

**HRB  
Overview  
Series**

**12**

**HRB**  
Health  
Research  
Board

**Alcohol and other  
drug use among  
children and young  
people in Ireland:  
prevalence, risk and  
protective factors,  
consequences,  
responses, and  
policies**

**Research. Evidence. Action.**



# HRB Overview Series 12

## Alcohol and other drug use among children and young people in Ireland: prevalence, risk and protective factors, consequences, responses, and policies

Anne Doyle, Salome Sunday, Brian Galvin, Deirdre Mongan

**Published by:**

Health Research Board, Dublin  
An Bord Taighde Sláinte  
© Health Research Board 2022

ISSN: 1649-7198

Health Research Board  
Grattan House  
67-72 Lower Mount Street  
Dublin 2  
D02 H638  
Ireland

t 353 1 234 5000  
e [hrb@hrb.ie](mailto:hrb@hrb.ie)  
w [www.hrb.ie](http://www.hrb.ie)

## **Citation information**

Doyle A, Sunday S, Galvin B, Mongan D (2022) Alcohol and other drug use among children and young people in Ireland: prevalence, risk and protective factors, consequences, responses, and policies. HRB Overview Series 12. Dublin: Health Research Board.

An electronic copy is available at: <https://www.drugsandalcohol.ie/36112/>

## **Acknowledgements**

We kindly acknowledge Dr Sabrina Molinaro, Head of the Department of Epidemiology and Health Services of the Institute of Clinical Physiology of the National Research Council of Italy, Dr Kirsimarja Raitasalo, Senior researcher at the National Institute for Health and Welfare, Helsinki, Finland and Dr Amanda Fitzgerald, Associate Professor in the School of Psychology, UCD, who peer reviewed this report. We also wish to thank Brenda O'Hanlon for editing services. Thanks to our colleagues in the HRB National Drugs Library, Mairead Nelson and Mary Dunne, for their support in preparing this report and to Dr Ciara Guiney and Lucy Dillon for their invaluable input into this report. Thanks also to all the authors of the articles, survey reports and other sources of information that are used in this overview and to our colleagues for providing valuable data from information systems in Ireland. We are also grateful to our colleagues in the Healthcare Pricing Office, particularly Karen Kearns, for providing Hospital Inpatient Enquiry (HIPE) scheme data, to NUI Galway for providing Health Behaviour in School-aged Children (HBSC) data, to the Central Statistics Office for providing PULSE data to Gerry McNally from the Probation Services, to Dr Aoife Kervick in the Road Safety Authority (RSA) and to our HRB colleagues, Dr Ena Lynn, Cathy Kelleher, Antoinette Daly, Dr Suzi Lyons and Dr Anne Marie Carew, for providing National Drug-Related Deaths Index (NDRDI) data, National Drug Treatment Reporting System (NDTRS) data and National Psychiatric Inpatient Reporting System (NPIRS) data.

The HRB National Drugs Library supports those working to develop the knowledge base around alcohol and other drug use in Ireland. We aim to enable evidence-informed decision-making by providing a comprehensive, timely and accessible information service. To access our research collection and other resources visit <https://www.drugsandalcohol.ie/>

## **Health Research Board**

The Health Research Board (HRB) is Ireland's lead funding agency supporting innovative health research and delivering data and evidence that improves people's health and patient care. We are committed to putting people first, and ensuring data and evidence are used in policy and practice to overcome health challenges, advance health systems, and benefit society and the economy.

# Table of Contents

|   |             |
|---|-------------|
| <b>List of tables</b>   | <b>x</b>    |
| <b>List of figures</b>  | <b>xi</b>   |
| <b>List of abbreviations and acronyms</b>                                 | <b>xv</b>   |
| <b>Glossary</b>   | <b>xvii</b> |
| <br>  |             |
| <b>Chapter 1. Summary</b>   | <b>1</b>    |
| <br>  |             |
| <b>Chapter 2. Introduction</b>  | <b>14</b>   |
| 2.1 Aims and objectives   | 16          |
| 2.2 Report structure  | 16          |
| 2.3 Understanding the findings presented in this overview                 | 17          |
| <br>  |             |
| <b>Chapter 3. Methodology</b>   | <b>18</b>   |
| 3.1 Literature search   | 19          |
| 3.2 Eligibility criteria  | 19          |
| 3.3 Screening and data extraction   | 20          |
| 3.4 Data sources  | 21          |
| 3.4.1 General population surveys  | 21          |
| 3.4.2 School-based surveys  | 22          |
| 3.4.3 Other surveys   | 23          |
| 3.4.4 Information systems data  | 24          |
| <br>  |             |
| <b>Chapter 4. Alcohol use and patterns of drinking among young people</b> | <b>28</b>   |
| 4.1 Prevalence of alcohol use among children and young people             | 29          |
| 4.1.1 Prevalence of alcohol use among young people                        | 30          |
| 4.1.2 Prevalence of alcohol use among schoolchildren                      | 31          |
| 4.2 Age of first use of alcohol   | 32          |
| 4.3 Trends in alcohol use   | 32          |
| 4.4 Patterns of drinking among young people                               | 35          |
| 4.4.1 Type of alcohol consumed  | 35          |
| 4.4.2 Frequency of drinking and number of drinks consumed                 | 36          |

|   |   |           |
|---|---|-----------|
| 4.4.3   | Highest number of standard drinks consumed on a single occasion | 37        |
| 4.4.4   | Hazardous and harmful drinking                                  | 38        |
| 4.4.5   | Perception of own alcohol use                                   | 42        |
| 4.5   | Drinking context  | 42        |
| 4.5.1   | Alcohol procurement   | 42        |
| 4.5.2   | Location of alcohol use   | 43        |
| 4.6   | Alcohol use among vulnerable populations                        | 44        |
| 4.7   | The COVID-19 pandemic and alcohol use                           | 45        |
| 4.8   | Alcohol-related knowledge and attitudes                         | 46        |
| 4.8.1   | Alcohol-related knowledge                                       | 46        |
| 4.8.2   | Alcohol-related attitudes                                       | 47        |
| 4.8.3   | Drinking motivation   | 49        |
| 4.9   | Summary: alcohol use and patterns among young people            | 50        |
| <b>Chapter 5. Drug use and patterns of use among young people</b> |   | <b>52</b> |
| 5.1   | Any illegal drug use  | 53        |
| 5.1.1   | Prevalence and patterns of any illegal drug use                 | 53        |
| 5.1.2   | Trends in any illegal drug use                                  | 54        |
| 5.2   | Cannabis  | 56        |
| 5.2.1   | Prevalence and patterns of cannabis use                         | 56        |
| 5.2.2   | Trends in cannabis use  | 58        |
| 5.2.3   | Perceived risks and availability of cannabis                    | 59        |
| 5.2.4   | Type of cannabis used   | 60        |
| 5.2.5   | Problems associated with cannabis use                           | 60        |
| 5.3   | Stimulants  | 61        |
| 5.3.1   | Ecstasy   | 61        |
| 5.3.2   | Trends in ecstasy use   | 62        |
| 5.3.3   | Cocaine   | 63        |
| 5.3.4   | Other stimulants  | 66        |
| 5.3.5   | Prevalence and patterns of stimulant use                        | 66        |
| 5.4   | Sedatives and tranquillisers                                    | 69        |
| 5.4.1   | Prevalence and patterns of sedative and tranquilliser use       | 69        |
| 5.4.2   | Trends in sedative and tranquilliser use                        | 70        |
| 5.5   | Hallucinogens   | 71        |

|  |  |           |
|--|--|-----------|
| 5.5.1  | Prevalence and patterns of hallucinogen use                | 71        |
| 5.5.2  | Trends in hallucinogen use                                 | 72        |
| 5.6  | Opioids and opiates  | 74        |
| 5.6.1  | Prevalence of problem opioid use                           | 74        |
| 5.7  | Volatile substances (inhalants/solvents)                   | 76        |
| 5.7.1  | Prevalence and patterns of inhalant and solvent use        | 76        |
| 5.7.2  | Trends in inhalants and volatile substances use            | 77        |
| 5.8  | New psychoactive substances                                | 78        |
| 5.8.1  | Prevalence and patterns of NPS use                         | 79        |
| 5.8.2  | Head shops   | 80        |
| 5.9  | Polydrug use   | 81        |
| 5.10   | Drug use among vulnerable populations                      | 82        |
| 5.10.1   | Drug use among early school leavers                        | 82        |
| 5.10.2   | Drug use among young people in the criminal justice system | 83        |
| 5.10.3   | Drug use among the young LGBTI population                  | 85        |
| 5.10.4   | Drug use among young people who are homeless               | 85        |
| 5.11   | The COVID-19 pandemic and drug use                         | 85        |
| 5.12   | Summary: drug use and patterns of use                      | 87        |
| <b>Chapter 6. Risk and protective factors associated with the use of alcohol and other drugs</b> |  | <b>89</b> |
| 6.1  | Personal factors   | 90        |
| 6.1.1  | Age of initiation  | 90        |
| 6.1.2  | Sex  | 91        |
| 6.1.3  | Ethnicity  | 91        |
| 6.1.4  | Sexual orientation   | 92        |
| 6.1.5  | Personal characteristics                                   | 92        |
| 6.1.6  | Participation in sport or physical activity                | 92        |
| 6.1.7  | Participation in music, art, drama or dance                | 93        |
| 6.1.8  | Attitudes and perceived risks                              | 93        |
| 6.1.9  | Availability of, and access to, alcohol and drugs          | 94        |
| 6.1.10   | Exposure to alcohol marketing                              | 95        |
| 6.2  | Familial factors   | 97        |
| 6.2.1  | Socioeconomic status                                       | 97        |
| 6.2.2  | Family support/parental relationships                      | 98        |

|   |  |            |
|---|--|------------|
| 6.2.3   | Parental monitoring  | 99         |
| 6.2.4   | Parental substance use                                     | 99         |
| 6.2.5   | Family composition   | 100        |
| 6.2.6   | Parental conflict and violence in the home                 | 101        |
| 6.2.7   | Parental attitudes substance use                           | 101        |
| 6.2.8   | Parental provision of alcohol                              | 101        |
| 6.3   | Social factors   | 102        |
| 6.3.1   | Peer substance use   | 102        |
| 6.3.2   | School experiences   | 104        |
| 6.4   | Summary: risk and protective factors                       | 106        |
| <b>Chapter 7. Consequences of alcohol and other drug use among young people</b> |  | <b>108</b> |
| 7.1   | Mental health and substance use                            | 109        |
| 7.1.1   | Substance use disorders                                    | 110        |
| 7.1.2   | Other mental health problems related to substance use      | 111        |
| 7.2   | Hospitalisations as a consequence of substance use         | 116        |
| 7.2.1   | Alcohol-related presentations to EDs                       | 116        |
| 7.2.2   | Alcohol- and drug-related hospital discharges              | 117        |
| 7.3   | Alcohol- and drug-related deaths                           | 123        |
| 7.4   | Substance use and crime                                    | 128        |
| 7.4.1   | Substance use and young offenders on probation supervision | 128        |
| 7.4.2   | Drink-driving and drug-driving                             | 133        |
| 7.4.3   | Controlled drug offences among young people                | 136        |
| 7.4.4   | Public order offences (disorderly conduct)                 | 138        |
| 7.4.5   | Young people involved in the illegal drugs trade           | 139        |
| 7.5   | Social consequences of drug and alcohol use                | 140        |
| 7.5.1   | Alcohol- and drug-related harms                            | 141        |
| 7.5.2   | Homelessness and substance use                             | 146        |
| 7.6   | Summary: consequences of alcohol and drug use              | 147        |



|   |            |
|---|------------|
| <b>Chapter 8. Responses to alcohol and other drug use among young people in Ireland</b> | <b>149</b> |
| 8.1 Substance use treatment   | 150        |
| 8.1.1 Alcohol treatment among young people  | 150        |
| 8.1.2 Drug treatment among young people   | 153        |
| 8.1.3 Adolescents attending treatment   | 158        |
| 8.2 Psychiatric admissions and discharges for drug and/or alcohol related disorders     | 158        |
| 8.2.1 Psychiatric hospital admissions for alcohol-related disorders                     | 159        |
| 8.2.2 Psychiatric hospital admissions for drug-related disorders                        | 160        |
| 8.3 Alcohol and drug prevention programmes  | 161        |
| 8.3.1 Categories of prevention  | 161        |
| 8.4 Summary: responses to alcohol and illegal drug use among young people in Ireland    | 166        |
| <br>  |            |
| <b>Chapter 9. Ireland’s policy and legislation governing alcohol and other drugs</b>    | <b>168</b> |
| 9.1 Ireland’s drug and alcohol strategies   | 170        |
| 9.1.1 Ireland’s broader youth policy context  | 170        |
| 9.2 Alcohol and other drugs, and the law  | 171        |
| 9.2.1 Public Health (Alcohol) Act 2018  | 171        |
| 9.2.2 Intoxicating Liquor Act 1927  | 173        |
| 9.2.3 Misuse of Drugs Act 1977  | 174        |
| 9.2.4 Misuse of Drugs (Supervised Injecting Facilities) Act 2017                        | 174        |
| 9.2.5 Criminal Justice Act 1994   | 174        |
| 9.2.6 Medical Cannabis Access Programme 2019  | 174        |
| 9.2.7 Road Traffic Act 1961   | 174        |
| 9.3 Summary: Ireland’s policy and legislation governing alcohol and drugs               | 175        |
| <br>  |            |
| <b>Chapter 10. Conclusion</b>   | <b>176</b> |
| <br>  |            |
| <b>Chapter 11. Appendices</b>   | <b>182</b> |
| Appendix 1 National Psychiatric Inpatient Reporting System (NPIRS) codes                | 183        |
| Appendix 2 ICD-10-AM codes used for HIPE  | 184        |
| <br>  |            |
| <b>References</b>   | <b>186</b> |

## List of Tables

|   |     |
|---|-----|
| <b>Table 1</b> Eligibility criteria for overview  | 20  |
| <b>Table 2</b> Information systems for responses to, and consequences of, young people’s substance use  | 25  |
| <b>Table 3</b> Main sources of survey data for substance use among children and young people  | 26  |
| <b>Table 4</b> Highest number of standard drinks consumed on a single occasion in the last year among 15–24-year-old drinkers Source: Mongan et al. 2021 [7]                                      | 37  |
| <b>Table 5</b> Percentage of 15–17-year-olds reporting where they got alcohol on the last occasion they drank Source: Költő, 2020 [11]  | 43  |
| <b>Table 6</b> Attitudes of 18–24-year-olds in relation to alcohol Source: Ipsos MORI, 2012 [65]  | 48  |
| <b>Table 7</b> Schoolchildren’s exposure to alcohol marketing Source: Fox et al. 2015 [168]   | 97  |
| <b>Table 8</b> Number of hospital discharges among young people aged 15–24 years with an alcohol-related diagnosis, by sex Source: HIPE data, 2015–2019   | 118 |
| <b>Table 9</b> Number of hospital discharges among young people aged 15–24 years, by alcohol-related diagnosis Source: HIPE data, 2015–2019   | 119 |
| <b>Table 10</b> Number of hospital discharges among young people aged 15–24 years with a drug-related diagnosis, by sex Source: HIPE data, 2015–2019  | 120 |
| <b>Table 11</b> Number of hospital discharges among young people aged 15–24 years, by drug-related diagnosis Source: HIPE data, 2015–2019   | 121 |
| <b>Table 12</b> Drug and alcohol poisoning deaths among young people aged 15–24 years Source: NDRDI data, 2008–2017   | 124 |
| <b>Table 13</b> Main drugs implicated in poisoning deaths among young people aged 15–24 years Source: NDRDI data, 2008–2017   | 124 |
| <b>Table 14</b> Type of drug recorded for lifetime history of drug use among young people aged 15–24 years who died of non-poisoning deaths due to traumatic events Source: NDRDI data, 2008–2017 | 126 |
| <b>Table 15</b> Main cause of non-poisoning deaths due to trauma among young people aged 15–24 years who had a lifetime history of drug/alcohol use Source: NDRDI data, 2008–2017                 | 127 |
| <b>Table 16</b> Percentage of arrests for driving/being in charge of a vehicle while over the legal alcohol limit, by age group Source: CSO data, 2018–2019                                       | 134 |
| <b>Table 17</b> Percentage of arrests for driving/being in charge of a vehicle while under the influence of drugs, by age group Source: CSO data, 2018–2019                                       | 134 |
| <b>Table 18</b> Percentage of arrests for disorderly conduct, by age group Source: CSO data, 2018–2019  | 139 |

|   |     |
|---|-----|
| <b>Table 19</b> ICD-10 codes used for NPIRS drug- and alcohol-related admissions to psychiatric hospitals Source: World Health Organization [253] | 183 |
| <b>Table 20</b> ICD-10-AM codes used for drug-related discharges for HIPE Source: World Health Organization [222]                                 | 184 |
| <b>Table 21</b> ICD-10-AM codes used for alcohol-related discharges for HIPE Source: World Health Organization [222]                              | 185 |

## List of figures

|   |    |
|---|----|
| <b>Figure 1</b> Prevalence of alcohol use among young people aged 15–24 years Source: Mongan et al. 2021 [7]  | 30 |
| <b>Figure 2</b> Percentage of adolescents aged 12–19 years who reported ever drinking alcohol, by school year Source: Dooley et al. 2019 [36]   | 31 |
| <b>Figure 3</b> Trends in alcohol consumption among young people aged 15–24 years Source: Mongan et al. 2021 [7]  | 33 |
| <b>Figure 4</b> Trends in percentage of schoolchildren aged 15–17 years who have ever had an alcoholic drink, 1998–2018 Source: HBSC data cited in O’Dwyer et al. 2021 [9]  | 34 |
| <b>Figure 5</b> Type of alcohol consumed in last month by adolescents aged 15–16 years, by sex Source: Sunday et al. 2020 [10]  | 35 |
| <b>Figure 6</b> Frequency of drinking among young drinkers aged 15–24 years Source: Mongan et al. 2021 [7]  | 36 |
| <b>Figure 7</b> Hazardous and harmful drinking among young adults, aged 18–25 years Source: Dooley & Fitzgerald, 2012, Dooley et al. 2019 [15,36]   | 39 |
| <b>Figure 8</b> Trends in lifetime drunkenness among adolescents aged 15–17 years Source: HBSC data cited in O’Dwyer et al, 2021 [9]  | 41 |
| <b>Figure 9</b> Location of most recent alcohol use among adolescents, by age Source: Költő, 2020 [11]  | 44 |
| <b>Figure 10</b> Comparison of alcohol use as a result of the COVID-19 pandemic among 18–34-year-olds between April and November 2020 Source: Central Statistics Office, 2020 [22,23]                                 | 45 |
| <b>Figure 11</b> Proportion of young people aged 18–24 who believe health conditions are related to consuming more than the recommended number of standard alcoholic drinks in a week Source: O’Dwyer et al, 2021 [9] | 47 |
| <b>Figure 12</b> Motivations for drinking alcohol among 15–16-year-olds, by sex Source: Sunday et al. 2020 [10]   | 49 |
| <b>Figure 13</b> Prevalence of use of any illegal drug among young people aged 15–24 years Source: Mongan et al. 2021 [7]   | 54 |
| <b>Figure 14</b> Trends in use of any illegal drug among young people aged 15–24 years Source: Mongan et al. 2021 [7]   | 55 |

|  |    |
|--|----|
| <b>Figure 15</b> Prevalence of cannabis use among adolescents aged 15–17 years<br>Source: Gavin et al. 2020 [12]   | 57 |
| <b>Figure 16</b> Trends in cannabis use among young people aged 15–24 years<br>Source: Mongan et al. 2021 [7]  | 58 |
| <b>Figure 17</b> Trends in lifetime use of cannabis among schoolchildren in<br>Ireland and Europe Source: Sunday et al. 2020 [10]                                      | 59 |
| <b>Figure 18</b> Perceived risks of cannabis use among cannabis users and<br>non-users aged 15–24 years Source: Barrett and Bradley, 2016 [82]                         | 60 |
| <b>Figure 19</b> Trends in ecstasy use among young people aged 15–24 years<br>Source: Mongan et al. 2021 [7]   | 63 |
| <b>Figure 20</b> Trends in cocaine powder use among young people aged 15–24 years<br>Source: Mongan et al. 2021 [7]  | 66 |
| <b>Figure 21</b> Prevalence of amphetamines and methamphetamine use among<br>15–16 year old schoolchildren Source: Sunday et al. 2020 [10]                             | 67 |
| <b>Figure 22</b> Trends in the use of amphetamines among young people aged<br>15–24 years Source: Mongan et al. 2020 [7]   | 68 |
| <b>Figure 23</b> Trends in lifetime amphetamine use among 15–16-year-olds in<br>Ireland and Europe Source: Sunday et al. 2020 [10]                                     | 68 |
| <b>Figure 24</b> Prevalence of sedative and tranquilliser use (prescribed and<br>non-prescribed) among young people aged 15–24 years<br>Source: Mongan et al. 2021 [7] | 69 |
| <b>Figure 25</b> Trends in sedative and tranquilliser use among young people<br>aged 15–24 years Source: Mongan et al. 2021 [7]  | 70 |
| <b>Figure 26</b> Last year prevalence of LSD and magic mushrooms use<br>among 15–24-year-olds Source: Mongan et al. 2021 [7]   | 72 |
| <b>Figure 27</b> Trends in lifetime use of LSD and magic mushrooms among young<br>people aged 15–24 years Source: Mongan et al. 2021 [7]                               | 73 |
| <b>Figure 28</b> Trends in lifetime use of LSD among schoolchildren aged 15–16 years<br>in Ireland and the European average Source: Sunday et al. 2020 [10]            | 73 |
| <b>Figure 29</b> Trends in the number of problem opioid users in Ireland aged<br>15–24 years between 2011 and 2014 Source: Hay et al., 2017 [100]                      | 75 |
| <b>Figure 30</b> Trends in lifetime use of poppers and solvents among young people<br>aged 15–24 years Source: Mongan et al. 2021 [7]                                  | 78 |
| <b>Figure 31</b> Prevalence of NPS use among young people aged 15–24 years<br>Source: Mongan et al. 2021 [7]   | 79 |
| <b>Figure 32</b> Impact of legislative changes in last year prevalence of NPS use<br>among young people aged 15–24 years Source: Mongan et al. 2021 [7]                | 81 |
| <b>Figure 33</b> Lifetime use of illegal drugs among school-attending schoolchildren<br>and early school leavers Source: Haase and Pratschke, 2010 [117]               | 83 |
| <b>Figure 34</b> Prevalence of drug use among the prisoner population aged<br>18–24 years Source: Drummond et al., 2014 [118]  | 84 |

|  |     |
|--|-----|
| <b>Figure 35</b> Illegal drug use since the beginning of the COVID-19 pandemic, by age group Source: Bruton et al., 2021 [127]   | 86  |
| <b>Figure 36</b> Difficulty accessing illegal drugs as a result of the COVID-19 pandemic, by age group Source: Bruton et al., 2021 [127]   | 87  |
| <b>Figure 37</b> Percentage of 15–17-year-olds reporting how easy or difficult it would be to buy alcohol, by age Source: Gavin et al. 2020 [12]   | 95  |
| <b>Figure 38</b> Correlation between peer alcohol and cannabis use and individual alcohol or cannabis use among schoolchildren aged 15–16 years Source: Western Region Drug and Alcohol Task Force, 2021 [18–20] | 103 |
| <b>Figure 39</b> Correlation between use of alcohol and other drugs and average academic grade earned among schoolchildren aged 15–16 years Source: Sunday et al. 2020 [10]                                      | 105 |
| <b>Figure 40</b> Experience of depression, by alcohol behaviour among young adults aged 18–25 years Source: Dooley et al. 2019 [16]  | 112 |
| <b>Figure 41</b> Experience of depression, by alcohol behaviour among adolescents aged 12–19 years Source: Dooley et al. 2019 [36]   | 113 |
| <b>Figure 42</b> Percentage of all alcohol-related ED admissions, by age group Source: McNicholl et al., 2018 [220]  | 117 |
| <b>Figure 43</b> Number of hospital discharges among young people aged 15–24 years with a drug-related diagnosis, by drug type Source: HIPE data, 2015–2019  | 122 |
| <b>Figure 44</b> Trends in drug and alcohol poisoning deaths among young people aged 15–24 years Source: NDRDI data, 2008–2017   | 123 |
| <b>Figure 45</b> Trends in non-poisoning deaths due to traumatic events among young people aged 15–24 years with a lifetime history of drug use Source: NDRDI data, 2008–2017                                    | 125 |
| <b>Figure 46</b> Trends in lifetime history of cannabis and/or cocaine drug use among young people – non-poisoning deaths due to traumatic events Source: NDRDI data, 2008–2017                                  | 127 |
| <b>Figure 47</b> Type of problematic alcohol use of Probation Service clients, by age group Source: Rooney, 2021 [120]   | 129 |
| <b>Figure 48</b> Most commonly misused drug by Probation Service clients, by age group Source: Rooney, 2021 [120]  | 130 |
| <b>Figure 49</b> Alcohol and drug use linked to current offence, by age group of Probation Service clients Source: Rooney, 2021 [120]  | 131 |
| <b>Figure 50</b> Probation Services referrals for substance misuse of young clients, by age group Source: Rooney, 2021 [120]   | 132 |
| <b>Figure 51</b> Number of arrests for possession of drugs for personal use, by sex Source: CSO data, 2018–2019  | 137 |
| <b>Figure 52</b> Number of arrests for possession of drugs for sale or supply, by sex Source: CSO data, 2018–2019  | 138 |

|  |     |
|--|-----|
| <b>Figure 53</b> Harms experienced in the last year from own drinking among young people aged 15–24 years Source: Mongan et al. 2021 [7]                                   | 141 |
| <b>Figure 54</b> Harms experienced as a result of own drinking among adolescents aged 15–16 years, by sex Source: Sunday et al. 2020 [10]                                  | 142 |
| <b>Figure 55</b> Prevalence of alcohol’s harm to others among young adults aged 18–29 years Source: Hope 2014 [241]  | 143 |
| <b>Figure 56</b> Attitudes towards sex after drinking among young adults aged 18–29 years Source: Byrnes and MacNeela, 2017 [239]  | 144 |
| <b>Figure 57</b> Sex-related alcohol consequences among young adults aged 18–29 years Source: Byrnes and MacNeela, 2017 [239]  | 144 |
| <b>Figure 58</b> Number of cases of young people aged 15–24 years treated with alcohol as their main problem substance, by treatment status Source: NDTRS data 2011–2020   | 151 |
| <b>Figure 59</b> Number of cases of young people aged 15–24 years entering treatment due to alcohol, by sex Source: NDTRS data, 2011–2020                                  | 152 |
| <b>Figure 60</b> Number of cases of young people aged 15–24 years treated in prison due to alcohol use Source: NDTRS data, 2011–2020                                       | 153 |
| <b>Figure 61</b> Number of cases of young people aged 15–24 years treated with drug use as main problem, by treatment status Source: NDTRS data, 2011–2020                 | 154 |
| <b>Figure 62</b> Number of new and previously treated cases of young people aged 15–24 years, by drug type Source: NDTRS data, 2011–2020                                   | 155 |
| <b>Figure 63</b> Number of cases of young people aged 15–24 years who attended treatment due to drug use, by sex Source: NDTRS data, 2011–2020                             | 156 |
| <b>Figure 64</b> Number of cases of young people aged 15–24 years treated in prison due to drug use Source: NDTRS data, 2011–2020  | 157 |
| <b>Figure 65</b> Number of cases of young people aged 15–24 years admitted to psychiatric hospitals with alcohol- and drug-related disorders Source: NPIRS data, 2011–2020 | 159 |
| <b>Figure 66</b> Number of cases of young people aged 15–24 years admitted to psychiatric hospitals with alcohol-related disorders, by sex Source: NPIRS data, 2011–2020   | 160 |
| <b>Figure 67</b> Number of cases of young people aged 15–24 years admitted to psychiatric hospitals with drug-related disorders, by sex Source: NPIRS data, 2011–2020      | 160 |

## List of abbreviations and acronyms

|                  |  |
|------------------|--|
| <b>AAI</b>       | Alcohol Action Ireland   |
| <b>ACE</b>       | Adverse Childhood Experiences  |
| <b>AUD</b>       | alcohol use disorder   |
| <b>AUDIT</b>     | Alcohol Use Disorders Identification Test  |
| <b>BAC</b>       | blood alcohol concentration  |
| <b>CBAS</b>      | community-based addiction services   |
| <b>CNS</b>       | central nervous system   |
| <b>CSO</b>       | Central Statistics Office  |
| <b>CTL</b>       | Central Treatment List   |
| <b>CUD</b>       | cannabis use disorder  |
| <b>DASS</b>      | Depression, Anxiety and Stress Scale   |
| <b>DAST</b>      | Drug Abuse Screening Test  |
| <b>DEIS</b>      | Delivering Equality of Opportunity in Schools  |
| <b>DRHA</b>      | drug-related emergency hospital admission  |
| <b>DSM-5</b>     | <i>Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition</i>  |
| <b>DSM-IV</b>    | <i>Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition</i>   |
| <b>DUHEI</b>     | Drug Use in Higher Education in Ireland  |
| <b>ED</b>        | emergency department   |
| <b>EMCDDA</b>    | European Monitoring Centre for Drugs and Drug Addiction  |
| <b>ESPAD</b>     | European School Survey Project on Alcohol and Other Drugs  |
| <b>EU</b>        | European Union   |
| <b>GAA</b>       | Gaelic Athletic Association  |
| <b>GP</b>        | general practitioner   |
| <b>GUI</b>       | Growing Up in Ireland – National Longitudinal Study of Children  |
| <b>HBSC</b>      | Health Behaviour in School-aged Children   |
| <b>HED</b>       | heavy episodic drinking  |
| <b>HIPE</b>      | Hospital In-Patient Enquiry  |
| <b>HRB</b>       | Health Research Board  |
| <b>HSE</b>       | Health Service Executive   |
| <b>ICD-10</b>    | <i>International Classification of Diseases, Tenth Revision</i>  |
| <b>ICD-10-AM</b> | <i>International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification</i> |

|               |  |
|---------------|--|
| <b>LGBTI</b>  | lesbian, gay, bisexual, transgender, and intersex          |
| <b>LSD</b>    | lysergic acid diethylamide                                 |
| <b>MDMA</b>   | 3,4-methylenedioxymethamphetamine                          |
| <b>M-CIDI</b> | Munich-Composite International Diagnostic Interview        |
| <b>mg</b>     | milligram  |
| <b>mL</b>     | millilitre   |
| <b>MUP</b>    | minimum unit price   |
| <b>MWS</b>    | My World Survey  |
| <b>MWS-1</b>  | My World Survey 1 (2012)                                   |
| <b>MWS-2</b>  | My World Survey 2 (2019)                                   |
| <b>NDAS</b>   | National Drug and Alcohol Survey                           |
| <b>NDRDI</b>  | National Drug-Related Deaths Index                         |
| <b>NDTRS</b>  | National Drug Treatment Reporting System                   |
| <b>NEPS</b>   | National Educational Psychological Service                 |
| <b>NPIRS</b>  | National Psychiatric Inpatient Reporting System            |
| <b>NPS</b>    | new psychoactive substances                                |
| <b>NSHRI</b>  | National Self-Harm Registry Ireland                        |
| <b>NUI</b>    | National University of Ireland                             |
| <b>OECD</b>   | Organisation for Economic Co-operation and Development     |
| <b>PCP</b>    | phencyclidine  |
| <b>PULSE</b>  | Police Using Leading Systems Effectively                   |
| <b>REACT</b>  | Responding to Excessive Alcohol Consumption in Third Level |
| <b>RSA</b>    | Road Safety Authority                                      |
| <b>SAOR</b>   | Support, Ask and Assess, Offer Assistance, Refer           |
| <b>SES</b>    | socioeconomic status                                       |
| <b>SEYLE</b>  | Saving and Empowering Young Lives in Europe                |
| <b>SHAG</b>   | Sexual Health and Attitudes, Galway                        |
| <b>SPHE</b>   | Social, Personal and Health Education                      |
| <b>SSIS</b>   | Suicide Support and Information System                     |
| <b>STIs</b>   | Sexually transmitted infections                            |
| <b>UNICEF</b> | United Nations Children’s Fund                             |
| <b>WHO</b>    | World Health Organization                                  |



## Glossary

- **Alcohol use disorder** is defined in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* criteria as a problematic pattern of alcohol use leading to clinically significant impairment or distress and manifested by 2 or more of the following 11 criteria occurring at any time in the last year: heavy and hazardous use leading to increased chances of getting hurt; unsuccessful attempts to quit or cut down; too much time spent on alcohol use or getting over the aftereffects; increased tolerance; continued drinking despite social and interpersonal problems caused by drinking; withdrawal; role impairment; reduced activities because of drinking; cravings; longer or more use than intended; and continued drinking despite psychological or physical problems. AUD severity levels can be classified as mild, moderate, or severe (2–3, 4–5, or ≥6). Alcohol dependency can be measured using the AUDIT screening tool [AUDIT score 20+: Possible dependence].
- **Alcohol Use Disorders Identification Test (AUDIT)** is a screening tool approved by the World Health Organization that is used to measure hazardous and harmful alcohol consumption and possible alcohol dependency..
- **Cannabis use disorder (CUD)** is defined as any cannabis abuse or dependence in the previous year. It was measured for the National Drug and Alcohol Survey (NDAS) using an instrument called the Munich-Composite International Diagnostic Interview (M-CIDI). The M-CIDI combines the four cannabis abuse and seven cannabis dependence criteria from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*. Cannabis abuse or dependence is manifested by a positive response to one or more of the following four domains: legal problems related to use; social or interpersonal problems; role impairment; or hazardous use. Cannabis dependence is determined by a positive response to three or more of the following seven domains: tolerance; withdrawal; longer or more use than intended; unsuccessful attempts to quit or cut down; much time spent obtaining cannabis or recovering from its effects; giving up or reducing important social, occupational, or recreational activities in favour of use; or continued use despite psychological or physical problems.
- **Central nervous system (CNS)** consists of the brain and the spinal cord and controls most functions of the body and mind.
- **Drug** refers to any psychoactive substance. For the purposes of this overview, ‘drug’ does not include alcohol.
- **Drug treatment** refers to interventions delivered to an individual or group of individuals with the aim of achieving abstinence from alcohol and other drugs, or reducing use.
- **Harmful drinking** refers to a pattern of alcohol use that is likely to cause harm (for example, physical or psychological harm and can include negative social consequences. [AUDIT score 16 – 19: High risk].
- **Hazardous drinking** refers to a pattern of alcohol use that increases the risk of harmful consequences for the user. The term describes drinking over the recommended low-risk

limits by a person who has no apparent alcohol-related health problems. [AUDIT score 8 – 15: Increasing risk].

- **Heavy episodic drinking or binge drinking** is defined in Ireland as drinking 60 g or more of pure alcohol (equivalent to six standard drinks) on a single occasion regardless of age or sex.
- **Health Service Executive (HSE) weekly low-risk alcohol guidelines** are fewer than 11 standard drinks for women or fewer than 17 standard drinks for men per week, drinks should be spread out over the week, with 2–3 alcohol-free days each week.
- **Illegal drugs** refers to any of the following drugs: cannabis, cocaine (including crack), ecstasy, lysergic acid diethylamide (LSD), opioids, magic mushrooms, amphetamines, methamphetamine, new psychoactive substances (NPS), solvents, and heroin.
- **Last month prevalence** refers to the use of a named substance in the last 30 days.
- **Last year prevalence** refers to the use of a named substance at any time in the last 12 months.
- **Lifetime prevalence** refers to the use of a named substance at any point in the person's life.
- **Non-poisoning deaths** refers to deaths of individuals with a history of drug dependence or non-dependent abuse of drugs, whether or not the use of a drug was directly implicated in the death.
- **Parental monitoring** refers to parental knowledge of where their adolescent son/daughter is at night.
- **Perceived risk** refers to awareness of the physical harm or negative social consequences of alcohol and/or drug use.
- **Polydrug use** is the simultaneous use of two or more drugs on the same occasion, or the concurrent use of two or more different drugs in a given time period.
- **Prevalence** refers to the proportion of young people who have used a substance over a specified period of time.
- **Protective factors** are biological, psychological, family, community or cultural characteristics associated with a lower likelihood of substance use or may reduce negative outcomes from substance use.
- **Risk factors** are characteristics or conditions that are associated with a higher likelihood of substance use or the negative outcomes associated with substance use.
- **Standard drink** in Ireland is defined as a drink with 10 g of pure alcohol. Examples include: a small 100 mL (12.5% volume) glass of wine, a pub measure (35.5 mL) of spirits, or a half pint of beer (4.3% volume).

