced by encouragement of Health Promotion Initiatives in Schools and Communities, such as Social Personal and Health Education (SPHE). These are being implemented within the framework of The National Health Promotion Strategy 2000-2005²⁴ using a Settings approach.

Smokebuster programmes were also tried in Eastern Health Board primary schools to encourage a peer group norm of non-smoking children. This was evaluated by the EHB Dept Public Health²⁵, which found that despite great enthusiasm by varied professional groups, the actual smoking behaviour of children had worsened, when checked one year after the programme. This illustrates the power of family, and other peer groups to maintain smoking patterns.

It is probably still too early to expect to detect prevalence changes in this survey, but such measures should gradually lead to real changes.

ALCOHOL

Almost everyone had lifetime experience of drink (85%). 81% were current drinkers. Women (79%) were only slightly less than men (82%).

In the under-18 age group, 41% were current drinkers (a drop of 3%), with 47% of boys, and 32% of girls drinking, narrowing the gender gap by 5%. 87% of under-18 current drinkers had been drunk - an increase of 15%, with equal sex prevalence.

There was a rapid increase in current drinking through the younger age groups. 23% drank at 15 years, 51% at 16-17 years, and 88% at 18-24 years.

These figures are consistent with the SLAN and HBSC ^{15 19 26}, ESPAD ¹⁶, NADC ^{12 13} studies, and other School-based surveys in the MWHB, and NEHB ^{17 27}. Detailed comparisons are made with these surveys later in this report.

This study shows that a high proportion of men (26%) drink in excess of guidelines, and the number of women drinking in excess of the guidelines, had doubled to 17% since 1996. These rates closely match the Risky Drinking estimates of Ramstedt and Hope ²⁸, who made detailed comparisons of Irish drinking patterns using European Comparative Alcohol Study (ECAS) methodology.

Quantity and Pattern of Alcohol Consumption

This survey showed that the mean alcohol intake in current drinkers was 18 units per week for men, and 9 units for women. There was no increase for men, but the significant increase of 30% for women since 1996 is worrying. This showed especially in the pattern of drinks women consumed, with premix spirits increasing by 5 times, and wine and spirits doubling. This pattern of female drinking is also confirmed by Ramstedt and Hope ²⁸, who state that women drink wine and spirits proportionately more than men.

The approximations of drinking levels to categories of problem drinking¹¹, confirmed that men had not changed their categories since 1996. However, women had shifted consumption significantly into more damaging categories, as follows:

Category 1 (Excessive)	doubled
Category 2 (Excessive with Problems)	trebled
Category 3 (Excessive with Problems and Dependence)	increased by 5.

One third overall, (- half the men, and a quarter of women) had had three or more episodes of binge drinking in the previous month. This prevalence approximates to the slightly higher threshold of bingeing once a week, of the Ramstedt and Hope report ²⁸. This pattern of drinking appears to be unique to Irish and UK subjects in contrast to European countries, and leads to considerable harm. 39% of men and 24% of women experienced at least one adverse consequence in the past year ²⁸.

The range of adverse effects of Binge drinking are also well summarised by O'Farrell ²⁹.

CAGE scoring of two or more, gives an indicator of problem or dependent use of alcohol. In adults, 22% of men and 11% of women gave this level of scoring. The latter showed an increase of 50% since 1996.

Cage screening has been shown to have reasonable utility in Primary Care and Ambulatory Medical clinical settings at a cut off Cage score of ≥ 2 ^{6 7}.

It is also worrying that so many drink under the legal age of 18 years, and that 87% of these admitted to being drunk – an increase of 15% since 1996.

Public Health Implications of Alcohol Consumption

It is some time since the Royal College of Psychiatry³⁰ 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.

Research in more recent years, reinforces the above view. The Strategic Task Force Reports on Alcohol^{31 32} fully endorse a population health approach to alcohol control. The Task force follows the Strategy areas outlined by the WHO European Charter on Alcohol^{33 34}.

1. Regulate availability
2. Control promotion of alcohol
3. Enhance capacity to respond to alcohol-related harm
4. Protect working environments
5. Responsible action from alcohol and beverage industry
6. Provide information and education
7. Provide effective treatment services
8. Support NGOs
9. Research and monitor progress
10. Control Drink Driving.

Detailed recommendations have been made for each of the areas.

It is important to remember that according to research supported by the WHO³⁵, *Alcohol is no ordinary commodity, and its harmful properties result in a wide range of problems.* The 2004 Strategic Task Force on Alcohol (STFA)³² quote extensively from this report, stating that alcohol is the third most detrimental risk factor for European ill-health and premature death. This is especially so, in the lives of young people, where it is estimated to cause 25% of deaths in young men of 15-29 years – mainly from injury.

The STFA expresses particular concern at Ireland’s per capita alcohol consumption, which was second highest in Europe, and was 13.5 L pure alcohol per adult (over 15yrs) in 2003³². This has doubled since the 1970s.

The range of problems caused by alcohol are well summarised by Cook³⁶, and shown in Appendix 2. He also shows the diversity of responses required in Appendix 4.

Mannix³⁷ in her analysis of Detoxification Requirements in the SHB area, cites estimates of those who drink seriously in excess e.g. Men 50+ units per week, and Women 35+ units per week. In Barnet (London), it was estimated that this comprised 4.4% of men and 1.4% of women. This estimate is closely matched by this study for adults in Category 3 drinking (Excessive with Problems and Dependence), which were 3.7% for men, and 1% for women. Detailed estimates of varied categories are available in the Recommendations, and Appendix 7.

As with Smoking, many Health Promotion activities have been initiated in the Southern Health Board area³⁸. SPHE, and Health Promoting Schools activities have expanded within the framework of the National Health Promotion Strategy²⁴.

In the SHB area, The Health Promoting Schools project has dramatically increased in the past year³⁹ for Primary Schools, with over 40% now participating in Nov 2005. In Secondary Schools only 23% are participating. However, schools from disadvantaged areas are prioritised.

The SHB Health Promotion Dept (HP), in almost 10% of key bars and nightclubs, has implemented the Club Cork Project^{38 39}, funded by the Local Drugs Task Force. This aims to train staff to take an active role in dealing with alcohol and substance misuse.

The HP Dept^{38 39} also offers Brief Intervention training to front-line staff who may encounter addiction situations. The latter scheme has recently been evaluated by the SHB Dept of Public Health⁴⁰, with recognition of its considerable potential.

It has been estimated that 16% of those attending GPs are at risk, or experiencing problems with alcohol⁴¹. It is suggested that opportunistic intervention in such a primary care setting, can have an important impact on alcohol related behaviour⁴², reducing problem use by at least 25%. GPs attitudes to screening and intervention can be mixed, but training and support is important⁴³.

The TrEAT project in the USA⁴⁴, exploring brief intervention carried out by physicians in primary care, found sustained reduction in alcohol use, health care utilisation, and motor vehicle accidents and costs, with marked positive benefit-cost findings. It was estimated that for every \$10,000 invested in early intervention, there would be a \$43,000 reduction in future health care costs, and even larger reduction in costs to society.

CAGE⁷, despite its brevity and utility, has low specificity. Other instruments such as AUDIT^{41 45} may therefore be more useful in the professional scene. This asks ten questions covering the domains of Hazardous alcohol use, Dependent use, and Harmful use. WHO offers a most helpful manual on brief intervention for the primary care setting, using AUDIT as a screening instrument⁴⁶.

DRUGS

As in 1996, the main drugs for Lifetime and Recent use were Cannabis, Stimulants, and Hallucinogens. Cannabis and Stimulant use has doubled. Opiate use has doubled for Lifetime use, and increased by 8 times for Recent use. However, these latter increases are from an extremely small baseline.

The changes within the Stimulant group of drugs are particularly worrying.

Ecstasy has doubled for Lifetime and Recent use.

Cocaine Lifetime use has increased by 5 times to 6%, and Recent use has increased by three times to 2.5%. Crack has increased by eight times for lifetime use to 2%. While the actual prevalence's are still low, the increases show a serious trend.

As before, the drug user in this survey tends to be young, male, from urban areas. However the both the Gender and Urban-Rural gaps have narrowed. The latter change may reflect population shifts from Cork City into the suburbs.

It is of particular interest, that when the Cork City Wards/Electoral Areas were examined, Cork N Central and Cork S West showed decreases of prevalence for Any Drug use, Lifetime, Recent and Current. Other areas for Recent Drug use showed only modest increases of 7%.

It is tempting to speculate if this damping down, in contrast to large increases in use elsewhere, could be due to intense Local Drugs Task Force Activities in the City areas. It was considered that these changes might simply reflect the move of younger populations out of the City areas into the Suburbs, where increases are high. However, young adult population shift is not a sufficient explanation of this trend, as there has not been sufficient change to support this hypothesis (See Appendix 8).

King reported recently on the Southern Regional Drugs Task Force⁴⁷. He set up focus groups with key workers in the drugs field, and asked them to comment on the SHB 1996 Substance Abuse Survey Findings¹. He found that key workers all commented that there had been marked increases in Overall use, Cannabis, Ecstasy, Cocaine, and Opiates. These increases have been strongly corroborated by the findings of this Current Survey in 2004, thus giving interesting confirmation for findings of qualitative research.

These trends are also confirmed by the threefold increase of Treated Problem Drug Use outside the Eastern Health Board area especially in the SHB^{48 49}. Treated Drug Use statistics are, however, service provision data and therefore resource dependent. However, they can give indicators of trends.

Despite increasing the weighting for urban deprivation in 2004, drug use for deprived areas did not show significant increases, indicating widespread use across regions.

Social Class 4-6, however, did show some increases for Cannabis, Opiates, and Sedatives.

The drug user also tends to be a current smoker or drinker, and has started smoking or drinking from an earlier age, and in greater quantities than non-drug users.

High frequency of pub and disco attendance, high frequencies of drunkenness, and low frequency of attendance at church, are all associated with increased drug use.

Recent and current drug uses are highest at younger ages, and fall dramatically over age 35 years.

These characteristics are confirmed by many other studies^{50 51 52 53 54}. Nicotine, alcohol, and cannabis dependence are seen to be closely linked⁵⁵⁻⁵⁷.

The National Drugs Strategy 2001-2008⁵⁸ recognised the complexity of issues involved in control of illegal substance use, and continued with the four strategic pillars of Supply, Prevention, Treatment and Rehabilitation, and Research, and appropriate inter-departmental cooperation. This Strategy underwent a Mid-Term Review⁵⁹ recently in which the original 100 recommendations were reviewed in terms of progress, and adaptations required. Drug Net⁶⁰ has also commented recently on the latter report.

The findings were that the aims and objectives of the Strategy were fundamentally sound, and progress had been achieved in almost all the pillars. The Supply area is beyond the scope of this report, but several points are relevant in other fields.

In Prevention, the importance of the SPHE programme was recognised, but great variability in implementation was noted, especially for substance misuse aspects. Time must be found on an extremely crowded curriculum, in which SPHE is not an exam topic. Parents and Families should be more involved, and non-school settings for early school leavers should be explored for this type of material.

The key issues recognised here were

1. Substance Use Policies should be developed and implemented in all LDTF area.
2. SPHE should be implemented more coherently, needing training and support
3. Non-School Settings for Substance Use programmes must be examined.
4. Support for Parents and Families need to be developed involving accessible factual information, and increased resources for Home School Community Liaison Schemes.

There is evidence that the Strengthening Families Together Program^{61 62} shows promise as an effective intervention in primary prevention of alcohol and substance misuse.

Morgan⁶³ reviewed the evidence for effective drug prevention strategies. He identified several promising interventions such as the On My Own Two Feet component of SPHE, and Strengthening Families Together, and Local Drugs Task Forces. He stressed that effective programmes must have certain characteristics:

1. Development Timing – they must begin early in life and continue.
2. Programme Intensity – there must be enough time scheduled to carry it out.
3. Direct Experience – there must be direct and consistent experiences for young people e.g.: with Teachers and Parents.
4. Breadth and Flexibility and Maintenance of skills must be considered.

COMPARISONS WITH OTHER SURVEYS

When the original Substance Use Survey in Cork and Kerry was carried out in 1996¹, almost no community surveys of Drug prevalence into adult years had been carried out. Most Irish studies were then on younger school-age populations.

Several surveys have been carried out in recent years to estimate substance use in the community. Many of these have targeted school children, but some have included adults.

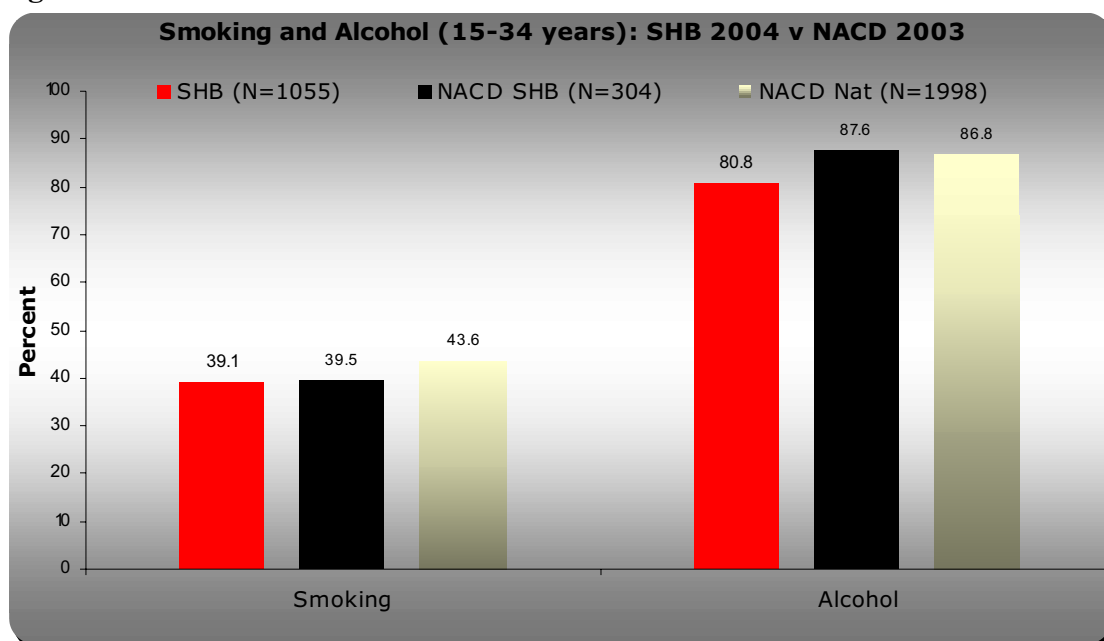
The National Advisory Committee on Drugs (NACD)^{12 13} commissioned a National survey in 2003. This was a household study carried out on children and adults up to 65 years in the community. The methodology was extremely similar to this SHB survey using quota-based random-location sampling.

The only significant difference in methodology was the SHB use of a Confidential Self-Completion Section for Problem Alcohol Use, and Personal Drug Use. The latter was in compliance with the EMCDDA suggestion, that sensitive questions could be explored through a confidential section of the questionnaire⁶⁴. If there was anything unclear, the interviewer was available to clarify any query or difficulty with comprehension. (See Appendix 10 Questionnaire - Self-Completion Section)

The NACD used direct interviewing throughout their questionnaire. This is discussed carefully in their Methodology Report⁶⁵. They also state compliance with EMCDDA criteria, and state that their use of direct interviewing throughout was to minimise the effect of illiteracy. Sample sizes were also smaller in NACD for individual Health Board regions.