**01**



# Summary



## Introduction

---

In most developed countries, substance use is a major public health issue, particularly among young people. Alcohol and other drug use is one of the leading risk factors for disease and injury and is also responsible for a considerable number of premature deaths. The national drugs strategy in Ireland aims to prevent early substance use and to minimise harm for those who have already started to use substances. The strategy also plans to develop existing prevention programmes, with an emphasis on tackling risk factors for vulnerable groups and improving services for young people.

## Aims and objectives

---

Using multiple information sources, this overview outlines the prevalence of alcohol and other drug use among young people in Ireland. It examines the risk and protective factors that may encourage or discourage young people to begin using such substances and/or lead to problematic use. It also examines the consequences of drug and alcohol use, such as hospitalisations, deaths, and crime. This overview outlines the responses to drug and alcohol use among young people, including treatment data and the strategies and legislation that guide stakeholders in preventing and minimising harm due to substance use.

## Data sources

---

The data used in this overview are based on published Irish literature as well as information systems and surveys. Using the Health Research Board (HRB) National Drugs Library, literature published since 2006 that examined drug and/or alcohol use among children and young people (aged 15–24 years) was identified, accessed, and screened for suitability. The majority of the data included in the prevalence chapters are from the National Drug and Alcohol Survey (NDAS). When examining data in relation to schoolchildren, the Health Behaviour in School-aged Children (HBSC) study and the European School Survey Project on Alcohol and Other Drugs (ESPAD) were the main sources. These sources were supplemented with data from Healthy Ireland Surveys (2016–2021), the Growing Up in Ireland (GUI) National Longitudinal Study of Children (interviewed in 2015–16 and 2018–19), the My World Surveys (MWS) of 2012 (MWS-1) and 2019 (MWS-2), the Planet Youth Surveys of 2018 and 2020, the Irish Health Survey in 2019, the 2021 Drug Use in Higher Education in Ireland Survey (DUHEI), and several others referenced throughout this overview. The various sources are included to complement each other, but as they use different methods and/or cover different age groups, comparisons cannot be made between them.

The consequences of, and the responses to, drug and alcohol use are examined primarily using national information systems. Hospital discharges related to drug and alcohol use are examined using previously unpublished Hospital In-Patient Enquiry (HIPE) scheme data

received from the Health Service Executive (HSE). Information on cases entering treatment was obtained from the National Drug Treatment Reporting System (NDTRS) and the National Psychiatric Inpatient Reporting System (NPIRS). Alcohol- and drug-related mortality was analysed using data from the National Drug-Related Deaths Index (NDRDI). Alcohol- and drug-related crime data from the Police Using Leading Systems Effectively (PULSE) system was provided by the Central Statistics Office (CSO) and 2016 Healthy Ireland Survey data were provided by the Department of Health and analysed by the HRB.

## Alcohol use

Alcohol use is deeply entrenched in Irish culture, and it is therefore unsurprising that alcohol is the most commonly used, and often the first substance used among young people. The legal age to purchase alcohol (18 years) in Ireland is not always enforced and hazardous patterns of drinking, including binge drinking, are common among young people. Early initiation and hazardous drinking patterns at this time of emotional, physical, and cognitive growth results in young adolescents being particularly vulnerable to the harmful effects of alcohol. In Ireland, the Public Health (Alcohol) Act 2018 acknowledges the public health issue of alcohol use, particularly among young people, and many of its components are specifically aimed at delaying initiation of and reducing young people's alcohol use.

Data from the 2019–20 NDAS indicated a decrease in the number of young people aged 15–24 years who had consumed alcohol in their lifetime since the 2002–03 NDAS. Males were more likely than females to report alcohol use, and the age of first alcohol use had increased from 15.6 years in the 2002–03 NDAS to 16.6 years in the 2019–20 NDAS.

Among schoolchildren, the 2018 HBSC study indicated a reduction in the percentage of 15- and 16-year-old schoolchildren consuming alcohol. A smaller reduction in alcohol use was noted among 17-year-old schoolchildren. The GUI study indicated that by the time respondents reached 17–18 years when interviewed in 2015–16, 90% had consumed alcohol.

According to the 2019 ESPAD, lifetime alcohol use among schoolchildren in Ireland (73%) was below the European average (79%) but reports of being drunk in the last month were higher in Ireland (16%) than the European average (13%). According to 2018 HBSC study data, 26% of 15-year-olds in Ireland reported being drunk in their lifetime, increasing to 46% of 16-year-olds, and 62% of 17-year-olds. Reports of drunkenness have been decreasing with each wave of the HBSC study, among 15- and 16-year-olds. However, little change was observed among 17-year-olds. Sex differences were small, but females reported more drunkenness than males, which is cause for concern as the neurotoxic effects of alcohol on the developing adolescent brain has been found to be more pronounced in females than in males.

Sex differences were also noted in alcoholic beverage use, with males most likely to consume beer (36%) and females most likely to consume spirits (32%).

Using 2019–20 NDAS data, patterns of alcohol use revealed that 64% of young drinkers aged 15–24 years were classified as hazardous drinkers; this was more common among young males (70%) than young females (57%). However, when asked to describe their own drinking,

23% of risky and alcohol-dependent drinkers appeared unaware that they were drinking in a hazardous manner, describing themselves as being either a light or a moderate drinker. Of a younger cohort, more than one-quarter of the adolescent sample (12–19 years) in the 2019 My World Survey 2 (MWS-2) (28%) were classified as hazardous drinkers.

In the period between the first NDAS in 2002–03 and the 2019–20 NDAS, monthly heavy episodic drinking (HED) decreased from 74% to 56% among those aged 15–24 years. The 2019–20 NDAS also indicated that young males (63%) were more likely than young females (49%) to report monthly HED. The 2019 ESPAD showed that among schoolchildren, last month HED had decreased between 1995 (47%) and 2015 (28%), but in 2019, reports of HED had increased to 33%.

The most commonly reported source of alcohol the last time they drank for 16- and 17-year-old schoolchildren in the 2018 HBSC study was parents (35% and 39%, respectively), and was 30% for 15-year-olds. Those aged 15 and 16 years were most likely to drink in their own home (28% and 22%, respectively) or a friend's home (27% and 33%, respectively), and 17-year-olds were most likely to report drinking in a bar or pub (39%) despite it being an offence to serve alcohol to a person under 18.

Understanding young people's attitudes towards and knowledge about alcohol provides an insight into how best to potentially tackle hazardous and harmful drinking among young people. Because alcohol use is so ingrained in Irish culture, it is easy for young people to dismiss the health-related harms of alcohol. A 2012 survey carried out by Ipsos MRBI on behalf of the HRB found that just 7% of 18–24-year-olds correctly identified the number of standard drinks in particular drink sizes and just 6% were aware of the HSE weekly low-risk alcohol guidelines. The same survey examined young people's attitudes to alcohol and found that overall, they reflected a rational perspective; for example, the majority said that alcohol use during pregnancy is unsafe, as is drink-driving.

Adolescent respondents in the 2019 ESPAD reported that they most commonly drink alcohol as it helps them enjoy parties (48%) and makes social gatherings more fun (49%). Of concern are those who reported that they drink alcohol as it helps them when they are feeling depressed or nervous (22%), to forget about their problems (20%) or to cheer up (22%).

## Drug use

Data on drug use among adolescents and young people in Ireland were collected through a number of surveys including the ESPAD, MWS, DUHEI, HBSC and GUI. The 2019–20 NDAS indicated that 27% of 15–24-year-olds had used an illegal drug in their lifetime, 19% reported use in the last year, and 11% reported use in the last month. Males were more likely than females to report drug use for all drug types with the exception of solvents. Last year use of any illegal drug among young people increased across each wave of the NDAS although has plateaued between the period 2014–15 to 2019–20. However, a different picture emerges when the data is stratified by sex as although males showed a decrease in last month illegal drug use, from 13% in the 2014–15 NDAS to 12% in the 2019–20 NDAS, females showed an increase, from 5.8% to 8.6% in the same reporting period.

This overview examined data available on the impact of the COVID-19 pandemic on substance use and although the full impact of the pandemic use will not be apparent for some time, the 2020 Planet Youth Survey found that more adolescents decreased their drug use as a result of the pandemic (25%) than increased their drug use (5.7%). This was also found in a study by the Department of Health that found reduced illegal drug use since the start of the pandemic among those aged 18–24 years. In that study, respondents indicated that accessing illegal drugs was problematic during this unprecedented time. A CSO survey early in the COVID-19 pandemic (April 2020) found that the majority of young respondents reported not changing their alcohol use since the pandemic started. The survey was repeated later in 2020 and again found that most respondents reported no change in their drinking. However, the fact that 30% of respondents in the first survey and 26% in the second survey reported increasing their alcohol use indicates that what may have begun as a short-term coping mechanism could potentially lead to a long-term problem.

### ***Cannabis***

Cannabis was the most commonly used illegal drug by young people in Ireland; 23% of respondents reported lifetime cannabis use in the 2019–20 NDAS and last year use was reported by 15% of young people. Males were more likely than females (16% versus 13%) to report last year cannabis use. A decrease in last year cannabis use was observed in the most recent NDAS, from 16% in 2014–15 to 15% in 2019–20, although this decline was not reflected in the young female data where an increase was shown.

Lifetime cannabis use among 15–16-year-old schoolchildren was higher in Ireland (19%) than the average use across participating European ESPAD countries (16%), and while many European countries have seen a decrease in lifetime use of cannabis since 2011, in Ireland its use has remained constant. Most adolescents in the 2019 ESPAD did not see great risk in cannabis use, and 42% reported that it would be ‘fairly’ or ‘very easy’ to get cannabis if they wanted to.

### ***Cocaine***

Cocaine use in the last year among young people in Ireland increased from 3.0% in 2014–15 to 4.4% in the 2019–20 NDAS. Last year cocaine use decreased among young males, from 5.1% in 2014–15 to 4.2% in 2019–20; in contrast, for females, an increase in cocaine use was observed, rising from 0.8% in 2014–15 to 4.5% in 2019–20.

Among 17–18-year-old adolescents participating in the GUI study, 4.2% used cocaine in their lifetime. A decrease in lifetime use of cocaine has been noted among 15–16-year-olds participating in the ESPAD across Europe, from 3.0% in 2007 to 1.9% in 2019, in Ireland however, although a decrease was noted between 2007 (4.0%) and 2015 (2.1%), an increase was evident in 2019 (3.3%).

### ***Ecstasy***

Data from the 2019–20 NDAS indicated that 7.2% of young people reported using ecstasy in the last year, with males (8.9%) more likely than females (5.4%) to report its use. Last month use of ecstasy rose from 0.2% in the 2010–11 NDAS to 4.4% in the 2019–20 NDAS. Among 15–16-year-olds participating in the 2019 ESPAD, 2.9% reported lifetime use of ecstasy.

### ***Other stimulants***

The 2019–20 NDAS indicated that 2.4% of young people had used amphetamines in the last year. Such use was more commonly reported among males (2.9%) than among females (1.9%), and there has been an increase in last year use since the 2014–15 NDAS (0.5%). Last month use also saw an increase from 0.2% in the 2014–15 NDAS to 0.9% in the 2019–20 NDAS.

The 2019 ESPAD captured amphetamine and methamphetamine use among schoolchildren. In Ireland, 2.1% of 15–16-year-olds reported lifetime use of amphetamines.

### ***Sedatives and tranquillisers***

Last year use of sedatives and tranquillisers (either prescribed or non-prescribed) was reported by 2.6% of 15–24-year-olds in the 2019–20 NDAS. Their use was more common among males than among females (3.1% versus 2.1%) and has decreased since the 2014–15 NDAS (2.7%). Among 2019 ESPAD respondents in Ireland, 2.6% of 15–16-year-olds reported lifetime use of sedatives or tranquillisers.

### ***Hallucinogens***

The most common type of hallucinogens used in Ireland are LSD and magic mushrooms. Of 15–24-year-old respondents in the 2019–20 NDAS, 2.4% reported last year use of LSD, an increase since the 2014–15 survey (0.8%). Males were more likely than females (3.8% versus 1.1%) to report last year use of LSD. Among schoolchildren, the 2019 ESPAD in Ireland indicated that 2.8% of 15–16-year-olds reported lifetime use of LSD, an increase from 1.8% in the previous survey in 2015.

Data from the 2019–20 NDAS indicated that 0.6% of young people reported last year use of magic mushrooms and there was a decrease in overall use since the 2002–03 survey (1.1%).

According to the 2019 ESPAD, 1.8% of schoolchildren had used magic mushrooms in their lifetime (3.1% of males and 0.4% of females).

### ***Volatile substances (inhalants/solvents)***

In the 2019–20 NDAS, 1.2% of 15–24-year-olds reported using solvents in their lifetime and 7.0% reported lifetime use of poppers. Where lifetime use of solvents has decreased since the survey in 2014–15, popper use has seen an increase in the same period. Males were more likely to report use of poppers (10%) than females (3.8%) whereas lifetime solvent use was more commonly reported among females compared to males (1.6% versus 0.8%). Among schoolchildren participating in the 2019 ESPAD, 7.2% reported lifetime use of inhalants.

### ***New psychoactive substances***

The prevalence of NPS use among young people decreased as a result of legislation introduced in 2010 and the resulting head shop closures; last year use decreased from 9.7% in the 2010–11 NDAS to 1.7% in the 2019–20 NDAS. Among schoolchildren in Ireland participating in the 2019 ESPAD, 4.7% reported lifetime NPS use.



## Risk and protective factors

There are a number of protective factors that may help to prevent and/or delay substance use and reduce the potential for harm when use does occur. There are also risk factors in young people's lives that can contribute to early initiation or harmful use.

### *Personal factors*

Personal risk factors include the age when a young person initiates drug or alcohol use; those who use substances at an early age are more likely to experience harms or progress to harmful patterns of drinking; studies outlined in this overview have shown that the earlier the age at which drinking is initiated, the more likely it is that harmful and hazardous drinking will be experienced later.

Males consistently report higher levels of drug use than females and were shown to report more hazardous patterns of drinking than females, although the gap between the sexes has narrowed. Those with concerns about their sexual orientation were reported to be more likely to use alcohol regularly and more likely to use drugs than their peers without such concerns.

A number of personality characteristics have been associated with substance use; those with traits including impulsivity and sensation seeking, higher extraversion, low conscientiousness, anxiety, sensitivity, neuroticism, low levels of self-esteem or body esteem, or resilience were more likely to use drugs and/or be harmful or hazardous drinkers or develop an AUD.

Children are exposed to alcohol marketing regularly and many own alcohol-branded merchandise. A study included in this overview found that increased exposure to alcohol advertisements and marketing, particularly in the form of owning alcohol-branded merchandise, increased the risk of children drinking alcohol, binge drinking, and reporting drunkenness, when compared with findings for children who were not exposed to alcohol marketing. The presence of alcohol marketing in social media and in sporting events was highlighted by a number of studies including one that reported that the majority of TikTok videos tagged with the "#alcohol" hashtag featured alcohol in a positive manner. Another study shone the spotlight on the extent of references made to alcohol during the Six Nations Championship 2020 games. The Public Health (Alcohol) Act 2018 includes provisions to restrict alcohol marketing in sporting events, and this section of the Act came into effect in November 2021.

### *Familial factors*

Several sources of data included in this overview point to the protective effect of having supportive parents and effective parental monitoring in delaying or preventing substance use with lower parental monitoring associated with higher levels of drunkenness and cannabis use as noted in the 2020 Planet Youth Survey.

The evidence also demonstrates that parental behaviours are often imitated by children. For example, adolescents who reported seeing a family member drunk were more likely to be regular drinkers than those who had not witnessed this and adolescents who reported that

their parent's used drugs were more likely to use drugs themselves

Family composition was noted as a factor potentially determining substance use; parental separation or where a parent is deceased was predictive of risky alcohol use, as was parental conflict. Those who reported experiencing parental conflict were more likely to report risky alcohol behaviour than those who had not experienced this. Liberal parental attitudes have also been shown to be a risk factor for substance use among young people. The 2020 Planet Youth Survey found that adolescents whose parents were more tolerant of drunkenness were more likely to report being drunk in their lifetime than those whose parents were disapproving of drunkenness. Irish and international literature has shown that parental provision of alcohol is linked to earlier initiation of alcohol use, drunkenness, increased risk of binge drinking, alcohol-related harm, and a greater chance of dependency later in life; it also increases the likelihood of seeking alcohol elsewhere.

### **Social factors**

Peers are hugely important to adolescents and influence many decisions and behaviours and have been shown to influence young people using substances; 32% of adolescents participating in the 2020 Planet Youth Survey reported drinking so as not to feel left out of their peer group and 9% said that they smoked cannabis for the same reason. Those who reported that their friends drink alcohol were more likely to report ever being drunk (73%) than those who reported that none or only a few of their friends drink alcohol (24%).

School experiences were reported to influence drug and alcohol use also. Skipping school was indicative of alcohol and drug use among 2019 ESPAD schoolchildren, with a higher percentage of respondents who had skipped school reported as current drinkers. In addition, 50% of those who skipped school reported lifetime cannabis use; the comparable figure for schoolchildren who had not skipped school was 15%. The 2019 ESPAD also showed an association between school grades and alcohol and drug use, with those who reported lower grades more likely to report alcohol use or cannabis use than those with higher grades.

## **Consequences of alcohol and drug use**

The harmful consequences of substance use are wide-ranging – from acute harms including accidents and/or poisonings to chronic consequences such as dependency, mental health problems, and diseases including seven types of cancer associated with alcohol use, diabetes and heart disease. Young people are equally susceptible, if not more, to these harms given that they are more likely to binge drink. The 2019–20 NDAS indicated that 38% of drinkers aged 15–24 years were classified as having an alcohol use disorder (AUD). The rate of young people drinking at this high level is of concern, given that children and adolescents are typically more vulnerable to the harmful effects of alcohol. The prevalence of cannabis use disorder among cannabis users was 19%.

### **Substance use and mental health**

The relationship between substance use and mental health is complex and the extent to which substance use causes or exacerbates mental health problems, or substances are used

as a method to cope with the symptoms of poor mental health is unclear. The MWS-2 found that adolescents who have attempted suicide were more likely to have smoked cannabis (36%) than adolescents who did not report having attempted suicide (14%). The same survey reported that adolescents classified as problem or hazardous drinkers were most likely to be in the severe category for depression (17%) and, where possible alcohol dependence was indicated, they were most likely to be in the very severe category for depression (33%); when compared to low-risk drinkers (55%). Of young adult respondents in MWS-2, those classified as having possible alcohol dependence were more likely to be in the moderate (29%), severe (13%), and very severe (24%) categories for depression than those in any other drinking behaviour category, and they were more likely to have engaged in deliberate self-harm and to have attempted suicide.

A history of substance misuse was evident in the majority of suicides among young people in Ireland; 74% of those aged 15–24 years had a history of alcohol and/or drug misuse and 24% had consumed alcohol prior to their death, 28% had consumed both alcohol and drugs according to a report published in 2016 using data from the Suicide Support and Information System.

### ***Hospitalisations***

Using HIPE scheme data for the period 2015–2019, hospital discharges indicated that alcohol-related hospitalisations among young people increased by 12% between 2015 and 2018 but decreased by 16% between 2018 and 2019.

The number of drug-related discharges increased by 26% between 2015 and 2018 but decreased by 3.2% in 2019. Across this 5-year period, males accounted for two-thirds (66%) of drug-related discharges. In 2019, cannabinoids accounted for 23% of diagnoses, opioids accounted for 21%, and cocaine for 20%. The number of cocaine-related diagnosis discharges increased by 83% between 2015 and 2019. Males were more likely than females to be discharged from hospital for both alcohol- and drug-related conditions.

As HIPE does not collect emergency department (ED) admissions, there are limited national data on alcohol- or drug-related presentations. However, a 2018 study which looked at alcohol-related ED presentations found that 33% of all alcohol-related presentations were observed in patients aged under 29 years.

### ***Drink-driving and drug-driving***

Of arrests for drink driving in 2018–2019, 14% were aged 18–24 years and 30% of arrests for drug-driving were aged 18–24 years with young males more likely than females to be arrested for both offences.

Half (49%) of young driver fatalities (aged 15–24 years) that occurred during 2013–2017 with a toxicology result available, had a positive toxicology for alcohol.

### ***Alcohol and drug-related deaths***

The NDRDI indicated that 322 young people aged 15–24 years died of drug or alcohol poisoning during the period 2008–2017. Although a decrease in poisoning deaths was observed during this period, over one in every 10 deaths among young people were due to

drug and/or alcohol poisoning in 2017. The majority (67%) of poisoning deaths involved more than one drug (including alcohol) and the majority (82%) of deaths were among males. The main drugs implicated in the drug poisoning deaths were diazepam (32%), heroin (31%), and methadone (30%) during the reporting period.

The NDRDI also collects data on non-poisoning deaths due to trauma (deaths among people with a lifetime history of drug use/dependency, alcohol dependency or where alcohol was implicated in the death). There were 412 such deaths during the period 2008–2017 and the majority (87%) of such deaths were male. Over half of these deaths had a history of cannabis use (54%), and 37% had a history of cocaine use.

### ***Crime***

A 2021 report notes that substance use was often the main offence that brought young people into contact with An Garda Síochána and subsequently to Probation Services and for many, this was the first occasion that their substance use was addressed. The majority of Probation Service clients reported drug and/or alcohol misuse and cannabis was the most common drug used, followed by benzodiazepines and cocaine. The link between substance use and the crime committed was highlighted. Probation Officers commonly referred clients to appropriate services to address their alcohol and drug use.

The PULSE data indicated that 43% of those arrested for controlled drug offences were aged 18–24 years; of these offences, young people represented 46% of arrests for possession of drugs for personal use; 36% of arrests for possession of drugs for sale or supply; and 26% of arrests for disorderly conduct.

### ***Social consequences***

Alcohol-related harms as a result of own drinking and others' drinking were more likely to be reported by younger people than by those in older age groups. The 2017 Sexual Health and Attitudes, Galway (SHAG) Survey found that 26% of young females (18–29 years) and 28% of males reported regretting sexual experiences and neglecting to use contraception due to alcohol use was also reported (by 26% of males and 25% of females).

## Responses to alcohol and illegal drug use

### *Treatment for substance use*

Data from the NDTRS indicated that during the period 2011–2020, 8,608 cases of young people aged under 25 years received treatment due to their alcohol use. Despite the high incidence of hazardous and harmful drinking and alcohol dependence among young people, only a small percentage of these drinkers receive treatment. In fact, a decrease in presentations for alcohol as the main problem substance has been noted for this period, declining from 1,413 cases in 2011 to 485 cases in 2020. Males were almost twice as likely than females to receive treatment for their alcohol use and it was common for young people to receive treatment for more than one substance. Polydrug use was reported by 44% of those attending treatment for their alcohol use, with cannabis, cocaine, and benzodiazepines the most commonly reported additional substances.

Over the same period (2011–2020), there were 27,569 cases of young people aged under 25 years who received treatment for their drug use; of these, 1,867 were treated in prison. The most common drugs for which treatment was received during that period were cannabis, opioids, and cocaine. Treatment for cocaine use increased substantially during the reporting period and treatment for opiate use decreased. Males were more likely than females to present for treatment due to drug use (80% versus 20%). Polydrug use was also common among those attending treatment for drug use.

This overview also looked at psychiatric discharges due to alcohol- and drug-related conditions. The NPIRS indicated that there were 3,656 cases of young people aged 15–24 years admitted to psychiatric hospitals due to drug or alcohol use during the period 2011–2020; of these, 793 cases were alcohol-related and 2,863 were drug-related.

### *Prevention programmes*

A number of prevention interventions exist in Ireland to prevent or delay substance use among children and to target specific populations considered to be at higher risk of substance use. These prevention interventions are grouped into several prevention types:

- Environmental preventions target the whole population and include taxes on alcohol and legislation, such as the Public Health (Alcohol) Act 2018 and drink-driving restrictions.
- Universal preventions include online resources, such as the HSE and Government-funded websites providing the public with information and resources. Universal preventions also include education-based programmes to prevent substance use, such as the Social, Personal and Health Education (SPHE) programme that is delivered in primary and post-primary schools across the country.
- Selective prevention interventions are those that target specific groups or communities, such as lower socioeconomic areas or children at risk of leaving school early.
- Indicated interventions include brief interventions such as referral to health screening or community-based projects.

## Ireland's policy and legislation governing alcohol and drugs

In Ireland, there are a number of strategies that focus on drug and alcohol use among young people and strategies that focus on children or specific populations. Part of the national drugs strategy is to prevent early substance use in children, to minimise harm for those who have already started to use substances and to develop harm reduction interventions targeting at-risk groups. Other complementary strategies include the children and young people's National Policy Framework; the National Youth Strategy that focuses on young people who are experiencing, or who are at risk of experiencing, the poorest outcomes; the Youth Justice Strategy; the National Strategy on Children and Young People's Participation in Decision-making, which allows for young people to become directly involved in the design, development, implementation, and evaluation of services that affect them; and the LGBTI+ National Youth Strategy that includes goals to improve the mental, physical, and sexual health and well-being of the entire LGBTI+ community.

In addition, there are several pieces of legislation that govern the use and sale or supply of alcohol and drugs. The Public Health (Alcohol) Act 2018 views alcohol as a public health issue aiming to reduce alcohol consumption and related harms, specifically among young people. Several components have been commenced while others remain outstanding. Other acts that govern alcohol and drug use and related harms include the Road Traffic Act 1961, the Misuse of Drugs Act 1977, the Criminal Justice Act 1951, and the Intoxicating Liquor Act 2008. All these Acts have been amended and updated over the years to reflect the changing nature of substance use and related harms.

## Conclusion

Young people in Ireland are generally happy and content with their lives, enjoying positive family and peer relationships, good health and doing well at school. Adolescence is a key period of experimentation and although most do not take illegal substances, the majority drink alcohol at some stage in their lives. This report focuses on alcohol and drug use, the consequences as a result of substance use and the aspects of young people's behaviour that cause concern, but it is important to keep this phenomenon in perspective. Understanding the extent of substance use and its effects is essential for stakeholders who work with young people and those responsible for policy making, law enforcement to respond effectively.

Approximately one in every five young people reported using an illegal drug in the last year, remaining almost unchanged since 2014–15. Cannabis use has stabilised but where change is seen is the increase in cocaine use, type of drugs used, and the prevalence of polydrug use. Although cannabis remains the most commonly used drug, the use of stimulants including ecstasy and cocaine has increased.

One welcome finding is that the drinking behaviours of young people are slowly changing, with more young people delaying alcohol use or choosing not to drink at all, nevertheless, there remains a pattern of hazardous drinking once alcohol use commences with rates of binge or heavy episodic drinking among adolescents in Ireland among the highest in Europe. This pattern of drinking is associated with increased risk of harm, both physically and psychologically, and this report outlines some of the key harmful consequences of this alcohol behaviour. Alcohol is interwoven in our lives and there seems to be a reluctance to accept that alcohol-related harm effects so many in this country and the impact of which can be wide-reaching; from individuals with dependency and their families, health care workers treating those in our hospitals with alcohol-related diseases and injuries, to the criminal justice system dealing with alcohol-related crimes.

Hospitalisations due to substance use have increased between 2015–2018, although a decrease was noted in 2019. The evidence indicates that mental health issues are more common among those who use cannabis regularly and among those who drink alcohol in a hazardous manner and self-harm and suicide attempts are more prevalent among young people who are alcohol dependent. Criminal justice services are also impacted by substance use, and we see how young people, especially males, are over-represented in drug and alcohol-related arrests. This overview also looked at the number of young people who died due to poisoning from substances as well as deaths of young people who with a history of substance use.

When addressing substance use among young people, a number of approaches have proven effective including treatment interventions and support from family, teachers, health professionals and others that work directly with children and young people. Also in place to address the issue of substance use are legislation and government strategies that aim to defer the use of alcohol, to target those deemed to be at greater risk of substance use and to support those who have already started to use substances in their rehabilitation and recovery. This overview intends to provide up-to-date information about the drug and alcohol situation among young people for policymakers, service providers and families.

02



# Introduction





Substance use among young people is a major health and social problem throughout the world. A systematic analysis of the World Health Organization (WHO) Global Burden of Diseases, Injuries, and Risk Factors Study found that among 10–24-year-olds, the second leading risk factor for disease and injury in 2019 was alcohol use and drug use was the sixth leading risk factor [1].

Adolescence is the peak period for initiation of substance use. A consistent finding from the international literature is that levels and frequency of the use of drugs, alcohol, and tobacco begin to increase in mid-adolescence and peak in early adulthood. These are key periods of change, cognitive and emotional development, and transitioning into further education, employment, and stable relationships.

We know a lot about patterns of behaviour among young people who use illegal substances, these studies report a typical temporal order of drug initiation, with use of cannabis and other drugs usually preceded by use of alcohol and tobacco. There is growing knowledge of the effect that genetic, social, or environmental factors have on substance use at a time when the brain's social and emotional processing capacity is rapidly developing, and peers are a particularly strong factor in decision-making. We are also more aware of the protective factors which make early initiation less likely and can help reduce the adverse effects that result from intoxication and substance use. While similar patterns can be observed across most high-income countries, there are cultural variations and countries may observe some phenomena that deviate from these patterns to a certain extent.

Ireland's national drugs strategy, which includes alcohol, *Reducing Harm, Supporting Recovery: A health-led approach to drug and alcohol use in Ireland 2017–2025*, sets out the goals to guide drug and alcohol policy in Ireland [2]. Goal 1 of the strategy aims to protect the public from threats to health and well-being related to substance use by preventing early use of alcohol and other drugs among young people; influence behaviour and challenge social norms and attitudes; and provide targeted interventions aimed at minimising harm for those who have already started to use substances. In line with the national drugs strategy, a key goal for policy-makers is the delay in the onset of substance use in order to minimise disruption to transitioning processes, prevent possible harm to the adolescent brain, and reduce the risk of problematic substance use later in life. Actions under this goal are concerned with further developing existing prevention programmes, improving services for young people, or tackling risk factors associated with substance abuse, such as early school leaving.

## 2.1 Aims and objectives

---

It is important that preventive measures and other interventions put in place to reduce the harm caused by young people's substance use are based on sound evidence and that such measures are informed by an awareness of the current situation regarding the extent, nature, and consequences of this use. Ireland is fortunate in that it has extensive available information on substance use among adolescents and young people. There are well-established, scientifically robust and professionally managed surveys, cohort studies, health surveillance systems, and administrative datasets that can provide detailed information on prevalence as well as important contextual and environmental data. Analysis of these data deepens our understanding of this complex and multifaceted phenomenon.

The aims and objectives of this overview are to provide the reader with information about what is known from existing Irish literature and data sources about substance use among young people; to what extent young people are using alcohol and other drugs, and how this has changed over time; at what age they start using substances; the risk and protective factors that may encourage or deter substance use among young people; the consequences of substance use; the responses to substance use; and the policies and legislation that exist to inform stakeholder decision-making to minimise substance use-related harm.

## 2.2 Report structure

---

Prior to this introductory chapter (Chapter 2), Chapter 1 provides a summary of the overview, Chapter 3 then outlines the methodology used for this overview. Chapter 4 describes alcohol use and patterns of drinking among children and young people in Ireland. Chapter 5 examines the use of drugs and patterns of use. Chapter 6 details the risk and protective factors associated with alcohol and drug use. Chapter 7 outlines the consequences of alcohol and drug use among young people, including information on young people receiving treatment for their alcohol and/or drug use based on analysis of treatment and hospital discharge data. Chapter 8 details the responses to alcohol and drug use, outlining the prevention programmes that exist to educate and inform young people regarding substance use, as well as the diversion programmes and community-based programmes that support young people who are using substances. Chapter 9 outlines the policy implications, including the existing Irish legislation that governs alcohol and drug use and sales. Finally, Chapter 10 provides a conclusion of the overview including highlighting potential gaps in the research.

## 2.3 Understanding the findings presented in this overview

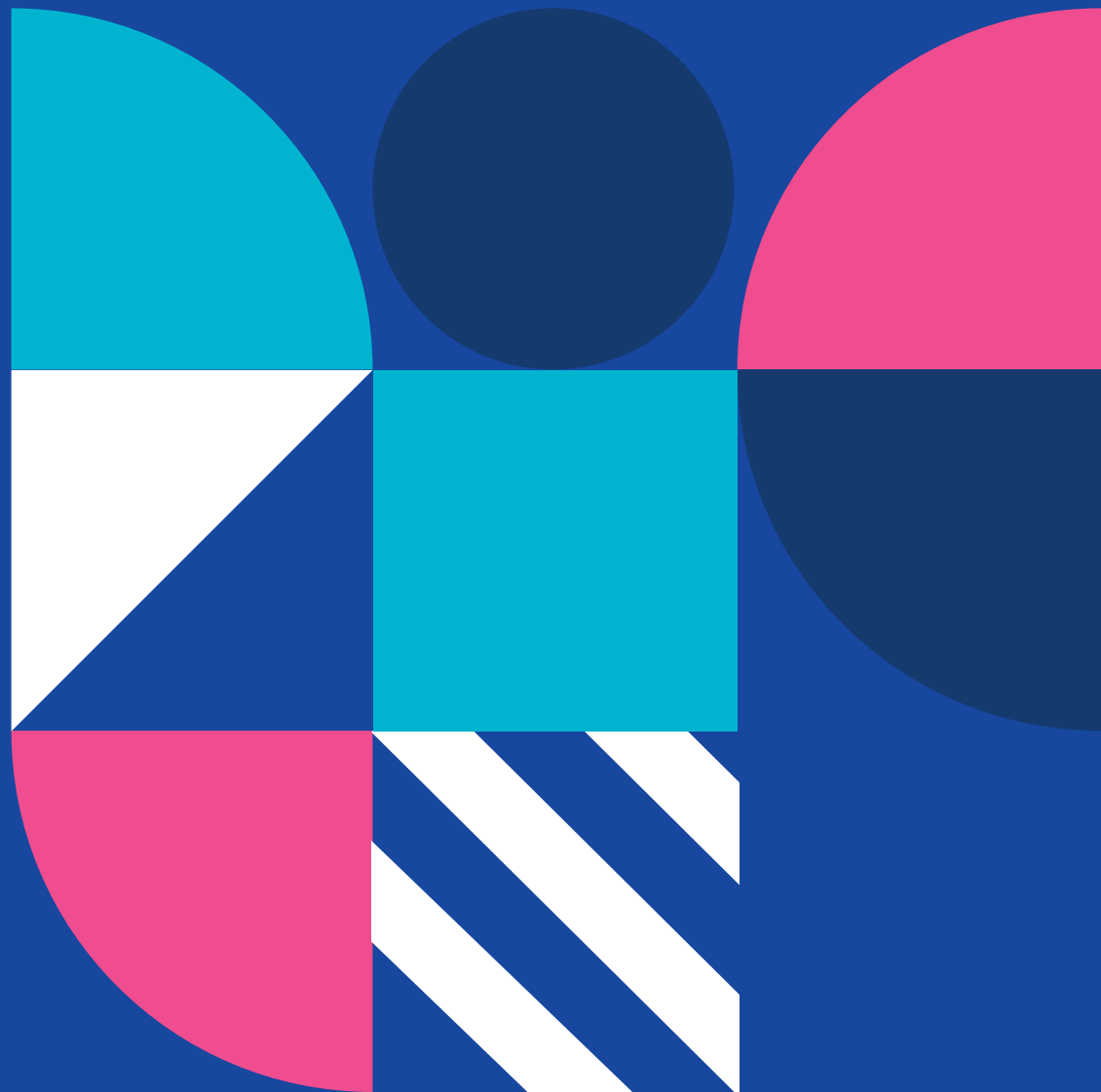
When interpreting the findings presented in this overview, note that within the text, percentages are rounded up/down to the nearest whole number. Percentages less than 10 are rounded to the first decimal place. In tables and graphs, percentages are presented to the first decimal place where available or as per original source. As a result, in some instances totals may not sum to 100% due to rounding of percentages and numbers presented in the text may differ slightly from those in the corresponding tables/graphs.

The language used may vary throughout this overview when referring to drug types and age cohorts. For example, the terms adolescent, teenager, and schoolchild; or binge drinking and heavy episodic drinking (or HED); and use, misuse and consumption and the term intoxication is also used to refer to drunkenness, these terms are used interchangeably. In parts of the overview, the literature and data refer to young people, young adults, adolescents, teenagers, schoolchildren interchangeably. This is done in order to reflect the original authors' terminology and to ensure that the results are not open to misinterpretation. The multiple sources of data used in this overview refer to certain drug types (for example, cannabis or cocaine) but also generically to drugs. Where the specific drug is noted in the original literature, it is also cited in this report but where the literature refers non-specifically to drugs, this is also reproduced here.

03



# Methodology



## 3.1 Literature search

A comprehensive search was conducted using the HRB National Drugs Library [3] to identify Irish literature on alcohol and drug use among young people published from 2006\* to 2021, including primary papers, systematic reviews, and policy documents. The literature search included umbrella reviews (reviews of systematic reviews), systematic reviews, and primary quantitative studies and qualitative studies. The HRB National Drugs Library provides access to all Irish research and policy material and a comprehensive collection of key international evidence. The PubMed database was also used to search for international literature where necessary.

## 3.2 Eligibility criteria

Information system data and the literature included studies and data relating to children and young people aged between 15–24 years, undertaken in Ireland, and with Ireland as the main focus of the study. Multi-country studies that included Ireland were also included. Although the emphasis is on Irish literature and sources, international literature is referenced throughout this overview to provide a wider context to support the Irish evidence. For the purpose of this overview, ‘young people’ refers to those aged 15–24 years. This age group was investigated as it is a standard age group used by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and many of the drug and alcohol prevalence surveys carried out in Ireland (and internationally) show that drug use among young people is often higher than that among older people. The age of 15 years is commonly used as the minimum age, reflecting the fact that in most countries, children aged under 15 years are less likely to use substances and that adolescence is a critical risk period for the initiation of substance use and is inclined to peak among young people aged 18–24 years [4–6]. In some cases, data are only available for a specific or wider age group – for example, those aged 15–34 years or 18–29 years – but are included in this overview as they provide valuable information on younger people and substance use, albeit using a broader age cohort. In other instances, data are available for narrower age groups – for example, adolescents aged 15–16 years only; where data are presented for such an age group, this is clearly stated. The full eligibility criteria are presented in Table 1.

---

\* Studies published before 2006 were excluded upon agreement by the authors that there was sufficient publications following 2006 and that earlier publications could be dated. Some older publications are included where there was a gap in knowledge.

Table 1 Eligibility criteria for overview

| Criteria          | Inclusion  | Exclusion  |
|-------------------|--|--|
| Population        | Young people aged between 15–24 years  | People aged under 15 years or over 24 years <sup>†</sup> |
| Location          | Studies conducted in Ireland or international surveys that include Ireland         | Other locations outside Ireland <sup>‡</sup>             |
| Type of substance | Alcohol and any illegal or prescribable <sup>§</sup> drug                          | Tobacco and nicotine products; e-cigarettes              |
| Study design      | Umbrella reviews; systematic reviews; primary quantitative and qualitative studies | Case studies   |
| Article type      | Peer-reviewed articles; reports; guidelines/factsheets; websites; datasets; books  | Letters to editors; theses; conference presentations     |
| Year              | 2006 to 2022   | Pre-2006 <sup>**</sup>                                   |
| Language          | English-language publications  | Non-English-language publications                        |

### 3.3 Screening and data extraction

The authors sought to establish what is known from the literature about substance use among young people; risk and protective factors related to initiating substance use; and the consequences of, and approaches to addressing substance use among this cohort. Using the HRB National Drugs Library, a search was conducted to identify and retrieve relevant literature. All database search results were screened for eligibility and following dual screening by two of the authors using the eligibility criteria outlined in Table 1, the remaining eligible results of the search were imported into and managed using Zotero bibliographic management software.

† Note that in some cases, data are presented that refer to a wider or narrower age cohort; where this occurs, it is specified within the text.

‡ A number of studies are based on data that include other countries; where this occurs, this overview focuses on the Irish findings. In addition, Irish literature is supported by international evidence throughout this overview.

§ For this overview, illegal drugs include cannabis, ecstasy, cocaine, stimulants, NPS, opioids, and hallucinogens; and prescribable drugs include, but are not confined to, opioid pain relievers, sedatives, tranquillisers and methadone.

\*\* Occasionally, older literature is referred to in the absence of more up-to-date information.

Material that met the eligibility criteria were summarised according to the outcomes of interest and were extracted into an extraction template in Microsoft Excel. The following data were extracted: author, title, category, data source, study group, article type, aim of study, type of drugs involved, age/age group, design/method, years of data, sample size, key findings, gaps in research identified, policy and/or practice implications identified, and main outcome measures.

## 3.4 Data sources

The data in this overview are based predominantly on published Irish literature, repeated surveys, and existing information systems. The principal data sources included in this overview are presented in Table 3 and are further described here. Additional sources not contained in Table 3 were also included to support these data. The sources of information include different target populations, age groups, and national and regional samples, and they differ in their research methods using both surveys and qualitative data collection methods, including interviews and focus groups. As a result, comparisons cannot be made between results from different sources; rather, the multiple data sources should be used to complement one another.

Additional unpublished data were requested and received from several sources and were analysed on our behalf or provided to us for analysis; PULSE data received from the CSO; HBSC data from the National University of Ireland (NUI) Galway; HIPE scheme data from the Healthcare Pricing Office, HSE; Healthy Ireland Survey data from the Department of Health; National Drug-Related Deaths Index (NDRDI), National Psychiatric Inpatient Reporting System (NPIRS) and National Drug Treatment Reporting System (NDTRS) data from the HRB.

### 3.4.1 General population surveys

General population surveys are those based on the entire population and can be used to collect information on any characteristic of interest, such as a particular disease or condition of clinical concern. For the purposes on this overview, general population surveys have been used to obtain comparable and reliable information on the extent and pattern of consumption of drugs and alcohol in the general population in Ireland. Such surveys may also capture the characteristics and behaviours of those who use substances, as well as perceptions and attitudes relating to alcohol and drug use.

#### 3.4.1.1 National Drug and Alcohol Survey

The NDAS collects information approximately every 4 years on alcohol, tobacco, and drug use, as well as gambling, among the general population in Ireland. The 2019–20 NDAS used probability sampling methods to select a representative sample of 5,762 people aged 15 years and over who were living in private households in Ireland [7]. The findings were then weighted and applied to the general population and thus are representative of the general population of Ireland. Previous waves of the NDAS were undertaken in 2002–03, 2006–07, 2010–11, and 2014–15, and comparisons can be made to identify changes over time. The information presented in this overview is based on findings for the 15–24-year-old age group in the NDAS [7].

A limitation of the NDAS is the absence of responses from those living in institutions such as prisons or nursing homes. It also does not include responses from members of the Traveller community or people who were experiencing homelessness, and as the survey did not make a specific provision for interviews to be conducted in languages other than English, those who did not speak English were also excluded. Where participants were less than 18 years, their parents could choose to be present during the interview which may have influenced responses.

### **3.4.1.2 Healthy Ireland Survey**

The Healthy Ireland Survey is carried out annually using probability sampling methods to select a representative sample of the population (typically approximately 7,500 people) aged 15 years and over living in Ireland. The survey collects information about respondents' behaviours and attitudes regarding a wide range of health-related issues, including smoking, alcohol use, diet and nutrition, use of health services, and other topics relevant to health and health services in Ireland. Limitations of the Healthy Ireland survey are similar to those of the NDAS as outlined above. The information in this report is primarily based on the 2021 Healthy Ireland Survey findings for the 15–24 years age group [8]. Additional unpublished data from 2016 were obtained from the Healthy Ireland Survey and analysed by the HRB, and some of these data have been published in the 2021 HRB alcohol overview *Alcohol consumption, alcohol-related harm and alcohol policy in Ireland* [9].

## **3.4.2 School-based surveys**

School-based surveys are targeted surveys among schoolchildren and can collect information on any area of interest within this population, including school experiences, patterns of key health behaviours, health indicators, and contextual variables that can describe the characteristics of schoolchildren. In this overview, school-based surveys have been used to describe drug and alcohol use among schoolchildren as well as the risk and protective factors that may influence their decisions to use alcohol and/or drugs, including mental health properties, home life, engagement in criminal behaviour, and others.

### **3.4.2.1 European School Survey Project on Alcohol and Other Drugs**

The ESPAD is a cross-national research project conducted every 4 years since 1995 in more than 35 European countries, including Ireland. The survey collects comparable data on the experiences with, and perceptions of, a variety of substances, including tobacco, alcohol, illegal drugs, inhalants, pharmaceuticals, and NPS, among schoolchildren aged 15–16 years in order to monitor trends within and between countries. The survey also collects information on gambling, social media use, and gaming. The survey uses random sampling process to select schools and the data are not weighted. The seventh ESPAD was carried out in Ireland in 2019 and is based on responses from 1,949 schoolchildren in Ireland [10]. Low school/class participation rates in Ireland (39%) resulted in a relatively small net sample size.

### **3.4.2.2 Health Behaviour in School-aged Children**

The HBSC study is a cross-national study conducted every 4 years since 1998 in more than 50 countries and regions across Europe and North America. The main aim of the study is to



monitor the health behaviours, outcomes, and social environments of school-aged children (aged 8–18 years). Areas addressed include general health, smoking, use of alcohol and other substances, food and dietary behaviour, exercise and physical activity, self-care, injuries, bullying, and sexual health behaviours. In 2018, the sixth HBSC study in Ireland surveyed 15,557 children from third class to fifth year who were aged 8–18 years [11]. Schoolchildren were sampled to be representative of the proportion of children in each of the eight geographical regions and cluster sampling was then applied to schoolchildren in a given classroom. The survey response rate was 63% of invited schools and of which, 84% of students responded. The data were representative of the population and were not weighted. This overview focuses on the 5,625 schoolchildren aged 15–18 years. Members of the Health Promotion Research Centre at NUI Galway provided an analysis for the HRB on alcohol and cannabis use among children aged 15–17 years who participated in the HBSC study [11,12].

### 3.4.3 Other surveys

#### 3.4.3.1 Growing Up in Ireland

GUI is a national longitudinal study of children and young people in Ireland carried out jointly by the Economic and Social Research Institute (ESRI) and Trinity College Dublin. It is managed by the Department of Children, Equality, Disability, Integration and Youth in association with the CSO. The study started in 2006 and follows the progress of two cohorts: Cohort '98 (previously referred to as the Child Cohort), which comprises those who were aged 9 years at first interview in 2007, and Cohort '08 (previously referred to as the Infant Cohort), which comprises those who were aged 9 months during the first wave of data collection in 2008. Based on all the children born in Ireland in 1998 and 2008, a random sample was selected, this was re-weighted to ensure representativeness. The results presented in this overview are based on Cohort '98, who were aged 17 and 18 years at the time of interview for Wave 3 in 2015–2016, and were aged 20 years during data collection for Wave 4 in 2018–2019 [13,14]. As a longitudinal study that follows the same participants over a period of time, a challenge of the GUI is retention of participants. The response rate at wave 3 (when participants were 17–18 years) was 76% and at wave 4 (at 20-years-old) was 65%.

#### 3.4.3.2 My World Survey

Developed by the University College Dublin (UCD) School of Psychology together with Jigsaw, the youth mental health charity, the MWS is a study of youth and adolescent mental health and well-being in Ireland. The study included a representative sample of students enrolled in post-primary schools in Ireland selected using multistage sampling. Of the 175 schools invited to participate in the MWS-2, the response rate was 47%. The MWS is a cross-sectional survey and was completed twice; results of My World Survey 1 (MWS-1) were published in 2012 [15], and the results of MWS-2, a follow-up to MWS-1, were published in 2019 [16].

The survey population for MWS-2 was made up of 19,407 young people and adolescents:

- 10,459 adolescents (aged 12–19 years) from 83 secondary schools
- 8,290 young adults (aged 18–25 years) in third-level education or employment, and
- a seldom-heard group consisting of:

- 314 young people in Youthreach
- 292 young people in colleges of further education/community training, and
- 52 young people with physical disabilities.

### 3.4.3.3 Planet Youth Survey

The Planet Youth Survey is a cross-sectional survey conducted by the Western Region Drug and Alcohol Task Force (WRDATF) based on principles outlined in the Planet Youth approach, an evidence-based approach to adolescent substance use prevention [17]. The Planet Youth method has been introduced in 34 countries around the world. The 2020 survey explored substance use, social circumstances, and potential risk factors associated with substance use among 15–16-year-old schoolchildren in schools in counties Galway (N=2,540) [18], Mayo (N=1,352) [19], and Roscommon (N=586) [20]. The survey also collects information on leisure-time activities, well-being, family, and school life. Data were collected from young people through a school-based lifestyle questionnaire that is updated biennially, carried out in 2018, 2020 and 2022<sup>††</sup>. All eligible schools in the three counties invited to participate took part in the 2020 survey and the response rate among schoolchildren was high (79% in Galway, 78% in Mayo, and 84% in Roscommon).

### 3.4.3.4 Other surveys

Other survey data on young people and substance use have also been used for this overview to complement those described above, and include the 2019 CSO Irish Health Survey [21]; CSO surveys on alcohol use during the COVID-19 pandemic [22,23]; the Drug Use in Higher Education in Ireland (DUHEI) survey [24]; the HRB National Alcohol Diary Survey [25]; and several others that are referenced throughout.

## 3.4.4 Information systems data

To add to the literature and the survey data, a number of information systems have been utilised to examine the consequences of, and responses to, substance use among young people and are presented in Table 2. These data include drug- and alcohol-related deaths data from the National Drug-Related Deaths Index (NDRDI); drug and alcohol treatment data from the National Drug Treatment Reporting System (NDTRS); psychiatric hospital admissions data from the National Psychiatric Inpatient Reporting System (NPIRS); and drug- and alcohol-related hospital discharge data using the Hospital In-Patient Enquiry (HIPE) scheme. Other database sources are also referenced throughout this overview in order to deepen our understanding of the consequences of substance use, including the National Self-Harm Registry Ireland (NSHRI) and An Garda Síochána PULSE system. This is not an exhaustive list of information systems; rather, the sources are included in this overview in order to inform readers of what research is currently being carried out in Ireland and potentially to identify where gaps exist in the literature.

---

<sup>††</sup> Data from the 2022 survey was not available at the time of publication.

Table 2 Information systems for responses to, and consequences of, young people's substance use

| Information system                                      | Description of information system   | Managed by                           |
|---|---|--------------------------------------|
| National Drug-Related Deaths Index (NDRDI)              | The NDRDI is an epidemiological database which records cases of death by drug and alcohol poisoning, and deaths among people who had a history of drug use and/or those who were alcohol dependent.   | HRB                                  |
| National Drug Treatment Reporting System (NDTRS)        | The NDTRS provides information on the number of cases that receive treatment for their drug and/or alcohol use in Ireland.  | HRB                                  |
| National Psychiatric Inpatient Reporting System (NPIRS) | The NPIRS provides information on admissions to inpatient psychiatric services in Ireland.  | HRB                                  |
| Hospital In-Patient Enquiry (HIPE) scheme               | HIPE is a health information system designed to collect demographic, clinical, and administrative information on discharges and deaths from acute hospitals nationally.                               | HSE/HPO                              |
| National Self-Harm Registry Ireland (NSHRI)             | The NSHRI is a national system of population monitoring for the occurrence of hospital-treated self-harm. It collects data on persons presenting to hospital EDs as a result of self-harm in Ireland. | National Suicide Research Foundation |

Table 3 Main sources of survey data for substance use among children and young people

| Source of data         | Most recent year   | Wave        | Frequency                   | Sample size                              | Data collection method  | Age group   | Main variables/areas of data collected   | Location                                      |
|------------------------|--|-------------|-----------------------------|--|---|---|--|---|
| NDAS                   | 2019–20  | 5th         | Every 4 years               | 5,762 (all ages)<br>432 (15–24)          | Interviewer-administered face-to-face survey in respondents' homes <sup>‡</sup>                         | 15–24 <sup>§§</sup>   | Alcohol use; drug use; gambling  | National sample                               |
| Healthy Ireland Survey | 2021   | 7th         | Yearly                      | 7,454 (all ages)                         | Interviewer-administered face-to-face survey in respondents' homes (2021 survey completed by telephone) | 15–24   | Smoking; alcohol; physical activity; health; sleep; caring responsibilities  | National sample                               |
| ESPAD                  | 2019   | 7th         | Every 4 years               | 1,949                                    | Self-completed school-based survey  | 15–16   | Alcohol and drug use; age of initiation; perceptions of access and risks; harms experienced; drunkenness, gambling, school experiences | National sample of schoolchildren             |
| HBSC study             | 2018   | 6th         | Every 4 years               | 15,557 (all ages)<br>5,625 (15–17 years) | Self-completed school-based survey  | 15–17   | Tobacco, alcohol, and cannabis use; home life; dieting; school; well-being   | National sample of schoolchildren             |
| Planet Youth Survey    | 2020   | 2nd         | Every 2 years               | 4,478                                    | Self-completed school-based survey  | 15–16   | Family life; physical health; school; alcohol use; drug use; social media use; self-harm   | Schoolchildren in Galway, Mayo, and Roscommon |
| GUI study              | Interviewed in 2015–16 and 2018–2019 and 2020 (COVID-19) | 3rd and 4th | Approximately every 4 years | 6,039 (Wave 3) and 5,190 (Wave 4)        | Interviewer-administered face-to-face survey in respondents' homes                                      | 17–18 years at wave 3 and 20 years at wave 4                    | Substance use, emotional development and behaviour, including leisure activities and family life, health, and education                | National sample                               |
| MWS                    | Interviewed in 2018–2019                                 | 2nd         | 2nd occasion                | 19,407                                   | Self-completed school-based survey  | Adolescent sample: 12–19 years; young adult sample: 18–25 years | Youth mental health; well-being, self-esteem and lifestyle; alcohol; drug use; depression; sexual behaviours; bullying; gambling       | National sample                               |
| DUHEI                  | 2021   | 1st         | n/a                         | 11,592                                   | Self-completed online survey  | Third-level students aged 18+. Median age: 21 years             | Student drug use, consequences of drug use, student well-being, COVID-19 and drug use, recovery from drug and alcohol addiction        | National sample of third-level students       |

<sup>‡</sup> Due to the onset of the COVID-19 pandemic, face-to-face interviews were halted, and a small number of interviews were then completed by telephone.

<sup>§§</sup> The NDAS and Healthy Ireland Survey collect data from all those aged 15 years or over, but for the purposes of this overview, only those aged 15–24 years are included (and in some instances only those aged 15–34 years as data available for this age group).

**04**

**Alcohol use  
and patterns  
of drinking  
among young  
people**



Alcohol (ethanol or ethyl alcohol) is a toxic and psychoactive substance with dependence-producing properties. It is formed when yeast ferments (breaks down without oxygen) the sugars in different foods. For example, wine is made from the sugar in grapes, beer from the sugar in malted barley (a type of grain), cider from the sugar in apples, and vodka from the sugar in potatoes, beets, or other plants. Alcohol is classed as a legal sedative drug as it depresses the central nervous system when consumed in high quantities. When alcohol is consumed, it is absorbed into the blood, where it can travel to the brain. At low levels, alcohol can act as a stimulant, inducing feelings of relaxation, euphoria, impulsivity, and talkativeness, but at higher levels, alcohol can impair coordination and judgement and lead to drowsiness, respiratory depression (where breathing becomes slow, shallow, or stops entirely), coma, or death. Alcohol also affects the regulation of body fluids, causing frequent urination and dehydration. Alcohol impairs memory, so people may struggle to remember what happened while they were drunk.

Alcohol is the most commonly used substance among young people in Europe and is most commonly the first substance used by children. Alcohol is regularly associated with celebration and has become embedded in Irish culture (and in most other countries in Europe, North America, and Australasia), consumed at the majority of social events – including religious ones, from christenings, communions, and weddings to funerals – and also routinely at home. Alcohol is so deeply entrenched in our lives that it is easy to discount the health and social damage caused or exacerbated by drinking alcohol.

The WHO has long recognised the damaging impact of alcohol and the level of alcohol-related mortality among young people; in 2016, 16% of all-cause mortality among 15–19-year-olds was attributable to alcohol, while for 20–24-year-olds, this was 23% [27]. This means that a substantial proportion of deaths among young people in 2016 occurred because of alcohol.

Despite the legal age for the purchase and sale of alcohol being 18 years in Ireland (and in most European countries), many young people begin using alcohol much earlier. This period of adolescence through to young adulthood is a key period of emotional and cognitive development [28], and with the high levels of alcohol use and binge drinking among young people, the WHO has identified alcohol use among young people as a health priority [29]. In Ireland, tackling alcohol use has also been a priority for the Government, with many of the components of the Public Health (Alcohol) Act 2018 aimed specifically at delaying and reducing young people's alcohol use [30].

## 4.1 Prevalence of alcohol use among children and young people

Alcohol was the most widely consumed substance among adolescents, with 59% of 15-year-olds having consumed alcohol in their lifetime according to international HBSC data [31]. The 2019 ESPAD, a cross-sectional survey of substance use among 99,647 students aged 15–16 years in 35 countries in Europe, reported that 79% of schoolchildren had drunk alcohol at least once by the time they were aged 16 years, and almost one-half (47%) reported drinking alcohol in the last month [32]. Schoolchildren in Ireland reported a lower rate of lifetime

alcohol use (73%) than the ESPAD average (79%) and a lower rate of last month alcohol use (41% in Ireland) than the ESPAD average (47%). However, rates of reporting being drunk in the last month were higher in Ireland (16%) than the ESPAD average (13%) [10,32].

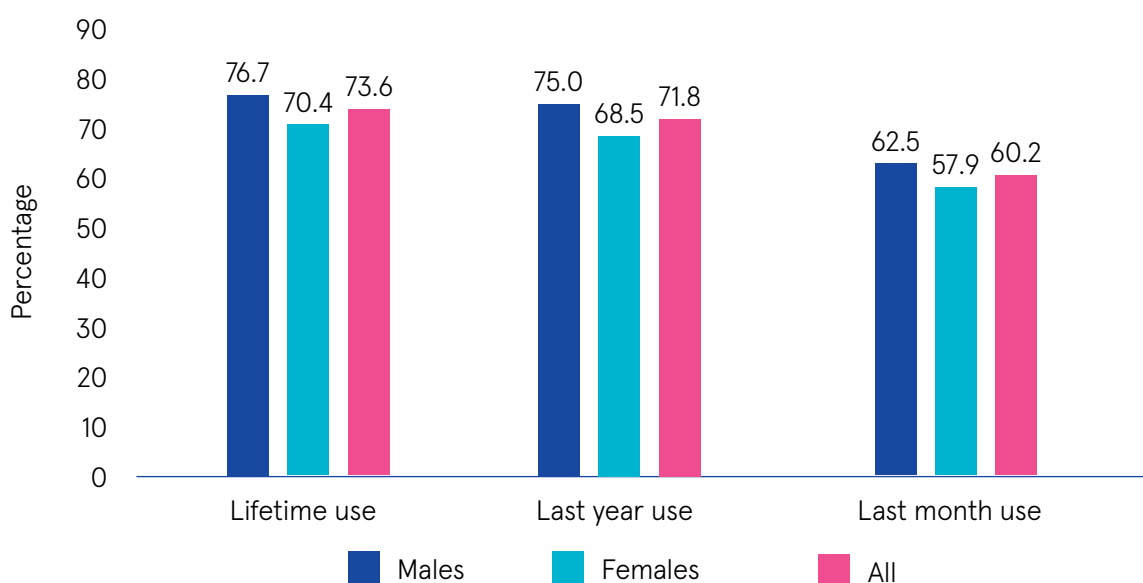
A study published in *The Lancet* analysed data from 195 countries and territories from 1990 to 2016 to investigate adolescent health and well-being [33]. The study found that Ireland had the third highest level in the world of female adolescent HED (or binge drinking) in the last year (61%) and the fourth highest level of male adolescent HED (59%). At a European level, a 2016 study using ESPAD and HBSC data, *Alcohol drinking cultures of European adolescents*, investigated the alcohol drinking cultures of European adolescents (aged 12–16 years) and found that adolescents in Ireland were ranked second among 25 European countries for the level of risky drinking (27%), while the rate of non-drinkers in Ireland (40%) was below the European average (44%) [34].

Of 28 European countries who returned prevalence data to the EMCDDA, rates of lifetime alcohol use among young people aged 15–24 years varied, ranging from 96% in Greece to 16% in Turkey. At the time of EMCDDA reporting in 2015, Ireland ranked 16th of those countries at 77% [5].

### 4.1.1 Prevalence of alcohol use among young people

Using 2019–20 NDAS data, in Ireland almost three-quarters (74%) of those aged 15–24 years reported drinking alcohol in their lifetime, 72% reported drinking alcohol in the last year, and 60% reported drinking alcohol in the last month (Figure 1). Males were more likely than females to report lifetime (77% versus 70%), last year (75% versus 69%), and last month (63% versus 58%) alcohol use [7]. These results are similar to the Irish Health Survey findings (67% of 15–24-year-olds reported that they currently drink alcohol) [21] and the 2021 Healthy Ireland Survey findings (70% of 15–24-year-olds reported that they consumed alcohol in the last six months) [8].

Figure 1 Prevalence of alcohol use among young people aged 15–24 years



Source: Mongan et al. 2021 [7]

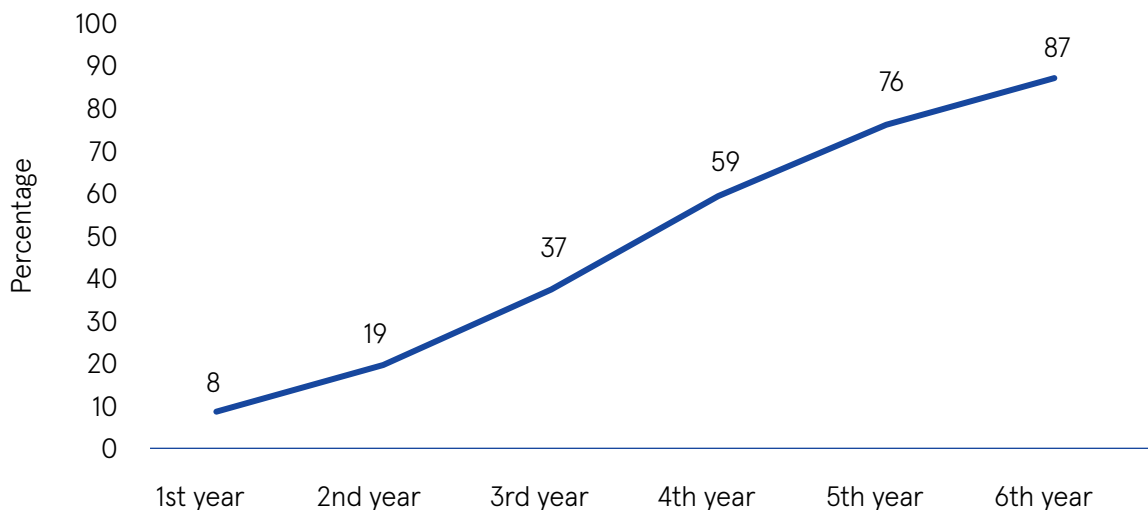
A systematic review of third-level students in both Ireland and the United Kingdom (UK) found high levels of alcohol consumption and binge drinking among third-level students, with more than 20% of participants exceeding low-risk limits every week [35].

### 4.1.2 Prevalence of alcohol use among schoolchildren

The 2018 HBSC study found that 50% of 15-year-old schoolchildren, 70% of 16-year-olds, and 82% of 17-year-olds in Ireland had consumed alcohol in their lifetime. There was little difference in lifetime drinking between males and females across all ages. Additional findings from other surveys exploring alcohol use among schoolchildren are as follows:

- The 2019 ESPAD found that 73% of schoolchildren in Ireland aged 15–16 years had consumed alcohol in their lifetime, 65% had consumed alcohol in the last year, and 41% had consumed alcohol in the last month [10]. There was little difference in alcohol consumption between males and females; 73% of males and 72% of females reported lifetime use of alcohol.
- The majority of 17–18-year-olds interviewed in 2015–2016 for the GUI study reported having consumed alcohol in their lifetime (90%) [13].
- Lower rates of alcohol consumption (43%) were noted in the 2019 MWS-2 cohort of adolescents (aged 12–19 years) [16], but this is likely due to the younger cohort of schoolchildren included in the sample age group. However, as illustrated in Figure 2, alcohol consumption increased as participants moved from first year to sixth year.

Figure 2 Percentage of adolescents aged 12–19 years who reported ever drinking alcohol, by school year



Source: Dooley et al. 2019 [36]



Differences in reports of lifetime alcohol consumption between surveys may be explained by a number of factors, including the age groups involved and the setting in which the questionnaire was completed. For example, a number of surveys are completed in an interview, face-to-face setting where parents may be present, whereas for others, the survey is completed anonymously in a school setting. This may have influenced responses.

## 4.2 Age of first use of alcohol

---

The NDAS found that the mean age of first alcohol use among those aged 15–24 years increased from 15.6 years in 2002–03 to 16.6 years in 2019–20 [7].

Among 17–18-year-olds interviewed in 2015–2016 for the GUI study, of the 90% who had consumed alcohol, 8% reported that they first consumed alcohol at age 13 years or under; 11% at age 14 years; 20% at age 15 years; 29% at age 16 years; 19% at age 17–18 years; and the remainder were unsure or refused to answer that question [13]. When interviewed at 20 years of age, GUI respondents stated that the average age they had started drinking alcohol was 16 years [37]. Parental knowledge of when they thought their child had first consumed alcohol closely matched responses given by GUI schoolchildren [13]. Chapter 6 considers the implications associated with early alcohol initiation.



Age of first alcohol use  
**increased**  
from 15.6 years in 2002–03 to  
**16.6 years in 2019–20**

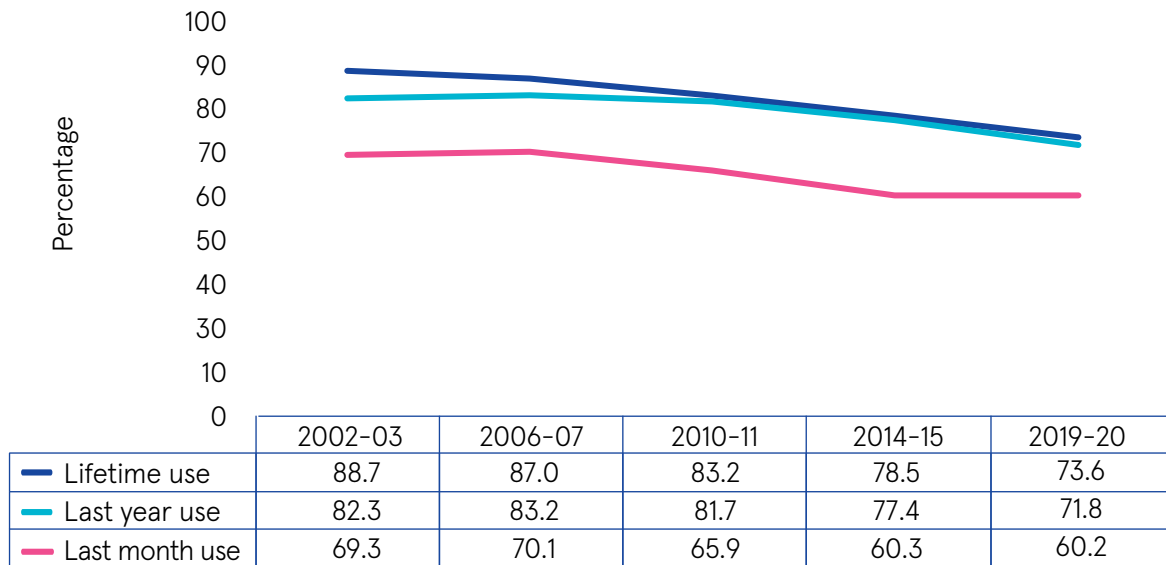
---

## 4.3 Trends in alcohol use

---

The NDAS saw a decline in the proportion of young people (aged 15–24 years) reporting lifetime, last year, and last month alcohol use from the first survey in 2002–03 to the most recent survey in 2019–20 (Figure 3) [7,38–41].

Figure 3 Trends in alcohol consumption among young people aged 15–24 years

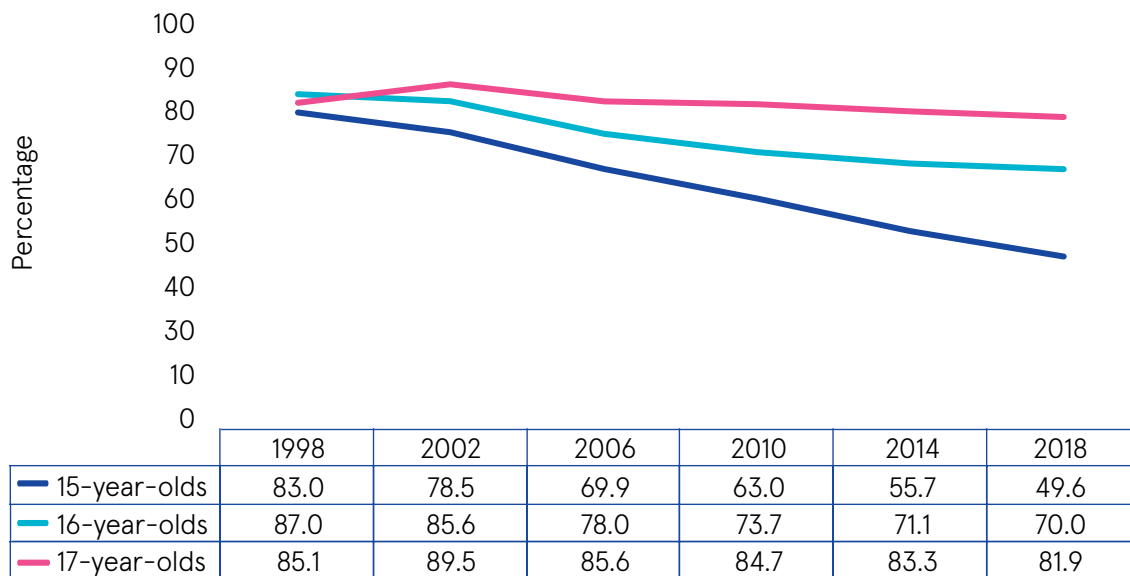


Source: Mongan et al. 2021 [7]

The ESPAD reported a notable reduction in the proportion of schoolchildren who reported drinking in the last year, from 79% in 2007 to 63% in 2015. Last month drinking also dropped from 56% in 2007 to 36% in 2015. However, for both last year and last month drinking, this downward trajectory has stalled, and an increase was evident between 2015 and 2019, with last year drinking increasing from 63% to 65% and last month drinking increasing from 36% to 41% in the same period [10,42,43].