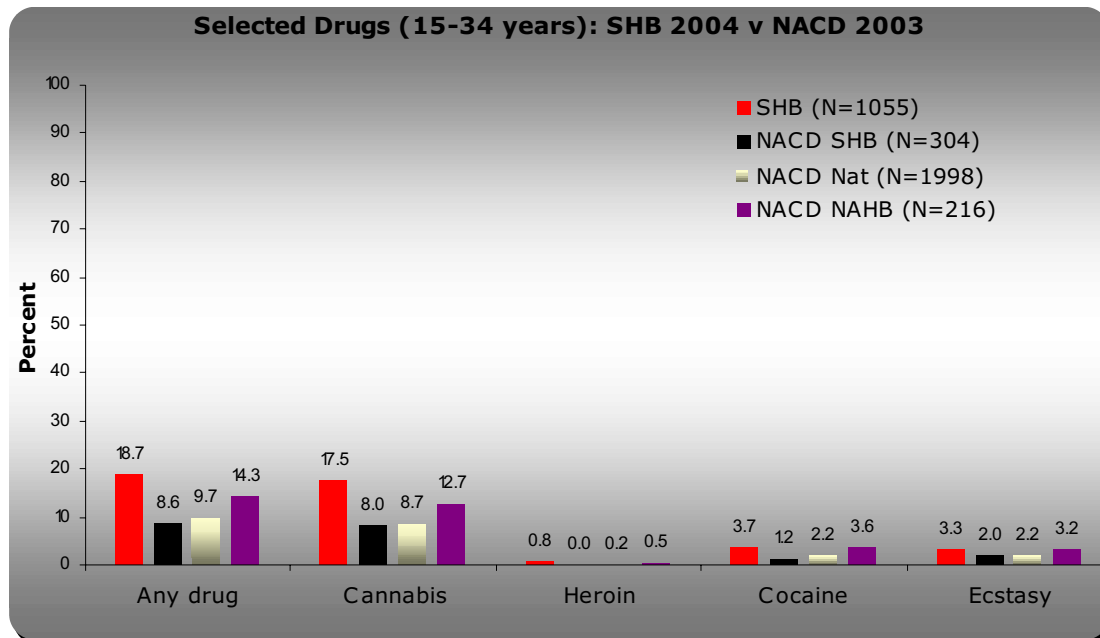
When examining ages 15-34 years, the SHB was closely comparable to NACD for Current Smoking and Alcohol. Current smoking was almost identical at 39% for both SHB and the NACD SHB subset, but slightly higher at 44% for the NACD Nationally. Current Drinking was 81% in SHB but slightly higher at 87% for the NACD. (Fig 152)

Fig 152



When Recent (Last Year) Drug Use, was examined for ages 15-34 years, the SHB estimates were generally twice that of the NACD. Only the Northern Area Health Board (NAHB) subset, including North Dublin, had comparable figures. This is an extraordinary finding, considering that the latter area would be the epicentre of the drug epidemic in Ireland. (Fig 153)

Fig 153



As already stated, the only marked difference in methodology appears to be the use of a confidential Personal Drug Use Self-completed Section by the SHB, in contrast to the NACD use of Direct Interviewing throughout.

Papers on research methodology suggest that Self-administered answer sheets markedly increased reported drug use, especially for stigmatised drugs^{66 67}. Direct interviewing can tend to a bias towards more “socially desirable” answers⁶⁸.

Further studies

The SHB Survey was also compared to several other surveys. All of these had Confidential Self Reporting of Drug and Alcohol use as a key feature of their methodology.

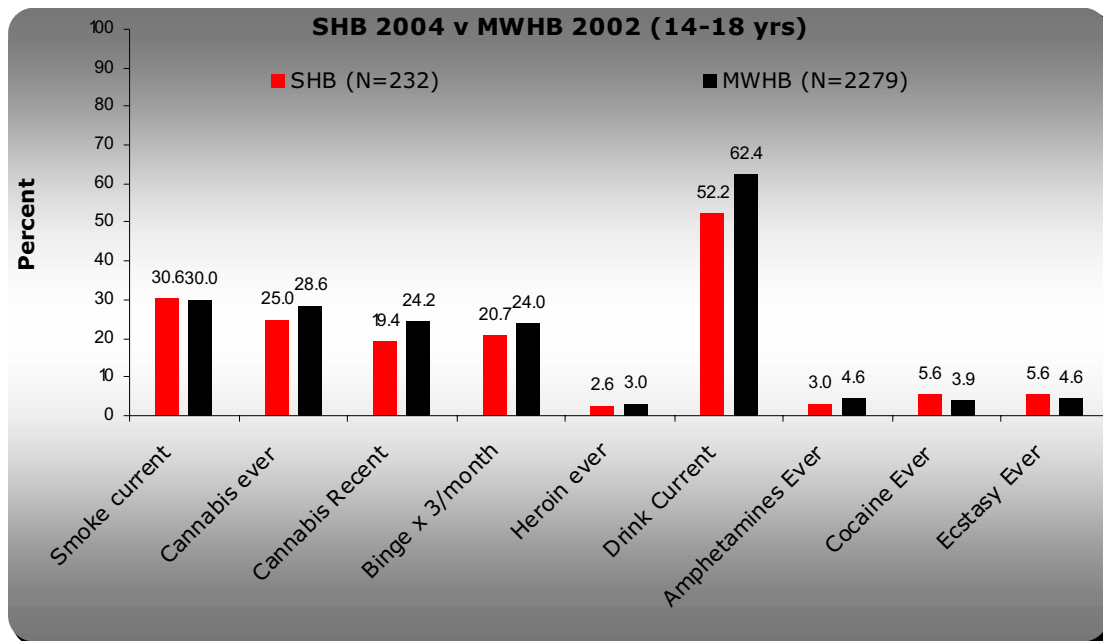
Mid-Western Health Board (Fig 154)

A SHB subset of Ages 15-18yrs was compared to Mid-Western Health Board (MWHB) Secondary Schools 14-18yrs ¹⁴.

The SHB was similar for Current Smoking, Cannabis, Binge three times a month, and Heroin ever. It was less for Current Drink, Amphetamines ever, and more for Cocaine ever, Ecstasy ever.

Despite these variations the figures were broadly comparable.

Fig 154



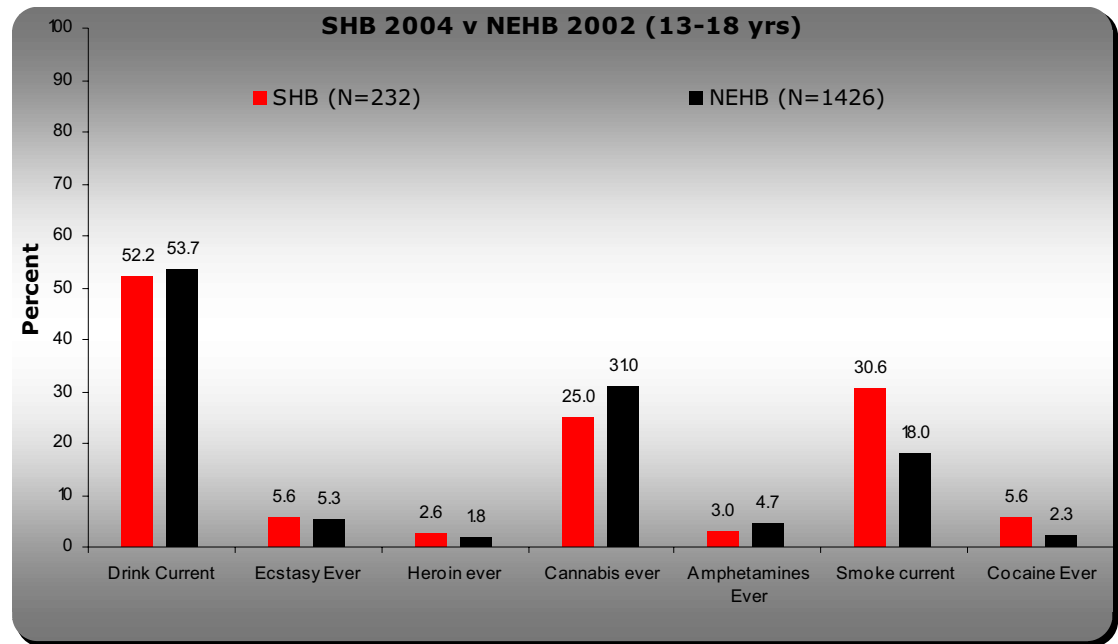
North Eastern Health Board (Fig 155)

A SHB subset of Ages 15-18yrs was compared to North Eastern Health Board (NEHB) Secondary Schools 13-18yrs¹⁷

The SHB was similar for Current Drink, Ecstasy ever, Heroin ever. It was less for Cannabis ever, Amphetamines ever; and more for Smoke current, Cocaine ever.

Despite these variations, and the slightly younger population in the NEHB, the figures were broadly comparable.

Fig 155



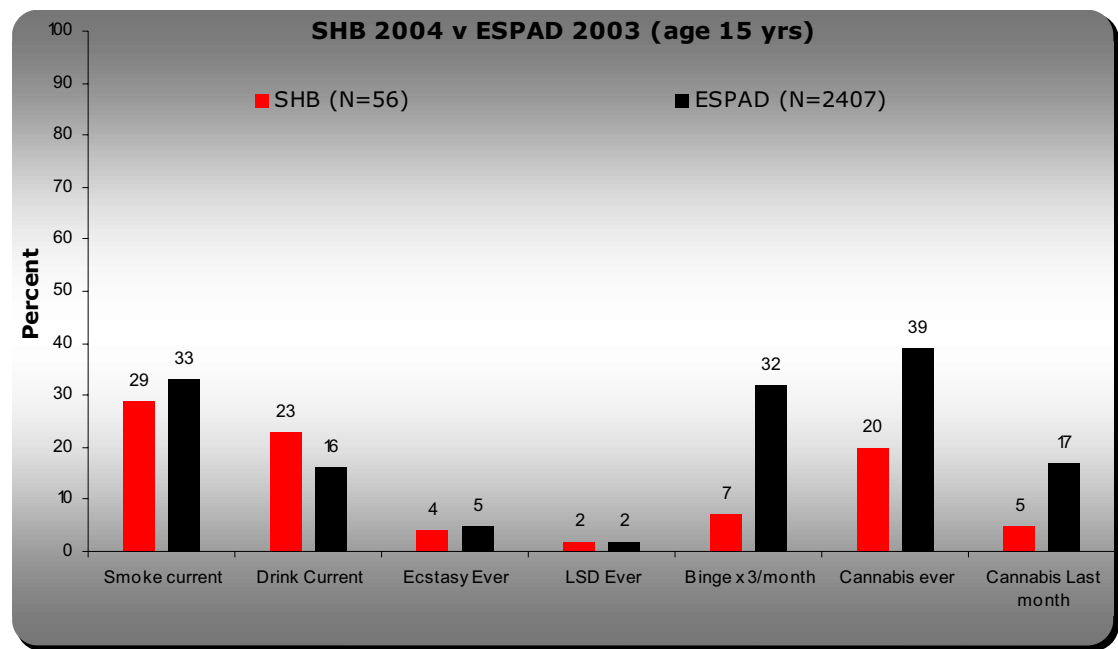
ESPAD 2003 (Fig 156)

A small SHB subset of Age 15 years was compared to the European School Survey Project on Alcohol and Other Drugs - ESPAD study 2003¹⁶.

The SHB was similar for Smoke, Drink, Ecstasy ever, and LSD ever. It was less for Bingeing and Cannabis.

Despite these variations the figures were broadly comparable, except for Bingeing and Cannabis last month.

Fig 156



SLAN 2002 18-34yrs (Fig 157)

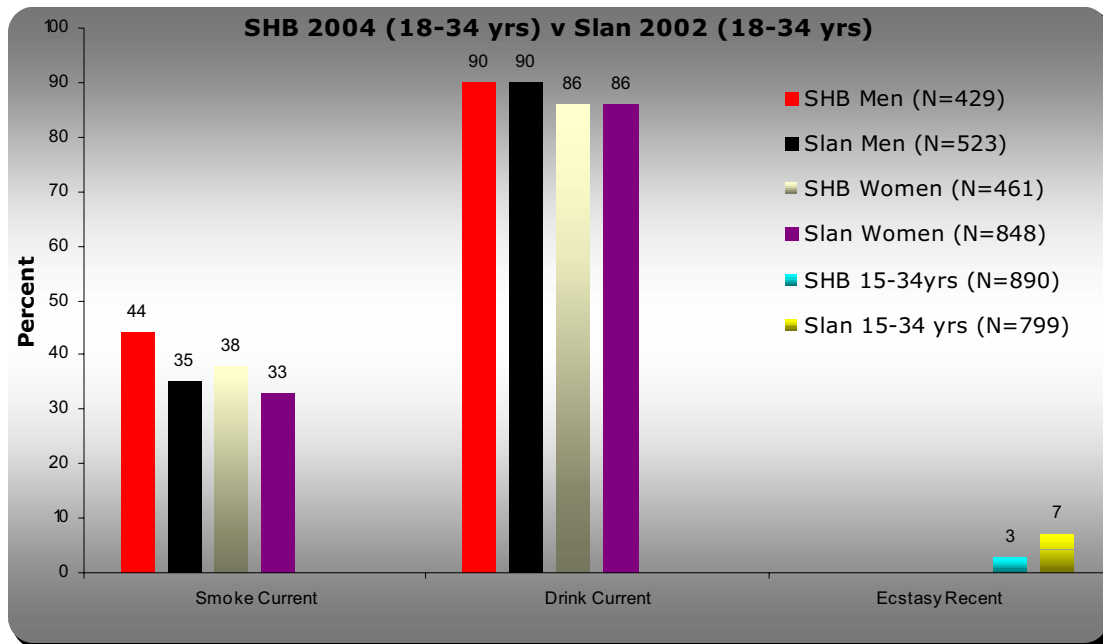
A SHB subset of Ages 18-34yrs was compared to the SLAN 2002 study^{15 19 26}

The SHB was identical for Current Drink in men and women.

SHB was greater than Slan for Current Smoking, and was less for Recent Ecstasy overall.

These figures were broadly comparable.

Fig 157

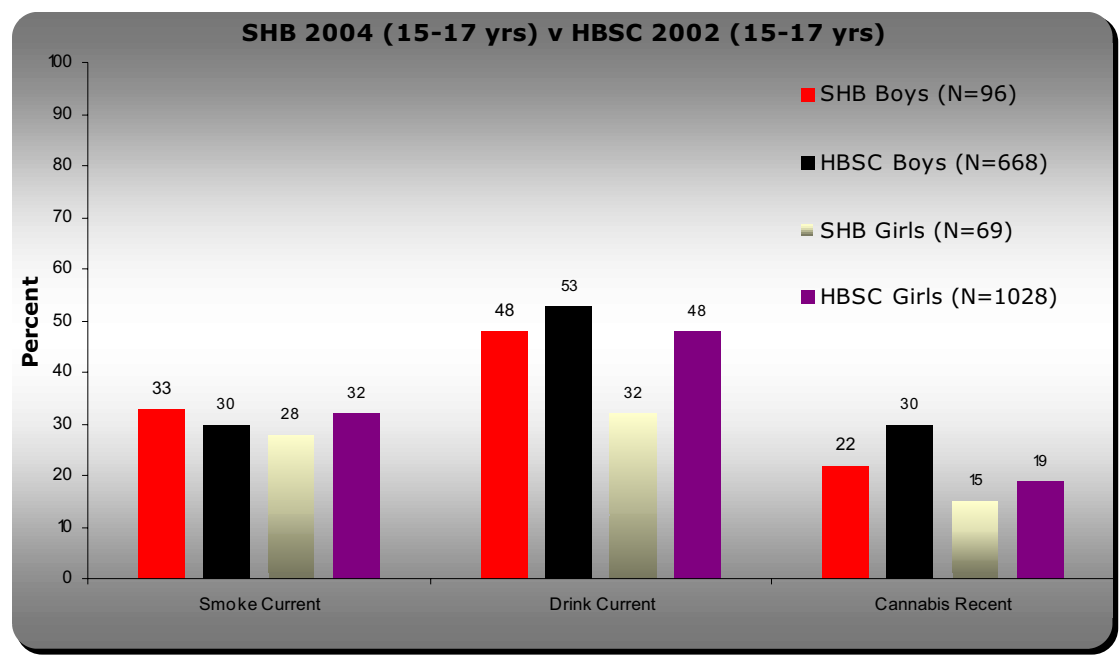


Health Behaviour in Secondary School Children (HBSC) 2002 15-17yrs (Fig 158)
A SHB subset of Ages 15-17yrs was compared to the HBSC 2002 study^{15 19 26}

The SHB was similar for Current Smoking, Current Drinking in boys, and Last Year Cannabis. It was less for Current Drinking in girls.

These figures were broadly comparable.

Fig 158



Irish Times/TNS mrbi Youth Poll 2003 ⁶⁹ (Fig 159)

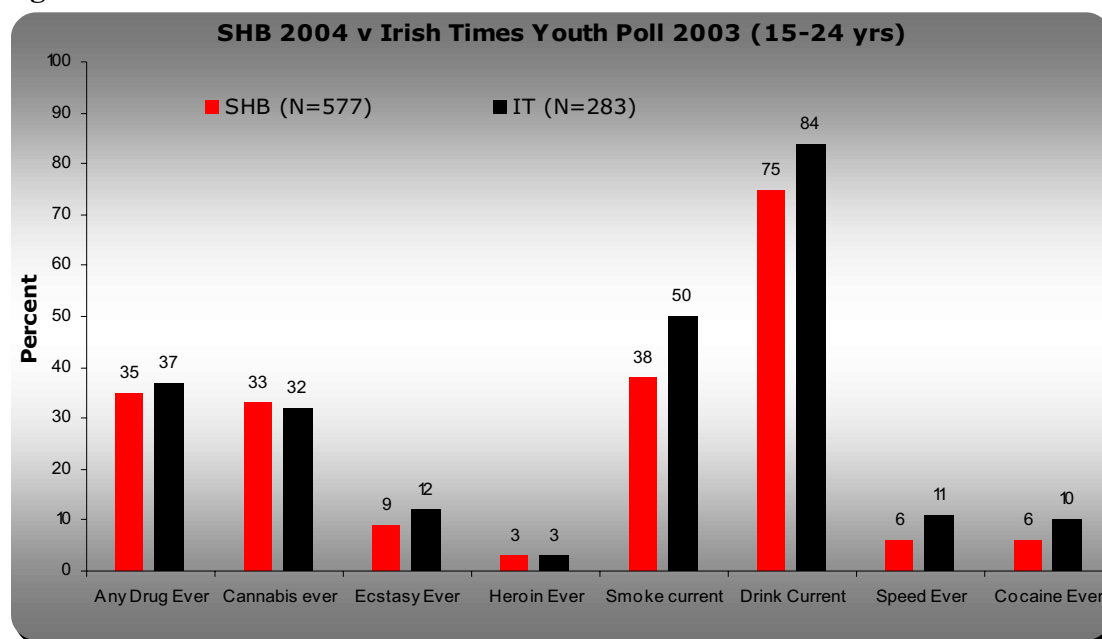
TNS mrbi carried out a household survey of young people aged 15-24 years in Autumn 2002. The methodology was almost identical to the SHB survey. Behaviour, Health and Lifestyle were explored, including substance use.

A SHB subset of Ages 15-24yrs was compared to the Irish Times study ⁶⁹

The SHB was similar for Any Drug, Cannabis, Ecstasy, and Heroin use. It was less for Smoke, Drink, Speed (Amphetamine), and Cocaine use

These figures were broadly comparable.

Fig 159



COMMUNITY PERCEPTIONS OF SUBSTANCE ABUSE ISSUES

Perception of Drug Issues in Areas

The high perception of drug related problems, especially for Drug use, Drugs offered, drug-related theft, and crime in the Cork city area, reflects a wide awareness of drug issues, especially in urban areas. Although there was a slight decrease for Offering, Thieving, and Inhaling, it was worrying to see that Kerry matched Cork quite closely for many factors. Social Class and Deprived Urban areas also showed higher perception of Drug Issues.

Perception of Harm

This is related to information and publicity about drugs, and personal experience. As in 1996, ranking of drugs by perceived harm showed heroin, ecstasy, crack, cocaine, 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 twice as frequent among those who think it least harmful compared with those who see it as harmful. This difference has reduced since 1996, probably indicating increasing tolerance of Cannabis in the population. This has important implications for health education, and information re cannabis use.

Cannabis has known detrimental effects on attention, psychomotor tasks, and short-term memory for up to 24 hours after use⁷⁰. Acute anxiety or panic attacks and psychotic symptoms have been reported after use⁷¹. Latent schizophrenia can be activated by heavy Cannabis use^{72 73}. Cannabis effects have recently been reviewed comprehensively in an NACD report⁷⁴, which confirms and clarifies earlier findings. Driving under the influence of Cannabis increases risk of a crash with fatality⁷⁵.

Ecstasy too shows worrying evidence that long term neurological damage can occur⁷⁶. 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. However, cognitive awareness of risk has been shown to have little impact on behavioural change in drug users, only adverse experience personally, or among friends might lead to cessation⁷⁷.

Personal Knowledge of Drug Situations

A high proportion claimed personal knowledge of drug situations. Especially in relation to cannabis and ecstasy where more than 50% claimed they knew those who had been offered or taken these substances. These situations had shown a marked increase since 1996, especially for Cannabis, Heroin, and Cocaine.

Agreement with Statements on Drug Policies

Significant changes had occurred in comparison with 1996. Disagreement for Cannabis being little different from legal substances was reduced, and agreement for Cannabis being a gateway drug was reduced. There was increased resistance to increasing alcohol pricing, but decreased resistance to raising tobacco prices.

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 (33%) seem to be agreeable to some legality for cannabis (increased from 21% in 1996). This is also reflected in the NACD study, which found that 27% of younger adults agreed that people should be allowed to take Cannabis for recreational reasons⁷⁸.

Knowledge of Substance Use Services offering advice or help for Alcohol and Drugs

GPs

GPs were the commonest general service mentioned for help (59%), especially in Kerry, where GPs were seen as a source of help by 76%.

SHB services

Arbour House and its Community Counselling Services was seen by 24% as a source of help, and Psychiatric Clinics by 19%.

However there were strong regional differences, in that Psychiatry was seen as the commonest SHB resource in Kerry at 37%, three times that in Cork.

The Community Counselling Service was also strongly recognised in Kerry at 15%.

Arbour House was seen as a resource by 28% in Cork City.

Voluntary Services

Knowledge of the main centres was dependent on location e.g.: 27% of those in Cork City knew of Tabor Lodge, and 40% in Kerry knew of Talbot Grove. There was little knowledge of the other centres.

There was also little knowledge of centres outside the SHB, the most recognised being Cuan Mhuire in Limerick by 7% in Cork County.

Self-Help Groups

AA was seen as a resource by 43%, especially in Cork City and County. NA was recognised by 11% in Cork City.

Knowledge of numbers of people known personally to have attended a service reflected these proportions.

Arbour House, Community Counselling Services and Voluntary Services have expanded enormously since 1996. A computerised version of the National Treated Drug Reporting System (NTDRS) has been developed in the SHB area, and a five-year analysis for 1999-2003, showed an expansion of clients attending services from 600 to 1800 per year⁷⁹. Health Promotion Activities such as SPHE, Brief Intervention Training, and Club Cork Project^{24 38 39}, have also increased. These services and general media publicity, have probably been influential in increasing public awareness of Substance Use issues.

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, discos more than once a month, and attendance at church less than once a month.

The associations with alcohol are already well recognised, as are the other social settings. Several studies confirm regular church attendance, and stable family situation as protective associations for substance use of both alcohol and drugs^{54 80 81}.

Personal Knowledge of those receiving professional help for Alcohol or Drugs

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. Alcohol was perceived to be the dominant substance for problem use, with two or more times the percentages receiving and needing help, than in the case of drug use.

Formerly, Alcohol was excluded from Treated Drug Misuse statistics for many years, but since 1994 it has been included. Alcohol statistics were collected prior to this, by only two areas outside the Eastern Health Board – SEHB and SHB. Study of their data, showed that about two-thirds presented at treatment centres for treatment of Alcohol use.⁸²

Injecting Drug Use

It is encouraging that only 25 (0.6%) in the total sample had ever injected. This occurred mainly in Urban Deprived areas.

RECOMMENDATIONS

SMOKING

ALCOHOL

DRUGS

RECOMMENDATIONS

Since this survey has shown increases in most substances in key target groups, it is important to structure the recommendations by substance group, which have been reported on by national committees. Some of these recommendations may inevitably overlap, but this should illustrate mutually reinforcing strategies.

SMOKING

Towards a Tobacco-Free Society²¹

This government report set the framework in four areas

1. Change Attitude
2. Support and Empower smokers to quit
3. Protect people from Environmental Tobacco Smoke (ETS)
4. Focus on Children

To implement these objectives the government have set up The Office of Tobacco Control.

Smoke-Free-Workplace Legislation

This was enacted in March 2004,²² and its implementation has been highly effective, with 94% of premises inspected being compliant with the legislation. Its purpose is to eliminate Environmental Tobacco Smoke (ETS) from the workplace.

Epidemiological evidence on protection of bar workers in the Republic of Ireland⁸³ shows that cotinine levels (indicating exposure to ETS) have dropped by 80%, and respiratory symptoms by 17% since the legislation. These were significantly lower than in the N Ireland sample where the legislation had not changed.

This high level of compliance needs to be maintained, by continued inspection and enforcement of appropriate legislation.

Other Legislation

Sale of cigarettes to minors under 18 years should be carefully policed, and appropriately enforced. Packets of 10 cigarettes should not be on sale, to discourage use by minors, as recommended by Towards a Tobacco Free Society²¹.

Price Control

It is recognised that 10% increase in cigarette prices will reduce consumption by 4% in affluent societies and 8% in poorer societies²¹. Taxation on tobacco is therefore a most efficient method of curbing use. Prices on cigarettes should be consistently increased above inflation rates in budgets. 2/3 to 4/5 of the price should be tax, to be consistent with other developed countries²¹.

Health Education

High-level interventions on price and legal control are the most effective measures. It is also important to reinforce these with appropriate Health Education and Promotion measures, targeted especially at children. SPHE measures should be available in all schools. The proportion of Health Promoting Schools should be increased further in

Cork and Kerry. Primary Schools involved should be increased beyond 40%, and Secondary Schools must certainly be increased beyond the current 23%.

Support for Smokers

It is important to ensure that smokers, who wish to quit, are given every encouragement and support. Nicotine Replacement Therapy (NRT) has been free to medical card holders since April 2001⁸⁴. Advice and counselling, and smoking-cessation programmes organised by the Health Promotion Dept., are currently easily accessible by telephone throughout Cork and Kerry. These should be continued.

ALCOHOL

The Strategic Task Force on Alcohol³² offers a framework for preventing and reducing harm from alcohol. The broad objectives are to reduce per capita consumption, to protect children, and to prevent and reduce the risk of alcohol-related harm. The best evidence-based interventions are those that target:

General population

Taxes, Access, Random Blood Testing, Lower Blood Alcohol limits

High Risk Groups

Minimum age of 18, enforcement of alcohol laws

High Risk Drinkers

Brief Interventions

Prevention

Decrease availability of alcohol

Price of alcohol should be increased markedly, by increased taxation.

Alcohol is relatively cheap in terms of modern wages. It is estimated in the UK that 10% increase in price could decrease alcohol mortality by up to 37%³²

Limit Outlets and Times of sale

Responsible Serving of Alcohol

It is particularly important that projects such as Club Cork^{38 39}, which involve training of bar, and night club staff in handling substance use issues, be continued and extended beyond Cork City, and into Cork Co and Kerry.

Limit children's access

No under 18s employed in licensed premises

No sales to under 18s

Limit times for under 18s in licensed premises

Enforce Drink Driving Laws

Random Blood Testing, and Lower Blood Alcohol Concentration limits should be implemented

Health Promotion in Schools – should be increased to reinforce the above, despite the evidence for these measures not being as strong.

Health Promoting Schools

Numbers participating should be increased from the current levels e.g.: 40% in Primary schools, and 23% in Secondary schools.

There is evidence also of the effectiveness of the Strengthening Families Program^{62 85}, which should be considered.

Treatment

The Four-Tier treatment strategy³⁶ (See Appendix 3) should be continued, and developed for an integrated community response to alcohol and drug misuse (Appx 4).

An integrated spectrum of treatment responses from Early Interventions, Detoxification, Treatment and Rehabilitation needs to be developed. Early Intervention and detoxification services should be available from GPs, and appropriate referral pathways developed for definitive treatment and rehabilitation.

Satellite and Outreach Community Counselling Clinics have been developed to extend early treatment opportunities into the community. These have been based on existing alcohol and drug treatment services in Arbour House. These services should continue and be extended, and appropriately resourced.

High Risk Drinkers

Brief Interventions Training³⁸⁻⁴⁰ for front-line staff should be continued and expanded. This training should be offered to all groups in contact with those harmfully drinking.

Appropriate screening tools for detection of harmful drinking should be used opportunistically in general practice⁸⁶ e.g. Audit, Cage.

Detoxification

The recommendations of the 2005 Detoxification Report⁸⁷ should be implemented to empower a community-wide detoxification response.

Arbour House Treatment Centre should continue to be a resource for training key people in the different sectors, especially for Tier 3 services. It must also be resourced to increase its capacity for Tier 3 services.

Voluntary Agencies giving counselling, treatment, and residential, and after-care services must be given appropriate support.

Alcohol is still the largest abused substance in the community, and resources should allow for this. Estimates of Problem and Dependent users should be used to target services appropriately (see Page 141, and Appendix 7)

There is considerable overlap of drug and alcohol services in the SHB area. 60% of those attending specialist counselling are for alcohol problems⁸⁸. The present practice of linking both alcohol and drug services, under a Drug and Alcohol Coordinator should continue with appropriate links between statutory and voluntary services.

Estimated Numbers Requiring Alcohol Treatment and Prevention Services

As stated earlier (page 19-20), estimates were made of those 18 years and over with:

	Men	Women
Category 2: problem drinking	7.8%	2.9%
Category 3: problem and dependent drinking.	3.7%	1.0%

These percentages can be applied to any known population structure to give estimates of those in need of services. The example below applies these estimates to the three main regions of the former Southern Health Board for a population of 18-64 years.

This model assumes a worst-case scenario of drinking patterns being maintained up to 64 years. It may be more accurate to keep within the survey parameters of 18-44 years, whose figures would be 0.65 of the 18-64 estimates. It assumes current drinking proportions of 0.82 for men, and 0.79 for women.

It can be seen that 15,833 are estimated to have Category 2 Problem drinking, and 6,977 to have Category 3 Problem and Dependent drinking.

Category 2 Problem drinkers should be targeted for Brief Intervention measures

Category 3 Problem and Dependent drinkers require therapeutic services.

A detailed breakdown of Problem Alcohol Use by Local Health Office Areas is shown in Appendix 7

18-64 Years	Men			Women			Total	
	Pop	Cat 2	Cat 3	Pop	Cat 2	Cat 3	Cat 2	Cat 3
Cork City	37563	2403	1140	39382	902	311	3305	1451
Cork County	103348	6610	3136	99822	2287	789	8897	3924
Kerry County	42195	2699	1280	40713	933	322	3632	1602
SHB	183106	11711	5555	179916	4122	1421	15833	6977

18-44 Years	Men			Women			Total	
	Current Drink	Cat 2	Cat 3	Current Drink	Cat 2	Cat 3	Cat 2	Cat 3
Cork City	19914	1553	737	20209	586	202	2139	939
Cork County	54791	4274	2027	51225	1486	512	5759	2540
Kerry County	22370	1745	828	20892	606	209	2351	1037
SHB	97075	7572	3592	92327	2677	923	10249	4515

DRUGS

The National Drugs Strategy (NDS)⁵⁹ supplies a framework for strategic intervention into drug misuse – Supply, Prevention, Treatment and Rehabilitation, and Research. These overlap considerably at certain points with smoking and alcohol strategies.

Supply

This is formally outside the brief of this report. It is, however, important to note that seizure of illegal drugs by Customs and Excise or Gardai; Gardai intelligence and activities against criminals involved in drug dealing; the Criminal Assets Bureau; and cooperation between the key legal enforcers have all been recognised by the NDS Steering Group as increasingly successful measures.

The National Steering Group stresses that increased Gardai Resources should be targeted to Regional Drugs Task Force areas to prevent drug dealing, and enhance community policing. The HSE services must continue to liaise with Local and Regional Drugs Task Forces.