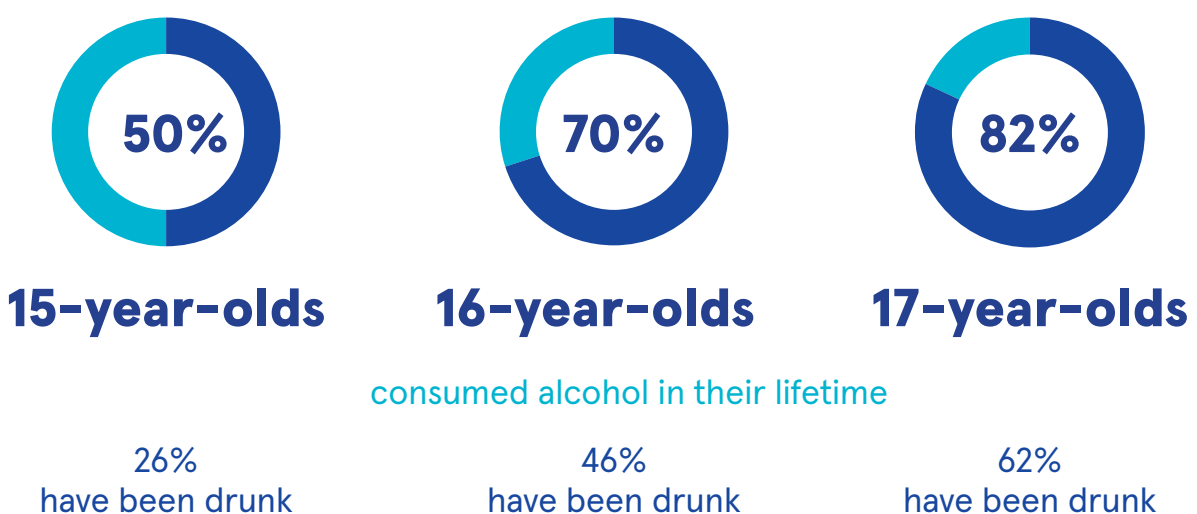
Figure 4 shows the decline in the number of 15-year-old schoolchildren participating in the HBSC survey who have ever consumed alcohol, from 83% in 1998 to 50% in 2018. Similarly, among 16-year-olds in 1998, 87% had consumed alcohol in their lifetime, whereas the comparable figure in 2018 was 70%. However, alcohol use among 17-year-olds remained relatively consistent in each of the six waves of the HBSC study conducted between 1998 (85%) and 2018 (82%) [11].

Figure 4 Trends in percentage of schoolchildren aged 15–17 years who have ever had an alcoholic drink, 1998–2018



Source: HBSC data cited in O’Dwyer et al. 2021 [9]

A decline in alcohol use among young people has been noted internationally since the early 2000’s with various possible explanations proposed [44–46]. An increased focus on personal health, home, school and family life and a decrease in peer pressure to drink has been suggested as potential reasons for this reduction [47,48].



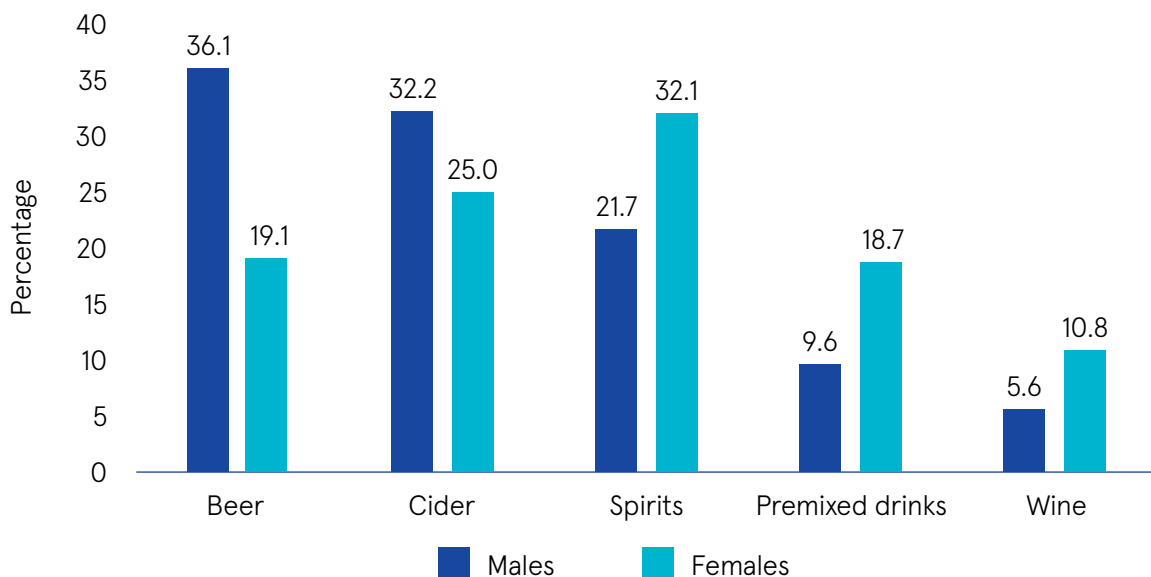
## 4.4 Patterns of drinking among young people

The prevalence of alcohol use among young people is an important measure to inform us about when children start to drink, but it is equally important to know how much young people are drinking, whether they are engaging in hazardous or harmful drinking, where they source and then consume their alcohol, what their motivations are for consuming alcohol, and their attitudes towards alcohol and its use. This evidence allows researchers and policy-makers to better understand the impact of alcohol use and tailor policies accordingly.

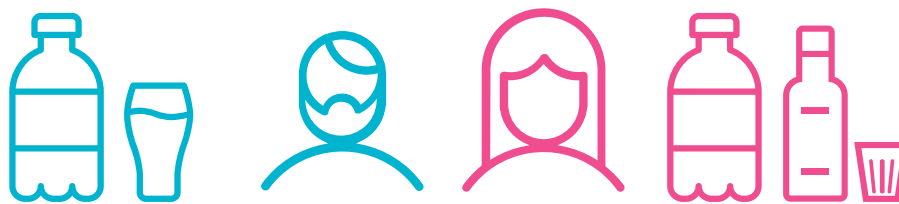
### 4.4.1 Type of alcohol consumed

Sex differences in types of drinks consumed are presented in Figure 5; beer was the most commonly consumed alcoholic drink in the last month (36%) among boys participating in the 2019 ESPAD, followed by cider (32%). Females were more likely to consume spirits (32%) and cider (25%) [10]. It is unclear why there are sex differences in drink preferences, but international research suggests that alcohol marketing potentially influences this, with certain drinks being promoted as 'feminine' [49,50]. Further research is required in order to investigate the role of marketing in drink choice.

Figure 5 Type of alcohol consumed in last month by adolescents aged 15–16 years, by sex



Source: Sunday et al. 2020 [10]



Adolescent boys aged **15–16 years** were more likely to drink beer and cider and girls, spirits and cider

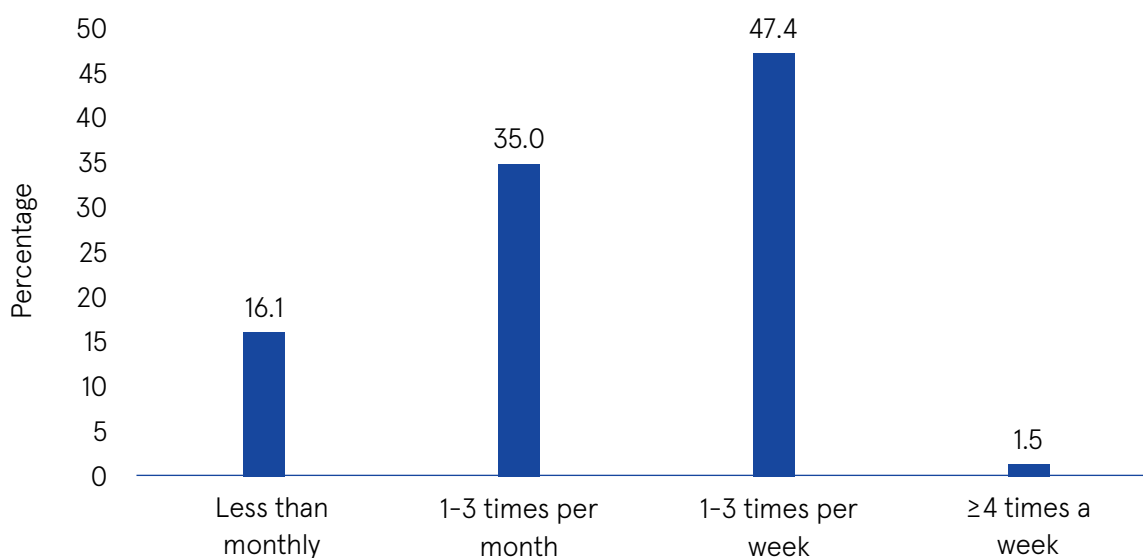
#### 4.4.2 Frequency of drinking and number of drinks consumed

Of 20-year-olds participating in the GUI study, 22% reported drinking alcohol once a month, 49% said they drank 2–4 times per month, 22% said 2–3 times per week, 3% said 4 times or more per week and 3% did not drink alcohol. Males (29%) were more likely to report drinking more frequently (twice a week or more) than females (21%) [37].

The 2019–20 NDAS reported that almost one-half (49%) of 15–24-year-old drinkers drank alcohol at least once per week and that the mean number of standard drinks consumed in one sitting was 6.1 drinks (Figure 6). On a typical drinking occasion, 12% reported drinking 1–2 drinks, 42% reported drinking 3–5 drinks, 28% reported drinking 6–9 drinks, and 18% reported drinking 10 or more drinks [7].

Almost one-half (46%) of 15–24-year-olds reported consuming at least six standard drinks per typical drinking occasion in the last year and this age group most commonly reported drinking between one to three times per week (47%).

Figure 6 Frequency of drinking among young drinkers aged 15–24 years



Source: Mongan et al. 2021 [7]



The mean number of standard drinks consumed among young drinkers in one sitting was

**6.1 drinks**

#### 4.4.3 Highest number of standard drinks consumed on a single occasion

Table 4 presents the highest number of standard drinks consumed on a single occasion in the last year among 15–24-year-old drinkers. More than one-third (36%) reported drinking between 10 and 19 standard drinks, and 14% reported drinking 20 or more standard drinks in one sitting. Males were more likely than females to report consuming 20 or more standard drinks on a single occasion in the last year (20% versus 8%) [7].

Table 4 Highest number of standard drinks consumed on a single occasion in the last year among 15–24-year-old drinkers

| Number of standard drinks consumed | Males (%) | Females (%) | All (%) |
|------------------------------------|-----------|-------------|---------|
| 1–5 drinks                         | 12.5      | 28.5        | 20.1    |
| 6–9 drinks                         | 23.8      | 37.1        | 30.1    |
| 10–19 drinks                       | 43.9      | 26.2        | 35.6    |
| ≥20 drinks                         | 19.8      | 8.3         | 14.4    |

Source: Mongan et al. 2021 [7]

Of Healthy Ireland Survey respondents aged 15–24 years in 2016 who reported drinking, almost one-third (32%) of males and one-quarter (25%) of females consumed their weekly HSE low-risk alcohol limit\* or more on a single occasion [9].

\* HSE weekly low-risk alcohol guidelines are fewer than 11 standard drinks for women or fewer than 17 standard drinks for men per week.



#### 4.4.4 Hazardous and harmful drinking

Where an individual drinks alcohol in a pattern that places them at risk of adverse health events, it is considered hazardous drinking. Where patterns of drinking and quantities of alcohol consumed result in adverse events such as physical or psychological harm, it is considered harmful drinking. Hazardous or harmful drinking is commonly measured using the WHO Alcohol Use Disorders Identification Test (AUDIT) [51], a screening tool that assesses alcohol consumption, drinking behaviours (including incidences of heavy episodic drinking [HED]), and alcohol-related problems with scored responses. A higher score indicates risky or hazardous consumption and/or alcohol use disorder (AUD). HED (also referred to as binge drinking) is defined as drinking six or more standard drinks in one sitting. Engaging in monthly HED is considered a hazardous pattern of drinking [52].

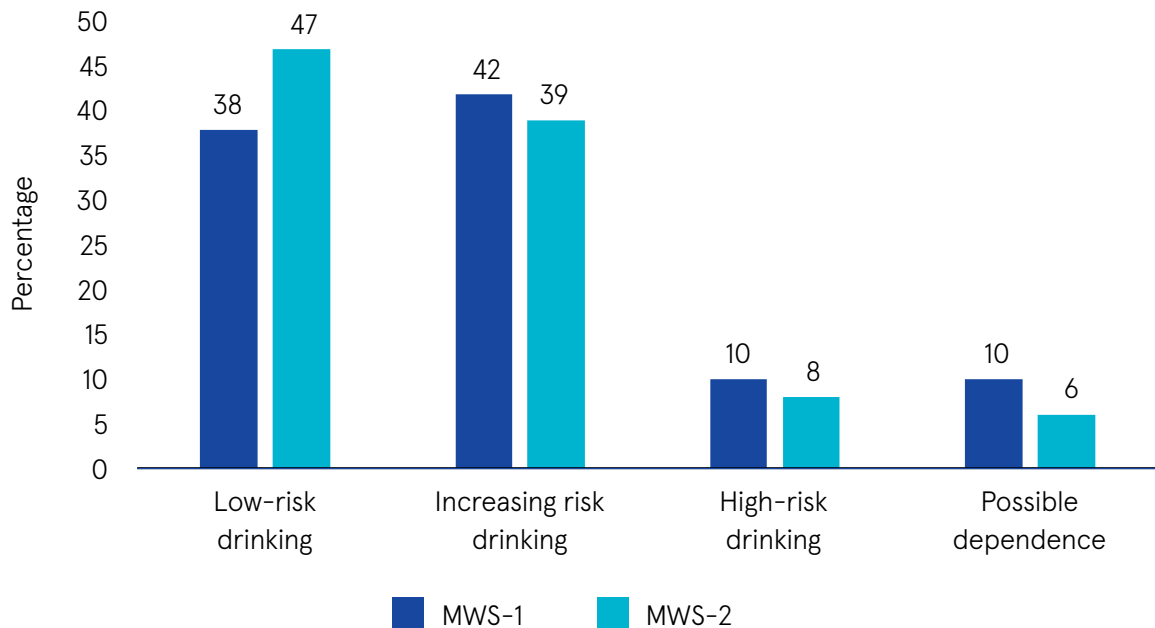
##### 4.4.4.1 Hazardous and harmful drinking among young people

The 2019–20 NDAS and the MWS-2 measured AUD using the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* [53]. AUD severity levels can be classified as mild (a score of 2–3), moderate (a score of 4–5), or severe ( $\geq 6$  score).

Almost two-thirds (64%) of all drinkers aged 15–24 years in the 2019–20 NDAS were classified as hazardous drinkers [7]. This was more common among young males (70%) than young females (57%). The 2016 Healthy Ireland Survey showed similar rates of hazardous drinking (72% of males and 56% of females) [9,54].

The MWS noted an increase in the percentage of young adult drinkers in the low-risk drinking category, from 38% in the 2012 MWS-1 to 47% in the 2019 MWS-2 (Figure 7) [36].

Figure 7 Hazardous and harmful drinking among young adults, aged 18–25 years



Source: Dooley & Fitzgerald, 2012, Dooley et al. 2019 [15,36]

The 2019–20 NDAS reported that among young drinkers, 38% were classified as having an AUD [7]. Using the AUDIT screening tool, 43% of 20-year-old GUI drinker respondents, were considered low-risk drinkers, 46% considered risky or hazardous drinkers, 7% as high-risk or harmful drinkers and 4% were very high-risk drinkers with possible alcohol dependence. Males (12%) were more likely to be in the high-risk and very high risk categories compared to females (9%) [37]. AUD is discussed in greater detail in Chapter 7.



The prevalence of **alcohol use disorder among 15–24-year-olds was 27%** - increasing to 38% when limited only to those who drink



#### 4.4.4.2 Hazardous and harmful drinking among adolescents

Among adolescents aged 12–19 years surveyed for the MWS-2 who had consumed alcohol, 65% were considered low-risk drinkers, 28% were classified as hazardous, or increasing risk drinkers, 4% were classified as harmful drinkers (high risk), and 3% were potentially alcohol dependent. More males than females reported the risky drinking categories. Most first-years who drank alcohol fell into the low-risk drinking category (88%), but this figure decreased with each school year, and by the time they get to sixth year, this had dropped to 51% [16]. A reduction in hazardous drinking was evident between waves among young adults, however, the same was not noted among adolescents who were more likely to be in the problem drinking and hazardous drinking categories for alcohol behaviour in MWS-2 than adolescents who participated in the MWS-1.

#### 4.4.4.3 Heavy episodic drinking

The proportion of young drinkers aged 15–24 years who reported monthly binge drinking or HED (six standard drinks or more on a single occasion) decreased from 74% in the 2002–03 NDAS to 56% in the 2019–20 NDAS. In the 2019–20 NDAS, almost two-thirds (63%) of young male drinkers and 49% of young female drinkers engaged in monthly HED. One-third (33%) of drinkers aged 15–24 years reported weekly HED and 23% reported HED one to three times per month [7]. Other surveys reported the incidence and frequency of HED among respondents; the findings are as follows:

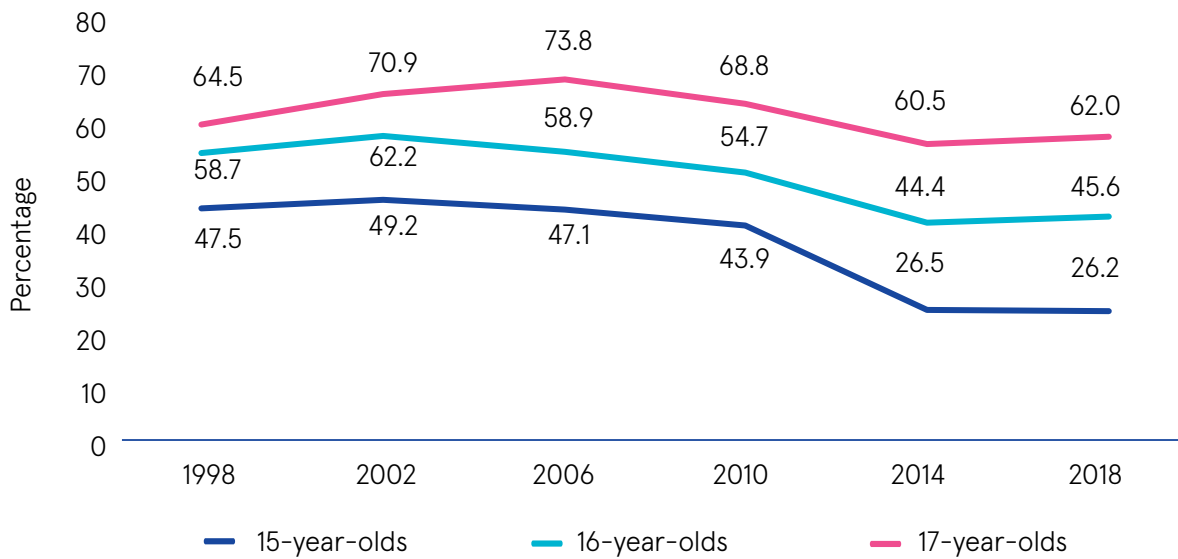
- Almost one-half (48%) of Irish Health Survey respondents aged 15–24 years reported HED at least once per month, and 28% reported HED less than once per month but at least once per year [21].
- Among 15–24-year-old Healthy Ireland Survey respondents in 2016, 67% of males and 39% of females reported HED on a typical drinking occasion [9,54].

Since 1995, Irish ESPAD data have shown a decrease in HED among adolescents, with the share of 15–16-year-olds engaging in HED in the last month falling from 47% in 1995 to 28% in 2015. However, an increase has been noted between the surveys in 2015 and 2019; reports of HED in the last month increased to 33% in 2019 [10].

#### 4.4.4.4 Proportion of schoolchildren reporting drunkenness

An overall decline in lifetime drunkenness among schoolchildren was evident in HBSC data from Ireland between 1998 to 2018 (Figure 8), particularly between 2010 and 2014. However, between 2014 and 2018, the percentages of 16- and 17-year-olds reporting drunkenness have increased [11]. Rates of lifetime drunkenness in 2018 were similar for males and females, with females reporting slightly higher rates of drunkenness, which is a concern given the findings from a systematic review that the neurotoxic effects of alcohol on the developing adolescent brain are more pronounced in females than in males [55].

Figure 8 Trends in lifetime drunkenness among adolescents aged 15–17 years



Source: HBSC data cited in O’Dwyer et al, 2021 [9]

Other surveys reporting drunkenness among schoolchildren have indicated the following:

- More than two-fifths (42%) of 15–16-year-old schoolchildren in the 2020 Planet Youth Survey reported being drunk once or more in the last year; 20% reported being drunk in the last month, reducing from 27% in 2018 [18,56].
- Of adolescents aged 15–16 years participating in the 2019 ESPAD, 36% reported being drunk in their lifetime; more females (37%) than males (35%) reported this [10]. Reports of being drunk in the last month was reported by 16% of adolescents aged 15–16 years; more commonly reported among young females (17%) than males (15%) and higher when compared to the average among participating ESPAD countries in Europe (13%).



Adolescents aged 15–16 years in Ireland had the **7th highest rate of drunkenness** among 35 European countries

### 4.4.5 Perception of own alcohol use

When drinkers who participated in the 2014–15 NDAS were asked to describe their own drinking, 23% of the risky drinkers and alcohol-dependent drinkers aged 15–24 years were aware that they were drinking in a hazardous manner. Just over one-fifth described themselves as being either a light or a moderate drinker (21%), indicating a lack of awareness among a substantial proportion of younger drinkers that they are drinking in a hazardous manner [57].

## 4.5 Drinking context

Limiting alcohol availability is a key strategic response to alcohol consumption by the WHO and the Irish government, particularly among young people [27]. Knowing where young people source and consume alcohol can help to concentrate efforts to reduce availability and increase the effectiveness of this response in reducing young people's drinking.

### 4.5.1 Alcohol procurement

Schoolchildren participating in the 2018 Irish HBSC study were asked where they sourced their alcohol the last time they drank. Parents or guardians were commonly reported as the source of alcohol for adolescents aged 16 and 17 years, and were second only to getting alcohol from friends for 15-year-olds (Table 5).

Of Planet Youth Survey respondents in 2020 aged 15–16 years, 18% said that their parents often gave them alcohol, and 10% reported getting alcohol from a friend's parent [18–20]. Children from middle socio economic groups were more likely to be given alcohol from a parent or guardian or to have bought alcohol in a supermarket or convenience store than those in the lower socioeconomic group [11]

Despite the legal age for purchasing alcohol being 18 years in Ireland, 17-year-old HBSC respondents were most likely to get alcohol in a pub/bar or disco (38%) [11]. A 2011 study by the United Nations Children's Fund (UNICEF) Ireland, *Changing the future: experiencing adolescence in contemporary Ireland: alcohol and drugs*, noted that 31% of schoolchildren reported buying alcohol using fake identification, females were more likely to do this than males [58].

Although fewer HBSC schoolchildren purchased alcohol themselves the last time they drank, it is important to consider how underage children can make such transactions. If fake identification remains a common method, the retail sector, parents, schools, health professionals, as well as An Garda Síochána, should be made aware of such practices as well as providing advice on how to best to work with those involved.

Table 5 Percentage of 15–17-year-olds reporting where they got alcohol on the last occasion they drank

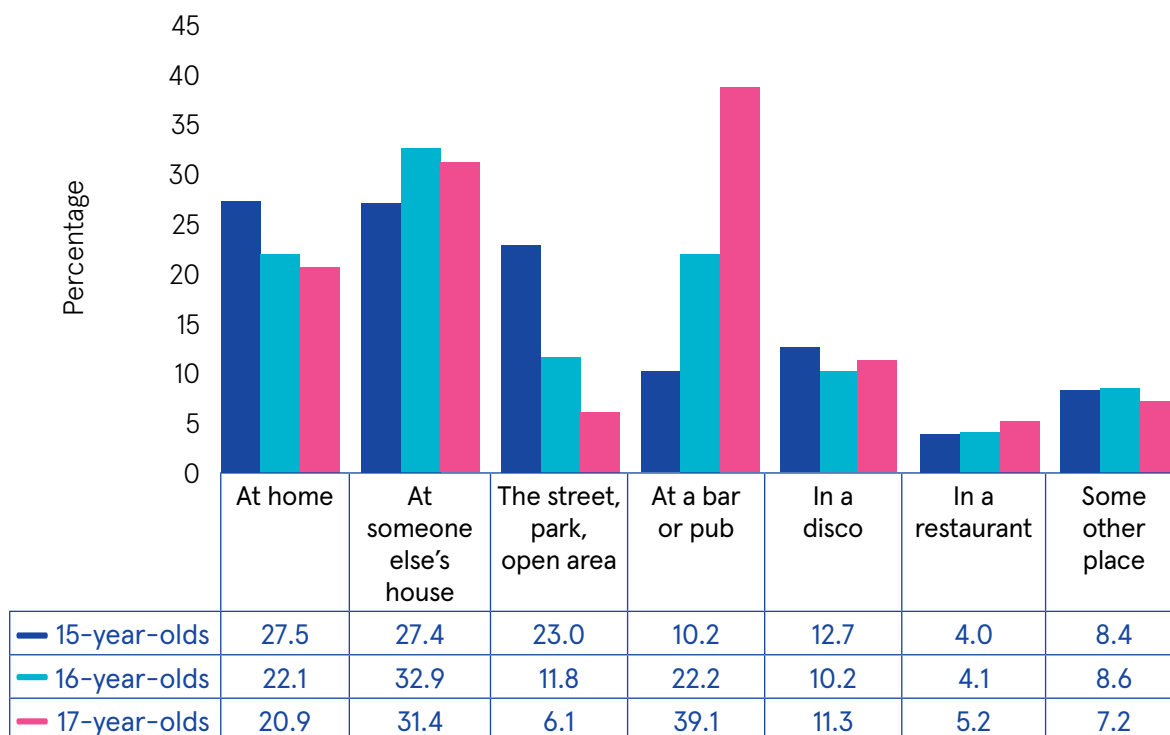
|                                     | 15-year-olds (%) | 16-year-olds (%) | 17-year-olds (%) |
|-------------------------------------|------------------|------------------|------------------|
| Parent/guardian                     | 29.6             | 35.3             | 39.1             |
| Took it from home                   | 11.0             | 9.3              | 7.9              |
| Supermarket/shop                    | 3.8              | 7.6              | 12.3             |
| Garage shop                         | 0.7              | 1.5              | 1.3              |
| Pub/bar/disco                       | 7.9              | 19.4             | 38.1             |
| Bought at off-licence               | 3.3              | 6.0              | 7.2              |
| Ordered online and had it delivered | 0.3              | 0.6              | 0.7              |
| Friend gave to me                   | 35.0             | 29.4             | 24.5             |
| From sibling(s)                     | 9.0              | 10.2             | 6.9              |
| I gave someone money to buy it      | 26.2             | 24.6             | 17.7             |
| Some other way                      | 9.3              | 5.2              | 2.5              |

Source: Költő, 2020 [11]

#### 4.5.2 Location of alcohol use

Fifteen-year-old schoolchildren in the 2018 HBSC study reported that their most recent drinking location was in their own home (28%) or in someone else's house (27%). Those aged 16 years reported similar locations; 33% reported drinking in someone else's home and 22% in their own home and of note, 22% of 16-year-olds also reported drinking in a bar or pub. The most common response for 17-year-olds was to drink in a bar or pub (39%) despite this being illegal (Figure 9) [11]. Respondents in the Planet Youth Survey aged 15–16 years in 2020 also confirmed that they were likely to drink in someone else's house (29%), as well as in outdoor locations such as parks (32%) [18–20].

Figure 9 Location of most recent alcohol use among adolescents, by age



Source: Költő, 2020 [11]

## 4.6 Alcohol use among vulnerable populations

A good deal is known about alcohol use among the general population of Ireland from our national surveys and schoolchildren surveys. However, a number of other populations remain elusive and may be considered more vulnerable due to their potential for marginalisation and social exclusion and for their increased susceptibility to alcohol and/or drug use and related problems. Young people who are homeless, who are involved in criminal behaviour, who leave school early, who live in socially disadvantaged areas, and who are immigrants or refugees and from ethnic minorities are just some population groups that may be at additional risk of substance use. This additional vulnerability may be a result of their disadvantaged locality accepting alcohol and drug use as a norm; it may be due to family dysfunction or substance use by parents; it may be due to personal characteristics such as low self-esteem, anxiety, or aggression, a lack of social and life skills; non-attendance at school, or exclusion from school; concerns relating to their sexuality; or in the case of immigrants, the vulnerability of moving to a new country [59,60].

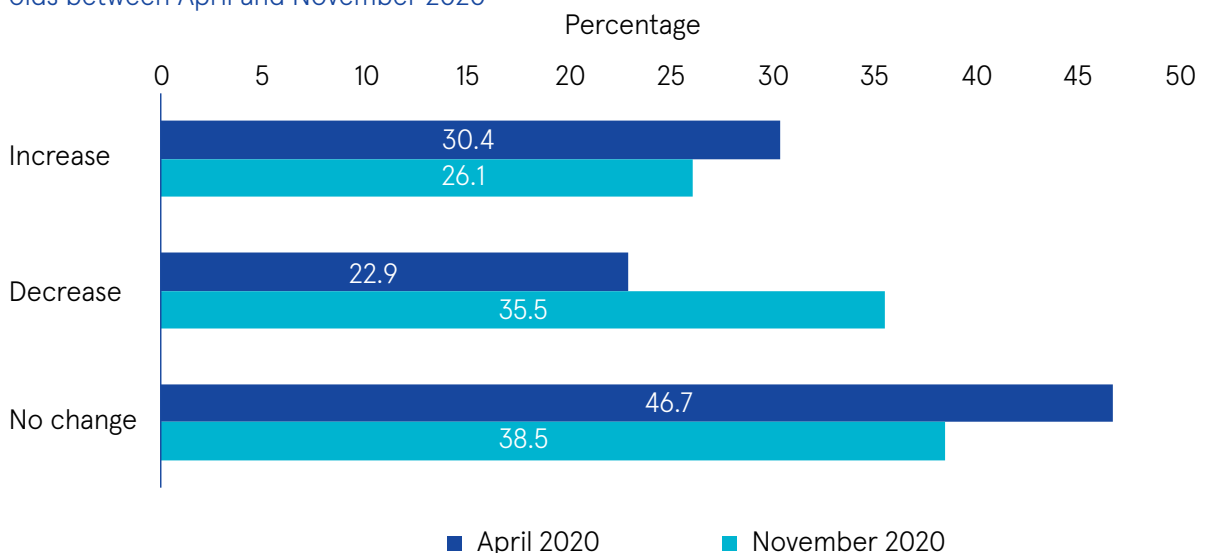
The LGBTI population may also be considered vulnerable, as members of this group can often face challenges relating directly or indirectly to their sexual orientation which can result in being at increased risk of drug and alcohol use. The majority (92%) of LGBTI participants (n=2,264; mean age=29.6 years) in a mental health and well-being survey reported alcohol use in their lifetime [61]. The 2016 study was a collaborative partnership between GLEN (Gay and Lesbian Equality Network), BeLong To, the National Office for Suicide Prevention and Trinity College Dublin. Almost one-half (47%) of the sample were aged 14–25 years, and using

the AUDIT screening tool, 48% of this young LGBTI sample showed some level of alcohol problems, with 12% showing high to very high levels of alcohol problems. Those aged 19–25 years had the highest AUDIT scores when compared with all other ages in the sample [61].

## 4.7 The COVID-19 pandemic and alcohol use

The COVID-19 pandemic declared in March 2020 had a profound effect on the lives of children and young people in Ireland and around the world. A series of unexpected national and regional lockdowns meant that children and adolescents across Ireland were faced with school closures, the cancellation of planned activities and events, and the inability to see their friends in person along with a background fear of contracting COVID-19, all of which tested their coping skills in this unprecedented time. In 2020, a survey carried out on behalf of the Department of Children and Youth Affairs, along with the Department of Health and the youth sector, collaborating with Spunout.ie, examined the COVID-19 pandemic experiences of 2,173 young people aged 15–24 years. The survey found that young people reported consuming too much alcohol as one of the physical health effects of the lockdowns as a result of the pandemic [62]. A further survey carried out by the CSO in April 2020 found that the majority of those aged 18–34 years<sup>†</sup> reported no change to their alcohol use since the introduction of COVID-19 restrictions (47%), however, 30% reported that their alcohol use had increased [22] when the survey was repeated in November 2020, 26% reported increased alcohol use and 36% reported decreased alcohol use (Figure 10) [23].

Figure 10 Comparison of alcohol use as a result of the COVID-19 pandemic among 18–34-year-olds between April and November 2020



Source: Central Statistics Office, 2020 [22,23]

\* Note that this study refers to an older age cohort (18–34 years). Results cannot be compared to other studies using a younger age cohort.

A GUI report, *Growing Up in Ireland. Key findings: special COVID-19 survey*, found that among 22-year-olds, 60% reported drinking less than they did before the COVID-19 pandemic, 17% reported drinking more, and 23% reported drinking the same amount [63]. A survey investigating alcohol consumption during pandemic lockdowns found that the younger age group (18–23 years) were more likely than the older age groups (24 years and older) to reduce their alcohol use during the COVID-19 pandemic lockdowns [64]. Among Planet Youth Survey respondents surveyed in 2020, 22% of schoolchildren in Galway, 22% in Mayo and 23% in Roscommon reported increasing their alcohol use since pandemic lockdown restrictions were implemented and 20% of respondents in the three counties reported drinking less [18–20].

It will take time for the long-term impacts of the COVID-19 pandemic on young people’s mental health to be revealed, along with whether any increases in alcohol use as a result of the COVID-19 pandemic that started as a short-term coping mechanism develop into a potential lifelong habit.

## 4.8 Alcohol-related knowledge and attitudes

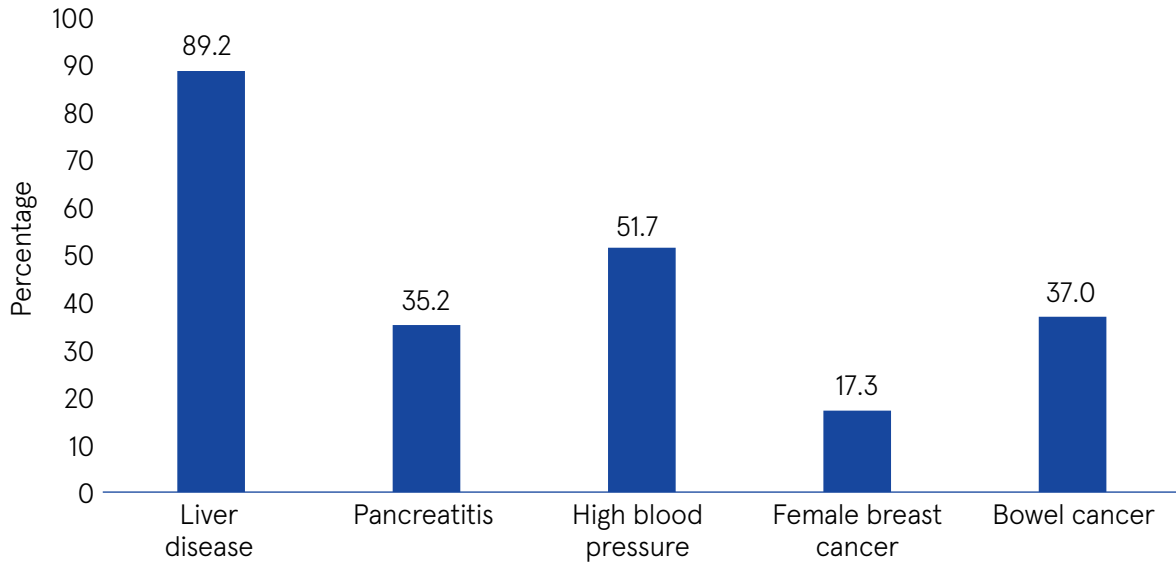
Understanding the attitudes and the level of knowledge among young people in relation to alcohol can be used to guide policy.

### 4.8.1 Alcohol-related knowledge

A survey was undertaken by Ipsos MORI on behalf of the HRB in 2012 to measure public knowledge, attitudes, and behaviours related to alcohol (N=1,020) [65]. Among the survey respondents, 60% of those aged 18–24 years reported being aware of the term ‘standard drink’; however, when asked to identify the number of standard drinks in a particular drink size (for example, a pint or a pub measure), only 7% answered all correctly. Just 6% of 18–24-year-olds were aware of the HSE weekly low-risk drinking guidelines for men and women [65].

The awareness of the risk of developing alcohol-related health conditions as a result of alcohol use was low despite the evidence indicating a causal relationship [66,67]. Using the 2016 Healthy Ireland survey data, respondents were asked if there was an association between alcohol use (drinking more than the recommended number of standard alcoholic drinks in a week) and five alcohol-related health conditions: liver disease, pancreatitis, high blood pressure, breast cancer and bowel cancer [9,54]. The majority of the youngest respondents (18–34 years) were aware that alcohol use increases the risk of developing liver disease (89%), however, awareness was poor for the remaining health conditions. Just 17% of younger respondents were aware of the link between alcohol and female breast cancer (Figure 11). Research has shown that breast tissue is particularly susceptible to carcinogens during early adolescence through to early adulthood and it is therefore critical that young people, especially young females, are informed of the risks associated with alcohol use [68,69].

Figure 11: Proportion of young people aged 18–24 who believe health conditions are related to consuming more than the recommended number of standard alcoholic drinks in a week



Source: O'Dwyer et al, 2021 [9]

A study analysing alcohol marketing on Twitter found that none of the Tweets gave information about the risks associated with alcohol use or provided links to independent health websites [70].

Children and young people are regularly exposed to alcohol marketing, but effective health warning messages rarely accompany the marketing as was confirmed by a UK study which found that the majority of a sample of children and adolescents (11–19 years) did not recall seeing any product-related information, health messages or warnings on alcohol packaging [71]. Given that this finding would likely be the same if duplicated among adolescents in Ireland and given the lack of awareness of alcohol-related health conditions, the implementation of health warning labels on alcohol products as per section 12 of the Public Health (Alcohol) Act 2018 is critical.

#### 4.8.2 Alcohol-related attitudes

Attitudes towards alcohol held by young people are also important to consider in order to understand their perspective. The 2012 Ipsos MORI survey found that the majority of young people aged 18–24 years (n=126) agreed that there are high rates of drunkenness on Irish streets at night (83%) and that the current level of alcohol use in Ireland is too high (79%). When asked if alcohol advertising should be prohibited, the responses were not as definite; 29% agreed, 46% disagreed and 25% did not know. More than two-thirds (67%) of young people believe that high levels of alcohol use in Ireland are tolerated, and when asked about drinking and driving, 74% agreed that it is not safe to drive after one alcoholic drink and 90% after two alcoholic drinks. Table 6 presents a breakdown of further attitudes expressed by those aged 18–24 years [65].



Table 6 Attitudes of 18–24-year-olds in relation to alcohol

|  | Agree (%) | Disagree (%) | Don't know/<br>neither agree<br>nor disagree<br>(%) |
|--|-----------|--------------|---|
| It is safe to drink alcohol in moderation during pregnancy.  | 6         | 73           | 21  |
| It is safe to drink one glass of wine per day during the last 12 weeks of pregnancy.                         | 4         | 78           | 18  |
| 'Distance sales' (drinks delivery services) are an easy way for people under the legal age to drink alcohol. | 64        | 13           | 23  |
| 'Distance sales' are strictly monitored.   | 21        | 34           | 45  |
| Alcohol advertising should not be allowed.   | 29        | 46           | 25  |
| Alcohol advertising should be limited to the product itself.   | 69        | 19           | 12  |
| The Government has a responsibility to implement public health measures to address high alcohol consumption. | 63        | 8            | 29  |
| The Government is doing enough to reduce alcohol consumption.  | 46        | 18           | 36  |

Source: Ipsos MORI, 2012 [65]

Schoolchildren participating in the 2019 ESPAD in Ireland were asked how much they thought drinkers were at risk of harming themselves physically or in other ways if they consumed varying levels and frequencies of alcohol. The majority recognised that there was great risk in consuming 4–5 drinks nearly every day (71%) compared to 4.9% who did not perceive this level and frequency of drinking to be a great risk. More schoolchildren perceived drinking five drinks or more every weekend as risky (45%), compared to 7% who believed there was no risk to this pattern of drinking. When asked if they perceived drinking one or two drinks nearly every day had great risk, 27% of schoolchildren reported that this placed the drinker at great risk, 43% said moderate risk and 20% said slight risk with 7.9% reporting no perceived risk in this frequency of drinking [10].

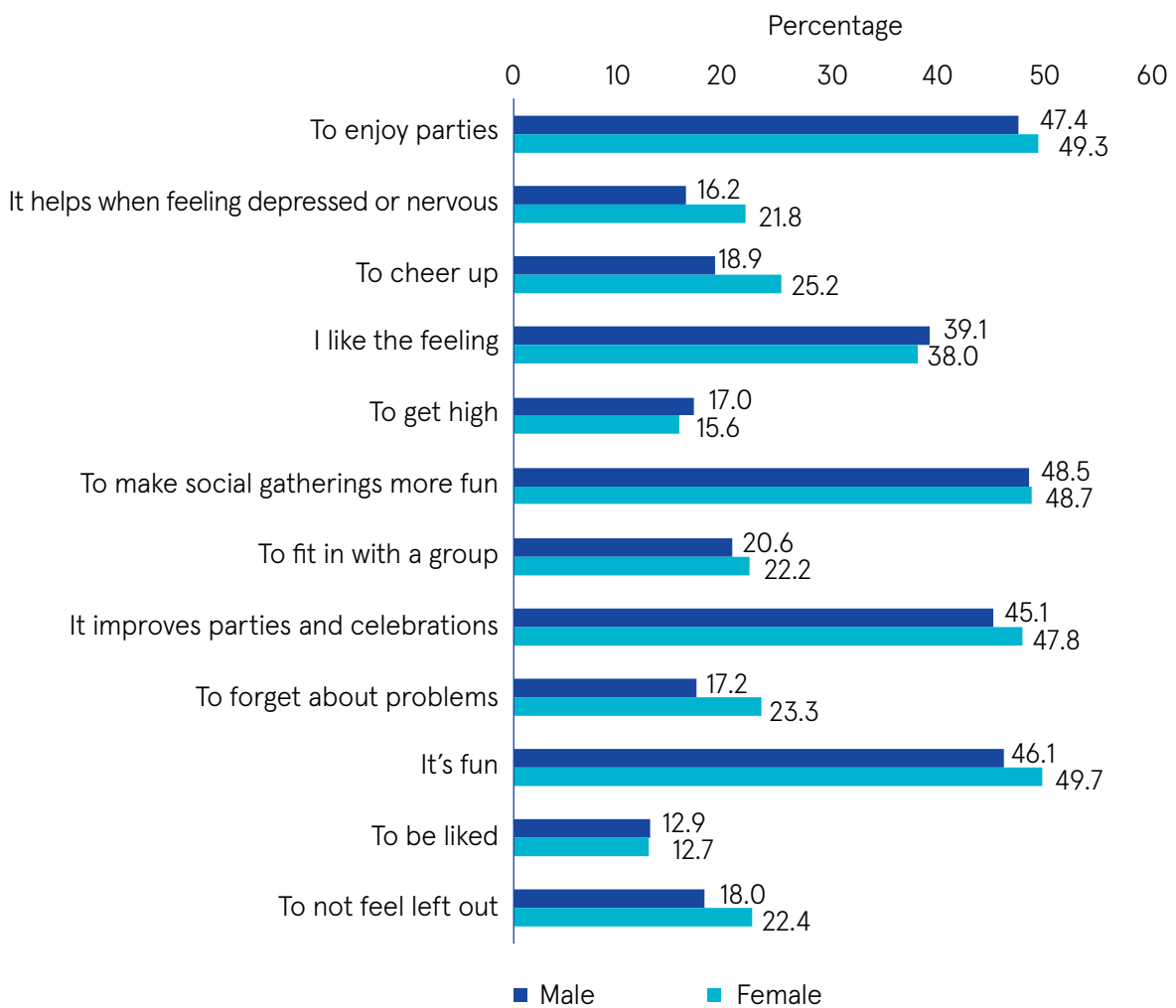
A 2010 study, *Drug and alcohol-related knowledge, attitudes and behaviour: a study of early school leavers in the West of Ireland* that investigated the attitudes towards alcohol use among a sample of early school leavers (aged 15–20 years) found that the majority were aware of the impact of heavy drinking on decision-making and the likelihood that it could lead to violence and sexual risk-taking. Sex differences were reported for perceived alcohol-related harms, with females considered vulnerable and at greater risk by walking home alone, leaving friends behind, or doing things that they had not intended to or would regret, such as having unprotected sex or taking drugs. For males, the primary alcohol-related harms were identified as violence and aggression [72].

### 4.8.3 Drinking motivation

Understanding young people’s motivations to drink can inform policies relating to alcohol use among young people. A number of Irish studies have identified several motivations for drinking alcohol among young people, with it being fun or due to boredom often cited as the most common reason given for drinking alcohol [10,43,72–76]. Among 2019 ESPAD respondents in Ireland, both males and females most frequently cited social reasons for drinking alcohol, including helping them enjoy parties (47% of males and 49% of females) and making social gatherings more fun (49% for both males and females) (Figure 12). Of concern is the number of adolescents reporting that they drink alcohol to cheer up (19% of males and 25% of females) and to forget about their problems (17% of males and 23% of females) [10].

It is important that young people are reminded that alcohol is a depressant, influencing our thoughts, feelings and actions which can also have lasting impact on mental health.

Figure 12 Motivations for drinking alcohol among 15–16-year-olds, by sex



Source: Sunday et al. 2020 [10]

Among a sample of third-level students (mean age=21 years), 73% reported that they drank alcohol as they enjoy it, or to be sociable (68%). Male students were more likely to report consuming alcohol for conformity reasons (5.4% of males compared to 2.2% of females), or because they were lonely (5.0% of males compared to 2.3% of females). The students also reported drinking alcohol to forget worries (11.8% of males and 12.4% of females) and 4.7% of third-level students reported drinking when feeling anxious or depressed [77].

A study investigating alcohol-related behaviours among early school leavers found that almost one-half reported drinking alcohol to help them forget their troubles (47%) [72].

Regional surveys also looked at motivations for alcohol use and found that a lack of amenities in the community (such as sporting activities, cinemas, and outdoor excursions) represented barriers to attaining healthier lifestyles and consequently led to increased alcohol use. These studies highlight how communities around Ireland could benefit from the development of initiatives to encourage children and adolescents to adopt a healthier lifestyle [74,75].

## 4.9 Summary: alcohol use and patterns among young people

Traditionally, alcohol is seen as an important part of Irish social and cultural life and as a rite of passage for children moving into adolescence. Children witness alcohol use from an early age and observe adults drinking alcohol on special occasions, but also routinely at home. Children are commonly exposed to alcohol marketing, and this is a factor in the high levels of alcohol use observed among adolescents and young people in Ireland.

However, patterns of drinking have changed, albeit slowly, especially among young people. Data from the NDAS indicated a decrease in lifetime alcohol use among 15–24-year-olds, declining from 89% in the 2002–03 survey to 74% in 2019–20. This decrease was more evident in a younger age cohort, from 83% of 15-year-olds in the HBSC study in 1998 to 50% in 2018. The delay in the age of initiation of alcohol is encouraging, as early use of alcohol has been shown to increase the likelihood of hazardous and harmful drinking later in life as well as the risk of alcohol-related harms. However, when young people do start to drink, many often do so in a hazardous manner, and the ESPAD survey showed that the reported levels of alcohol intoxication among adolescents in Ireland are among the highest in Europe. These patterns of alcohol use may become established and continue into adulthood. A worrying trend is the narrowing of the gap in the rates of reported drunkenness between males and females, as the neurotoxic effects of alcohol on the developing adolescent brain have been found to be more pronounced in females than in males. We know from studies on attitudes and behaviour that young people are often unaware of what constitutes hazardous drinking; that there is poor knowledge around what determines a standard drink and that the HSE low-risk guidelines are not adhered to.

Surveys by the CSO, Planet Youth and the GUI study carried out early in the COVID-19 pandemic showed that, for most young people, their drinking remained unchanged or decreased, however, of concern are the 30% who reported an increase in alcohol use.

However, despite the closure of pubs, bars, clubs, and restaurants for much of 2020, there was little reduction in overall alcohol sales in Ireland and drinking at home became the new norm. Using alcohol as a short-term coping mechanism during the COVID-19 pandemic may result in longer-term changes in individuals' drinking patterns and while it will be some time before we know the true impact of the pandemic, there is a concern that these behavioural changes could result in long-term problem alcohol use.

An effective response to young people's drinking behaviour needs to be based on an awareness of why children and adolescents consume alcohol and on their existing level of knowledge around alcohol. Young people drink not only for social reasons, to deal with boredom, and to conform to perceived norms, but also as a means of coping with anxiety and other mental health problems. Providing the opportunity for young people to socialise without alcohol could reduce the risk of harm from alcohol. The Public Health (Alcohol) Act 2018 includes a provision for labelling to be displayed on all alcohol products, with information about the dangers of alcohol use, including the link between alcohol and a number of cancers; the calorie contents; and how many standard drinks are in a single container – all of which could potentially enable young people to be more knowledgeable about what they are drinking, to make more informed choices about the risks they are potentially taking, and to know when they are exceeding the low-risk alcohol use guidelines.

# 05



## Drug use and patterns of use among young people



Use of illegal substances by young people is of concern across Europe, including Ireland, and reliable and up-to-date data on the use of drugs and patterns of drug use in Ireland are necessary in order to ensure the design and delivery of effective evidence-based responses to drug problems among young people [78]. This chapter presents data on the prevalence and patterns of drug use in an international context and in Ireland.

Data on drug use in Ireland are mainly drawn from Irish general population surveys, school-based surveys, and other sources of data. This chapter reports results from the most recent NDAS (2019–20), which provides information on drug use among the general population in Ireland [7]. School-aged populations are described using results from the 2019 Irish ESPAD and 2018 HBSC study in Ireland. Other sources of information include the GUI study when participants were 17–18 years old and again when they were 20 years of age [13,14], the 2020 Planet Youth Survey [18–20] the 2021 Drug Use in Higher Education in Ireland (DUHEI) survey [24] and the MWS-2 [15]. International data are also referenced to supplement the Irish information.

## 5.1 Any illegal drug use

For the purposes of this overview, any illegal drug includes cannabis, ecstasy, cocaine powder, magic mushrooms, amphetamines, LSD, NPS, crack, and heroin, as well as volatile substances. This section looks at illegal drug use where studies refer to illegal substance use in a general term. The following sections will then examine each of these substances individually.

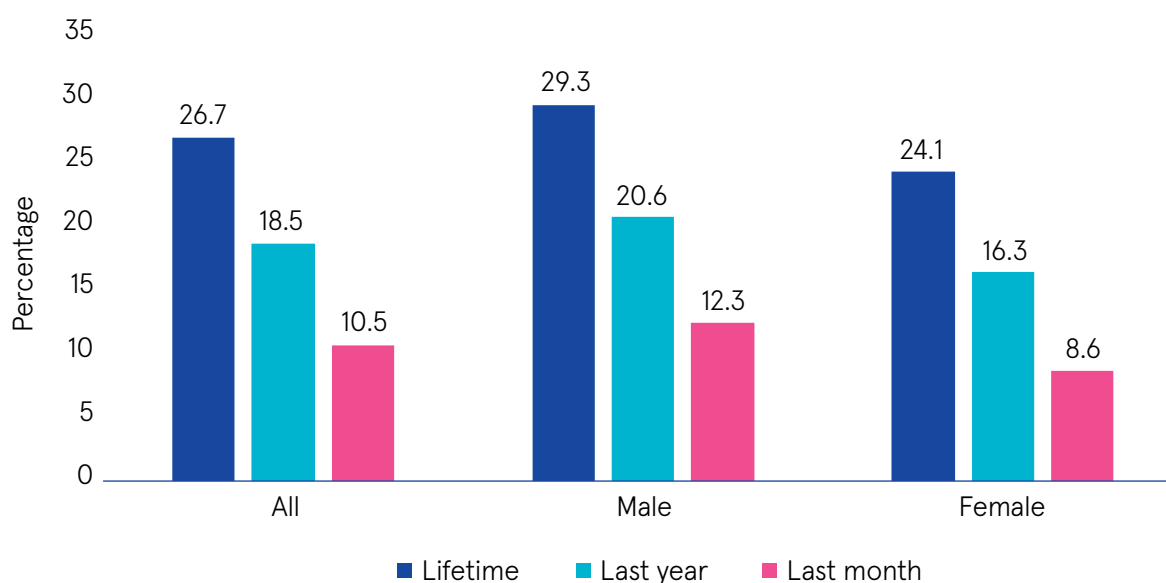
### 5.1.1 Prevalence and patterns of any illegal drug use

Prevalence data from the EMCDDA indicated that out of 27 European countries, use of any illegal drug in the last year among 15–24-year-olds was highest in Czechia (34.4%) followed by France (27.9%). Ireland (18.7%) ranked 13th of the 27 countries [5]. The 2019 ESPAD reported that 17% of schoolchildren aged 15–16 years across 35 participating European countries had used an illegal drug in their lifetime (19% of males and 14% of females) and Ireland ranked higher than the average at 20% [10,32].

#### 5.1.1.1 Any illegal drug use among young people

The 2019–20 NDAS indicated that among those aged 15–24 years, 27% reported lifetime use of any illegal drug, 19% reported last year use, and 11% reported last month use. More males than females reported use of any illegal drug for all reference periods (Figure 13) [7].

Figure 13 Prevalence of use of any illegal drug among young people aged 15–24 years



Source: Mongan et al. 2021 [7]

Over one-half of the sample of third-level students participating in the *Drug Use in Higher Education in Ireland* (DUHEI) survey (N=11,592), in 2021 reported lifetime use of an illegal drug (55%) [24].

### 5.1.1.2 Any illegal drug use among schoolchildren

Results from the 2019 ESPAD in Ireland indicated that 20% of schoolchildren (aged 15–16 years) had used an illegal drug in their lifetime, with illegal drug use being more prevalent among males (25%) than among females (15%) [10].

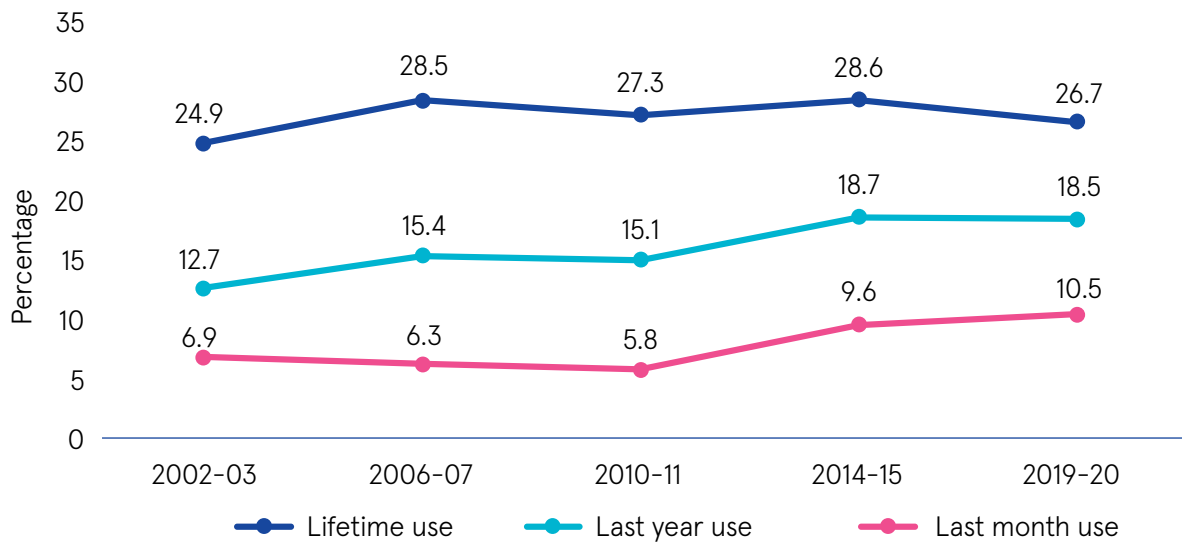
Of 17–18-year-old GUI participants when they were interviewed in 2015–2016, 35% reported lifetime use of any illegal drug [13].

## 5.1.2 Trends in any illegal drug use

According to data from the 2019–20 NDAS, lifetime use of any illegal drugs among young people increased from 25% in 2002–03 to 27% in 2019–20 (Figure 14). Last year illegal drug use also increased between 2002–03 (13%) and 2019–20 (19%), and last month use increased from 6.9% to 11% in the same period [7].

However, when examined by sex, lifetime prevalence of any illegal drug use has decreased among young males over a 5-year period, from 37% in the 2014–15 NDAS to 29% in the 2019–20 NDAS; yet among young females, an increase was noted (from 20% in the 2014–15 NDAS to 24% in the 2019–20 NDAS). Last month use of any illegal drug also saw sex differences, with the percentage of young males reporting last month illegal drug use decreasing from 13% in the 2014–15 NDAS to 12% in the 2019–20 NDAS. In contrast, for young females, an increase in last month use was noted, from 5.8% in 2014–15 to 8.6% in 2019–20.

Figure 14 Trends in use of any illegal drug among young people aged 15–24 years



Source: Mongan et al. 2021 [7]

A decrease in lifetime illegal drug use was noted among ESPAD schoolchildren in Ireland, from 23% of 15–16-year-olds in 2007 to 20% in 2015, however remains unchanged between 2015 and 2019 at 20% [10,43,79].

## 19% of 15–24-year-olds

have used an illegal drug in the last year (21% of males and 16% of females). The 3 most commonly used illegal drugs used in the last year were:



**Cannabis**



**Ecstasy**



**Cocaine**



## 5.2 Cannabis

Cannabis (also called marijuana) is a psychoactive drug derived from a family of plants that contain hundreds of compounds called cannabinoids. The main psychoactive compound is called tetrahydrocannabinol. The drug is available in a number of different forms, including resin (or hash), grass or weed, oil, concentrates, and edibles; it can be smoked, eaten, and vaporised (used in vapes). Its use has been associated with several short- and long-term effects, including euphoria, increased appetite, hallucinations, dependency and abuse, psychosis, adverse mental health, and psychosocial problems [80].

### 5.2.1 Prevalence and patterns of cannabis use

Cannabis is the most widely used illegal drug in Europe: the *European Drug Report 2021: Trends and Developments*, an annual publication prepared by the EMCDDA, reported that 19% of 15–24-year-olds across European countries had used cannabis in the last year and 10% had used it in the last month [78].

The 2018 international report of the HBSC study estimated that 13% of adolescents aged 15 years in Europe and Canada had used cannabis in their lifetime, while 7% had used it in the last month. Cannabis use was higher among males (15%) than among females (11%); 8% of males reported last month use, compared with 5% of females [31].

Findings from the international 2019 ESPAD reported that 16% of schoolchildren aged 15–16 years in the participating ESPAD countries had used cannabis in their lifetime, and 7.1% had used it in the last month. More males than females reported lifetime (18% versus 13%) and last month (8.5% versus 5.8%) use of cannabis [32].

#### 5.2.1.1 Cannabis use among young people

The 2019–20 NDAS indicated that 23% of young people aged 15–24 years had used cannabis in their lifetime, 15% in the last year, and 6.8% in the last month. The survey also reported that more males than females had used cannabis in their lifetime (25% versus 20%), in the last year (16% versus 13%), and in the last month (8.2% versus 5.5%) [7].

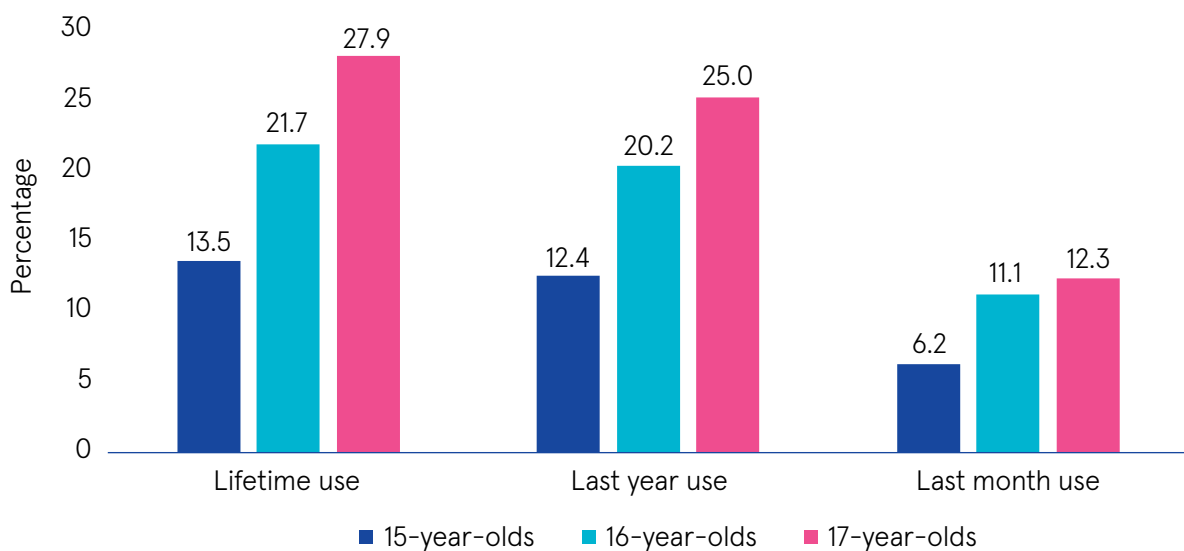
Other surveys reported cannabis use among young people as follows:

- Higher levels of cannabis use was reported among 20-year-olds participating in the GUI study than that reported by the 2019–20 NDAS respondents, with 59% reporting that they had used cannabis in their lifetime; 26% had used it once or twice, 18% had used it occasionally, 6% had used it more than once per week, and 9% reported using cannabis in the past but were no longer users [14,37].
- Among the young adults aged 18–25 years participating in the MWS-2, 53% reported using cannabis in their lifetime; males (59%) were more likely than females (50%) to have used cannabis [16].
- Of third-level students participating in the DUHEI survey, 30% reported that they had used cannabis in the last year [24].

### 5.2.1.2 Cannabis use among schoolchildren

The 2018 Irish HBSC study indicated that 14% of 15-year-olds (16% of males and 11% of females), 22% of 16-year-olds (25% of males and 19% of females), and 28% of 17-year-olds (33% of males and 23% of females) reported lifetime use of cannabis (Figure 15) [12]. Sex differences were noted for last year use of cannabis, with males more likely than females to report last year cannabis use (15% versus 10% for 15-year-olds, 24% versus 17% for 16-year-olds, and 30% versus 20% for 17-year-olds).

Figure 15 Prevalence of cannabis use among adolescents aged 15–17 years



Source: Gavin et al. 2020 [12]

According to the 2019 ESPAD, the prevalence of schoolchildren in Ireland who used cannabis was among the highest in Europe (based on data from 35 countries); 19% of schoolchildren aged 15–16 years had used cannabis in their lifetime, placing Ireland above the ESPAD average (16%) [32]. Sixteen per cent of respondents had used cannabis in the last year and 9% had used it in the last month. The survey also reported that more males than females had used cannabis in their lifetime (24% versus 15%), in the last year (20% versus 12%), and in the last month (12% versus 6.7%) [10]. These findings are similar to the prevalence of lifetime cannabis use reported in the 2020 Planet Youth Survey; 18% of 15–16-year-olds in Galway reported lifetime cannabis use; 16% in Mayo; and 15% in Roscommon [18–20].

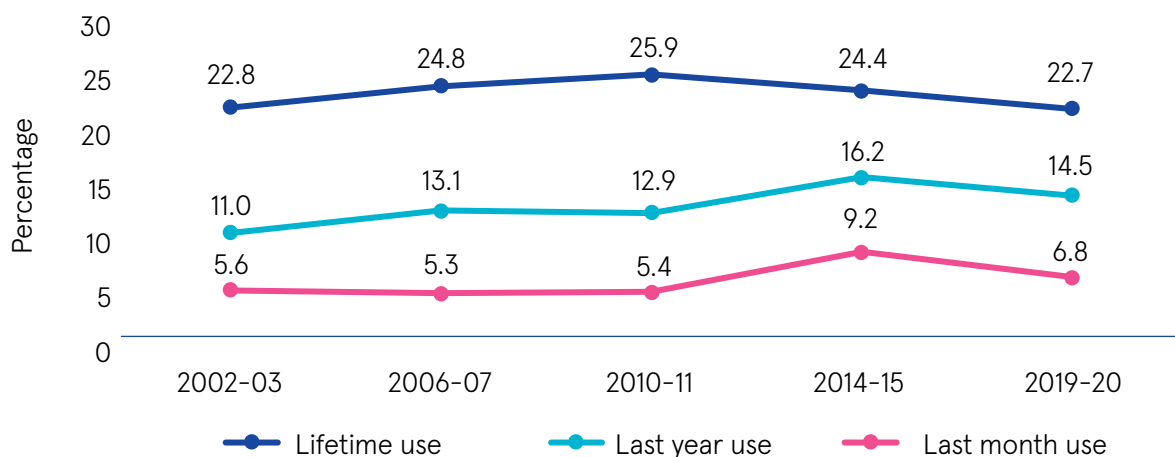
Other surveys reported on cannabis use, as follows:

- Results from interviews with 17–18-year-olds participating in the 2015–2016 GUI study indicated that 30% had used cannabis in their lifetime, 7% reported using cannabis occasionally, and 2% used cannabis more than once per week. The study also reported that more males than females ever used cannabis (33% versus 27%) [13].
- Of the adolescent sample (aged 12–19 years) in the 2019 MWS-2, 15% reported that they used cannabis in their lifetime (18% of males and 13% of females) [16].

### 5.2.2 Trends in cannabis use

The 2019–20 NDAS reported a decrease in lifetime use of cannabis among 15–24-year-olds, from 24% in 2014–15 to 23% in 2019–20 (Figure 16). Between 2014–15 and 2019–20, the prevalence of last year and last month use also decreased from 16% to 15% and from 9.2% to 6.8% respectively [7]. However, when sex was considered, a decrease was noted in last year prevalence of cannabis use among young males between surveys, from 22% in 2014–15 to 16% in 2019–20. On the other hand, among young females, an increase in last year prevalence of cannabis use was noted, increasing from 11% in 2014–15 to 13% in 2019–20.

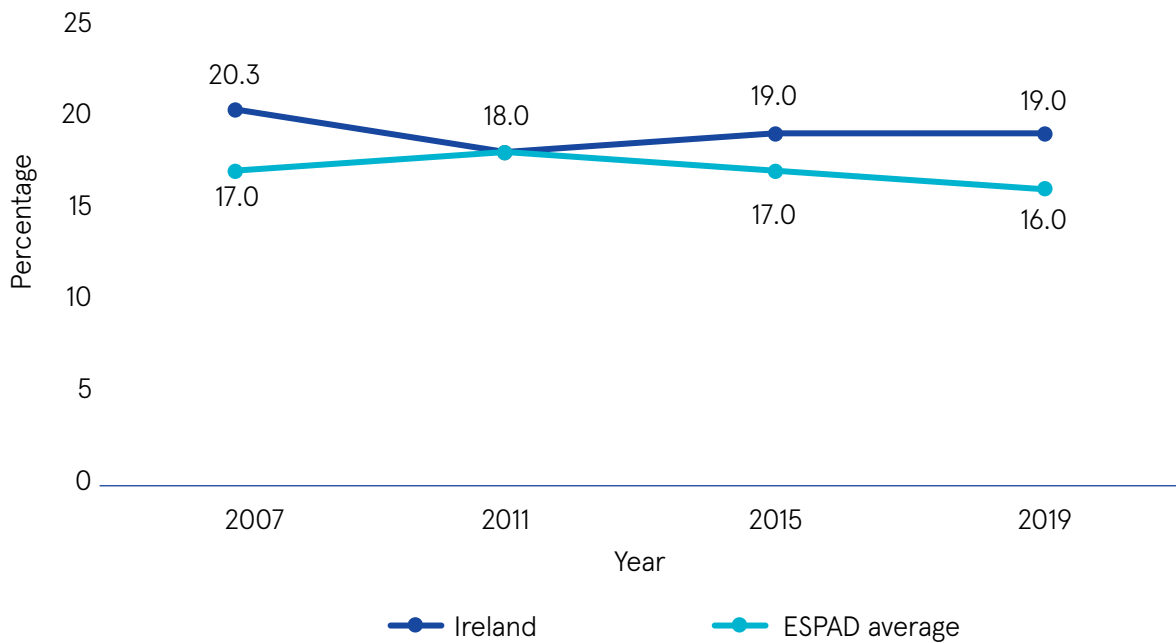
Figure 16 Trends in cannabis use among young people aged 15–24 years



Source: Mongan et al. 2021 [7]

According to the 2019 ESPAD, the prevalence of lifetime use of cannabis among schoolchildren in Ireland decreased between 2007 and 2011 (Figure 17) but has remained stable since 2011 at 19% [10,32,42]. The 2018 HBSC study revealed a decreasing trend between 1998 (27% of males and 17% of females) and 2018 (22% of males and 14% of females) in last year cannabis use among adolescents aged 15–17 years [81].

Figure 17 Trends in lifetime use of cannabis among schoolchildren in Ireland and Europe

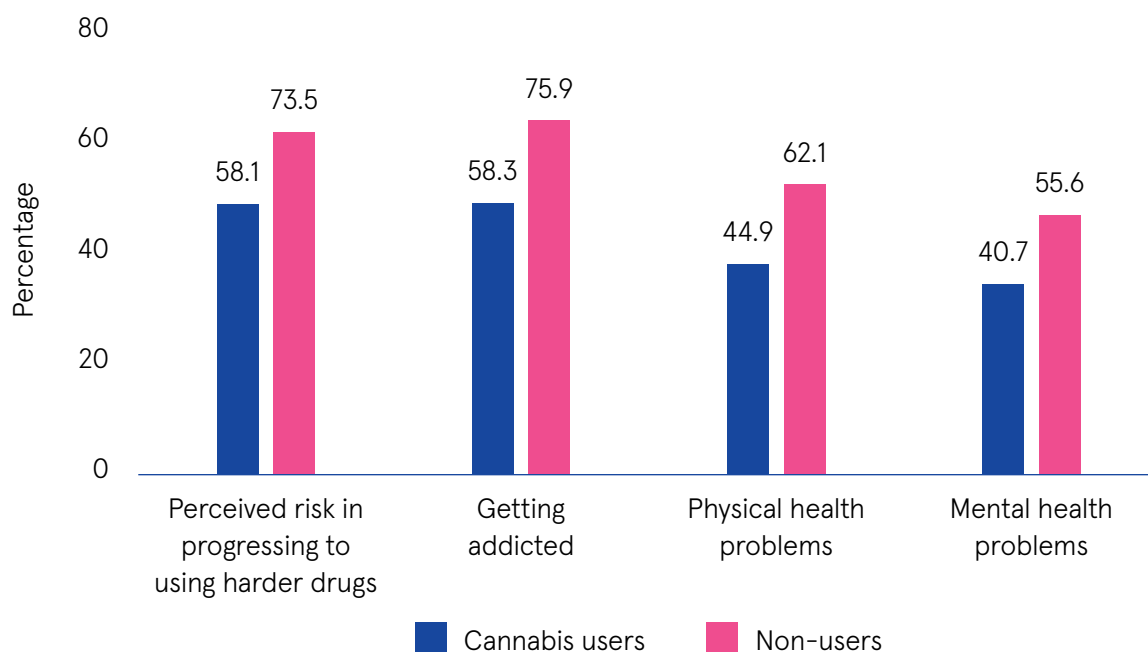


Source: Sunday et al. 2020 [10]

### 5.2.3 Perceived risks and availability of cannabis

There were low levels of perceived risk of cannabis use among schoolchildren and young people. Findings from the 2019–20 NDAS indicated that 40% of 15–24-year-olds perceived a great risk in smoking cannabis regularly, with females more likely than males (48% versus 32%) to perceive a great risk [7]. Among a younger cohort in the 2019 ESPAD, 10% of schoolchildren perceived great risk in using cannabis once or twice [10]. A 2016 survey by Barrett and Bradley [82] of the attitudes and perceived risk of cannabis use among Irish adolescents; cannabis users were less likely (58%) than non-users (74%) to perceive a great risk in progressing to using harder drugs, developing dependency on cannabis, or developing mental or physical problems as a result of cannabis use (Figure 18). Chapter 7 of this overview provides detail of cannabis use disorder (CUD) and the prevalence among young people.

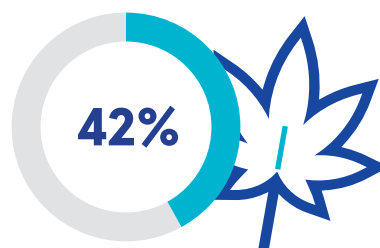
Figure 18 Perceived risks of cannabis use among cannabis users and non-users aged 15–24 years



Source: Barrett and Bradley, 2016 [82]

The 2019 ESPAD reported that 42% of schoolchildren believed that it would be fairly or very easy to get cannabis if they wanted to [10].