Prevention

It is recognised that central policy decisions on legislation and fiscal control have the greatest potential impact for public health in the case of legal substances, and this has been noted in the appropriate sections on smoking and alcohol. These controls are not available for illegal substances.

Comprehensive Substance Use Prevention Programmes must continue to be available and implemented. SPHE, the Health Promoting Schools programme, and Substance Use Policies have been implemented in many secondary and primary schools, but still only to a minority. These activities should be extended beyond prioritised deprived areas, since the evidence of this survey is that substance use is prevalent across all communities. Parental support and education is important, and 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 Dept Mid Term Review proposals on the NDS^{38 39}, should be implemented with especial emphasis at improving child self-reliance and resistance to substance use. The Strengthening Families Program^{62 85} should also be considered, especially for those at most risk. The aim must be to delay the age of experimentation with substance use, especially tobacco and alcohol.

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.

Regional and Local Drugs Task Forces can actively encourage

Outreach Drug Projects in local communities, especially for early school leavers. These should have close links with Youth Services.

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

Progress in these areas needs to be evaluated regularly

Treatment

As in the alcohol section the four-tier model⁸⁹ is required, which can be briefly summarised as follows:

Tier 1: Open – access services

Tier 2: Community treatment, counselling, and support services

Tier 3: Specialist community treatment services

Tier 4: Specialist residential and rehabilitative services.

This is shown in more detail in appendix 3.

The Addiction Treatment Strategy should continue to try to develop an integrated response from all available services in the area. e.g.: SHB, Local Authority, Community, Education, Justice at all levels, rather than in isolation. The Local and Regional Drugs Task Forces are succeeding in achieving this in many areas, and their work should be commended and continued.

Harm reduction strategy involving methadone maintenance should be increased. Level Two GPs who can initiate treatment should be increased. Current numbers would not justify any needle-exchange scheme.

Research

Information Systems

It is essential to maintain epidemiological data. The existing Treated Drug Misuse System has been computerised in the main drug treatment centres. Core data is now compatible with the National System, which now includes data fields exploring alcohol use, and performance indicators. These developments have been incorporated into the National System, and should be maintained. Ideally, a quarterly report should be prepared for the Regional Drugs Coordinator on Treatment Trends.

A range of Performance Indicators have been suggested by Marsden et al⁸⁹, which could be applied to relevant services.

Survey

This type of community survey gives valuable epidemiological information. It allows comparison with other National Surveys, such as Slan, and NACD, and school-based studies. It is important that this survey is repeated regularly to monitor community substance use. WHO⁶⁴ recommends population surveys every six years.

It might also be possible to target this survey, with appropriate adaptations, for ethnic groups such as Travellers, or Immigrant communities.

APPENDICES

- 1 References**
- 2 Range of problems associated with alcohol**
- 3 4-Tier Model of Substance Use**
- 4 Range of Responses to alcohol and substance use**
- 5 Clinical features of opioid and cocaine disorders**
- 6 Detailed Drug Classification**
- 7 Substance Use Summaries**
- 8 Young Adult Population Changes in Cork City**
- 9 Detailed Methodology of Sampling**
- 10 Questionnaire**

APPENDIX 1

References

1. Jackson T.M.R. Smoking, Alcohol, and Drug Use in Cork and Kerry. Cork: Southern Health Board, 1997:124.
2. Central Statistics Office. Census 2002 Vol 1 Population Classified by Area. Dublin: Stationery Office, 2003.
3. Central Statistics Office. Census 2002 Vol 2 Ages and Marital Status. Dublin: Stationery Office, 2003.
4. Central Statistics Office. Census 2002 Small Area Population Statistics (SAPS). Dublin: Stationery Office, 2003.
5. Small Area Health Research Unit (SARHU) TC, Kelly A. A New National Deprivation Index for Health and Health Services Research Part 2 Regional Index - SHB. *SARHU Technical Report*. Dublin: Small Area Health Research Unit Department of Public Health and Primary Care Trinity College Dublin, 2004.
6. Aertgeert B, Buntinx F, Kester A. Review: sensitivity of the CAGE questionnaire for the DSM diagnosis of alcohol abuse and dependence in general clinical populations was 71% at cut points ≥ 2 . *Evidence Based Medicine* 2005;10(February 2005):26.
7. Aertgeerts B, Buntinx F, Kester A. The value of CAGE in screening for alcohol abuse and alcohol dependence in clinical populations: a diagnostic meta-analysis. *Journal of Clinical Epidemiology* 2004;57:30-39.
8. Central Statistics Office. Census 2002 Vol 6 Occupations. Dublin: Stationery Office, 2003.
9. ESOMAR. ICC/ESOMAR International Code of Marketing and Social Research Practice, 2001.
10. ESOMAR. ESOMAR Guidelines on Interviewing Children and Young People, 2001.
11. Edwards G, Unnithal S, editors. *Alcohol Misuse: From Health Care Needs Assessment Ch 15. First Series, 1st Edition Vol 2*. Oxford: Radcliffe Medical Press, 1994.
12. NACD and DAIRU. Drug Use in Ireland and Northern Ireland First Results from the 2002/2003 Drug Prevalence Survey. Dublin and Belfast: National Advisory Committee on Drugs (NACD) and Drug and Alcohol Information and Research Unit (DAIRU), 2003:16.
13. NACD and DAIRU. Drug Use in Ireland and Northern Ireland 2002/2003 Drug Prevalence Survey: Health Board (Ireland) and Health and Social Services Board (Northern Ireland) Results. Dublin and Belfast: National Advisory Committee on Drugs (NACD) and Drug and Alcohol Information and Research Unit (DAIRU), 2004:28.
14. Kelleher K, Cowley H, Houghton F. Teenage Smoking and Drug Use in the Mid-Western Health Board region 2002. Limerick: Mid-Western Health Board, 2003:76.
15. SLAN. The National Health and Lifestyle Surveys - Results of SLAN and HBSC. Galway and Dublin: Centre for Health Promotion Studies, NUI,G, 2003:68.

16. Hibell B, Andersson B, Ahlstrom S, Balakireva O, Bjarnasson T, Kokkevi A, et al. The 2003 ESPAD Report - Alcohol and Other Drug Use Among Students in 35 European Countries. Stockholm: The Swedish Council for Information on Alcohol and Other Drugs, and The Pompidou Group at the Council of Europe, 2004:435.
17. Flanagan E, Bedford D, O'Farrell A, Howell F. Smoking, Alcohol and Drug Use among Young People: North Eastern Health Board, 2003:83.
18. SLAN. The National Health and Lifestyle Surveys - The Regional Results from SLAN and HBSC. Galway and Dublin: Health Promotion Unit, Department of Health and Children and Centre for Health Promotion Studies, NUI,G, 1999:54.
19. SLAN. The National Health and Lifestyle Surveys 2003. Galway and Dublin: Health Promotion Unit and NUIG, 2003:11.
20. Hibell B, Andersson B, Ahlstrom S, Balakireva O, Bjarnasson T, Kokkevi A, et al. The 1999 ESPAD Report - Alcohol and Other Drug Use Among Students in 30 European Countries. Stockholm: The Swedish Council for Information on Alcohol and Other Drugs, and The Pompidou Group at the Council of Europe, 2000:353.
21. Department of Health and Children. Towards a Tobacco Free Society. In: Group TFPR, editor, 2000.
22. Office of Tobacco Control. Office of Tobacco Control. Annual Report 2004. In: Control OoT, editor: Office of Tobacco Control, 2004.
23. Office of Tobacco Control. Irish Government Ratifies world tobacco treaty. Minister Martin receives WHO award for his tobacco control activities. In: Control OoT, editor, 2004.
24. Department of Health and Children. The National Health Promotion Strategy 2000-2005. Dublin: Department of Health and Children, 2000:79.
25. EHB Department of Public Health. Public Health in the Eastern Health Board Region - Department of Public Health Report. Dublin: EHB Department of Public Health, 1998:87-89.
26. SLAN. The National Health and Lifestyle Surveys 2003 - Regional Results of the National Lifestyle Surveys SLAN (Survey of Lifestyle, Attitudes and Nutrition) and HBSC (Health Behaviour in School Aged Children). Dublin and Galway: Health Promotion Unit and NUIG, 2003:110.
27. MWHB DoPH. Teenage Smoking, Alcohol and Drug Use in the Mid-Western Health Board Region. Limerick: Mid-Western Health Board, 1998.
28. Ramstedt M, Hope A. The Irish Drinking Habits of 2002: Drinking and drinking-related harm, a European comparative perspective. *Journal of Substance Abuse* 2003;In Press.
29. O'Farrell A. Ireland and its Drink Problem: the Immediate Adverse Effects of binge Drinking in Ireland (Editorial). *IMJ* 2004;97(6):165-166.
30. Royal College of Psychiatrists. Alcohol our favourite drug: Royal College of Psychiatrists, 1986.
31. Department of Health and Children. Strategic Task Force on Alcohol Interim Report May 2002. Dublin: Department of Health and Children, 2002:47.
32. Department of Health and Children. Strategic Task Force on Alcohol, Second Report, September 2004. Dublin: Department of Health and Children, 2004.
33. WHO. European Charter on Alcohol: WHO Regional Office for Europe, 1995.
34. WHO. European Alcohol Action Plan 2000-2005: WHO Regional Office for Europe, 2000:20.

35. Babor T F; Caetano R. CSea. *Alcohol: No Ordinary Commodity. Research and Public Policy*. Oxford and London: Oxford University Press, 2003.
36. Cook C, editor. *Alcohol Misuse: From Health Care Needs Assessment Ch 15. First Series, 2nd Edition Vol 2*. 2nd ed. Oxford: Radcliffe, 2004.
37. Mannix M. Drug and Alcohol Detoxification Services: A Needs Assessment for Health Service Executive - Southern Area, 2005.
38. Department of Health Promotion SHB, editor. *Southern Health Board, Health Promotion Dept, Mid-Term Review for National Drugs Strategy. Departmental Report. August 2004*. Cork: Dept Health Promotion, SHB, 2004.
39. Department of Health Promotion SHB. Update on Dept of Health Promotion Activities. Cork, 2005.
40. Foley-Nolan C, Kelly J. BRIEF INTERVENTIONS TRAINING EVALUATION. Cork: Dept of Public Health SHB Cork, 2004.
41. Paton-Simpson G, McCormick IR, Powell A, Adams P, Bunbury D. Problem drinking profiles of patients presenting to general practitioners: analysis of Alcohol Use Disorders Identification Test (AUDIT) scores for the Auckland area. *NZ Med J* 2000;113:74-7. 2000.
42. Dinh-Zarr T, Goss C, Heitman E, Roberts I, DiGuseppi C. Interventions for preventing injuries in problem drinkers. Cochrane Review. *Cochrane Library. Issue 3. Oxford: Update Software*, 2004.
43. Deehan A, Marshall EJ, Strang J. Tackling alcohol misuse: opportunities and obstacles in primary care. (Review) (74 refs). *Br J Gen Pract* 1998; Nov; 48(436):1779-82. 1998.
44. Fleming MF, Mundt MP, French MT, Manwell LB, Stauffacher EA, Barry KL. Brief physician advice for problem drinkers: long-term efficacy and benefit-cost analysis. *Alcoholism: Clinical and Experimental Research* 2002;26:36-43 2002.
45. Babor TF, de la Fuente RJ, Saunders J, Grant M. AUDIT The Alcohol Use Disorders Identification Test: guidelines for use in primary health care. 1989.
46. WHO, Babor T F, Higgins-Biddle JC. Brief Intervention. A manual for Use in Primary Care: WHO Dept of Mental Health and Substance Dependence, 2001.
47. King P. Southern Regional Drugs Task Force Strategic Plan 2005-2008. Presented to National Drugs Strategy Team. Cork: Southern Regional Drugs Task Force, 2005.
48. HRB. Trends in treated problem drug use in the seven health board areas outside the Eastern Regional Health Authority, 1998-2002. Occasional paper no.12. Dublin: Drugs Misuse Research Division, 2004:pages 20.
49. HRB. Trends in treated problem drug use in Ireland, 1998-2002. Occasional paper no.17. Dublin: Drugs Misuse Research Division, 2005:pages 24.
50. Wagner F, Anthony J. Into the world of illegal drug use: exposure opportunity and other mechanisms linking the use of alcohol, tobacco, marijuana, and cocaine. *American Journal of Epidemiology* 2002;55(10):918-925.
51. Best D, Rawaf S, Rowley J, Floyd K, Manning V, Strang J. Drinking and smoking as concurrent predictors of illicit drug use and positive drug attitudes in adolescents. *Drug Alcohol Depend* 2000 Nov 1; 60 (3): 319 - 21 2000.
52. Merrill JC, Kleber HD, Shwartz M, Liu H, Lewis SR. Cigarettes, alcohol, marijuana, other risk behaviours, and American youth. *Drug Alcohol Depend* 1999 Oct 1; 56 (3): 205-12 1999.
53. Galanti LM, Manigart P, Dubois P. Tobacco smoking in a large, young healthy population. *Arch Environ Health* 1998 Mar-Apr; 53 (2): 156-60 1998.

54. Wallace JM Jr, Brown T, Bachman J, Laveist T. The influence of race and religion on abstinence from alcohol, cigarettes, and marijuana among adolescents. *J Stud Alcohol* 2003;64(6):843-8.
55. Hall W, Solowij N. Adverse effects of cannabis. *Lancet* 1998;352:1611-1616.
56. Collins C, Crowley D, Connolly J, Morgan M. An overview of scientific and other information on Cannabis. In: Morgan M, editor. Dublin: NACD, 2004.
57. Farrell M, Howes S, Bebbington P, Brugha T, Jenkins R, Lewis G, et al. Nicotine, alcohol and drug dependence and psychiatric comorbidity: Results of a national household survey. *Br J Psychiatry* 2001;179(5):432-437.
58. Department of Tourism S, and Recreation. National Drugs Strategy 2001-2008. Building on Experience. Dublin: Department of Tourism, Sport, and Recreation, 2001.
59. Department of Community R, and Gaeltacht Affairs. Mid-Term Review of the National Drugs Strategy 2001-2008. Report of the Steering Group. Dublin: Department of Community, Rural, and Gaeltacht Affairs, 2005.
60. Galvin B. A re-focused and re-energised National Drugs Strategy. *Drug Net Issue 14 Summer 2005*. Dublin: Health Research Board, 2005.
61. Foxcroft D, Ireland D, Lister-Sharp D, Lowe G, Breen R. Primary Prevention for Alcohol Misuse in Young People (Cochrane Review). *The Cochrane Library* 2004(3).
62. Kumpfer K. Strengthening Families Program, 2005.
63. Morgan M. Drug Use Prevention: An Overview of Research. In: Drugs NACo, editor. Dublin: Government Publications Sales Office, Sun Alliance House, Molesworth St, Dublin 2, 2001.
64. European Monitoring Centre for Drugs and Drug Addiction. Handbook for surveys on drug use among the general population. Lisbon: European Monitoring Centre for Drugs and Drug Addiction, 2002:153.
65. NACD, DAIRU, MORI MRC. Population Survey on the Prevalence of Drugs: Technical Report. Dublin and Belfast: National Advisory Committee on Drugs (NACD) and Drug and Alcohol Information and Research Unit (DAIRU), 2006:277.
66. Harrison L. The validity of self-reported drug use in survey research: an overview and critique of research methods. In: USA NIOdAN, editor. *The validity of Self-reported Drug Use: Improving the Accuracy of Survey Estimates*: National Institute on Drug Abuse (NIDA) USA, 1997.
67. Harrell A V. The Validity of Self-Reported Drug Use Data: The Accuracy of Responses on Confidential Self-Administered Answered Sheets. In: USA NIOdAN, editor. *The validity of Self-reported Drug Use: Improving the Accuracy of Survey Estimates*, 1997.
68. Okamoto K, Ohsuka K, Shiraishi T, Hukazawa E, Wakasugi S, Furuta K. Comparability of epidemiological information between self- and interviewer-administered questionnaires. *J Clinical Epidemiology* 2002;2002 May; 55(5):505-11.
69. McShane. Irish Times TNS/mrbi Youth Poll: Irish Times, 2003:90.
70. Pope H, Gruber A, Yurgelun-Todd D. The residual neuropsychological effects of cannabis: the current status of research. *Drug-Alcohol-Depend.* 1995 Apr; 38 (1); 25-34 1995.
71. Thomas H. A community survey of adverse effects of cannabis use. *Drug-Alcohol-Depend.* 1996 Nov; 42 (3): 201-7 1996.

72. Arseneault L, Cannon M, Poulton R, Murray R, Caspi A, Moffitt TE. Cannabis use in adolescence and risk for adult psychosis: longitudinal prospective study. *BMJ* 2002;325(7374):1212-1213.
73. Arseneault L, Cannon M, Witton J, Murray RM. Causal association between cannabis and psychosis: examination of the evidence. *British Journal of Psychiatry* 2004;184:110-117.
74. Claire Collins JC, Dominique Crowley, Mark Morgan. An overview of scientific and other information on Cannabis. In: Morgan M, editor. Dublin: NACD, 2004.
75. Laumon B, Gadegbeku B, Martin J-L, Biecheler M-B, The SAM Group. Cannabis intoxication and fatal road crashes in France: population based case-control study. *BMJ* 2005; 331: 1371-4 2005.
76. Green A, Goodwin G. Ecstasy and neurodegeneration. *British Medical Journal* 1996 June 15; 312: 1493 1996.
77. Gamma A, Jerome L, Liechti ME, Sumnall HR. Is ecstasy perceived to be safe? A critical survey. *Drug and Alcohol Dependence* 2004.
78. NACD and DAIRU. Drug Use in Ireland and Northern Ireland 2002/2003 Drug Prevalence Survey: Cannabis Results. Dublin and Belfast: National Advisory Committee on Drugs (NACD) and Drug and Alcohol Information and Research Unit (DAIRU), 2005:31.
79. Jackson T, Cronin J. An Analysis of the Treated Drug Reporting System in SHB Over Five Years 1999-2003. *Faculty Public Health Medicine Summer Scientific Meeting*. Dublin: Irish Journal of Medical Science Vol 2 no 26 2004, 2004.
80. Yarnold B, Patterson V. Marijuana use among Miami's adolescents, 1992. *J Health Soc Policy* 1998;1998 10(1):65-79.
81. Sutherland I, Shepherd J. Social dimensions of adolescent substance use. *Addiction* 2001;2001 Mar 96(3):445-58.
82. HRB. Treatment demand for problem alcohol use in the South Eastern and Southern Health Board areas, 2000-2002. Dublin: Drug Misuse Research Division, 2004:12.
83. Allwright S, Paul G, Greiner B, Mullally B, Purcell L, Kelly A, et al. Legislation for smoke-free workplaces and health of bar workers in Ireland: before and after study. *British Medical Journal* 2005 Nov 11; 331: 1117 2005.
84. Office of Tobacco Control. Promoting a tobacco free society. In: Control OoT, editor: Office of Tobacco Control, 2004.
85. Foxcroft DR, Ireland D, Lowe G, R B. Primary prevention for alcohol misuse in young people (Review). *Cochrane Collaboration* 2002.
86. McCormick R, Patton R. Alcohol screening and intervention from BMJ Learning: <http://www.bmjlearning.com/>, June 2005.
87. Mannix M. Drug and Alcohol Detoxification Services: A Needs Assessment for Health Service Executive - Southern Area: Dept of Public Health HSE SA, 2005.
88. Long J, Jackson T, Kidd M, Kelleher T, Sinclair H. Treatment demand for problem alcohol use in the South Eastern and Southern Health Board areas, 2000 to 2002. *Drug Misuse Research Division, Health Research Board, Occasional Paper No 10* 2004.
89. Marsden J, Strang J, editors. *Drug Misuse: From Health Care Needs Assessment Ch 16. First Series, 2nd Edition Vol 2*. 2nd ed. Oxford: Radcliffe, 2004.

APPENDIX 2

Range of problems associated with alcohol.

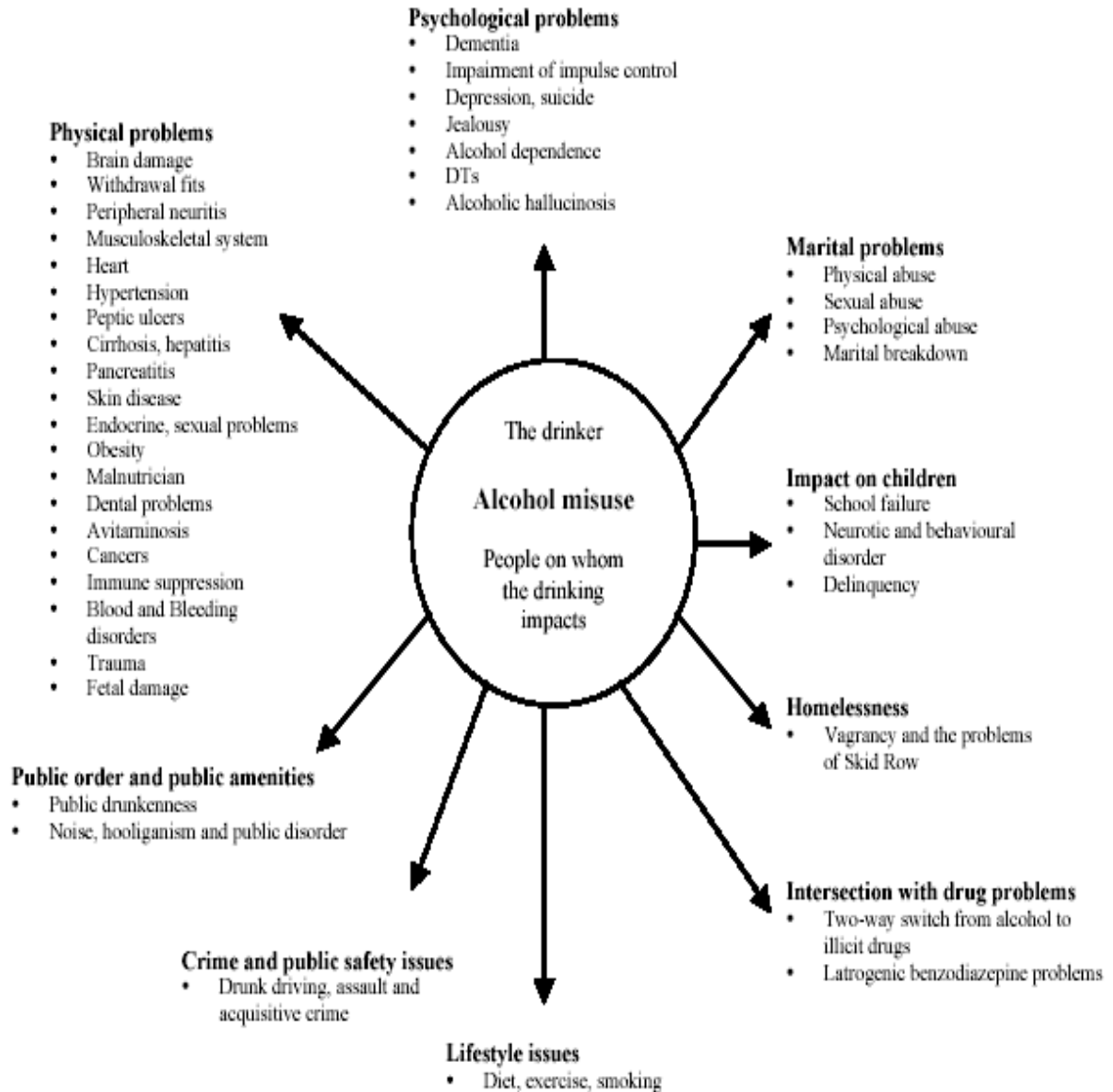


Figure 2: Alcohol misuse: the problem context.

Cook C: Alcohol Muses: From Health Care Needs Assessment Ch 15. First Series, 2nd Edition Vol 2.

APPENDIX 3

4-Tier Model of Substance Use Intervention applied to Alcohol

<i>Tier 1</i>	<i>Tier 2</i>	<i>Tier 3</i>	<i>Tier 4</i>
Services In Non-Specialist Settings	Low Threshold Specialist Services For Problem Drinkers And Their Families or Carers	Specialist Alcohol Screening Assessment and Interventions	Specialist In-patient Residential and Recovery Services
Identification assessment	Drop-in services	Specialist Alcohol Screening and Assessment in the Criminal Justice System	Residential rehabilitation and in-patient detoxification
Education in alcohol related harms		Community Detoxification	Wet services
Opportunistic Brief Interventions	Opportunity Brief interventions	Specialist Brief interventions	Floating support
Motivational interviewing	Motivational interviewing	Motivational Interviewing	Assertive outreach
Harm Reduction Approaches		Structured specialist counselling	Supported Tenancies
		Liaison services	Liaisons services
		Aftercare	Aftercare
		Controlled drinking interventions	Controlled drinking interventions
			Structured day programmes

Mannix M; Drug and Alcohol Detoxification Services

4-Tier Model of Substance Use Intervention applied to Drug Misusers

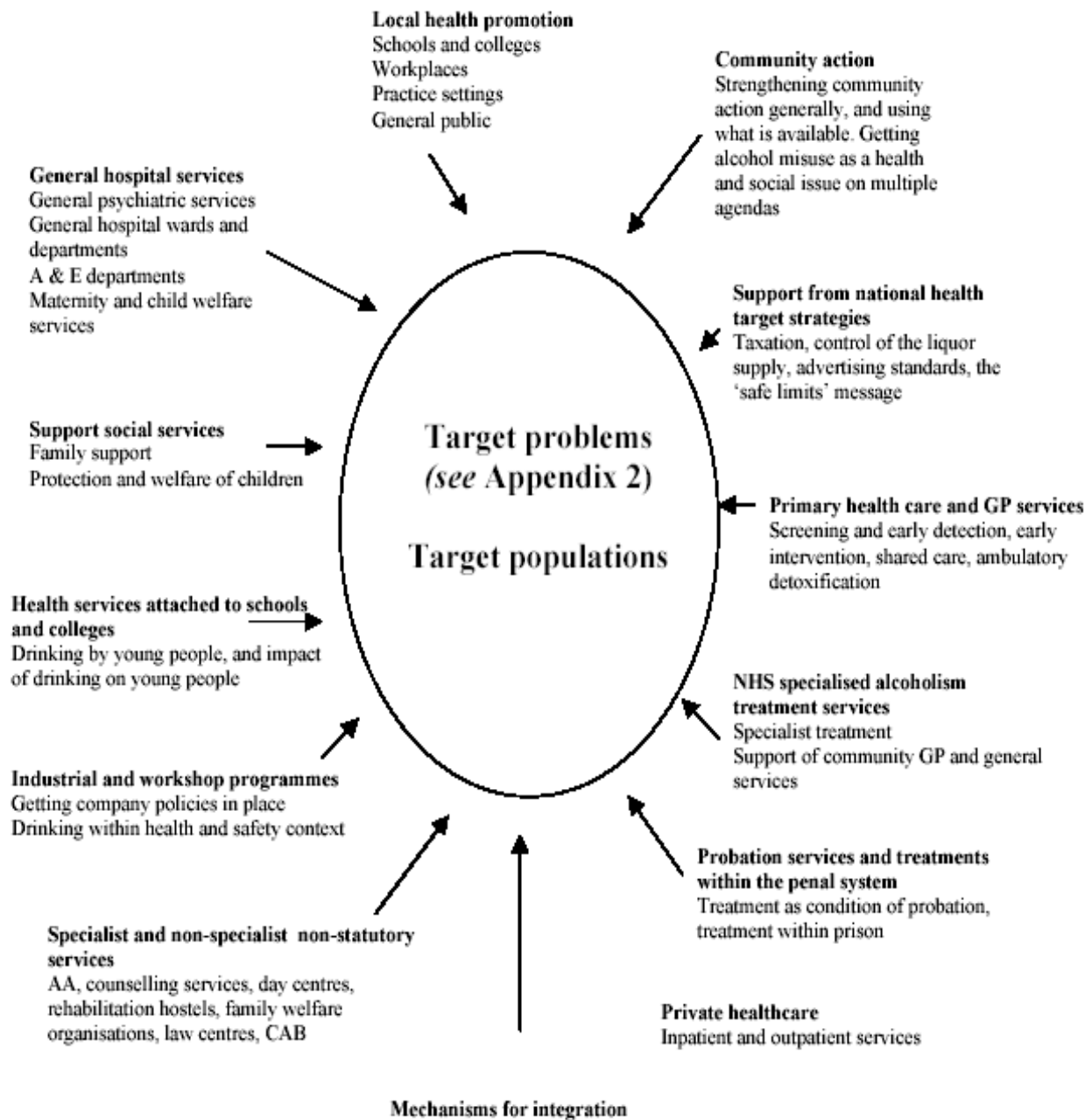
Table 1: Services provided in the four tiers of services for drug misusers

Tier	Core Function	Severity of client problem at contact
I (open access)	Advice, information; syringe exchange/distribution; education; primary medical services	Mild to severe
II (community treatment, counselling and support)	Assessment, education, advice, counselling; GP-led substitute prescribing; counselling, prescribing and assistance for psychiatric comorbidity; aftercare and support	Mostly moderate
III (specialist community treatment)	Specialist (supervised) prescribing; structured counselling/day programmes; treatment of complex cases; pregnancy comorbidity; community detoxification; counselling; referral; training and development	Mostly moderate to severe
IV (specialist residential and rehabilitative)	Specialist detoxification in controlled environments with counselling to prevent relapse; rehabilitation	Mostly severe

Marsden J; Strang J; From Health Care Needs Assessment Ch 16. First Series, 2nd Edition Vol .2

APPENDIX 4

Diagram of range of responses to alcohol and substance use.



APPENDIX 5

Clinical features of opioid and cocaine disorders⁸⁹

Opioid disorders

The opioid substances include both natural products (e.g. morphine) derived from the poppy (*Palaver somniferous*), semi-synthetic substances (e.g. diamorphine) and synthetic products (e.g. methadone and dihydrocodeine). Illicit heroin is the most commonly used. Heroin is a powerful, relatively short-acting analgesic, and heroin powder is prepared for consumption either through inhalation or insufflation (sniffing into the nose), or by intravenous or intramuscular injection routes. The clinical features of opioid intoxication (which are largely determined by dose levels, route of administration and tolerance) may include:

- initial euphoria
- increased well-being and diminished anxiety
- drowsiness and dysphoric mood
- papillary constriction
- in acute intoxication (overdose), papillary dilation is due to anoxia
- slurred speech and impairment in attention.

Opioid dependence (ICD-10 code, F11.2; DSM-IV code, 304.00) is defined under DSM in the following manner. Most individuals with opioid dependence have significant levels of tolerance and will experience withdrawal on abrupt discontinuation of opioid substances. Opioid dependence includes signs and symptoms that reflect compulsive, prolonged self-administration of opioid substance. Clinical features may include:

- a subjective awareness of compulsion to use
- a diminished capacity to control use
- salience of drug-seeking behaviour.

People who misuse opioids, but are not dependent, are likely to represent a small segment of the opioid using population and will tend to use heroin infrequently. The usual clinical features of opioid withdrawal that follow abrupt cessation of use in someone who has used the drug on a heavy and prolonged basis (or are precipitated by the administration of an opioid antagonist such as naloxone) are as follows:

- dysphoric mood and distress
- yawning
- nausea and vomiting
- diarrhoea
- muscle aches
- insomnia.

The speed of onset of these symptoms is usually between 6-12 hours for heroin, reaching peak intensity between 48-72 hours and then diminishing over a period from 5-7 days. The time-course for methadone is considered to be more protracted, with a slower onset but longer duration of the withdrawal syndrome.

Cocaine disorders

Cocaine is a psychostimulant (benzoylecgonine) extracted from the leaves of the plant *Erythroxylon coca*. In the UK, two illicit cocaine products are available: cocaine hydrochloride (a white crystalline salt usually containing other local anaesthetics and / or other bulk additives) and a whitish crystalline free-base form known as 'crack' or 'rock'. The effects of cocaine include elevated mood, increased alertness, and suppression of appetite and fatigue. It also has local anaesthetic and vasoconstrictive properties. The clinical features of cocaine intoxication (determined largely by dose, route of administration and tolerance) are quite complex and include:

- euphoria and increased confidence
- becoming talkative and mentally alert
- reduced appetite
- restlessness
- social withdrawal (with chronic administration).