42% of adolescents aged 15–16 years reported that it would be **‘fairly’ or ‘very’ easy to get cannabis** if they wanted to



### 5.2.4 Type of cannabis used

Among current cannabis users aged 15–24 years in the 2019–20 NDAS, the most common type of cannabis used was weed (88%), followed by hash (8.7%) and grass (3.5%) [7]. Among ESPAD schoolchildren who reported using cannabis, weed/skunk was the most common (63%), followed by cannabis resin (21%) and cannabis oil (17%) [10].

### 5.2.5 Problems associated with cannabis use

A number of patterns of behaviour related to cannabis use are indicative of problematic use and potential CUD. Among schoolchildren who had used cannabis in the last year, the

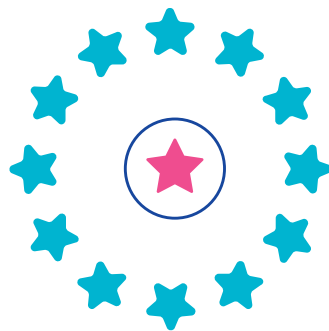
2019 ESPAD asked further questions about their use to establish the extent of potential problematic use and found that 46% had used the drug before midday (49% of males versus 40% of females); 31% had smoked cannabis alone (35% of males versus 27% of females) and 37% had memory problems as a result of cannabis use. Almost one-quarter (23%) had got into a fight, argument, or accident or had a bad result at school because of cannabis use, and 18% had tried unsuccessfully to stop (22% of males versus 13% of females) [10].

## 5.3 Stimulants

Stimulants refer to a group of psychoactive drugs that are used to speed up activity in the central nervous system (CNS). Stimulants include ecstasy, cocaine, amphetamines, and methamphetamine. These substances are examined separately in further detail below.

### 5.3.1 Ecstasy

Ecstasy, also known as MDMA, is a synthetic drug that acts as a CNS stimulant and hallucinogen. Ecstasy is typically consumed in tablet form, but the powdered form can also be injected, snorted, or inhaled [83]. The effects of ecstasy can include increased extroversion, well-being, empathy and enhanced sensory perception. Ecstasy can also cause a number of acute adverse health effects, for example hypertension, fainting, panic attacks, and in severe cases, a loss of consciousness and seizures [84].



**Ecstasy**  
use among young people  
in Ireland was the  
**2nd highest in  
Europe**

#### 5.3.1.1 Prevalence and patterns of ecstasy use

The 2021 EMCDDA report estimated that 2.2% of young people aged 15–24 years in Europe had used ecstasy in the last year [85]. Ireland (7.2%) ranked second highest in ecstasy use in the last year among young people in Europe, second only to the Netherlands (8.6%). The international 2019 ESPAD reported that 2.3% of 15–16-year-old schoolchildren had used ecstasy in their lifetime, with higher rates of lifetime use reported by males than by females (2.5% versus 2.1%) [32].

### 5.3.1.1.1 Ecstasy use among young people

Findings from the 2019–20 NDAS reported that 10% of young people aged 15–24 years had used ecstasy in their lifetime, 7.2% had used it in the last year (higher than the European average, 2.2%), and 4.4% had used it in the last month. The survey also reported sex differences, with males more likely than females to report lifetime ecstasy use (12% versus 7.8%), last year use (8.9% versus 5.4%), and last month use (5.9% versus 2.8%) [7].

Other surveys reported on ecstasy use, as follows:

- Among a sample of 742 third-level students in Limerick City, 6.3% of respondents had used ecstasy once or twice over the last year [86].
- Among 20-year old GUI respondents, 17% reported lifetime use of ecstasy [37].
- Of third-level students participating in the DUHEI survey, 11% reported using ecstasy in the last year [24].

### 5.3.1.1.2 Ecstasy use among schoolchildren

Data from the 2019 ESPAD in Ireland revealed that 2.9% of schoolchildren had used ecstasy in their lifetime (above the ESPAD average of 2.3%) and 2.6% had used ecstasy in the last year. Sex differences were observed among schoolchildren in Ireland; more males than females reported lifetime use of ecstasy (3.8% versus 2.0%) and last year use (3.5% versus 1.8%) [10].

Other surveys also reported ecstasy use among schoolchildren, as follows:

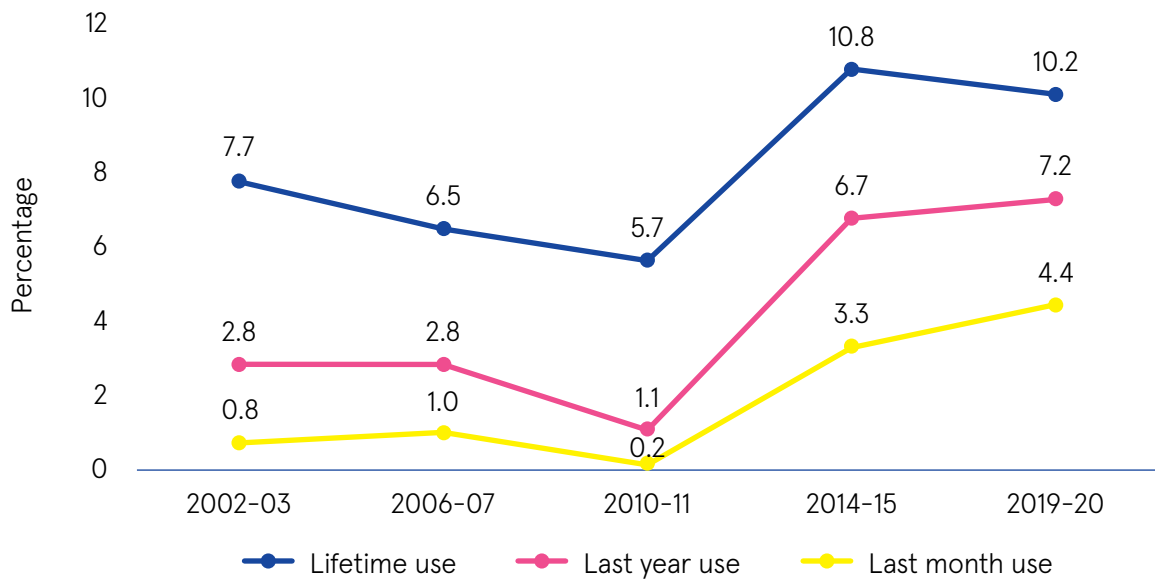
- The GUI study indicated that 2% of adolescents aged 17–18 years in 2018 had used ecstasy in their lifetime [13].
- In the 2020 Planet Youth Survey, 4% of 15–16-year-olds in Galway reported lifetime use of ecstasy, 2% in Mayo, and 2% in Roscommon [18–20].
- Results of the Irish Child and Adolescent Self-harm in Europe study among students aged 15–17 years in Irish schools (N=2,716) indicated that 2.7% of the sample reported using ecstasy in the last month [87].

## 5.3.2 Trends in ecstasy use

Data from the 2019–20 NDAS showed an increase in lifetime use of ecstasy among 15–24-year-olds, from 7.7% in 2002–03 to 10.2% in 2019–20 (Figure 19). Over the same period, last year use increased from 2.8% to 7.2%, and last month use increased from 0.8% to 4.4%.

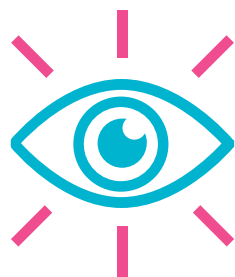
Between 2006–2007 and 2010–11, there was a decrease in the prevalence of ecstasy use. This may be due to the high prevalence of NPS use prior to the 2010–11 NDAS and the introduction of the Criminal Justice (Psychoactive Substances) Act 2010 banning the unregulated availability of NPS from so-called ‘head shops’. Last year use of ecstasy among young males decreased between the 2014–15 NDAS (9.7%) and the 2019–20 NDAS (8.9%); however, there was an increase in last year use of ecstasy among young females, from 3.7% to 5.4% in the 5-year period between surveys [7].

Figure 19 Trends in ecstasy use among young people aged 15–24 years



Source: Mongan et al. 2021 [7]

Data from the 2019 ESPAD demonstrated that lifetime ecstasy use among schoolchildren in Ireland decreased between 2007 (4.0%) and 2011 (2.0%), but then increased to 2.9% in 2019 [10,42,43]. Similar fluctuations were observed in participating European ESPAD countries, the prevalence of ecstasy use has been declining, from a peak of 4.4% in 2007 to 2.3% in 2019 [32].



While cannabis use has stabilised, there has been an **increase in stimulant use** among young people in Ireland

### 5.3.3 Cocaine

Cocaine (also known as coke) is a stimulant produced from the leaves of the coca plant cultivated in South America [88]. It is the second most commonly used illegal drug (after cannabis) among young people across Europe, although its prevalence varies between countries. The drug is available in two forms: cocaine powder and crack cocaine. Crack cocaine is a form of cocaine which is made into small lumps or ‘rocks’ and is smoked using plastic bottles or glass pipes [89].



The effects of cocaine use include feeling more alert, energetic, exhilarated and confident and also include insomnia, loss of appetite, and has been associated with aggression and violence, depression and anxiety. Its use can cause seizures, breathing problems and cardiac conditions, particularly if taken with alcohol, due to the two substances being metabolized in the liver forming a substance known as cocaethylene. The addition of cocaethylene to the alcohol and cocaine already in the system can produce effects that are much more powerful than the effects that alcohol or cocaine alone produce [84].

There are no reliable, up-to-date data sources on crack cocaine prevalence in Ireland; a 2008 HRB report, *Crack cocaine in the Dublin region: an evidence base for a crack cocaine strategy*, found that the number of people using crack in Ireland was low, with users representing 1% of drug users who present for treatment and 0.1% of the general population [90]. In 2008, the typical profile of the majority of crack users was that they had used more than one drug (mostly heroin) alongside crack; they were individuals who were homeless, unemployed, and with no formal educational qualifications; and were male aged between 20 and 29 years. These data are now outdated, and it is timely to investigate the prevalence of crack cocaine in Ireland, especially among young people.

This section of the overview will focus on cocaine powder.

### 5.3.3.1 Prevalence and patterns of cocaine use

The 2021 EMCDDA statistical bulletin reported varying prevalence of lifetime use of cocaine between European countries, from 0.3% of 15–24-year-olds in Turkey to 11.3% in the UK. Ireland had the second highest lifetime prevalence of cocaine use at 6.8% among this age group [5].

Findings from the 2019 ESPAD indicated that among schoolchildren aged 15–16 years in participating countries, 1.9% had used cocaine in their lifetime (2.2% of males and 1.6% of females), Ireland had the second-highest prevalence of lifetime cocaine use among this age group (3.3%) after Cyprus (3.8%) [32].



**Cocaine**  
use among young people  
in Ireland was the  
**2nd highest in  
Europe**

---

#### **5.3.3.1.1 Cocaine use among young people**

Results from the 2019–20 NDAS showed that 6.8% of 15–24-year-olds had used cocaine powder in their lifetime, 4.4% had used it in the last year, and 1.1% had used it in the last month [7]. Sex differences were reported in the use of cocaine, with more males than females reporting lifetime use (7.2% versus 6.5%) and last month use (1.9% versus 0.3%).

Other sources reporting the prevalence of cocaine use among young people are presented here:

- Among 20-year-olds participating in the GUI study, 22% reported lifetime use of cocaine [37].
- Of third-level students participating in the DUHEI survey, 16% reported using cocaine in the last year [24].

#### **5.3.3.1.2 Cocaine use among schoolchildren**

Among schoolchildren in Ireland, the 2019 ESPAD reported that 3.3% of 15–16-year-olds had used cocaine in their lifetime and 2.8% reported its use in the last year. Lifetime use was higher among males than among females (4.6% versus 2.0%), and also for last year use (2.6% versus 2.0%) [10].

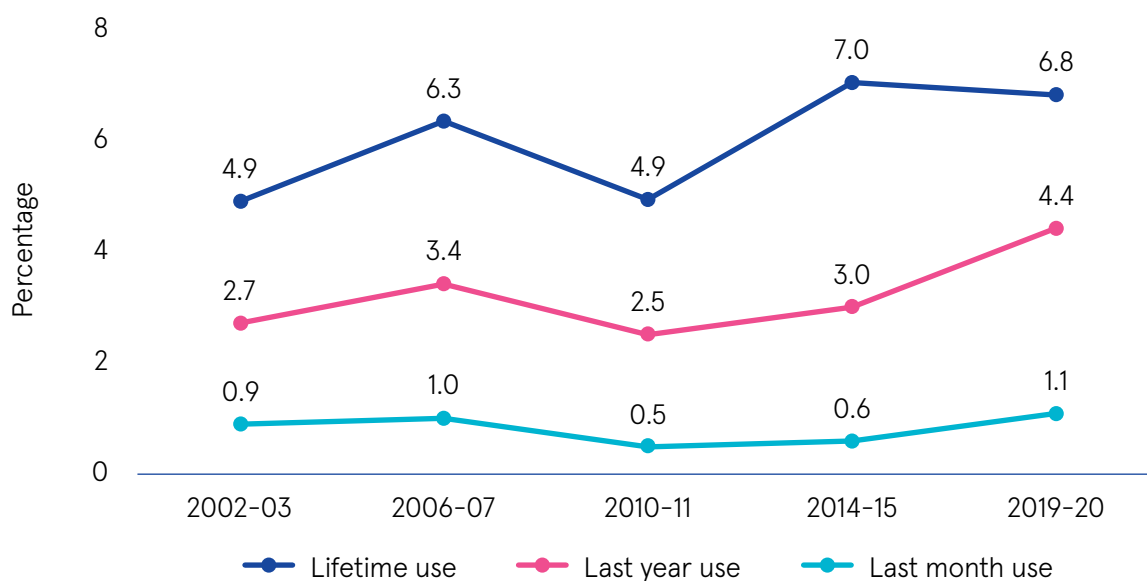
Other surveys reported on cocaine use among schoolchildren, as follows:

- The GUI study indicated that 4.2% of 17–18-year-olds in 2018 had used cocaine in their lifetime [13].
- Results from the 2020 Planet Youth Survey indicated that 2.9% of 15–16-year-olds in Galway, 3.4% in Mayo, and 2.3% in Roscommon had used cocaine at least once in their lifetime [18–20].

#### **5.3.3.2 Trends in use of cocaine**

The 2019–20 NDAS data showed an overall increase in lifetime use of cocaine among 15–24-year-olds, from 4.9% in 2002–03 to 6.8% in 2019–20. Last year use also increased from 3.0% in 2014–15 to 4.4% in 2019–20 (Figure 20). However, when broken down by sex, a decrease in lifetime and last year use of cocaine was noted for young males, from a lifetime use of 9.7% in the 2014–15 NDAS to 7.2% in the 2019–20 NDAS and last year cocaine use decreasing from 5.1% to 4.2% in the same period. Conversely, for young females an increase in lifetime use of cocaine was noted over the same time period (from 4.2% to 6.5%) and last year use increased from 0.8% to 4.5% [7].

Figure 20 Trends in cocaine powder use among young people aged 15–24 years



Source: Mongan et al. 2021 [7]

Data from the Irish ESPAD highlighted that the number of schoolchildren who used cocaine in their lifetime varied from 4.0% in 2007 to 2.1% in 2015, but increased to 3.3% in 2019 [10]. In ESPAD participating European countries, the mean prevalence of lifetime cocaine use decreased from 3.0% in 2007 to 1.9% in 2019 [32,42].

### 5.3.4 Other stimulants

For the purposes of this overview, the term ‘other stimulants’ refers to substances such as amphetamines and methamphetamine, also known as speed and crystal meth.

Amphetamines and methamphetamine (frequently grouped together as amphetamines) refer to synthetic substances that act on the CNS, producing feelings of improved performance in physical and mental tasks, increased energy, and heightened curiosity, among others. Prolonged use, especially among young people, can result in a high potential for abuse and dependency. These drugs are usually injected, ingested, or snorted, and the crystalline form of methamphetamine can be smoked [91,92].

### 5.3.5 Prevalence and patterns of stimulant use

EMCDDA data indicated that 1.3% of 15–24-year-olds used amphetamines in the last year [81]. Across Europe, schoolchildren aged 15–16 years who participated in the 2019 ESPAD, 1.7% reported using amphetamines and 1.1% reported using methamphetamine in their lifetime; amphetamines were more commonly used by boys (2.0%) than girls (1.4%). Methamphetamine was also more commonly used among boys than among girls (1.4% versus 0.9%) [32].

### 5.3.5.1 Stimulant use among young people

In Ireland, the 2019–20 NDAS indicated that 2.8% of young people aged 15–24 years had used amphetamines in their lifetime, 2.4% reported last year use, and 0.9% reported their use in the last month. Both lifetime and last year use were more common among males than among females (3.3% versus 2.3% for lifetime use and 2.9% versus 1.9% for last year use) [7].

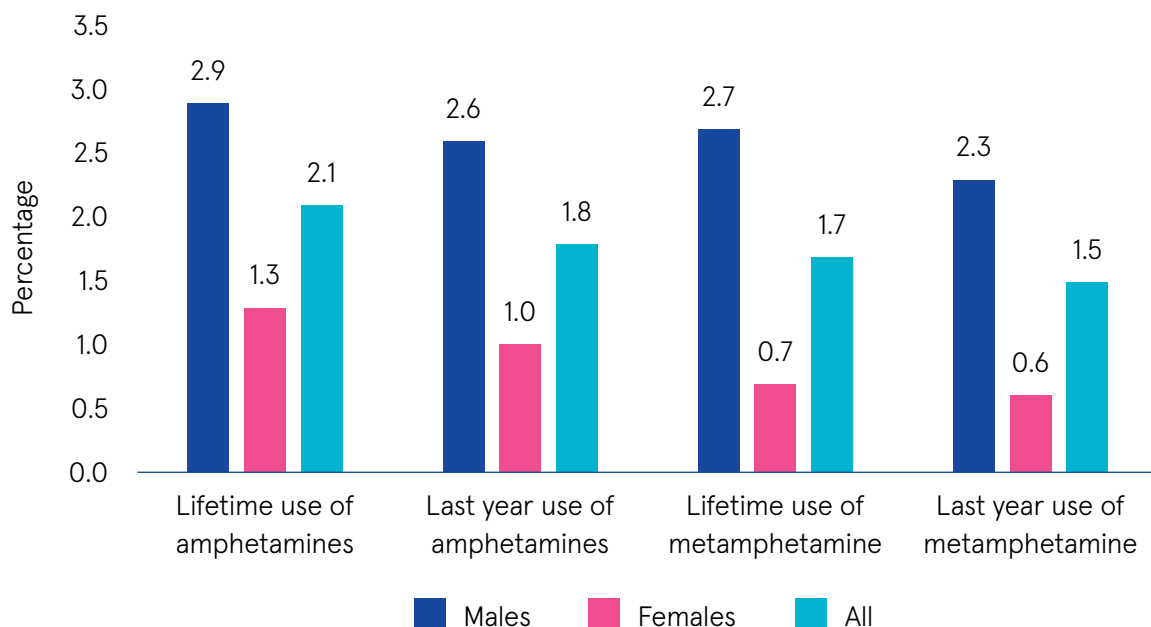
Other sources of data available reporting the prevalence of stimulant use among young people include the following:

- Of GUI respondents who were interviewed when they were 20 years of age, 4% reported having used amphetamines at least once in their lifetime [37].
- Of third-level students participating in the DUHEI survey, 2.7% reported that they had used amphetamines in the last year [24].

### 5.3.5.2 Stimulant use among schoolchildren

Among 15–16-year-olds in the Irish 2019 ESPAD, 2.1% had used amphetamines in their lifetime and 1.8% had used them in the last year. Males were more likely than females to have used amphetamines in their lifetime (2.9% versus 1.3%) and in the last year (2.6% versus 1.0%). Lifetime methamphetamine use was reported by 1.7% of respondents, and last year methamphetamine use was reported by 1.5% of respondents. Males were more likely than females to report using methamphetamine in their lifetime (2.7% versus 0.7%) and in the last year (2.3% versus 0.6%) (Figure 21) [10].

Figure 21 Prevalence of amphetamines and methamphetamine use among 15–16 year old schoolchildren

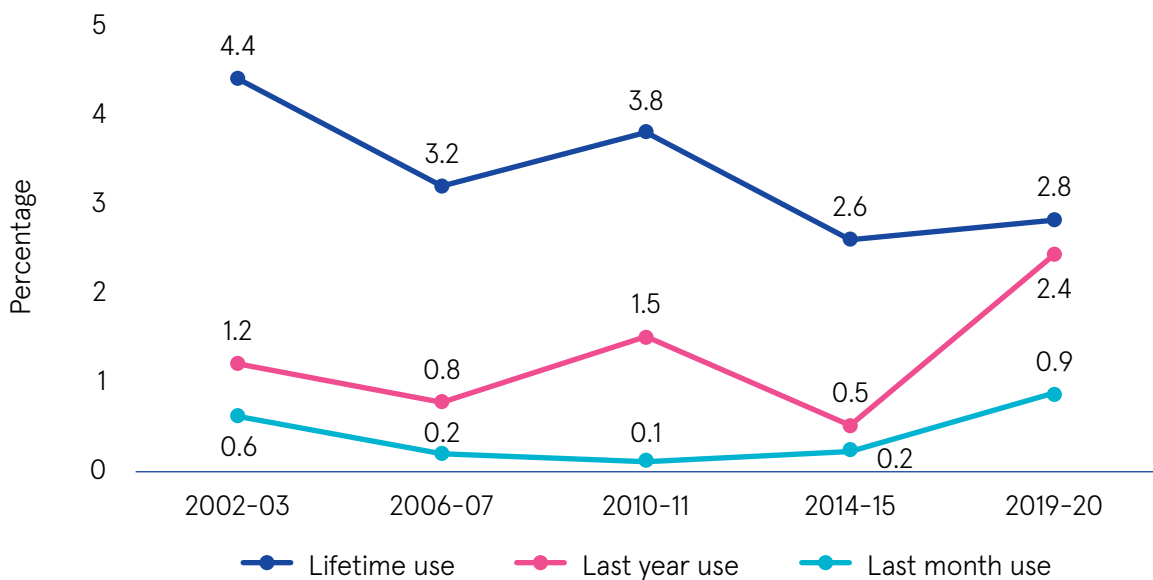


Source: Sunday et al. 2020 [10]

### 5.3.5.2 Trends in use of other stimulants

Figure 22 shows an increase in last year use of amphetamines among 15–24-year-olds between 2014–15 (0.5%) and 2019–20 (2.4%) [7,38–41].

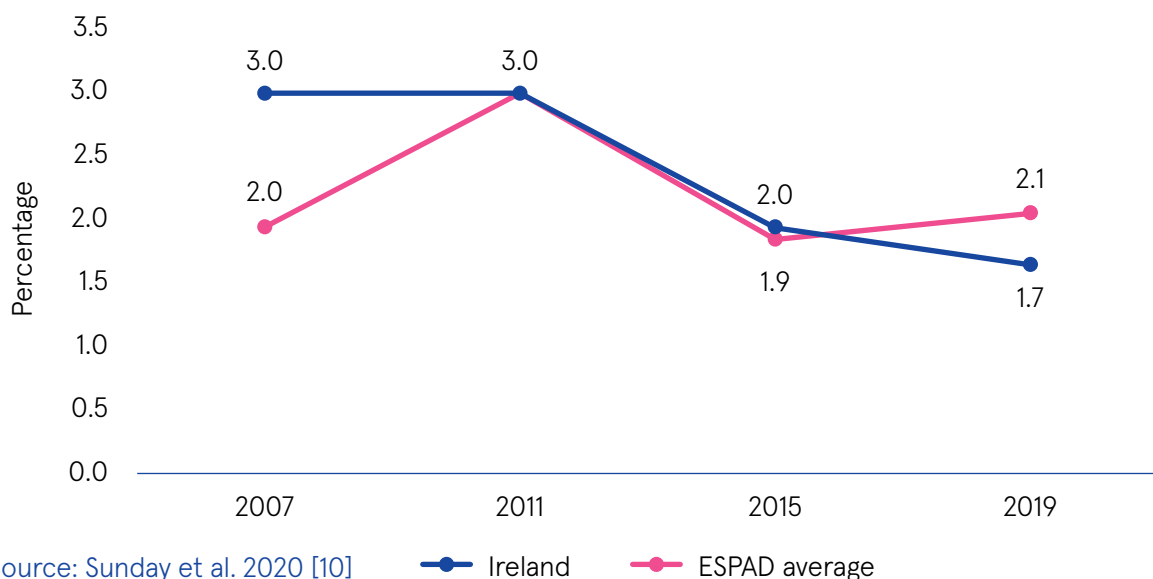
Figure 22 Trends in the use of amphetamines among young people aged 15–24 years



Source: Mongan et al. 2020 [7]

Findings from European countries participating in the ESPAD survey, as well as Ireland, showed a decline in the lifetime prevalence of amphetamine use among 15–16-year-old schoolchildren between 2011 and 2015 although an increase was noted in Ireland between 2015 and 2019 (Figure 23) [10].

Figure 23 Trends in lifetime amphetamine use among 15–16-year-olds in Ireland and Europe



Source: Sunday et al. 2020 [10]

## 5.4 Sedatives and tranquillisers

Sedatives and tranquillisers are a group of psychoactive drugs that act as CNS depressants and are mostly prescribed to treat anxiety, epilepsy, and sleep disorders [93]. The most common types of sedatives and tranquillisers are z-drugs and benzodiazepines such as alprazolam, diazepam, zopiclone and flurazepam [94]. Sedatives and tranquillisers are largely considered safe for short-term use; however, when used for longer periods, there is a risk of abuse and dependence, and of overdose when used with other substances simultaneously [95]. The terms ‘sedatives’, ‘tranquillisers’, and ‘benzodiazepines’ are used interchangeably in this overview, in accordance with the terms reported in each study referenced. Prevalence data for prescribed and non-prescribed use of sedatives and tranquillisers are presented where available.

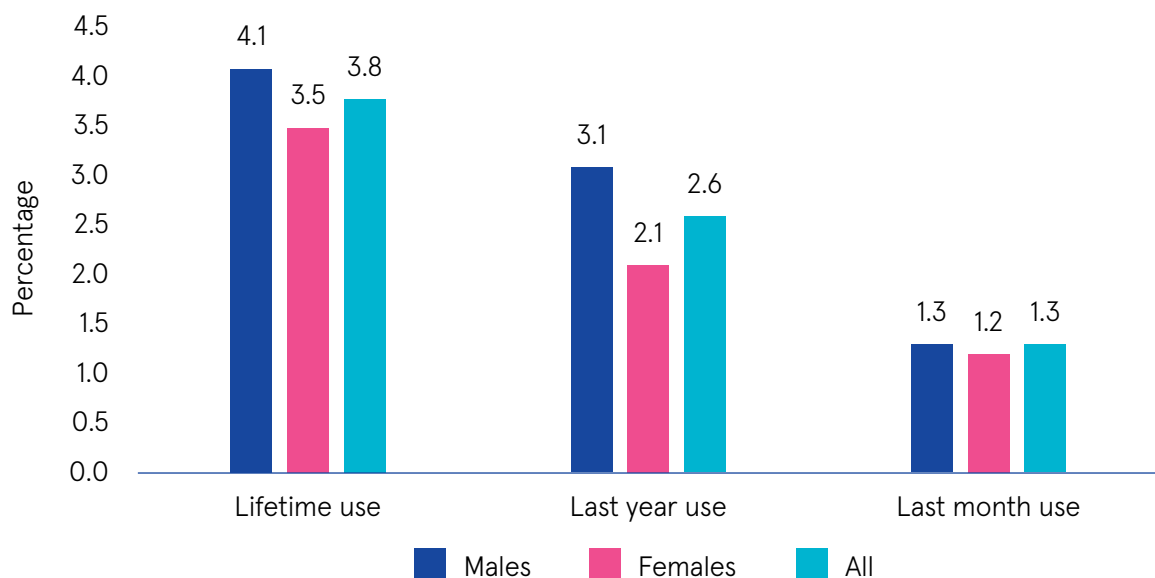
### 5.4.1 Prevalence and patterns of sedative and tranquilliser use

Across European countries participating in the ESPAD survey in 2019, 6.6% of schoolchildren aged 15–16 years have used non-prescribed sedatives and tranquillisers, more adolescent females than adolescent males reported lifetime use (8.0% versus 5.1%) [32].

#### 5.4.1.1 Sedative and tranquilliser use among young people

Data from the 2019–20 NDAS indicated that 3.8% of 15–24-year-olds reported using sedatives and tranquillisers (either prescribed or non-prescribed) in their lifetime, 2.6% in the last year, and 1.3% in the last month and males were more likely than females to report their use (Figure 24) [7].

Figure 24 Prevalence of sedative and tranquilliser use (prescribed and non-prescribed) among young people aged 15–24 years



Source: Mongan et al. 2021 [7]

Of GUI study respondents who were interviewed at 20 years of age, 2.2% reported having used benzodiazepines at least once in their lifetime [37].

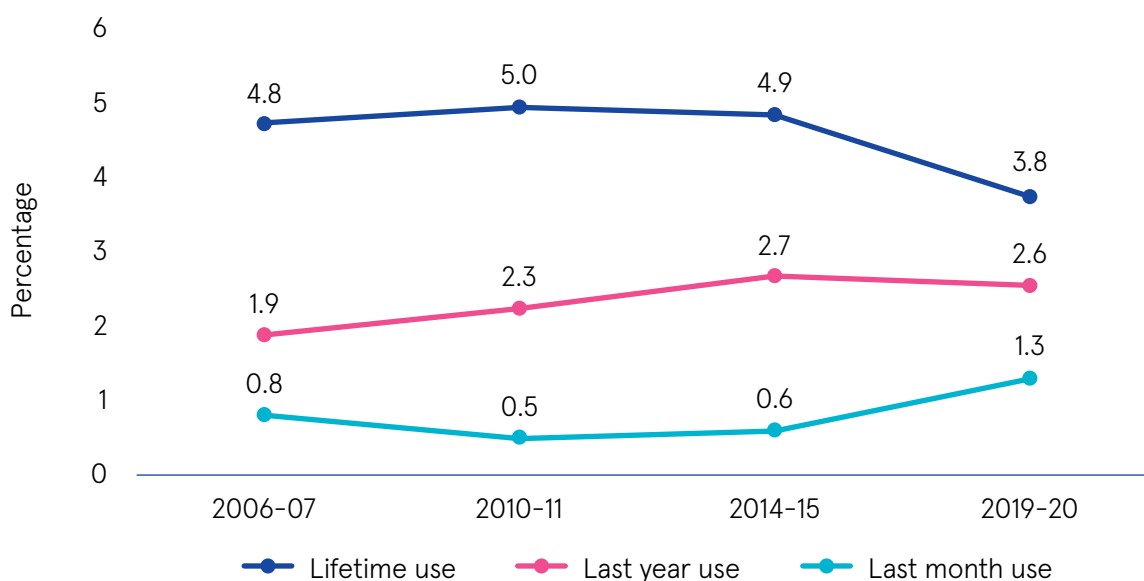
### 5.4.1.2 Sedative and tranquilliser use among schoolchildren

The 2019 ESPAD highlighted that 2.6% of schoolchildren in Ireland aged 15–16 years reported using non-prescribed sedatives or tranquillisers in their lifetime (lower than the ESPAD average of 6.6%); 2.9% of males and 2.4% of females [10].

### 5.4.2 Trends in sedative and tranquilliser use

Data from the 2019–20 NDAS showed a decrease in lifetime use of sedatives and tranquillisers between 2014–15 (4.9%) and 2019–20 (3.8%) (Figure 25). Over the same time period, last year use decreased from 2.7% to 2.6%, and last month use increased from 0.6% to 1.3% [7].

Figure 25 Trends in sedative and tranquilliser use among young people aged 15–24 years



Source: Mongan et al. 2021 [7]

Among ESPAD schoolchildren in Ireland, the prevalence of lifetime use of non-prescribed sedatives and tranquillisers has remained consistent since 2007 (2.6%) to 2.6% in 2019. The rates in Europe (6.6% in 2019) were higher than in Ireland [10,32].

## 5.5 Hallucinogens

Hallucinogens, also known as psychedelic drugs, are a diverse group of drugs that disrupt the interaction of nerve cells and the neurotransmitter serotonin, causing hallucinations. Some hallucinogens are manufactured, like LSD, phencyclidine (PCP), or ketamine. LSD, or acid, is a semi-synthetic hallucinogenic drug and one of the most powerful and widely used hallucinogens. It comes in two forms: as a liquid, or as a piece of paper with images on it (which is usually swallowed). Its use has been associated with several short- and long-term effects, ranging from hallucinations to mental health problems [96].

Other hallucinogens are found in particular plants; for instance, certain mushrooms containing psychedelic properties, which are also known as magic mushrooms. Magic mushrooms are wild or cultivated mushrooms that contain psychoactive and hallucinogenic substances. They are usually eaten raw but can be dried out and put into food or tea for consumption. Magic mushrooms can cause nausea, introspective experiences, nervousness, feelings of relaxation or drowsiness, paranoia, panic, hallucinations, and psychosis. Their use in Ireland largely began in the mid-1970s, when they emerged as an alternative to LSD [96,97].

Ketamine is a medication primarily used for induction and maintenance of anaesthesia (human and veterinary) but since the mid-1990s, ketamine has been used illegally as a recreational drug due to its hallucinogenic properties [98]. Ketamine is a dissociative drug, producing visual and auditory distortion, and a detachment from reality and can cause memory loss, nausea, depression and a numbing sensation where the user cannot feel pain and as a result, they can injure themselves and be unaware of it. Ketamine can increase heart rate and blood pressure and mixing it with other substances is dangerous and can be fatal [84].

### 5.5.1 Prevalence and patterns of hallucinogen use

Among young people aged 15–24 years across Europe, less than 1% reported last year use of LSD and of magic mushrooms [78]. In 2019 in Europe, 2.1% of schoolchildren aged 15–16 years reported LSD use in their lifetime, with more males than females reporting lifetime use (2.4% versus 1.7%) [32].

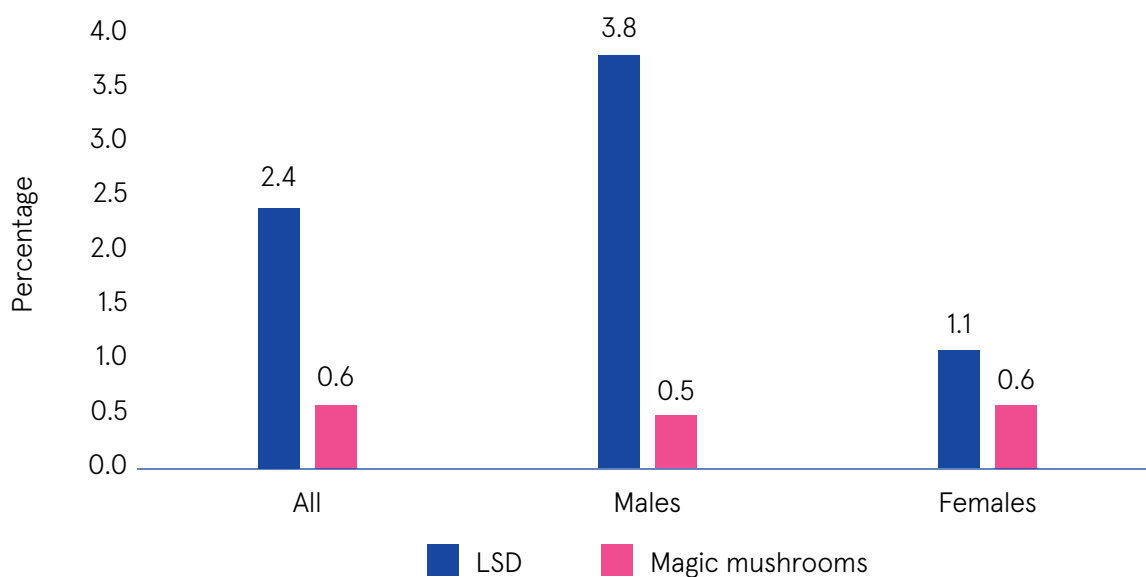
#### 5.5.1.1 Hallucinogen use among young people

Of 15–24-year-old respondents in the 2019–20 NDAS, 3.9% reported lifetime use of LSD, 2.4% reported last year use, and 1.7% reported last month use. Prevalence of LSD use was more common among males than females for all reference periods (Figure 26) [7].