The short-term physiological effect of cocaine include constricted blood vessels, dilated pupils and increased temperature, heart rate and blood pressure. Large amounts (several hundred milligrams or more) may lead to bizarre, erratic and violent behaviour.

Relatively short period of problematic use may be encountered by non-dependent users (characterised by interpersonal conflicts, financial problems, tiredness and irritability) but usually ameliorate following cessation of cocaine use. On the other hand, cocaine dependence (ICD-10 code, F14.2; DSM-IV code, 304.20) is characterised by the following features:

- substantial impairment of the ability to control the amounts used
- high-dose, usually episodic consumption pattern
- increased anxiety and depression
- paranoid-type ideation (in some users)
- weight loss.

The existence of a defined withdrawal syndrome following termination of heavy and prolonged cocaine use has been somewhat controversial. No coherent syndrome is usually seen, and there are marked intra-and inter-individual variations in the type and severity of problems experienced. Some studies have reported no or few signs of cocaine withdrawal amongst clients receiving inpatient treatment, while other research has suggested a transient cluster of symptoms, including dysphoric mood, general depression and sleep disturbance. Diagnostic criteria for cocaine withdrawal include:

- dysphoric mood
- fatigue
- unpleasant dreams
- insomnia or hypertension
- increased appetite
- psychomotor retardation or agitation.

APPENDIX 6

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)

Non-prescription Codeine

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 Tems, Midget, Gems)

Barbiturates (also called Downers, Barbies, Blues, Reds, Sekkies)

Triazolam (also called Upjohns)

Unprescribed use of Sleeping Tablets

Unprescribed use of Tranquillisers (e.g. Valium, Librium, Ativan)

Alcohol

SOLVENTS

Sniffing Glue, Gas, Aerosol

APPENDIX 7

Substance Use Summaries

Alcohol Drinking Categories by Local Health Office Areas

Selected Substances by Age Groups

Selected Substances by Gender

Alcohol: Drinking Categories by Local Health Office Areas in Cork and Kerry (Cat2=problem: Cat3 = problem + dependent)

Selected Substances by Age Groups

Selected Substances (Age: 15-44) by Gender

APPENDIX 9

Detailed Methodology of Sampling

Detailed Sampling Methodology

TNS mrbi/105380/05 Technical Appendix

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 North Central, North East, North West, South Central, South East, South West and suburbs.

Table I sets down the aforementioned adult population matrix as derived from the 2002 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. BORO	186,239	100%	63	504
CORK COUNTY				
Towns 10,000+	11,191	4%	3	24
Towns 5,000 - 10,000	38,463	15%	11	88
Towns 1,500 - 5,000	39,132	15%	12	96
Rural	172,804	66%	37	296
Total Cork County	261,590	100%	63	504
KERRY				
Towns 10,000+	35,124	27%	17	136
Towns 5,000 - 10,000	-	-	-	-
Towns 1,500 - 5,000	9,833	7%	4	32
Rural	87,570	66%	42	336
Total Kerry	132,527	100%	63	504
Total Southern Health Board	580,356	-	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.

Technical Appendix I includes the sampling points which were drawn within each of the three regions.

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 2002 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.

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

AGE	MALES				FEMALES				TOTAL	
	SINGLE POP.	N.	MARRIED POP.	N.	SINGLE POP.	N.	MARRIED POP.	N.	POP.	N.
15-19	4,932	40 8%	11	-	5,142	46 9%	18	-	10,103	86 17%
20-24	6,737	55 11%	97	-	7,852	66 13%	173	-	14,859	121 24%
25-34	7,591	66 13%	2,117	20 4%	6,899	55 11%	2,826	25 5%	19,433	166 33%
35-44	2,347	20 4%	5,407	46 9%	1,975	14 3%	6,074	51 10%	15,803	131 26%
<u>TOTAL</u>	21,607	181 36%	7,632	66 13%	21,868	181 36%	9,091	76 15%	60,198	504 100%

TABLE III: QUOTA CONTROL MATRIX – CORK COUNTY

AGE	MALES				FEMALES				TOTAL	
	SINGLE POP.	N.	MARRIED POP.	N.	SINGLE POP.	N.	MARRIED POP.	N.	POP.	N.
15-19	13,293	45 9%	9	-	12,417	45 9%	16	-	25,735	90 18%
20-24	11,748	40 8%	156	-	10,274	36 7%	399	-	22,577	76 15%
25-34	14,927	51 10%	9,489	30 6%	11,732	40 8%	12,625	45 9%	48,733	166 33%
35-44	5,430	20 4%	19,552	71 14%	3,561	10 2%	20,911	71 14%	49,454	172 34%
<u>TOTAL</u>	45,398	156 31%	29,206	101 20%	37,984	131 26%	33,951	116 23%	146,539	504 100%

TABLE IV: QUOTA CONTROL MATRIX – KERRY COUNTY

AGE	MALES				FEMALES				TOTAL	
	SINGLE POP.	N.	MARRIED POP.	N.	SINGLE POP.	N.	MARRIED POP.	N.	POP.	N.
15-19	5,265	51 10%	5	-	5,022	45 9%	17	-	10,309	96 19%
20-24	4,597	40 8%	87	-	4,066	35 7%	211	5 1%	8,961	80 16%
25-34	5,949	55 11%	3,307	30 6%	4,536	41 8%	4,220	35 7%	18,012	161 32%
35-44	2,427	20 4%	6,906	61 12%	1,540	15 3%	7,758	71 14%	18,631	167 33%
<u>TOTAL</u>	18,238	166 33%	10,305	91 18%	15,164	136 27%	12,206	111 22%	55,913	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 e.g.: younger people living in more deprived areas.

In 1996, this sub-sample universe was defined as:

- 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.

Specific electoral areas which matched the above criteria were then identified from CSO data, and surveying restricted to Local Authority streets/estates within these areas. In order to further ensure as representative a sample of individuals as possible, quota controls within each area were set in terms of Sex X Age X Marital Status.

Since 1996, the Southern Health Board has been liasing with the Small Area Health Research Unit (SAHRU) of TCD in relation to its development of a more precise deprivation index.

As such, it was decided that the universe of high-risk individuals for 2004 would be based upon adults aged 15-24 years living in level 10 areas of Urban deprivation, as per the SAHRU deprivation index.

The actual sampling points drawn according to this SAHRU classification procedure are included at Section 2.2.

TABLE V: SOUTHERN HEALTH BOARD HIGH RISK AREAS *

Cork City	No. of Households	% Total Person Unemployed 15+	% SAHRU Index
Ballyphehane A	271	12	10
Ballyphehane B	315	14	10
Blackpool A	245	19	10
Blackpool B	598	17	10
Centre A	123	27	10
Centre B	643	17	10
Churchfield	501	29	10
City Hall A	267	25	10
Commons	321	19	10
Evergreen	620	10	10
Fairhill A	278	13	10
Fairhill B	354	18	10
Fairhill C	1,215	21	10
Farranferris A	702	16	10
Farranferris B	356	21	10
Farranferris C	236	20	10
Gillabbey A	663	9	10
Gillabbey B	463	6	10
Greenmount	781	12	10
Gurranbraher A	296	21	10
Gurranbraher B	303	16	10
Gurranbraher C	480	14	10
Gurranbraher D	375	16	10
Gurranbraher E	457	20	10
Knocknaheeny	1,243	32	10
Mahon B	1,238	20	10
Mayfield	1,168	25	10
Pouladuff A	330	12	10
Pouladuff B	680	14	10
St. Patricks A	624	15	10
St. Patricks B	536	17	10
Shanakiel	912	17	10
Shandon A	469	19	10
Shandon B	400	30	10
South Gate B	406	12	10
Sundays Well B	328	12	10
The Glen A	712	39	10
The Lough	576	13	10
Togher A	788	22	10
Togher B	298	14	10
Turners Cross C	278	9	10

*** Not directly comparable with 1996**

**TABLE V: SOUTHERN HEALTH BOARD HIGH RISK AREAS
(Cont'd)**

Cork County	No. of Households	% Total Person Unemployed 15+	% SAHRU Index
Fermoy Urban	887	11	10
Kinsale Urban	842	14	10
Midleton Urban	1,373	13	10
Youghal Urban	2,161	15	10
Kerry			
Listowel Urban	1,328	12	10
Tralee Urban	2,506	19	10

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. Technical Appendix 1 (pg 158) 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 – DEPRIVED AREAS**

	Total No. Homes In LA Areas	%	No. of Sampling Points	No. of Interviews
<u>Cork City</u>				
Ballyphehane A	271	1	1	8
Ballyphehane B	315	1	1	8
Blackpool A	245	1	1	8
Blackpool B	598	3	1	8
Centre A	123	1	1	8
Centre B	643	3	1	8
Churchfield	501	2	1	8
City Hall A	267	1	1	8
Commons	321	1	1	8
Evergreen	620	3	1	8
Fair Hill A	278	1	1	8
Fair Hill B	354	2	1	8
Fair Hill C	1,215	6	2	16
Farranferris A	702	3	2	16
Farranferris B	356	2	1	8
Farranferris C	236	1	1	8
Gillabbey A	663	3	1	8
Gillabbey B	463	2	1	8
Greenmount	781	4	2	16
Gurranbraher A	296	1	1	8
Gurranbraher B	303	1	1	8
Gurranbraher C	480	2	1	8
Gurranbraher D	375	2	1	8
Gurranbraher E	457	2	1	8
Knocknaheeney	1,243	6	2	16
Mahon B	1,238	6	2	16
Mayfield	1,168	5	2	16
Pouladuff A	330	2	1	8
Pouladuff B	680	3	1	8
St. Patrick’s A	624	3	1	8
St. Patrick’s B	536	2	1	8
Shanakiel	912	4	2	16
Shandon A	469	2	1	8
Shandon B	400	2	1	8
South Gate B	406	2	1	8
Sundays Well B	328	2	1	8
The Glen A	712	3	2	16
The Lough	576	3	1	8
Togher A	788	4	2	16
Togher B	298	1	1	8
Turners Cross C	278	1	1	8
<i>Total</i>	<i>21,849</i>	<i>100</i>	<i>50</i>	<i>400</i>

**TABLE VI: SOUTHERN HEALTH BOARD “HIGH RISK AREA”
SAMPLE DISTRIBUTION – DEPRIVED AREAS (Cont’d)**

	Total No. Homes In LA Areas	%	No. of Sampling Points	No. of Interviews
Cork County				
Fermoy Urban	887	17	5	40
Kinsale Urban	842	16	5	40
Midleton Urban	1,373	26	8	64
Youghal Urban	2,161	41	14	112
<i>Total</i>	<i>5,263</i>	<i>100</i>	<i>32</i>	<i>256</i>
Kerry				
Listowel Urban	1,328	35	11	88
Tralee Urban	2,506	65	21	168
<i>Total</i>	<i>3,834</i>	<i>100</i>	<i>32</i>	<i>256</i>

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 TNS mrbi by the CSO.

TABLE VII: BOOSTER SAMPLE: QUOTA CONTROL MATRIX – DEPRIVED AREAS

Cork City	15-19				20-24				TOTAL
	MALE		FEMALE		MALE		FEMALE		
	Single	Married	Single	Married	Single	Married	Single	Married	
Ballyphehane A	28	-	17	-	36	1	20	1	0.8
Ballyphehane B	36	-	42	-	34	-	37	-	1.2
Blackpool A	25	1	23	-	13	1	18	2	0.7
Blackpool B	46	-	45	1	89	2	78	2	2.1
Centre A	19	-	7	-	50	2	52	1	1.0
Centre B	24	-	40	-	163	4	230	5	3.7
Churchfield	71	-	56	-	64	-	53	2	1.9
City Hall A	11	-	13	-	37	1	73	1	1.1
Commons	37	2	24	2	45	2	44	4	1.3
Evergreen	38	-	41	-	74	-	134	3	2.3
Fair Hill A	20	-	23	-	23	-	25	-	0.7
Fair Hill B	24	-	29	-	31	1	23	1	0.9
Fair Hill C	261	-	290	-	218	3	211	3	7.8
Farranferris A	55	1	72	-	71	6	92	7	2.4
Farranferris B	45	-	47	-	52	-	41	1	1.5
Farranferris C	17	-	29	-	23	-	26	-	0.7
Gillabbey A	81	1	138	-	209	-	412	2	6.7
Gillabbey B	43	-	69	-	136	-	166	-	3.3
Greenmount	76	-	68	-	120	1	170	1	3.4
Gurranbraher A	38	-	32	-	23	2	32	1	1.0
Gurranbraher B	30	-	26	-	26	-	31	1	0.9
Gurranbraher C	36	-	32	-	41	-	45	3	1.2
Gurranbraher D	32	-	32	-	45	-	51	-	1.3
Gurranbraher E	44	-	49	-	49	1	49	1	1.5
Knocknaheeny	226	-	212	-	192	2	220	7	6.8
Mahon B	274	-	235	1	171	6	167	10	6.8
Mayfield	154	-	141	-	123	-	163	4	4.6
Pouladuff A	30	-	34	-	21	-	23	-	0.9
Pouladuff B	69	-	62	1	47	1	49	-	1.8
St. Patrick's A	17	-	27	2	97	2	136	8	2.3
St. Patrick's B	52	3	27	-	84	3	88	7	2.1
Shanakiel	181	1	169	-	187	4	178	7	5.8
Shandon A	36	-	26	1	79	5	79	12	1.9
Shandon B	37	-	23	1	100	7	120	11	2.4
South Gate B	23	-	44	-	90	-	129	-	2.3
Sundays Well B	23	-	31	-	49	1	95	-	1.6
The Glen A	121	-	91	-	154	2	87	3	3.6
The Lough	45	-	68	-	113	2	139	3	2.9
Togher A	115	-	132	-	74	3	86	1	3.3
Togher B	28	-	15	-	23	-	26	-	0.7
Turners Cross C	21	-	22	-	33	-	27	1	0.8
Total	2,589	9	2,603	9	3,309	65	3,925	116	12,625
	20%	*	21%	*	26%	1%	31%	1%	100%
Sample	80	-	84	-	104	4	124	4	400

**TABLE VII: BOOSTER SAMPLE: QUOTA CONTROL MATRIX – DEPRIVED
AREAS (Cont'd)**

	15-19				20-24				TOTAL
	MALE		FEMALE		MALE		FEMALE		
	Single	Married	Single	Married	Single	Married	Single	Married	
Cork County									
Fermoy Urban	59	-	62	-	77	1	97	7	14.9
Kinsale Urban	60	-	51	-	90	-	109	2	15.3
Midleton Urban	124	-	118	2	145	2	149	7	26.8
Youghal Urban	202	-	209	-	235	3	220	9	43.0
Total	445	-	440	2	547	6	575	25	2,040
	22%	-	22%	*	27%	*	28%	1%	100%
Sample	56	-	56	-	69	-	72	3	256
Kerry									
Listowel Urban	125	1	124	-	88	3	120	12	28.2
Tralee Urban	201	2	212	7	372	14	379	19	71.8
Total	326	3	336	7	460	17	499	31	1,679
	20%	*	20%	*	27%	1%	30%	2%	100%
Sample	51	-	51	-	69	3	77	5	256

SAMPLE METHODOLOGY TECHNICAL APPENDIX 1

Southern Health Board Sampling Points/Assignment Number

Main Sample – Cork County Borough

North Central	Assignment Number
Commons	1101
Farranferris A	1102
Gurranbraher B	1103
Gurranbraher E	1104
Shandon B	1105
The Glen B	1106
North East	
Mayfield	1107
Montenotte A	1108
Montenotte B	1109
St. Patrick's A	1110
The Glen A	1111
Tivoli A	1112
North West	
Bishopstown A	1113
Fair Hill C	1114
Farranferris B	1115
Gillabbey B	1116
Knocknaheeny	1117
Mardyke	1118
Shanakiel	1119
South Central	
Ballyphehane B	1120
City Hall A	1121
Gill Abbey A	1122
Pouladuff A	1123
South Gate A	1124
The Lough	1125
Turners Cross B	1126
South East	
Ballinlough B	1127
Ballinlough C	1128
Knockrea A	1129
Mahon A	1130
Mahon B	1131-1132
Mahon C	1133
Tramore B	1134
Tramore C	1135