Of 15–24-year-old respondents in the 2019–20 NDAS, 2.5% reported lifetime use of magic mushrooms, 0.6% in the last year, and 0.3% in the last month [7].



Figure 26 Last year prevalence of LSD and magic mushrooms use among 15–24-year-olds



Source: Mongan et al. 2021 [7]

Other sources of data reporting prevalence of hallucinogens are presented here:

- Of respondents aged 20 years in the GUI study, 6% reported lifetime use of magic mushroom use and 4% reported lifetime use of LSD [37].
- Of third-level students participating in the DUHEI survey, 5.2% reported magic mushrooms in the last year and 9.5% reported using ketamine illegally in the last year [24].

### 5.5.1.2 Hallucinogen use among schoolchildren

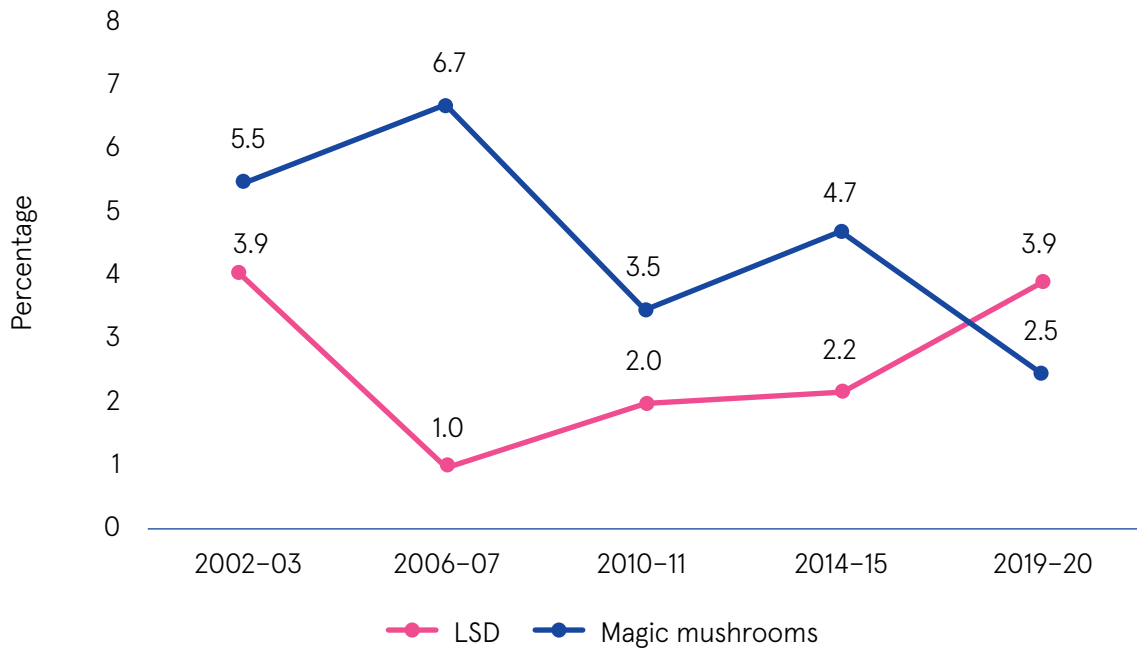
The 2019 ESPAD reported that 2.8% of schoolchildren in Ireland had used LSD in their lifetime, more commonly used among males than among females (3.6% versus 1.9%). Lifetime use of magic mushrooms was reported by 1.8% of schoolchildren (3.1% of males and 0.4% of females) [10].

## 5.5.2 Trends in hallucinogen use

Data from the 2019–20 NDAS showed that lifetime use of LSD among 15–24-year-olds has increased since 2014–15, from 2.2% to 3.9% in 2019–20, following a decrease between 2002–03 and 2006–07 [7]. Similarly, the prevalence of last year and last month use increased between 2006–07 and 2019–20, from 0.2% to 2.4% for last year use and from 0% to 1.7% for last month use.

NDAS data indicated that lifetime use of magic mushrooms has fluctuated between surveys, from a peak in 2006–07 (6.7%) to their lowest level in 2019–20 (2.5%) (Figure 27) [7].

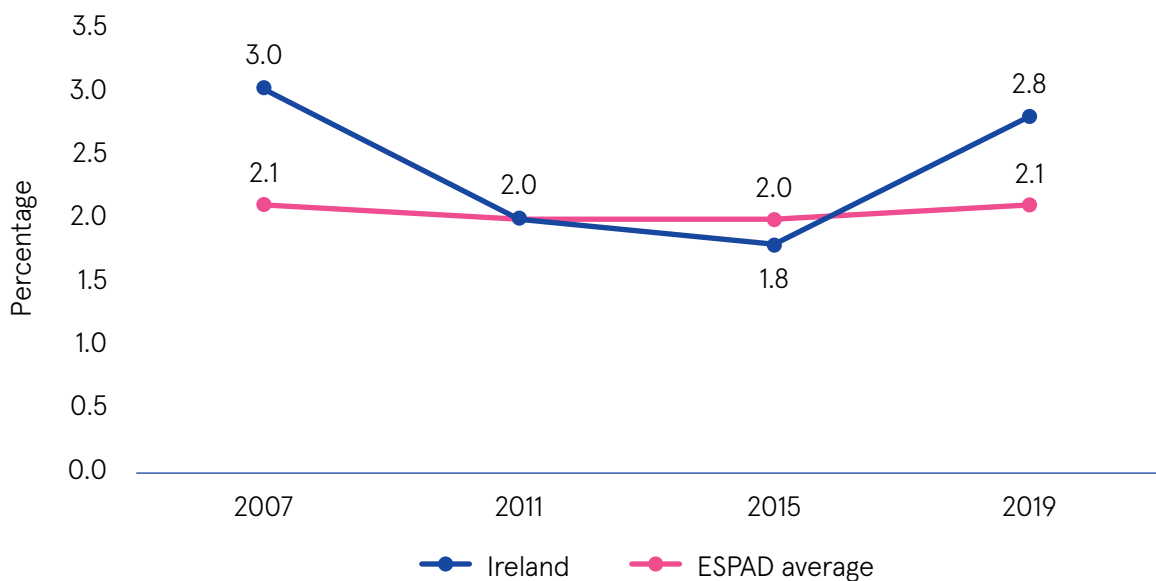
Figure 27 Trends in lifetime use of LSD and magic mushrooms among young people aged 15–24 years



Source: Mongan et al. 2021 [7]

Figure 28 shows trends in lifetime use of LSD among schoolchildren in Ireland compared to the European average. Lifetime use of LSD in Ireland increased between 2015 and 2019 and is now higher than the ESPAD European average [32].

Figure 28 Trends in lifetime use of LSD among schoolchildren aged 15–16 years in Ireland and the European average



Source: Sunday et al. 2020 [10]

## 5.6 Opioids and opiates

Opioids (or opiates) are a group of natural, semi-synthetic, or synthetic compounds that interact with opioid receptors in the brain and body, and are addictive, sedating, narcotic drugs. The terms 'opioids' and 'opiates' are often used interchangeably but there is a difference. An opiate is a naturally occurring narcotic derived from the opium poppy plant and includes morphine, codeine and heroin. An opioid is a synthetic narcotic produced from an opiate plant and is not naturally occurring and includes oxycontin, methadone, tramadol, fentanyl and other similar substances that can be prescribed but are also available on the illegal market. We have used the terms as per each study cited. Opioids and opiates are commonly prescribed for valid medical purposes, including the management of pain, due to their analgesic and sedative effects. However, opioids and opiates can cause euphoria in addition to pain relief, which can lead to misuse, addiction, and overdose [78,99].

General population surveys (such as the NDAS) and school-based surveys do not accurately measure the prevalence of opioid and opiate use, particularly heroin, as its use often occurs among vulnerable groups not generally accessible through such surveys. In order to overcome this, a four-sample capture-recapture method has been adopted to ascertain more accurate estimates of the prevalence of problem opioid use among people in Ireland. The capture-recapture method, as recommended by the EMCDDA, uses data from prison records, the Probation Service, and drug treatment clinics, as well as information from general practitioners (GPs), to predict the size of the uncaptured population [100,101].

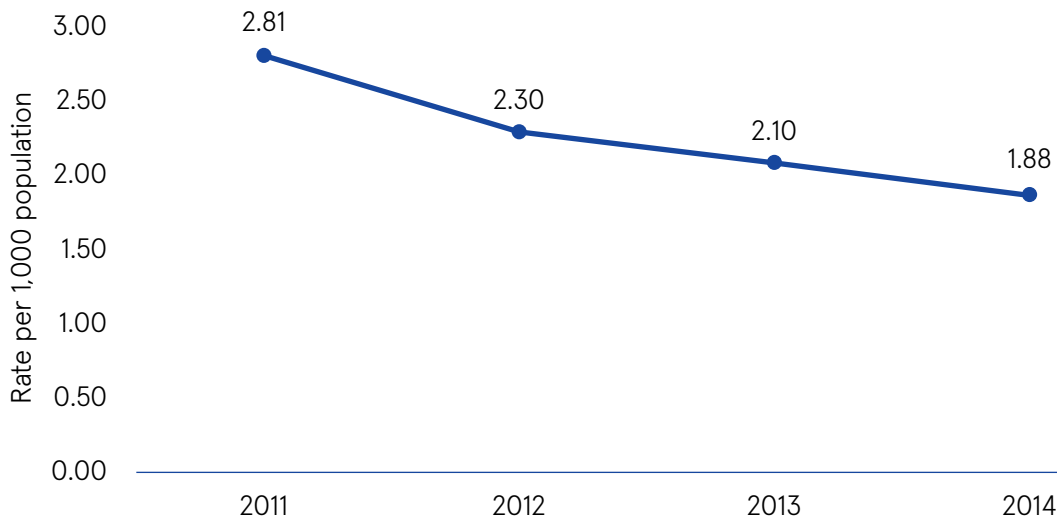
### 5.6.1 Prevalence of problem opioid use

To date, four problematic opioid use studies (three national and one regional) have been conducted to estimate the prevalence of problematic opioid use in Ireland. These were undertaken in 1996 (Dublin only) [102], 2001, [103], 2006 [104] and 2014 [100].

The 2014 problematic opioid use study estimated that there were 1,092 problem opioid users aged 15–24 years in Ireland (95% CI: 1,076–1,234) in 2014. This corresponds to a prevalence rate of 1.88 per 1,000 of this population age group (95% CI: 1.85–2.13) [100].

Figure 29 shows that there has been a decline in the rates of problematic opioid use among 15–24-year-olds in Ireland, from 2.81 per 1,000 population in 2011 to 1.88 per 1,000 population in 2014.

Figure 29 Trends in the number of problem opioid users in Ireland aged 15–24 years between 2011 and 2014



Source: Hay et al., 2017 [100]

Since 2011, the overall prevalence of problem opioid users in Ireland has remained relatively stable; the number of young problem opioid users (aged 15–24 years) has declined, but the number of those aged 35–64 years has increased, representing an ageing cohort effect. When compared with international studies of opioid prevalence across all age groups, estimates in Ireland are among the highest in Europe although there is no age specific data available [5, 105].

#### 5.6.1.1 Prevalence of non-medical use of opioid pain relievers

Non-medical use of opioid pain relievers was defined for the 2019–20 NDAS as the use of these medicines without personal prescription from an appropriate practitioner, taking larger doses than prescribed, taking these medicines for a longer period, or taking them for different purposes than prescribed [7].

The proportion of 15–34-year-olds in the 2019–20 NDAS who reported non-medical use of opioid pain relievers in the last year was 2.0% (2.4% of females and 1.5% of males) [7]. Among schoolchildren participating in the ESPAD in Ireland in 2019, 5.4% reported using ‘painkillers to get high’ in their lifetime. The prevalence of use of these substances in Ireland in 2019 was above the European average (4.0%) [10,32].

## 5.7 Volatile substances (inhalants/solvents)

Volatile substances are inhalants and solvents that include glues, gases, and aerosols. They can be inhaled through the nose or mouth, usually by sniffing, snorting, bagging, or huffing, and they contain substances that have psychoactive properties when inhaled. The high from inhalants is short-lived (minutes), and so they are often used repeatedly to achieve the same high in a short space of time [106].

Volatile substances are a diverse group of substances whose chemical vapours can be inhaled to produce psychoactive or mind-altering effects. These substances vaporise at room temperature and include a variety of products commonly found in the home, school, and workplace which contain volatile substances that can be inhaled. The products are not illegal substances, and people do not typically think of these products as drugs, because they were never intended to induce intoxicating effects, yet young children and adolescents can easily obtain these toxic substances. A number of different terms are used interchangeably in this section to refer to volatile substances, including *poppers*, *nitrous oxide*, *aerosols* and *solvents*.

Although other substances can be inhaled, the term ‘inhalants’ is used to describe a variety of substances whose main common characteristic is that they are rarely, if ever, taken by any route other than inhalation. They usually come in small bottles or cannisters and are inhaled directly from the bottle or from a cloth. They work by dilating blood vessels, allowing more blood to reach the heart, and as the heartbeat speeds up, blood rushes to the head and thus the high/euphoria is achieved. The effects of using inhalants can range from headaches, nausea, coughing, dizziness, and skin problems around the nose and mouth to passing out, and can be fatal if the inhalants are swallowed [106].

### 5.7.1 Prevalence and patterns of inhalant and solvent use

In participating European countries in the ESPAD, 7.2% of schoolchildren reported lifetime inhalant use, with more males than females reporting their use (7.3% versus 7.1%) [32].

#### 5.7.1.1 Inhalant and solvent use among young people

In the 2019–20 NDAS, 1.2% of 15–24-year-olds reported using solvents in their lifetime; more commonly used among males (1.6%) than females (0.8%) [7].

Lifetime use of poppers was reported by 7.0% of young people: 10% of males and 3.8% of females. Last year use of poppers was 4.6% (7.3% among males and 1.9% among females) [7].

Other surveys capturing volatile substance use are presented here:

- When interviewed at 20 years of age, 4% of GUI study respondents reported having used poppers in their lifetime [37].
- Among a sample of third-level students in Limerick, 2.5% reported using solvents once or twice in the last year, and more males than females reported solvents use (2.8% versus 2.2%) [86].

### 5.7.1.2 Inhalant and solvent use among schoolchildren

According to the 2019 ESPAD, lifetime use of inhalants among schoolchildren in Ireland was 10%, higher than the ESPAD average of 7.2% (11% among males and 9.5% among females) [10]. Last year use was 5.4% (5.6% among males and 5.3% among females).

Among 2019 ESPAD respondents, the mean age of first use of inhalants was 14 years [10]; this was lower among a sample of schoolchildren who used drugs in the Blanchardstown Local Drug and Alcohol Task Force area, at 13 years in 2019 (although this was an increase from 12 years in 2018) [107].

Other surveys captured volatile substance use and found the following:

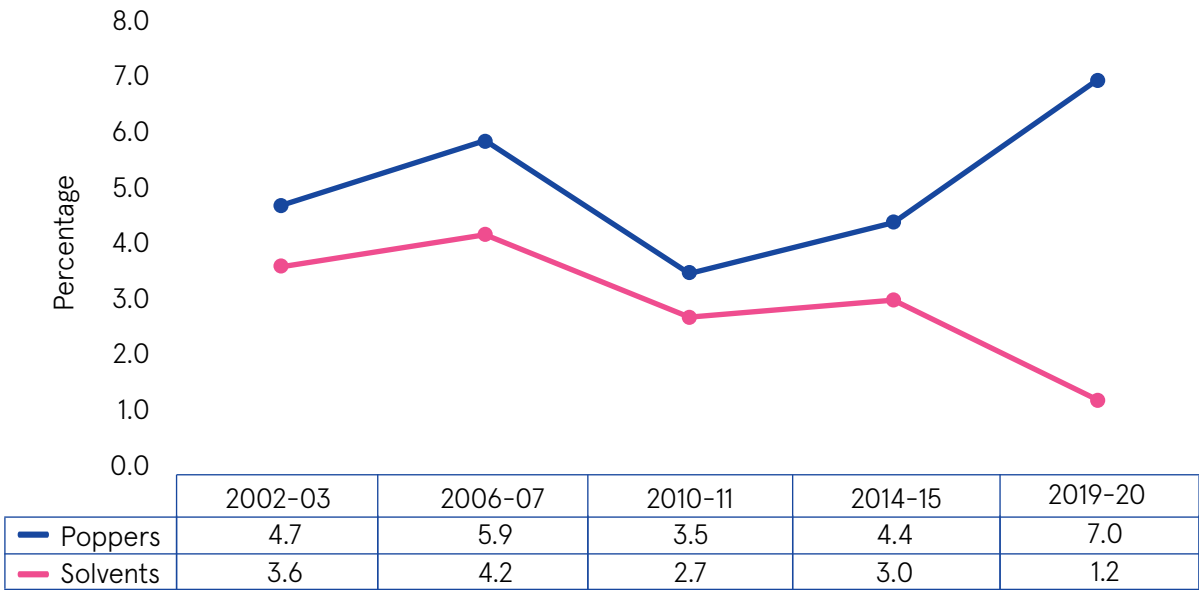
- The GUI study found that 4.4% of 17–18-year-olds interviewed in 2015–16 had used aerosols or solvents [13].
- The 2020 Planet Youth survey found that 3.7% of adolescents aged 15–16 years reported use of nitrous oxide [18–20].

A qualitative study, *Solvent use among young Irish adolescents: a growing concern for youth workers, teachers and parents?*, involved a group of 20 young people (mean age=13.2 years) who reported volatile substance use. The schoolchildren were classified as ‘seasonal social users’, because they used solvents in groups, most commonly outdoors and during the summer. The authors noted that this was likely due to increased free time during holidays, lack of parental supervision, and lack of appropriate opportunities for recreation. The reported reasons for using volatile substances were out of curiosity, sensation seeking, enjoying the experience, and boredom, and use was determined mostly by cost and household availability. The average age of first use among this group was 10 years. Frequency of subsequent use was sporadic and opportunistic, and most stopped using by the age of 13 years. A common response regarding reasons for no longer using volatile substances was progressing to using alcohol and other drugs [108].

### 5.7.2 Trends in inhalants and volatile substances use

The 2019–20 NDAS data showed a decrease in lifetime use of solvents between 2014–15 (3.0%) and 2019–20 (1.2%) (Figure 30). The rates of last year (0.5%) and last month (0.1%) use have also decreased between 2014–15 and 2019–20. Lifetime use of poppers, on the other hand, has fluctuated between surveys, from 4.7% in 2002–03 to its highest level, 7.0%, in 2019–20 [7].

Figure 30 Trends in lifetime use of poppers and solvents among young people aged 15–24 years



Source: Mongan et al. 2021 [7]

In Ireland, lifetime use of inhalants among ESPAD schoolchildren has dropped from a high of 15% in 2007 to 10% in 2019. The rate of inhalant use in Europe have remained relatively stable since 2007 (8.8%) [10].

## 5.8 New psychoactive substances

New psychoactive substances (NPS) are those that are not controlled by the 1961 Single Convention on Narcotic Drugs or the 1971 Convention on Psychotropic Substances, but which may threaten the health of the public [109]. NPS that imitate the effects of illegal drugs such as cannabis or ecstasy are sometimes called ‘legal highs’, ‘ethnobotanicals’, or ‘research chemicals’ and can come in different forms (herbal mixtures, powders, crystals, or tablets). The two main groups of NPS are synthetic cathinones and synthetic cannabinoids.

Since 1997, the EMCDDA has played a central role in Europe’s response to NPS. Its main responsibilities in this field are to operate the EU Early Warning System with its partner Europol, and to undertake risk assessments of new substances when necessary. The EU Early Warning System works by collecting information on the appearance of new substances from the 27 member states, and also from Turkey and Norway, and then monitoring them for signals of harm, allowing the EU to respond rapidly to emerging threats [109]. It is difficult to measure the extent to which young people are using NPS, but there have been a number of attempts to measure prevalence, and they are considered here.

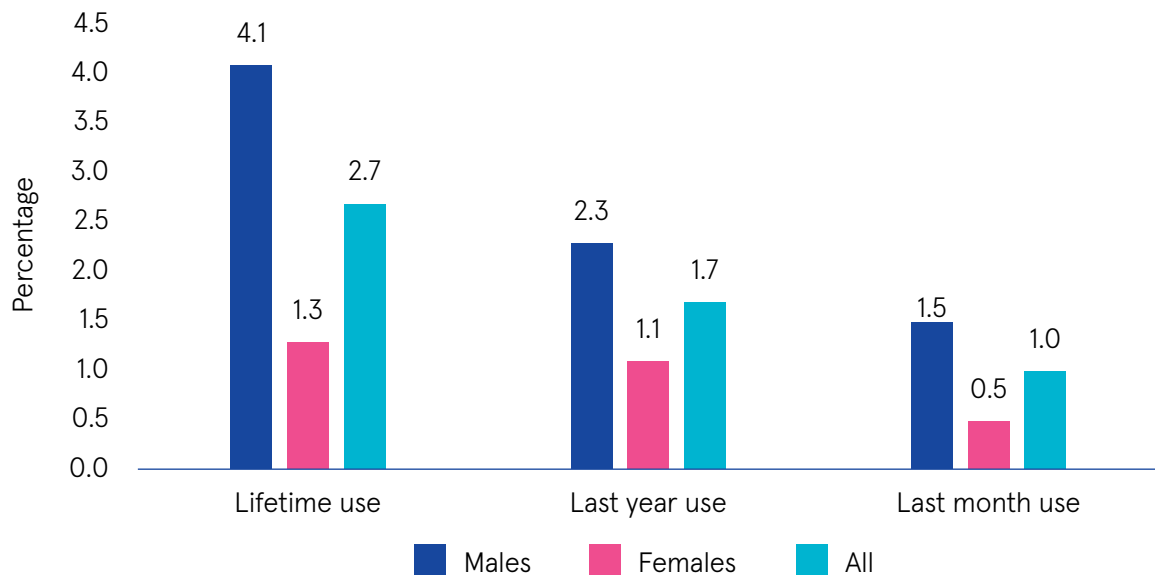
## 5.8.1 Prevalence and patterns of NPS use

ESPAD schoolchildren in participating countries across Europe were asked if they had ever used substances that imitate the effects of illegal drugs, as well as the type of substance that they used [32]. The ESPAD prevalence of lifetime NPS use was 3.4% (3.4% for males and 3.3% for females). The lifetime prevalence of synthetic cannabinoid use was 3.1% (3.5% for males and 2.7% for females) and the lifetime prevalence of synthetic cathinone use was 1.1% (1.4% for males and 0.8% for females).

### 5.8.1.1 NPS use among young people

The 2019–20 NDAS indicated that 2.7% of 15–24-year-olds reported lifetime use of NPS, 1.7% reported last year use, and 1.0% reported last month use. Males were more likely than females to report NPS use (Figure 31) [7].

Figure 31 Prevalence of NPS use among young people aged 15–24 years



Source: Mongan et al. 2021 [7]

Among third-level students participating in the DUHEI survey, 3.1% reported NPS use in the last year [24].

### 5.8.1.2 NPS use among schoolchildren

Among the Irish 2019 ESPAD sample, 4.7% reported lifetime NPS use. More males than females reported lifetime use of NPS (6.6% versus 2.9%) [10].

With regard to specific NPS, 1.7% of ESPAD respondents in Ireland reported lifetime use of synthetic cannabinoids and 2.5% reported lifetime use of synthetic cathinones. More males than females reported using synthetic cannabinoids (2.4% versus 1.0%) and synthetic cathinones (2.7% for males versus 2.3% for females) [10].



## 5.8.2 Head shops

Prior to legislation introduced in 2010, head shops were retail outlets that specialised in paraphernalia used for cannabis and tobacco consumption, such as pipes, bongs (water pipes), weighing scales, plant-growing equipment, and a number of products that were still legal (before 2010), but were ultimately used to alter mood and sensory perception. These shops sold substances such as herbal incense, a cannabis alternative that often contains synthetic cannabinoids; products imitating the effects of opiates; cocaine alternatives in the form of bath salts; pills designed to mimic the effects of speed; party pills designed to give an ecstasy-like euphoria; and psychoactive herbs sold at various strengths with hallucinogenic properties. The products were unregulated and were often potent and dangerous and, as a result, the Irish Government made an order declaring the so-called 'legal highs' to be controlled substances under the Misuse of Drugs Act 1977. Legislative changes in 2010 meant that head shops (or anyone else) could no longer sell NPS, and thus NPS were no longer easily available [110,111].

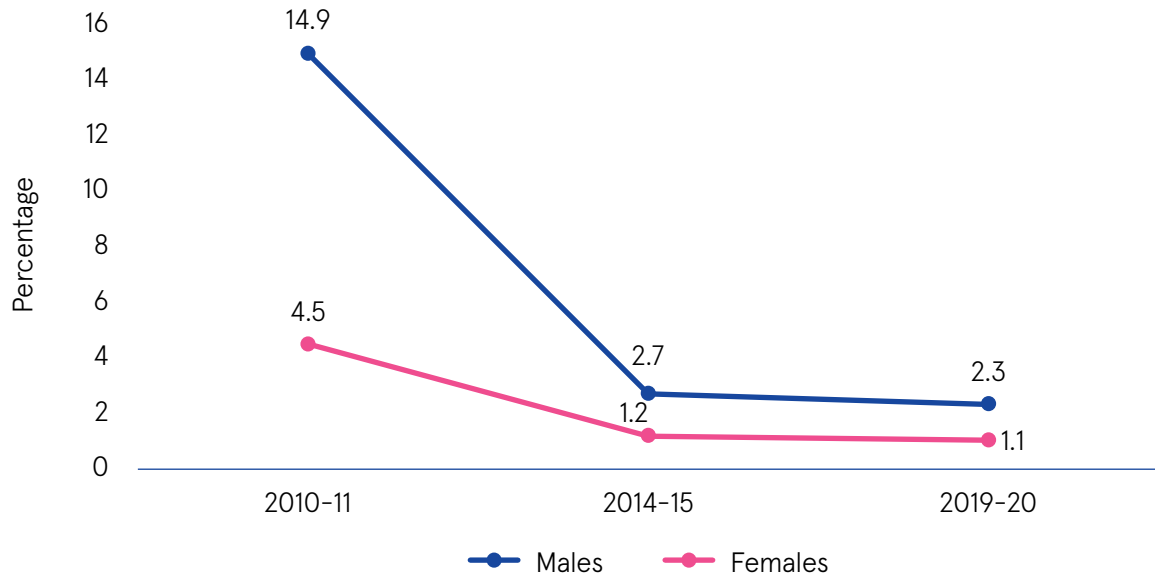
### 5.8.2.1 Impact of legislative changes on NPS use

A 2015 study, *"So prohibition can work?" Changes in use of novel psychoactive substances among adolescents attending a drug and alcohol treatment service following a legislative ban*, analysed treatment data to investigate the impact of the legislation and changes in substance use among 92 treatment-attending adolescents (median age=17 years) [112]. The study compared assessments between a 6-month period before the ban and a 6-month period shortly after the ban. Although rates of lifetime use of NPS were very similar in the two periods (82% pre-ban and 77% post-ban), adolescents attending for treatment after the ban demonstrated lower rates of both recent (82% pre-ban and 28% post-ban) and problematic (32% pre-ban and 0% post-ban) use of NPS. The introduction of the legislation did not eliminate the use of NPS, but this study confirmed a substantial reduction in the use of NPS among adolescents entering treatment shortly after the ban.

Another study investigating the impact on NPS use following the introduction of the legislation looked at drug-related emergency hospital admissions (DRHAs) in the period following the ban [113]. The period before the legislation came into effect (the first 8 months of 2010) saw a rate of DRHAs that was 9% higher than the same period in 2008. In order to assess the impact of the legislation, all DRHAs to Irish hospitals among people aged 15–34 years were analysed. Over the course of the 2 years following the implementation of the legislation, during which time NPS were not sold freely, the rate of DRHAs fell by 30% [114].

Figure 32 illustrates the impact that the introduction of the legislation had on reports of last year use of NPS, which fell from 9.7% (15% among males and 5% among females) in 2010–11 NDAS to 1.7% in 2019–20.

Figure 32 Impact of legislative changes in last year prevalence of NPS use among young people aged 15–24 years



Source: Mongan et al. 2021 [7]

## 5.9 Polydrug use

Polydrug use, the use of two or more drugs (including alcohol) either on the same occasion or within a specified period of time can be a dangerous practice but is common among young people and, as such, where data in this overview refer to a specific drug, it is to be expected that there is overlap between use of other drugs too. The 2019–20 NDAS analysed each substance separately but the survey did reveal that of those aged 15–24 years who reported use of any illegal drug, 51% reported the use of one drug, 22% reported using two drugs, and 27% reported using three or more drugs in the last year [7].

A number of studies have investigated polydrug use including one that examined a sample of Irish festivalgoers. The majority reported polydrug use, most commonly an average of three substances (with a minimum of two and a maximum of eight); combinations involving alcohol, cocaine, ketamine, and ecstasy were the most commonly cited [115].

Of third-level students surveyed for the DUHEI survey in 2021 about their drug use, 44% of those who were current drug users reported using two or more drugs on the same occasion [24]. Among a sample of 36 adolescents (mean age 16.6 years) attending a treatment service, polydrug was common (42%) [116].

The prevalence of polydrug use needs to be examined further and the dangers of such use highlighted to young people as they can have serious and devastating consequences, both psychologically and physically, for example, the combination of cocaine with alcohol

where cocaethylene develops in the liver as a result of the metabolic processing of both substances. The issue of polydrug use, including what combinations of drugs are used, is highlighted as a gap in the literature.



**44% of third-level students**  
who were current drug users reported using  
two or more drugs on the same occasion

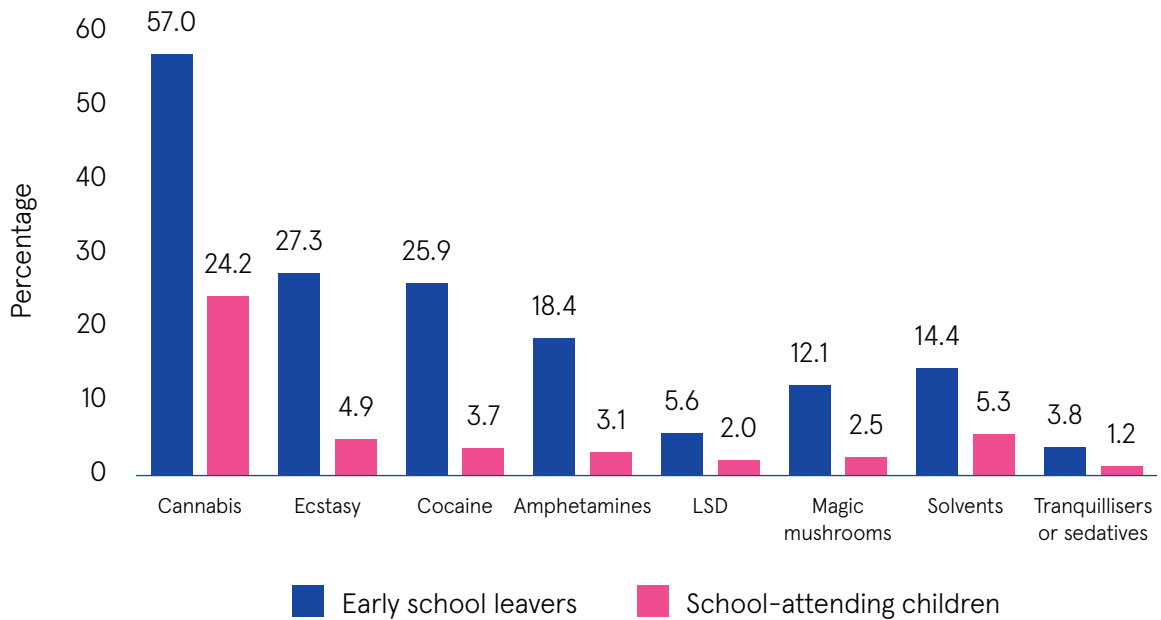
## 5.10 Drug use among vulnerable populations

While much data are collected on drug use in the general population, it is of equal importance to gain insight into drug use among certain subpopulations (for example, early school leavers, individuals in prison, individuals who are homeless, sex workers, and members of the Traveller community). Such information can help to monitor who is at current and future risk of harmful drug use, inform the development and targeting of intervention planning, and assist in policy monitoring. In addition to presenting international and Irish prevalence and patterns of drug use, this overview presents data relating to drug use among these vulnerable populations in Ireland, where available.

### 5.10.1 Drug use among early school leavers

In 2010, a comparative survey of illegal drug use among 479 early school leavers who were attending either a Youthreach or community training centre, and 512 school-attending schoolchildren aged 15–18, was completed [117]. The study reported higher prevalence of illegal drug use among early school leavers than among their school-attending peers. Cannabis was the most commonly used drug among early school leavers in their lifetime (57%) and last year use (43%) (compared with 24% and 15% for their school-attending peers). Higher rates of use were also reported for other drugs among early school leavers than among school-attending children (Figure 33).

Figure 33 Lifetime use of illegal drugs among school-attending schoolchildren and early school leavers

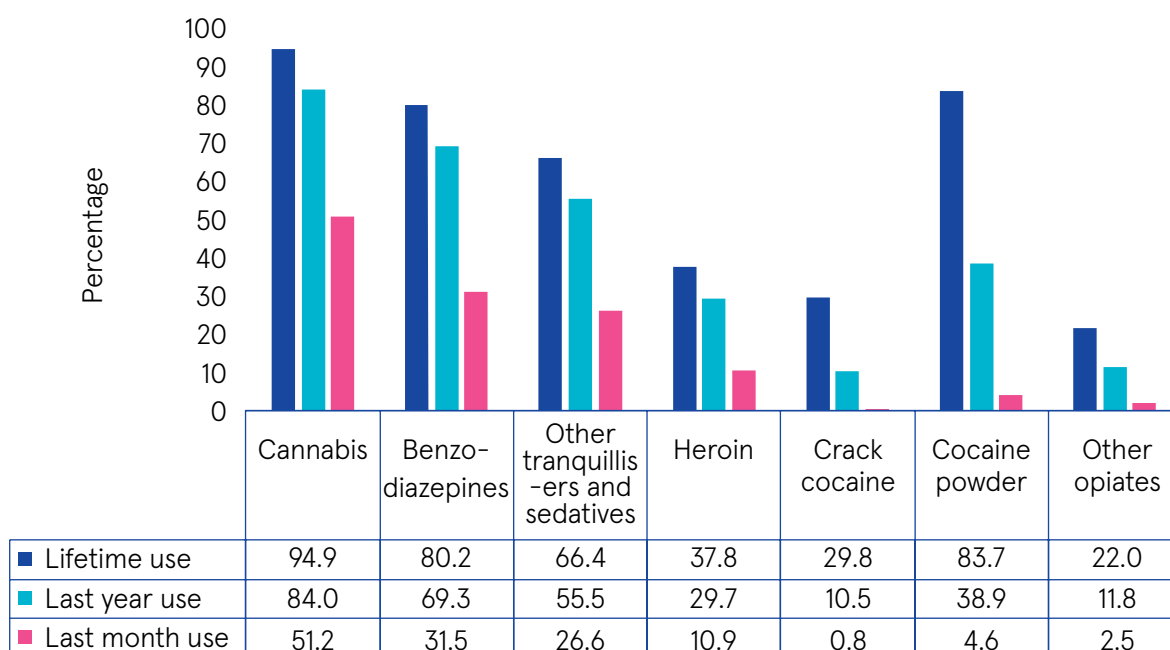


Source: Haase and Pratschke, 2010 [117]

### 5.10.2 Drug use among young people in the criminal justice system

A 2011 study of drug use prevalence among 824 inmates (sentenced and on remand) in prison in Ireland, of whom 31% (n=254) were aged 18–24 years, found a pattern of increased drug use among this younger age group of prisoners. More respondents aged 18–24 years had used cannabis in their lifetime (95%) compared with older age groups (93% of those aged 25–34 years and 70% of those aged 35–64 years). In addition, 84% of the younger inmates had used cannabis in the last year compared to 73% of 25–34-year olds and 46% of 35–64 year olds, and 51% had done so in the last month (Figure 34) (compared to 47% of 25–34-year-olds and 29% of 35–64-year-olds [118]).