Main Sample – Cork County Borough (Cont'd)

South West	Assignment Number
Bishopstown B	1136
Bishopstown C	1137
Bishopstown D	1138
Bishopstown E	1139
Glasheen B	1140
Glasheen C	1141
 Suburbs	
Rathcooney	1142-1143
Caherlag	1144-1145
Inishkenny	1146
St. Mary's	1147-1148
Riverstown	1149
Carrigtohill	1150
Douglas	1151-1155
Ballincollig	1156-1160
Lehenagh	1161-1162
Bishopstown	1163

Main Sample – Rest Of Cork

Towns 10,000+	Assignment Number
Carrigaline	2201-2203
 Towns 5,000-10,000	
Cobh	2301-2303
Mallow	2304-2305
Midleton	2306-2308
Youghal	2309-2310
Bandon	2311
 Towns 1,500-5,000	
Fermoy	2401
Passage West	2402-2403
Clonakilty	2404
Kinsale	2405
Mitchelstown	2406
Bantry	2407
Tower	2408
Macroom	2409
Rathluirc	2410
Skibbereen	2411
Kanturk	2412

Main Sample – Rest Of Cork (Cont'd)

Rural – Towns <1,500

<i>RD</i>	<i>DED</i>	<i>Assignment Number</i>
Bandon	Boulteen	2501
Bandon	Knockavilly	2502
Bandon	Teadies	2503
Bantry	Glencarriff	2504
Castletown	Ardrigole	2505
Clonakilty	Coolcraheen	2506
Clonakilty	Roscarberry	2507
Cork	Ballynaglogh	2508
Cork	Cobh Rural	2509
Cork	Glenville	2510
Cork	Knockraha	2511
Cork	Ovens	2512
Dumanway	Dunmanway South	2513
Fermoy	Castletownroche	2514
Fermoy	Kilcor	2515
Fermoy	Leitrim	2516
Kanturk	Boherboy	2517
Kanturk	Glenlara	2518
Kanturk	Meens	2519
Kinsale	Ballymartle	2520
Kinsale	Kinure	2521
Macroom	Candroma	2522
Macroom	Kilcullen	2523
Macroom	Warrenscourt	2524
Mallow	Doneraile	2525
Mallow	Liscarroll	2526
Mallow	Springfort	2527
Midleton	Ballyspillane	2528
Midleton	Cloyne	2529
Midleton	Garryvoe	2530
Midleton	Mogeely	2531
Millstreet	Rathcool	2532
Mitchelstown	Farahy	2533
Skibbereen	Bredagh	2534
Skibbereen	Myross	2535
Skull	Kilcoe	2536
Youghal	Ardagh	2537

Main Sample – Kerry

Towns 10,000+	Assignment Number
----------------------	------------------------------

Tralee	3201-3211
Killarney	3212-3217

Towns 1,500-5,000

Listowel	3401
Castleisland	3402
Kenmare	3403
Dingle	3404

Rural – Towns <1,500

<i>RD</i>	<i>DED</i>	
Caherciveen	Ballybrack	3501
Caherciveen	Curraghbeg	3502
Caherciveen	Lickeen	3503
Caherciveen	Teerlaneearagh	3504
Dingle	Castlegregory	3505
Dingle	Inch	3506
Dingle	Minard	3507
Kenmare	Castlecove	3508
Kenmare	Greenane	3509
Kenmare	Tahilla	3510
Killarney	Aglish	3511
Killarney	Churchtown	3512
Killarney	Coom	3513
Killarney	Dromin	3514
Killarney	Kilbonane	3515
Killarney	Killarney Rural	3516
Killarney	Knocknahoe	3517
Killarney	Molahiffe	3518
Killarney	Currans	3519
Killarney	Kilfelim	3520
Killarney	Milltown	3521
Killarney	Rathmore	3522
Listowel	Astee	3523
Listowel	Ballyhorgan	3524
Listowel	Drommartin	3525
Listowel	Gunsborough	3526
Listowel	Kilshenane	3527
Listowel	Listowel Rural	3528
Listowel	Shronowen	3529
Listowel	Urlee	3530
Listowel	Killehenry	3531
Tralee	Arabela	3532

Tralee	Ballyheigue	3533
Tralee	Ballyseedy	3534
Tralee	Boolteens	3535
Tralee	Clogherbrien	3536
Tralee	Derreen	3537
Tralee	Kerryhead	3538
Tralee	Kilgobban	3539
Tralee	Knocknagoshel	3540
Tralee	Millbrook	3541
Tralee	Ratass	3542

APPENDIX 10

QUESTIONNAIRE

I.D. No. (1-4)

Ass. No. _____

Qst. No. _____

TNS mrbi/105380/04

Good morning/afternoon. My name is _____ from TNS mrbi, 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 substances e.g. tobacco, alcohol and 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 a repeat of a survey carried out in 1996 in the Southern Health Board Region.

The questionnaire itself covers a variety of topics, some more sensitive than others. I can assure you that if you do agree to participate in this survey, 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 Valerie Aylward or Kate O'Toole at our main office, FREEPHONE 1800 513 513.

A. GENERAL VIEWS ON LOCAL AREA

Q.1 SHOW CARD A 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 <u>using</u> drugs	1	2	3	4	0
People being offered drugs <u>for sale?</u>	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

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 People hear about these things in different ways. How are you aware of people taking drugs in this area? **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

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.

Q.4 When you think about drugs, what names come to mind for drugs that people use other than as prescribed? CODE ALL MENTIONED IN GRID. PROMPT: Which others?

Q.5 SHOW CARD B

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)

ASK ALL

SHOW CARD B

- 1 **Cannabis** (also called Marijuana, Grass, Pot, Hash., Draw, Dope, Ganja, Nodge, Nine Bar, Soaps, Weed, Dubby)
- 2 **Heroin** (also called Smack, Horse, Junk, Tackle, Gear, H , Skag)
- 3 **Amphetamines** (also called Speed, Whizz, Uppers, Sulph, Sulphate, Billy, Buzz, Ket, K)
- 4 **LSD** (also called Acid, Tabs, Trips, Blotters, Microdot)
- 5 **Cocaine** (also called Coke, Ice, Rocks, Snow , Base, Snuff)
- 6 **Ecstasy** (also called E, MDMA, XTC, Ms, Disco Biscuits, Love Doves , Shamrock, Champagne, Chiefs)
- 7 **Crack** (also called Rock, Crystals, Crack Cocaine, Crank)
- 8 **Magic Mushrooms** (also called Mushies, Shrooms, Boomers)
- 9 **Methadone** (also called MST, Physeptone, Syrup)
- 10 **Diconal** (also called Dyke)
- 11 **Amyl Nitrate** (also called Poppers, Liquid Gold, Rush, Juice)
- 12 **Temazepam** (also called Jellies, Eggs, Bean, Maze, Pammys)
- 13 **Temgesic** (also called GGs, Tems, Midget, Gems)
- 14 **Semeron**
- 15 **Barbiturates** (also called Downers, Barbies, Blues, Reds, Sekkies)
- 16 **DF118s** (also called Dfs, Hydra, Scratchers, 8's)
- 17 **Triazolam** (also called Upjohns)
- 18 Unprescribed use of **Sleeping Tablets** (e.g. Rohypnol, Mogadon, Moggys, Nollys, Roffies)
- 19 Unprescribed use of **Tranquillisers** (e.g. Valium, Librium, Ativan, Diazepam, Roche, D5s, Diazzy's, Seds)
- 24 Non prescription **codeine products** from pharmacy/chemist e.g. Solpadeine etc.
- 20 Sniffing Glue, Gas, Aerosol, Petrol, Thinners
- 21 Other (Code and write in)
1.....
2.....
- 00 NONE of the above / NONE

Q.4	Q.5
Spontaneous Awareness	Prompt Awareness
01	01
02	02
03	03
04	04
05	05
06	06
07	07
08	08
09	09
10	10
11	11
12	12
13	13
14	14
15	15
16	16
17	17
18	18
19	19
24	24
20	20
21	21
22	22
00	00

IF NO DRUGS MENTIONED AT Q.4 OR Q.5, SKIP TO Q.7. REST: Q.6.

Q.6 SHOW CARD C

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)

<u>SHOWCARD C</u>		Q.6				
		<u>Very harmful</u>	<u>Harmful</u>	<u>Not particularly harmful</u>	<u>Not at all harmful</u>	<u>Don't Know</u>
1	Cannabis (also called Marijuana, Grass, Pot, Hash., Draw, Dope, Ganja, Nodge, Nine Bar, Soaps, Weed, Dubby)	1	2	3	4	0
2	Heroin (also called Smack, Horse, Junk, Tackle, Gear, H , Skag)	1	2	3	4	0
3	Amphetamines (also called Speed, Whizz, Uppers, Sulph, Sulphate, Billy, Buzz, Ket, K)	1	2	3	4	0
4	LSD (also called Acid, Tabs, Trips, Blotters, Microdot)	1	2	3	4	0
5	Cocaine (also called Coke, Ice, Rocks, Snow , Base, Snuff)	1	2	3	4	0
6	Ecstasy (also called E, MDMA, XTC, Ms, Disco Biscuits, Love Doves , Shamrock, Champagne, Chiefs)	1	2	3	4	0
7	Crack (also called Rock, Crystals, Crack Cocaine, Crank)	1	2	3	4	0
8	Magic Mushrooms (also called Mushies, Shrooms, Boomers)	1	2	3	4	0
9	Methadone (also called MST, Physeptone, Syrup)	1	2	3	4	0
10	Diconal (also called Dyke)	1	2	3	4	0
11	Amyl Nitrate (also called Poppers, Liquid Gold, Rush, Juice)	1	2	3	4	0
12	Temazepam (also called Jellies, Eggs, Bean, Maze, Pammys)	1	2	3	4	0
13	Temgesic (also called GGs, Tems, 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, 8's)	1	2	3	4	0
17	Triazolam (also called Upjohns)	1	2	3	4	0
18	Unprescribed use of Sleeping Tablets (e.g. Rohypnol, Mogadon, Moggys, Nollys, Roffies)	1	2	3	4	0
19	Unprescribed use of Tranquillisers (e.g. Valium, Librium, Ativan, Diazepam, Roche, D5s, Diazzy's, Seds)	1	2	3	4	0
24	Non prescription codeine products from pharmacy/chemist e.g. Solpadeine etc.	1	2	3	4	0
20	Sniffing Glue, Gas, Aerosol, Petrol, Thinners	1	2	3	4	0
21	Other (Code and write in)					
	1.....	1	2	3	4	0
	2.....	1	2	3	4	0

C. USAGE OF DRUGS

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

ASK ALL

Q.7 SHOW CARD D. 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.8 STILL SHOWING CARD D. 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 Q.8. REST

SKIP TO Q.10

Q.9 STILL SHOWING CARD D. 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.10 STILL SHOWING CARD D. Have you been at any social gathering (in the past 5 years) where others have been taking drugs? **PROMPT:** Which drugs? **PROMPT:** Which others?

CODE ALL DRUGS MENTIONED.

		<u>Q.7 Known Offered</u>	<u>Q.8 Known Taken</u>	<u>Q.9 Regular Takers</u>	<u>Q.10 Social Gatherings</u>
1	Cannabis (also called Marijuana, Grass, Pot, Hash., Draw, Dope, Ganja, Nodge, Nine Bar, Soaps, Weed, Dubby)	01	01	01	01
2	Heroin (also called Smack, Horse, Junk, Tackle, Gear, H , Skag)	02	02	02	02
3	Amphetamines (also called Speed, Whizz, Uppers, Sulph, Sulphate, Billy, Buzz, Ket, K)	03	03	03	03
4	LSD (also called Acid, Tabs, Trips, Blotters, Microdot)	04	04	04	04
5	Cocaine (also called Coke, Ice, Rocks, Snow , Base, Snuff)	05	05	05	05
6	Ecstasy (also called E, MDMA, XTC, Ms, Disco Biscuits, Love Doves , Shamrock, Champagne, Chiefs)	06	06	06	06
7	Crack (also called Rock, Crystals, Crack Cocaine, Crank)	07	07	07	07
8	Magic Mushrooms (also called Mushies, Shrooms, Boomers)	08	08	08	08
9	Methadone (also called MST, Physeptone, Syrup)	09	09	09	09
10	Diconal (also called Dyke)	10	10	10	10
11	Amyl Nitrate (also called Poppers, Liquid Gold, Rush, Juice)	11	11	11	11
12	Temazepam (also called Jellies, Eggs, Bean, Maze, Pammys)	12	12	12	12
13	Temgesic (also called GGs, Tems, Midget, Gems)	13	13	13	13
14	Semeron	14	14	14	14
15	Barbiturates (also called Downers, Barbies, Blues, Reds, Sekkies)	15	15	15	15
16	DF118s (also called Dfs, Hydra, Scratchers, 8's)	16	16	16	16
17	Triazolam (also called Upjohns)	17	17	17	17
18	Unprescribed use of Sleeping Tablets (e.g. Rohypnol, Mogadon, Moggys, Nollys, Roffies)	18	18	18	18
19	Unprescribed use of Tranquillisers (e.g. Valium, Librium, Ativan, Diazepam, Roche, D5s, Diazzy's, Seds)	19	19	19	19
24	Non prescription codeine products from pharmacy/chemist e.g. Solpadeine etc.	24	24	24	24
20	Sniffing Glue, Gas, Aerosol, Petrol, Thinners	20	20	20	20
21	Other (Code and write name of drug in)				
	1.....	21	21	21	21
	2.....	22	22	22	22
	3 Name of drug(s) not known.....	23	23	23	23
00	NONE of the above / NONE	00	00	00	00

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

People have differing views about the use of drugs and what the community should do about it.

Q.11 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.12 **SHOW CARD E.** I am going to read out a list of statements that people have made about drugs, tobacco and alcohol, 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
There is little difference in health terms between smoking cannabis and smoking tobacco or drinking alcohol	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
The minimum age for drinking and smoking should be increased (i.e.: to 20 or 21 years)	1	2	3	4	5	0
The new Smoking Ban is a good policy	1	2	3	4	5	0
The price of alcohol should be increased through taxation	1	2	3	4	5	0
The price of tobacco should be increased through taxation	1	2	3	4	5	0

Q.13 There has been talk about whether certain drugs should be made legal, perhaps with restrictions on their availability. **SHOW CARD F.** 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 prescription) 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

Q.14 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.14 ASK Q.15. IF NONE KNOWN, SKIP TO Q.17.

Q.15 Do you know anyone who has ever approached...(NAME PLACE) for help?

ASK Q.16 FOR EACH MENTION AT Q.15, IF NONE, SKIP TO Q.17.

Q.16 **SHOW CARD G.** How helpful or otherwise did they find the advice or information?

Services Available	Q.14	Q.15		Q.16				
		Yes	No	Very Helpful	Fairly Helpful	Not Very Helpful	Not at all Helpful	Don't know
<u>General</u>								
GP	01	1	2	1	2	3	4	0
Chemist / Pharmacist	02	1	2	1	2	3	4	0
Gardai/Police	12	1	2	1	2	3	4	0
Church	13	1	2	1	2	3	4	0
Youth Club	14	1	2	1	2	3	4	0
<u>SHB</u>								
Psychiatric Clinic/Hospital	03	1	2	1	2	3	4	0
<u>SHB Treatment Centres</u>								
SHB Arbour House(Cork)	04	1	2	1	2	3	4	0
SHB Community Counselling and Advisory Service	20	1	2	1	2	3	4	0
<u>Voluntary Services SHB Area</u>								
<u>Outpatient</u>								
Anchor Treatment Centre Mallow	21	1	2	1	2	3	4	0
<u>Residential Centres</u>								
Tabor Lodge (Cork)	05	1	2	1	2	3	4	0
Talbot Grove (Kerry)	07	1	2	1	2	3	4	0
Cara Lodge Adolescent Centre (Enniskeane)	22	1	2	1	2	3	4	0
<u>Centres Outside SHB</u>								
Ashairi Centre, Cahir	08	1	2	1	2	3	4	0
Aislinn Centre, Co Kilkenny	23	1	2	1	2	3	4	0
Cuan Mhuire Centre, Limerick	24	1	2	1	2	3	4	0
Coolmine Centre, Dublin	09	1	2	1	2	3	4	0
<u>Cork Local Drugs Task Force Projects</u>								
	25	1	2	1	2	3	4	0
<u>Self Help Groups</u>								
AA (Alcoholics Anonymous)	26	1	2	1	2	3	4	0
NA (Narcotics Anonymous)	15	1	2	1	2	3	4	0
<u>Other</u>								
Other Voluntary Advice Agency	16	1	2	1	2	3	4	0
Other (Code and Write in)								
1.....	17	1	2	1	2	3	4	0
2.....	27	1	2	1	2	3	4	0
None	19							
Don't Know	00							

E. GENERAL

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

Q.17 SHOW CARD H. Which of these places do you ever go to? **PROMPT:** Which others?
ASK Q.18 FOR ALL MENTIONS AT Q.17. IF NONE, SKIP TO Q.19.

Q.18 SHOW CARD I. How often, on average, do you go to.....?

	Q.17 Ever Do	Q.18 Frequency							
		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/Clubbing.....	1	2	3	4	5	6	7	8	0
Party.....	1	2	3	4	5	6	7	8	0
Rave/DJ Event	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/Activities: e.g.- self/club, jog, cycle, train, aerobics.....	1	2	3	4	5	6	7	8	0
Watch Sports Event	1	2	3	4	5	6	7	8	0
Cinema/Theatre	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.19 How long ago did you last have an alcoholic drink?

During the last six days	1
One week to 1 month ago	2
5-12 weeks ago (2 – 3 months ago)	3
13 weeks to 12 months ago (4 – 12 months ago)	4
More than 12 months ago	5
Never had alcohol beyond sips or tastes	6 GO TO Q.34

Q.20 How old were you when you had your first alcoholic drink? **WRITE AGE IN BOX PROVIDED.**

--	--

Q.21 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.22 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.23 Do you drink now, even occasionally?

- Yes 1 **CONTINUE**
- No..... 2 **GO TO Q.33**

Q.24 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
 Premix spirit bottle
 A glass of wine
 A glass of sherry
 A measure of spirits

**NO. OF DRINKS IN
A TYPICAL WEEK**

Beer (Stout, Ale, Lager)	<input type="text"/>
Cider.....	<input type="text"/>
Wine	<input type="text"/>
Sherry/Port/Vermouth	<input type="text"/>
Spirits (Whiskey, Gin, Vodka etc.) ...	<input type="text"/>
Premix Spirit Drinks (Bacardi Breezer, Smirnoff Ice)	<input type="text"/>

Q.25 How regularly would you drink any of the following drinks? **READ OUT DRINKS. SHOW CARD J.**

	Every day	4-5 times a week	2-3 times a week	Once a week	2-3 times a month	About once a month	One or a few times a year	Never	DK/ NA
Beer (Stout, Ale, Lager).....	1	2	3	4	5	6	7	8	9
Cider.....	1	2	3	4	5	6	7	8	9
Wine.....	1	2	3	4	5	6	7	8	9
Sherry/Port/Vermouth	1	2	3	4	5	6	7	8	9
Spirits (e.g. Whiskey, Gin, Vodka).....	1	2	3	4	5	6	7	8	9
Premix spirit drinks (Bacardi Breezer, Smirnoff Ice)	1	2	3	4	5	6	7	8	9

Q.26 And on each occasion how much would you usually take of the following drinks ...?

READ OUT ALL DRINKS CODED 1-7 AT Q.25. SHOW CARD K.

	½ pint/ glass beer/ cider	Pint beer/ cider	Small Can 330ml	Large Can 500ml	330 ml bottle	Pint bottle	Glass of wine/ fortified wine	¼ bottle wine	Bottle wine	Spirit measure
Beer (Stout, Ale, Lager)										
Cider										
Wine										
Sherry/Port/Vermouth										
Spirits (e.g. Whiskey, Gin, Vodka)										
Premix Spirit Drinks (Bacardi Breezer, Smirnoff Ice)										

Q.27 On the last occasion that you were drinking, how many drinks did you have?

Number of drinks: _____

Q.28 In an average week, on how many different occasions would you drink caffeine-based stimulant drinks, e.g. Red Bull, as a mixer with something else?

WRITE IN NUMBER OF OCCASIONS IN BOX PROVIDED

Q.29 In an average week, on how many different occasions would you drink caffeine-based stimulant drinks, e.g. Red Bull, on their own – i.e. without mixing with anything else?

WRITE IN NUMBER OF OCCASIONS IN BOX PROVIDED

Q.30 In the last month or 30 days, how many times have you had 6 or more drinks in a row?

None 1
Once 2
Twice 3
Three to five times 4
Six to nine times 5
Ten or more times 6

Q.31 Have you ever had enough of any alcoholic drink to feel drunk?

Yes 1 **CONTINUE**

No..... 2 **GO TO Q.34**

Q.32 How old were you the first time you ever felt drunk from an alcoholic drink?

WRITE AGE IN BOX PROVIDED.

--	--

Q.33 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
-
- Less often 6

SMOKING

Q.34 Have you *ever* smoked?

- Yes 1
- No..... 2 **GO TO CLASSIFICATION**
-

Q.35 How old were you the first time you ever smoked a cigarette?

--	--

Years old

Q.36 And do you smoke now, even occasionally?

- Yes 1 **ASK Q.37**
- No..... 2
-

Q.37 Overall, how many cigarettes do you smoke daily?

--	--

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**

--	--

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

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

MARITAL STATUS:

Married..... 1
Living as married/cohabiting with partner 6
Widowed 2
Separated 3
Divorced..... 4
Single 5

OCCUPATION OF HEAD OF HOUSEHOLD: _____

Professional workers 1
Managerial & technical 2
Non-manual 3
Skilled manual 4
Semi-skilled..... 5
Unskilled 6
Farmer 50+ acres 7
Farmer -50 acres/farm labourer 8

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

F1 (farmer 50+ acres) 7 F2 (Farmer -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
.....

RESPONDENT:

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

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?

Yes 1 No..... 2

Do you have a telephone here in your home?

Yes 1 No..... 2 Refused No 3

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

Do you personally own a mobile phone? By mobile phone I mean a telephone whose number begins with 085, 086 or 087.

Yes 1 No 2

And do you have access to the Internet at home?

Yes 1 No 2

I certify that I have interviewed the above named respondent in accordance with survey instructions.

SIGNED: _____

DATE: _____

**LENGTH OF TIME TAKEN TO COMPLETE
 MAIN QUESTIONNAIRE:**

Mins

**LENGTH OF TIME TAKEN TO COMPLETE
 SELF-COMPLETION QUESTIONNAIRE:**

Mins

SELF COMPLETION BOOKLET

Ass. No. _____

Qst. No. _____

TNS mrbi/105380/04

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 or circle the answers which apply at each question.

Q.1 Assuming you are at a party or festival where drugs are available. How likely is it that you will take drugs when you are there? Which drugs?

DRUG ↓	Very Likely	Likely	Unlikely	Very Unlikely
Cannabis (also called Marijuana, Grass, Pot, Hash., Draw, Dope, Ganja, Nodge, Nine Bar, Soaps, Weed, Dubby)	1	2	3	4
Heroin (also called Smack, Horse, Junk, Tackle, Gear, H , Skag)	1	2	3	4
Amphetamines (also called Speed, Whizz, Uppers, Sulph, Sulphate, Billy, Buzz, Ket, K)	1	2	3	4
LSD (also called Acid, Tabs, Trips, Blotters, Microdot)	1	2	3	4
Cocaine (also called Coke, Ice, Rocks, Snow , Base, Snuff)	1	2	3	4
Ecstasy (also called E, MDMA, XTC, Ms, Disco Biscuits, Love Doves , Shamrock, Champagne, Chiefs)	1	2	3	4
Crack (also called Rock, Crystals, Crack Cocaine, Crank)	1	2	3	4
Magic Mushrooms (also called Mushies, Shrooms, Boomers)	1	2	3	4
Methadone (also called MST, Physeptone, Syrup)	1	2	3	4
Diconal (also called Dyke)	1	2	3	4
Amyl Nitrate (also called Poppers, Liquid Gold, Rush, Juice)	1	2	3	4
Temazepam (also called Jellies, Eggs, Bean, Maze, Pammys)	1	2	3	4
Temgesic (also called GGs, Tems, Midget, Gems)	1	2	3	4
Semeron	1	2	3	4
Barbiturates (also called Downers, Barbies, Blues, Reds, Sekkies)	1	2	3	4
DF118s (also called Dfs, Hydra, Scratchers, 8's)	1	2	3	4
Triazolam (also called Upjohns)	1	2	3	4
Unprescribed use of Sleeping Tablets (e.g. Rohypnol, Mogadon, Moggys, Nollys, Roffies)	1	2	3	4
Unprescribed use of Tranquillisers (e.g. Valium, Librium, Ativan, Diazepam, Roche, D5s, Diazzy's, Seds)	1	2	3	4
Non prescription codeine products from pharmacy/chemist e.g. Solpadeine etc.	1	2	3	4
Sniffing Glue, Gas, Aerosol, Petrol, Thinners	1	2	3	4
Other (Code and write in)				
1.....	1	2	3	4
2.....	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.

Q.2 Which, if any, of these have you ever tried, even if it was a long time ago? (Except on a doctor's prescription)

Q.3 If you ever tried drugs, what age were you when you first tried?

WRITE AGE IN YEARS NEXT TO DRUG.

Q.4 Which, if any, of these have you tried, in the last 12 months (except on a doctor's prescription)?

Q.5 Which, if any, of these have you tried, in the last month (except on a doctor's prescription)?

DRUG ↓	Q.2 Ever tried	Q.3 Age when first tried	Q.4 Tried in past 12 months	Q.5 Tried in past month
Cannabis (also called Marijuana, Grass, Pot, Hash., Draw, Dope, Ganja, Nodge, Nine Bar, Soaps, Weed, Dubby)	01	age	01	01
Heroin (also called Smack, Horse, Junk, Tackle, Gear, H , Skag)	02	age	02	02
Amphetamines (also called Speed, Whizz, Uppers, Sulph, Sulphate, Billy, Buzz, Ket, K)	03	age	03	03
LSD (also called Acid, Tabs, Trips, Blotters, Microdot)	04	age	04	04
Cocaine (also called Coke, Ice, Rocks, Snow , Base, Snuff)	05	age	05	05
Ecstasy (also called E, MDMA, XTC, Ms, Disco Biscuits, Love Doves , Shamrock, Champagne, Chiefs)	06	age	06	06
Crack (also called Rock, Crystals, Crack Cocaine, Crank)	07	age	07	07
Magic Mushrooms (also called Mushies, Shrooms, Boomers)	08	age	08	08
Methadone (also called MST, Physeptone, Syrup)	09	age	09	09
Diconal (also called Dyke)	10	age	10	10
Amyl Nitrate (also called Poppers, Liquid Gold, Rush, Juice)	11	age	11	11
Temazepam (also called Jellies, Eggs, Bean, Maze, Pammys)	12	age	12	12
Temgesic (also called GGs, Tems, Midget, Gems)	13	age	13	13
Semeron	14	age	14	14
Barbiturates (also called Downers, Barbies, Blues, Reds, Sekkies)	15	age	15	15
DF118s (also called Dfs, Hydra, Scratchers, 8's)	16	age	16	16
Triazolam (also called Upjohns)	17	age	17	17
Unprescribed use of Sleeping Tablets (e.g. Rohypnol, Mogadon, Moggys, Nollys, Roffies)	18	age	18	18
Unprescribed use of Tranquillisers (e.g. Valium, Librium, Ativan, Diazepam, Roche, D5s, Diazzy's, Seds)	19	age	19	19
Non prescription codeine products from pharmacy/chemist e.g. Solpadeine etc.	24	age	24	24
Sniffing Glue, Gas, Aerosol, Petrol, Thinners	20	age	20	20
Other (Code and write in)				
1.....	21	age	21	21
2.....	22	age	22	22
NONE of the above / NONE	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?

Q.7 Do you sometimes drink alcohol together with Unprescribed/Illegal Drugs?

Yes 1 No..... 2

IF YES: Which drugs?

Q.7(a) Do you sometimes drink alcohol together with codeine containing products e.g. Solpadeine?

Yes 1 No..... 2

IF YES: Which codeine containing products?

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

Q.11(a) How many of each of the following types of people do you personally know who have received professional advice or help for

WRITE NUMBER IN BOX PROVIDED. IF NONE APPLY, TICK APPROPRIATE BOX.

	Family		Friends		Work		Other	
Alcohol related problems								
	None		None		None		None	
Drugs related problems.....								
	None		None		None		None	
Both alcohol and drugs related problems								
	None		None		None		None	

Q.11(b) How many of each of the following types of people do you personally know who might need professional advice or help, but are not receiving it now for

WRITE NUMBER IN BOX PROVIDED. IF NONE APPLY, TICK APPROPRIATE BOX.

	Family		Friends		Work		Other	
Alcohol related problems								
	None		None		None		None	
Drugs related problems.....								
	None		None		None		None	
Both alcohol and drugs related problems								
	None		None		None		None	

Q.12 Have you ever injected a drug?

Yes 1

No..... 2 **GO TO INSTRUCTION @ BOTTOM OF PAGE 19**

IF YES AT Q.12, ANSWER Q.13(a):

Q.13(a) When did you last inject a drug?

Within the last month 1

Within the last year 2

More than a year ago 3

Q.13(b) Which of the following drugs have you ever injected?

ANSWER Q.13(c) OF ALL DRUGS EVER INJECTED AT Q.13(b)

Q.13(c) And when was the last time you injected this drug?

DRUG ↓	Q.13(b) Ever Injected Yes	Q.13(c) LAST TIME INJECTED		
		Within last month	Within last year	More than 1 yr ago
Cannabis (also called Marijuana, Grass, Pot, Hash., Draw, Dope, Ganja, Nodge, Nine Bar, Soaps, Weed, Dubby)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Heroin (also called Smack, Horse, Junk, Tackle, Gear, H , Skag)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Amphetamines (also called Speed, Whizz, Uppers, Sulph, Sulphate, Billy, Buzz, Ket, K)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
LSD (also called Acid, Tabs, Trips, Blotters, Microdot)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Cocaine (also called Coke, Ice, Rocks, Snow , Base, Snuff)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Ecstasy (also called E, MDMA, XTC, Ms, Disco Biscuits, Love Doves , Shamrock, Champagne, Chiefs)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Crack (also called Rock, Crystals, Crack Cocaine, Crank)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Magic Mushrooms (also called Mushies, Shrooms, Boomers)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Methadone (also called MST, Physeptone, Syrup)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Diconal (also called Dyke)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Amyl Nitrate (also called Poppers, Liquid Gold, Rush, Juice)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Temazepam (also called Jellies, Eggs, Bean, Maze, Pammys)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Temgesic (also called GGs, Tems, Midget, Gems)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Semeron	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Barbiturates (also called Downers, Barbies, Blues, Reds, Sekkies)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
DF118s (also called Dfs, Hydra, Scratchers, 8's)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Triazolam (also called Upjohns)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Unprescribed use of Sleeping Tablets (e.g. Rohypnol, Mogadon, Moggys, Nollys, Roffies)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Unprescribed use of Tranquillisers (e.g. Valium, Librium, Ativan, Diazepam, Roche, D5s, Diazzy's, Seds)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Non prescription codeine products from pharmacy/chemist e.g. Solpadeine	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Sniffing Glue, Gas, Aerosol, Petrol, Thinners	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Other (Code and write in)				
1	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

THANK YOU FOR ANSWERING THESE QUESTIONS. NOW PLEASE SEAL THE BOOKLET IN THE ENVELOPE PROVIDED AND RETURN IT TO THE INTERVIEWER.