Figure 34 Prevalence of drug use among the prisoner population aged 18–24 years



Source: Drummond et al., 2014 [118]

In a 2013 report of young offenders on probation supervision, *Drug and alcohol misuse among young offenders on probation supervision in Ireland: findings from the Drugs and Alcohol Survey 2012*, 87% had misused a substance (12% had misused drugs only, 12% had misused alcohol only and 63% had misused both drugs and alcohol). Cannabis was the second most misused substance (reported by 20% of males and 15% of females) on a weekly basis, after alcohol. Males were more likely than the females to have misused one or more substances (89% versus 74%) [119].

When the survey was repeated in 2021, findings from the 2021 Probation Services report, *Informing & Supporting Change: Drug and Alcohol Misuse among People on Probation Supervision in Ireland*, there was little change in the situation since the 2012 survey; 86% of offenders aged 18–24 years had misused drugs and/or alcohol (20% had misused drugs only, 9% had misused alcohol only and 57% had misused both drugs and alcohol) [119,120]. Cannabis misuse was higher among the 18–24-year-old male offender population than among the female offender population.

A 2019 report derived from a review of the files of young people aged 14–18 years in detention in the Oberstown Children Detention Campus, *Key characteristics of young people in detention: A snapshot*, found that among those in the Detention Campus, 71% were considered to have substance misuse problems [121].

### 5.10.3 Drug use among the young LGBTI population

A 2007 report on substance use, *Drug use amongst Lesbian, Gay, Bisexual and Transgender young adults in Ireland*, found that, of a sample of 173 LGBTI individuals aged 18–26 years, nearly two-thirds (60%) had used drugs in the last year, 40% in the last month, and 29% in the last week, while 21% had systematically used drugs [122]. The most frequently used drug reported in their lifetime was cannabis (56%), followed by ecstasy (33%), cocaine (32%), and amphetamines (20%). Of those who had used drugs, 8% reported that ‘something to do with their sexuality’ led to their first occasion of drug use. Another study, *The LGBT Ireland report: national study of the mental health and wellbeing of lesbian, gay, bisexual, transgender and intersex people in Ireland*, found that 50% of participants aged 14–25 had used drugs in their lifetime; 30% of those aged 14–18 years and 63% of those aged 19–25 years [61].

A study, *Drug use among men who have sex with men in Ireland: Prevalence and associated factors from a national online survey*, found that among men who have sex with men, almost one-half (48%) of respondents aged 18–25 years had used any illegal drug in the last year and cannabis was the most commonly reported drug used (43%) [123].

### 5.10.4 Drug use among young people who are homeless

Research conducted in Ireland has found that young people who are homeless are more likely to use drugs than older people who are homeless. A study among a sample of 601 adults who were homeless, *Homelessness: an unhealthy state. Health status, risk behaviours and service utilisation among homeless people in two Irish cities*, found that those aged 18–20 years reported higher levels of current and past drug use than those in older age groups. Among current drug users in the 18–20 years age group, the most common substances used in the last three months were cannabis (58%), benzodiazepines (55%), heroin (44%), and cocaine (18%) [124].

Findings from a study examining the health of 115 women who were homeless, *Women’s health and homelessness in Cork. A joint snapshot study of the health and related needs of women who are homeless in Cork*, indicated that 24% of 16–26-year-olds were current drug users, and cannabis was the most commonly reported drug (12%) [125].

Cannabis was again the most commonly used drug in another study, *Not just homelessness... A study of ‘out of home young people in Cork’*, where 37 young people aged 16–25 years who were homeless or living in insecure accommodation in Cork city were interviewed. As well as cannabis, cocaine, ecstasy, and prescription medicine were the most commonly used substances [126].

## 5.11 The COVID-19 pandemic and drug use

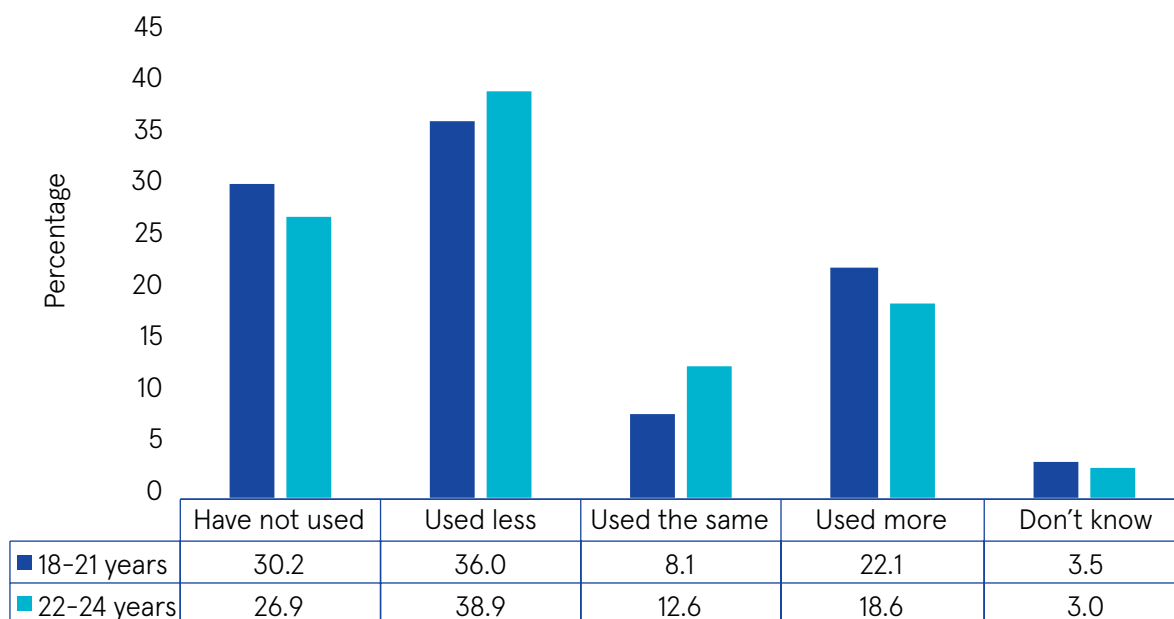
Evidence of substance use during the COVID-19 pandemic is still emerging and it will take time before the full effects are revealed. Several surveys have been carried out to establish changes in drug and alcohol use as a result of the COVID-19 pandemic. Among Planet Youth Survey respondents surveyed in 2020 in counties Galway, Mayo, and Roscommon, 25%

of schoolchildren reported reducing their drug use following lockdowns as a result of the COVID-19 pandemic, while 5.7% reported increased drug use [18–20].

The DUHEI survey among third level students found that 36% of students who reported recent drug use or current drug use felt that the frequency of their drug use had decreased since the start of the pandemic, 24% felt it had increased, while 14% felt it had remained the same. For those who reported increased drug use since the start of the pandemic, 45% said it was due to boredom, 36% said it was because they had more time to use drugs, 28% said their increased drug use was due to the stress caused by the pandemic, 26% said that it was due to spending more time using drugs with household or partner, 20% said they were using drugs as a reward for coping with the pandemic situation and 19% said it was because they were feeling depressed. Participants could select more than one reason [24].

A Department of Health survey (N=696), *Impact of COVID-19 on drug and alcohol services and people who use drugs in Ireland*, assessed the impact of the COVID-19 pandemic on drug and alcohol services. Two-fifths of the sample were aged 18–24 years and among those, more young people reported decreasing their illegal drug use since the start of the pandemic (Figure 35) [127].

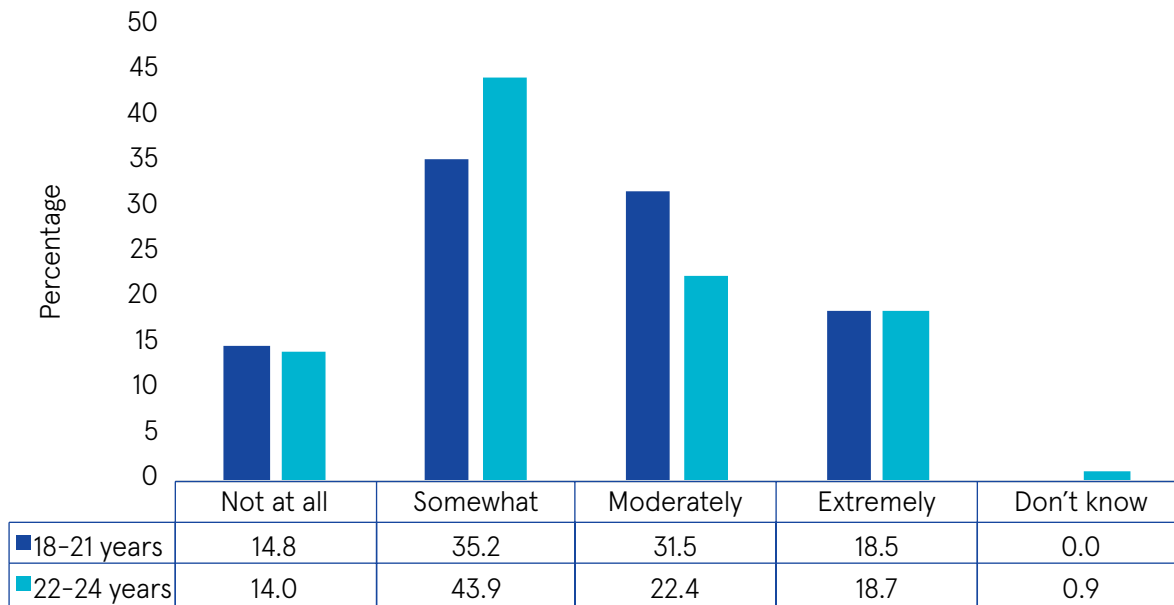
Figure 35 Illegal drug use since the beginning of the COVID-19 pandemic, by age group



Source: Bruton et al., 2021 [127]

Respondents were also asked if there had been a change in their intention to seek professional support for their use of illegal drugs since the COVID-19 pandemic began. The majority of those aged 18–24 years did not experience any change in their intentions during the pandemic (84% of 18–21-year-olds and 87% of 22–24-year-olds); however, 13% of 18–21-year-olds and 10% of 22–24-year-olds reported an increase in their intentions to seek professional support [127]. The majority of 18–24-year-olds reported some level of difficulty accessing illegal drugs as a result of the COVID-19 pandemic (Figure 36).

Figure 36 Difficulty accessing illegal drugs as a result of the COVID-19 pandemic, by age group



Source: Bruton et al., 2021 [127]

Young people (n=113) participating in Garda Youth Diversion Projects completed surveys with Youth Justice Workers to examine their compliance with COVID-19 pandemic public health measures and how the restrictions had impacted their lives. The study revealed that there was a tendency for non-compliance by a minority of young people to be associated with at-risk behaviour including drug and alcohol misuse and that the mental health of many of the young people was an important issue identified which in turn led to increased substance use [128].

## 5.12 Summary: drug use and patterns of use

This chapter presented information on the prevalence of drug use among adolescents and young people. More than one-quarter of young people aged 15–24 years in Ireland reported use of an illegal drug in their lifetime and almost one-fifth reported illegal drug use in the last year similar to that reported elsewhere in Europe. Lifetime use of all drugs reported in the NDAS has plateaued between the 2014–15 survey and the 2019–20 survey, although use of stimulants increased between surveys.

Illegal drug use among schoolchildren in Ireland were higher than the European average, specifically cannabis, ecstasy, cocaine, and inhalants. However, sedative and tranquilliser use among schoolchildren in Ireland was lower than the European average, and although an increase in their use was evident across Europe, there was a decrease in Ireland.



Cannabis was the most commonly reported drug used by young people in Ireland as well as the rest of Europe and has remained so since the first NDAS in 2002–03. Ecstasy was the second most commonly reported drug used, followed by poppers and cocaine. The rate of ecstasy use among schoolchildren in Ireland was the second highest reported in all participating ESPAD countries, and cocaine and LSD use in Ireland saw an increase between 2015 and 2019. Higher rates of drug use among vulnerable populations was evident, with early school leavers reporting higher rates of drug use when compared to their school-attending peers. Also displaying higher levels of drug use were those in prison, people who were homeless, and those within the LGBTI population.

Although drug use has remained fairly static since the early-2000's, its prevalence remains a cause for concern. The fall in the levels of opiate use among young people is a positive development, and the much lower rate of NPS use since 2010 demonstrates what robust legislation can achieve. However, increasing use of stimulants (particularly ecstasy and cocaine) and the greater use of two or more substances simultaneously are worrying developments. Young males were more likely than females to report use of any illegal drug. However, there are indications of a narrowing of the gap between sexes, with a decline in last month any illegal drug use reported by males but an increase reported by females between the 2014–15 and 2019–20 NDAS. While the use of cannabis has declined slightly among the younger population cohort (15–24 years), the perception that cannabis is easy to obtain and the fact that young people are less likely than those in older age groups to perceive a risk in cannabis use need to be considered when developing prevention responses.

# 06

---

## **Risk and protective factors associated with the use of alcohol and other drugs**



Adolescence through to early adulthood is often a challenging and vulnerable period for young people, as they experience various psychological and social factors in their environment that impact on their health, mental well-being, and maturation. There are several stressors in their lives, including exams, new relationships, and additional responsibilities. How adolescents cope with these changes can have long-term influences on all aspects of their development. Risky coping mechanisms such as alcohol, drugs, and smoking may reduce the feeling of stress in the short term but have potentially harmful side effects and ultimately fail to resolve the original difficulty [13]. Research has shown that changes in the brain's cognitive control system during puberty results in increased risk-taking, particularly when with peers, and declines between adolescence and adulthood as young adult's capacity for self-regulation improves [129].

Along with cultural and societal norms around substance use and the influence of alcohol marketing and the media (including social media), a number of risk and protective factors impact the initiation of substance use among young people and potentially the development of problematic use. These factors include personality characteristics, family, peers, school and education, socioeconomic status, environmental factors, and other factors. The risk and protective factors are not mutually exclusive, and no one factor alone suggests that an individual is more or less likely to experience problems with alcohol and/or drugs; however, the more risk factors there are in a young person's life, the more likely they are to engage in problematic behaviours. Conversely, the more protective factors young people have in their lives, the less likely they are to engage in such behaviours [130]. The evidence, both from Ireland and that supplemented from international sources, confirms that such factors play a role in shaping substance use behaviours, particularly during adolescence. Herein, selected risk and protective factors for adolescent substance use are divided into three main categories: personal, familial and social factors.

## 6.1 Personal factors

### 6.1.1 Age of initiation

Irish studies on substance use behaviours among adolescents have shown that early substance use among adolescents is associated with an increased likelihood of risky drinking and drug use later in life and an increased likelihood of experiencing alcohol- and drug-related harms [131–133]. Findings from the GUI study of 17–18-year-olds interviewed in 2015–16 confirm this link: higher AUDIT scores were reported by those who began drinking alcohol at an earlier age (13 years) than by those who had not started drinking this young [13], and the likelihood of risky drinking later in adolescence increased the earlier individuals started drinking [131,132]. When GUI respondents were interviewed again at 20 years of age, *The lives of 20-year-olds: Making the transition to adulthood*, those who reported drinking at or before 13 years of age remained more likely to be categorised as high-risk drinkers (10% or very high-risk (7%), compared to 7% and 4% respectively of those who did not report initiating alcohol use this early [37] In a 2017 study, Smyth et al. found that early initiation of alcohol use and use of cannabis were predictors of lifetime use of cocaine among young adults in Ireland [134].

Intervention strategies should therefore seek to delay alcohol use and other drugs as a means of avoiding problems later in life, and this is central to the Public Health (Alcohol) Act 2018 and the national drugs strategy [2,30].

---



## Earlier initiation of alcohol use was associated with riskier drinking

---

### 6.1.2 Sex

Evidence from surveys among adolescents indicate that sex is a key predictor for drug use. Across geographical areas and time, research has consistently reported a higher prevalence of drug use and a greater tendency to develop dependence on drugs among adolescent males than among females [7,9,10,13,32,135].

For alcohol use, especially among schoolchildren, the gap between male and females has been closing, with young females equally as likely to report alcohol use and drunkenness as young males in the 2019 ESPAD, 2020 GUI, and 2018 HBSC studies [10,11,136]. However, among a wider age cohort (15–24 years) in the 2019–20 NDAS, the gap between males and females is more pronounced. It shows a higher prevalence of alcohol use (particularly HED, and hazardous and harmful drinking) among males than among females; the findings were similar among 2018 Healthy Ireland Survey respondents aged 15–24 [7,9,137]. However, sex differences were less pronounced for prevalence of AUD as females (38%) were as likely as males (37%) to be classified as having an AUD in the 2019–20 NDAS.

### 6.1.3 Ethnicity

There is limited Irish literature on the role of ethnicity and substance use. However, young people from the Traveller community and non-white ethnic minorities have been reported to be less likely than the general population of young people to consume alcohol and to use cannabis [117,138]. Although there was no age breakdown provided, the Irish Health Survey reported that non-Irish nationals were the least likely to report HED patterns when compared with all other respondent groups [21]. Among members of the Traveller community aged under 30 years participating in the 2010 *All Ireland Traveller Health Study*, a higher percentage reported never drinking alcohol (41%) when compared with respondents in the 2007 Survey of Lifestyle, Attitudes, and Nutrition (SLÁN) (11%) [138]. However, this information is now outdated and it is timely to address this area.

### 6.1.4 Sexual orientation

Adolescence is a period of experiencing and exploring sexual feelings, and interest in sexuality intensifies during the onset of puberty. For some, this can be a difficult experience as they process their feelings and emotions, especially if there are concerns about their sexual orientation. The 2010 Saving and Empowering Young Lives in Europe (SEYLE) study examined several areas – including substance use, mental health difficulties, and suicidal behaviour – and found that adolescents and young adults who reported being worried about their sexual orientation were at least 16.5 times more likely to use alcohol regularly and 9.3 times more likely to have previously used drugs than their peers without these concerns [139].

A survey of 1,112 Irish adolescents (mean age=14 years), *Victimisation and psychosocial difficulties associated with sexual orientation concerns: a school-based study of adolescents*, reported an association between concerns about sexual orientation and reports of being drunk. The majority of adolescents with sexual orientation concerns reported experiences of being drunk (91%) whereas the comparable figure for their peers without such concerns was 36% [140].

### 6.1.5 Personal characteristics

International evidence has confirmed that certain personality characteristics can be linked to HED and the development of substance use disorders, such as impulsivity and sensation seeking, higher extraversion, low conscientiousness, anxiety, sensitivity, and neuroticism [141,142]. Irish surveys have identified a number of characteristics that appear to be linked to increased alcohol and drug use. For example, low-risk drinkers in the MWS-2 displayed higher levels of optimism, personal competence, friend support, and self-esteem than harmful and hazardous drinkers and those classified as possibly alcohol dependent, who displayed low levels of self-esteem, body esteem, and resilience [16]. In addition, those who were likely to display aggressive ‘acting-out’ behaviour were more likely to use alcohol and drugs [117].

### 6.1.6 Participation in sport or physical activity

Young people commonly cite boredom and a lack of amenities in their community as a reason for using alcohol and drugs [10,74,76,108,143,144] and, as such, participation in sports and physical activity may prevent young people from using substances. However, international evidence indicates that sport participation is positively associated with alcohol use and that those who participated in group sport activities drank more than those who participated in sport activities as individuals [145–147].

An Irish study looking at alcohol consumption patterns, behaviours, and harms among Gaelic Athletic Association (GAA) players (N=960; mean age=24 years) found that the majority (90%) were current drinkers, with more than one-half (54%) reporting regular HED [148]. Although the cohort included older players, the study provides an important indicator of alcohol use and harms among GAA players. The majority of players had high AUDIT scores, and 12% had a score that would warrant referral for diagnostic evaluation and treatment. The vast majority (88%) of players reported experiencing harm due to their drinking, and there were strong

associations between regular HED and reporting harms such as being in a fight, missing time from work or college, or being in an accident.

Conversely, in a cross-sectional study of 176 adolescent substance users aged 12–21 years who were attending residential addiction programmes in Ireland, increased participation in physical activity was linked to low drug use among adolescents. These results are consistent with results of systematic reviews suggesting that engagement in physical activity is protective against drug use but not alcohol use [146,149].

These findings are supported by those in the 2018 Planet Youth survey. Among adolescents in Mayo participating in the 2018 Planet Youth survey, those who reported being very active in a sports club or team (four times a week or more) were less likely to report lifetime cannabis use (11%) than those who did not participate in sports with a club or team (19%). However, the finding was not replicated for reports of drunkenness; those very active with a sports club or team were more likely (28%) than those not active (24%) to report lifetime drunkenness [150].

### **6.1.7 Participation in music, art, drama or dance**

In the 2020 Planet Youth survey, schoolchildren who participated in music, art, drama or dance were less likely to report being drunk in their lifetime (42%) compared to those who did not participate in such activities (49%). Similarly, those who participated in these activities were less likely than those who did not, to report lifetime use of cannabis (19% versus 12%) [18–20].

### **6.1.8 Attitudes and perceived risks**

The attitudes and beliefs held by young people may influence their alcohol and drug use behaviours. Their environment and what they witness around them can form an important part of their lifestyle and influence the choices they make. Results from the 2019–20 NDAS indicated that respondents aged 15–34 years who had used ecstasy, cocaine, or cannabis were, unsurprisingly, less likely to disapprove of their use; 33% of those who had ever used cannabis disapproved of its occasional use, and 30% of cannabis users perceived a great risk in smoking cannabis regularly. Moreover, almost one-half (49%) of younger NDAS respondents (aged 15–34 years) did not perceive great risk in binge drinking (43% of males and 53% of females) [7].

In a 2016 study, *Attitudes and perceived risk of cannabis use in Irish adolescents*, secondary school students aged 15–18 years were asked about their attitudes towards, and perceived risks of, cannabis use. Cannabis users were less likely to perceive a great risk in regular cannabis use than those who had not used cannabis [82]. Millar et al. noted that the increased risk of CUD among the 15–24 years age group (higher than all other age groups in the NDAS) may be as a result of peer influence and a reduced perception of the health risks associated with cannabis use among adolescents and young people [151].

A study carried out in 2013–14 by the North Inner City Drugs and Alcohol Task Force facilitated a number of conventions to hear the views of 400 local young people (aged 15–17 years) about drugs and alcohol [152]. When asked, the young people involved spoke of how alcohol and drugs were widely used and acceptable and were associated with having fun,

relaxing, boosting confidence, and lowering inhibitions. However, they were also aware of the negative effects of alcohol and drugs and spoke of the concerns of getting into a fight or getting into trouble with the gardaí.

Of third-level students who were current drug users participating in the DUHEI survey, 30% said that they were fully informed of the risks involved in drug use, 27% said that they knew a lot, 23% knew a moderate amount and 3% said they knew very little or nothing about the risks associated with drug use [24]. A study in the UK found that many schools were delivering alcohol-related education through materials provided by an alcohol industry funded organisations [153]. The authors of that study noted that this practice represented a conflict of interest and urged policy-makers ensure that alcohol-related education resources are developed independently of alcohol industry influence.

Despite the international evidence of the growing harms associated with alcohol and the WHO's commitment to tackle alcohol-related harms [29], the David and Goliath allegory has been used to compare public health messaging with alcohol marketing by global alcohol corporations [154]. The public health messaging is largely silenced by the vast resources that global corporations invest in alcohol marketing and, consequently, alcohol marketing dominates people's thoughts and attitudes about alcohol. In addition to the exposure to alcohol marketing adding to the seeming acceptance of alcohol-related harms, there exists an entrenched tradition of drinking in Irish culture, which in turn has normalised alcohol-related harms, and people are unable to conceptualise behavioural change around alcohol use.

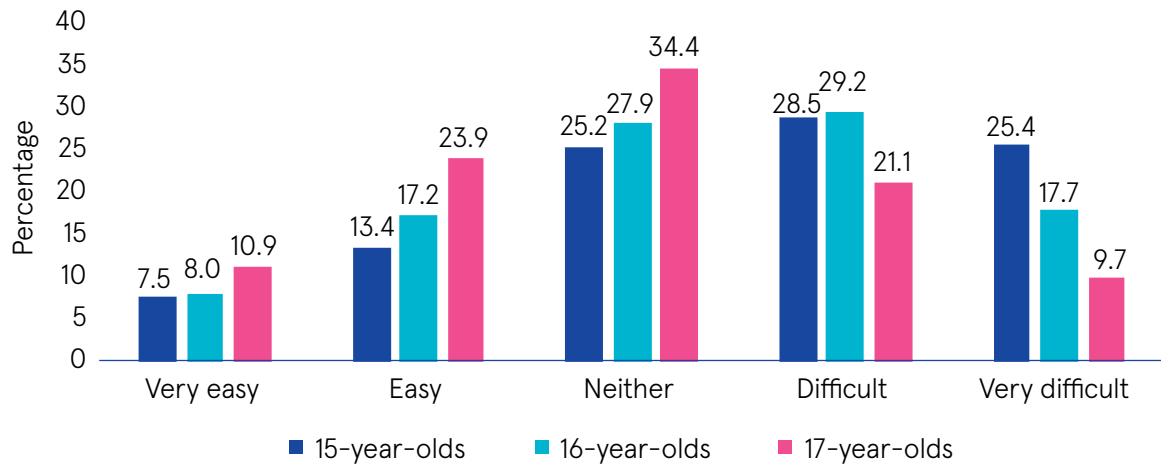
Evidently, the tone and/or delivery of health warning messages to young people about the dangers associated with alcohol, particularly hazardous and harmful drinking, are not effective for this age group. Enactment of health warning labels as per the Public Health (Alcohol) Act 2018 may help inform young drinkers about the harms associated with alcohol use and thus counteract the attitudes commonly held by young people.

### **6.1.9 Availability of, and access to, alcohol and drugs**

Undoubtedly, easy access to alcohol and drugs increases their risk of use. Both international and Irish research has highlighted that ease of access to alcohol and drugs constitutes a risk factor for young people to begin using alcohol and/or drugs but also to continue to use them and/or to use them problematically [117,155,156].

More than one-fifth (21%) of 15-year-old HBSC respondents in Ireland reported that it would be easy or very easy to buy alcohol where they live and go to school (Figure 37) [12]. In the 2019 ESPAD, 15% of schoolchildren indicated that it would be very easy to obtain cannabis [10], and a regional survey of 16–18-year-olds found that financing alcohol and drug use was mostly done using both pocket money and part-time employment income [157].

Figure 37 Percentage of 15–17-year-olds reporting how easy or difficult it would be to buy alcohol, by age



Source: Gavin et al. 2020 [12]

### 6.1.10 Exposure to alcohol marketing

Young people who have greater exposure to alcohol marketing are more likely to subsequently initiate alcohol use and engage in HED/binge and hazardous drinking [158,159]. An international systematic review found a positive association between exposure to alcohol marketing and self-reported alcohol use, and highlighted that indirect exposure to alcohol sports sponsorship was associated with increased levels of drinking among schoolchildren [160]. Section 15 of the Public Health (Alcohol) Act 2018, introduced in November 2021, aims to address this issue, as it prohibits alcohol advertising in a sports area during a sporting event; at events aimed at children or at events in which the majority of participants or competitors are children; and at events involving driving or racing motor vehicles [30]. While this legislation is welcomed, given the level of alcohol marketing children are exposed to, it falls short of the proposed complete ban on sports sponsorship recommended by the steering group that was established to advise the Government on the National Substance Misuse Strategy (2009–2016) when alcohol was included for the first time in 2009 [161,162].

Analysis of incidents of alcohol advertising at the 2020 Six Nations Championship found that there were 1,444 references to alcohol observed across two matches played in Ireland. On average, this equated to between 3.8 and 4.0 references per minute in the two games (approximately once every 15–16 seconds), highlighting the level of exposure children are potentially exposed to during sporting events [163].





## Schoolchildren in Ireland

are exposed regularly to alcohol marketing, which increases their likelihood of drinking alcohol and engaging in risky drinking behaviour.

Global corporations' advertising expenditure is immense and widespread, and public health responses have struggled to keep up with industry innovations in digital and social marketing [164]. This point is emphasised in an international study looking at the top 100 videos on the social media platform TikTok using the hashtag "#alcohol" [165]. The study found that the vast majority (98%) of the videos portrayed alcohol in a positive light. With one-half of all TikTok users aged 16–24 years, and 7 in 10 adolescents saying that they regularly use the social media platform, the authors expressed their concerns about this level of exposure to positive alcohol depictions and how social media platforms can influence health behaviour.

A further study examined child-friendly advertising of alcohol-branded products, *Easter eggs & 'Easter eggs': alcohol branded chocolate eggs & intoxicogenic environments in Ireland*. The study highlighted how there are potential gaps in the Public Health (Alcohol) Act that allow Easter eggs featuring alcohol branding and logos be sold alongside other well-known chocolate brands, exposing children to alcohol branded products [166]. A study, *Awareness of alcohol marketing one year after initial implementation of Ireland's Public Health (Alcohol) Act and during the COVID-19 pandemic*, examined the impact of the sections of the Act that ban some outdoor, cinema and public transport alcohol advertising and found that there was a small decrease in respondents' recollection of alcohol marketing when cross-sectional surveys were carried out at two different time points, one before commencement of the legislation and one after [167]. The study cautiously highlighted the positive effectiveness of the Act.

In 2015, Alcohol Action Ireland (AAI) commissioned the Health Promotion Research Centre at NUI Galway to investigate exposure to alcohol marketing and alcohol-related behaviours among a sample of adolescents in Ireland. The survey involved 686 schoolchildren aged 13–17 years (53% males, 47% females). The schoolchildren were asked to complete an alcohol marketing diary by recording all alcohol marketing they encountered, including the brand being advertised and the media channel through which it was presented [168]. The majority of the schoolchildren reported being exposed to alcohol advertising (offline) in the week prior to the study (91%); 77% were exposed to alcohol marketing on social media; and 61% reported owning alcohol-branded merchandise (particularly young males) (Table 7).

The findings from the study indicated that increased exposure to alcohol advertisements and marketing, particularly in the form of owning alcohol-branded merchandise, resulted in an increased risk of children engaging in drinking alcohol, binge drinking, and drunkenness. This risk was higher than that posed to children who were not exposed to alcohol marketing.

Table 7 Schoolchildren's exposure to alcohol marketing

|                 | Online exposure (%) | Non-online exposure (%) | Alcohol-branded merchandise ownership (%) | Last sports event attended was sponsored by an alcohol brand (%) | Last music event attended was sponsored by an alcohol brand (%) |
|-----------------|---------------------|-------------------------|---|--|---|
| All students    | 77.2                | 90.9                    | 61.2                                      | 18.3   | 16.1  |
| Males           | 74.0                | 90.5                    | 71.4                                      | 22.8   | 15.4  |
| Females         | 80.8                | 91.3                    | 50.0                                      | 13.2   | 16.9  |
| 13–15-year-olds | 74.9                | 90.7                    | 63.9                                      | 18.6   | 14.6  |
| 16–17-year-olds | 79.6                | 91.0                    | 58.5                                      | 18.0   | 17.6  |

Source: Fox et al. 2015 [168]

An AAI poll conducted in 2021 found that 58% of young people (18–24 years) supported banning alcohol advertising from being shown on television before 9pm and 53% also supported restrictions to limit what alcohol advertising children see and hear [169]. Further research into the effectiveness of the Public Health (Alcohol) Act 2018 will be required in the future in order to establish whether restrictions on alcohol sports sponsorship have been effective in reducing harmful drinking among young people.

## 6.2 Familial factors

Familial factors – such as parent–child relationships, parental monitoring and support, parental substance use and socioeconomic status – have been recognised as characteristics that may influence adolescent substance use [130,170–174].

### 6.2.1 Socioeconomic status

Socioeconomic status (SES), such as educational level, family income or parental education level, and whether the individual lives in a deprived or affluent neighbourhood, has been identified as an influencing factor on an individual's alcohol and drug use and related outcomes.

Higher SES has been found to be a predictor of substance use among young people. The GUI study respondents who were 17 and 18-years old in 2015–2016 whose parents were educated to degree level or higher were more likely to have used cannabis than their peers whose parents had a lower level of educational attainment (35% versus 25%) [13]. When GUI respondents were interviewed again at 20 years of age, those whose parents had a degree or more were more likely to use cannabis occasionally or more (28%), compared to those whose parents had completed lower second level education or less (19%) [37].

Education level of parents was also associated with alcohol use when the GUI respondents were interviewed in 2018–19 at 20 years of age. More 20-year-olds whose parents had the highest education level reported consuming alcohol more than once per week (32%), compared to those whose parents had the lowest level education (18%) [37]. A similar pattern was noted for those who were categorised as high-risk and very high-risk drinkers; those whose parents had the highest education level were more likely to be high-risk and very high-risk drinkers (14%) compared to those whose parents had the lowest level education (9%).

Household social class was also associated with frequent drinking; 20-year-olds from the highest income families were more likely to drink more frequently (32%) than those from the lowest income families (19%) and those in the high-risk and very high-risk drinker category were more likely (16%) to be from the highest income families compared to those from the lowest income families (8%) [37].

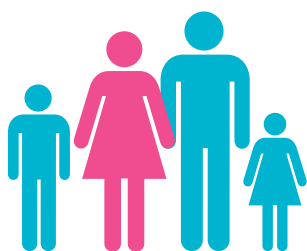
Although substance use is more often associated with those from a higher SES, those with a lower SES bear a disproportionate burden of negative alcohol-related consequences even when consuming a similar amount of alcohol as those with a higher SES [175–178].

## 6.2.2 Family support/parental relationships

Decision-making by adolescents, including decisions relating to alcohol and drug use, is likely to be partially influenced by the quality of their relationships with their parents. Perceived tension in the relationship between parents and adolescents has been associated with increased risk of substance use, whereas encouraging and supportive parenting has been shown to be predictive of reduced substance use in adolescence. A number of Irish studies have investigated this association, including a study that investigated the role of family, peer, and school relationships in predicting substance use among 3,346 schoolchildren aged 15–17 years [173]. The study found that those who reported a negative relationship with their parents were more likely to report sustained use of substances. This finding is not unique; Fitzgerald et al. also found that poor parent-child relationships increased the likelihood of adolescent substance use [172]. In their study, lower levels of family cohesion and higher levels of maternal criticism were found to be associated with higher levels of adolescent substance use.

The degree of warmth that parents convey to their children has been shown to be a protective factor; higher rates of drunkenness were observed in the MWS-2 adolescents who reported that it was difficult to receive caring and warmth from their parents [16]. In the MWS-2, adolescents and young adults in the harmful and hazardous drinking category and the possible alcohol dependence category, as well as those in the moderate/substantial/severe categories for drug use, reported lower levels of family support than those with no substance use problems or who were in the low-level categories for substance use [16].

The 2018 Planet Youth survey found that adolescents who reported that it was difficult to discuss personal affairs with their parents were more likely to report drunkenness in the last month (30%) than those who found it easy to discuss personal affairs with their parents (25%). Similar findings were reported for cannabis use; those who reported that it was difficult to discuss personal affairs with their parents were more likely to have used cannabis (24%) than those who reported it would be easy to discuss personal affairs with their parents (16%) [56].



**Positive parental relationships**  
were associated with  
decreased substance use

### 6.2.3 Parental monitoring

The balancing act for parents negotiating their children's adolescence to, on the one hand, grant children the autonomy they need to develop independently and, on the other, monitor and be aware of their children's behaviours and whereabouts, are among the indicators often linked with reduced risk for substance use. The 2019 ESPAD found that parental monitoring (knowledge of their adolescent child's whereabouts, activities, and friends) was a positive protective factor. Schoolchildren whose parents usually did not know where they are on a particular night of the week were more likely to use alcohol and drugs than students whose parents always knew where they were [10].

The 2020 Planet Youth survey reported that schoolchildren were less likely to report lifetime use of cannabis (14%) when their parents know the parents of their friends compared to those whose parents do not know their child's friend's parents (25%) [18]. The same study found that where parental support and monitoring was lower (indicated by schoolchildren being out late at night), those who were out after midnight were more likely to report drunkenness in their lifetime (70%), drunkenness in the past month (45%) and cannabis use in their lifetime (34%) than those who had not been out late at night (44%, 16% and 14%, respectively) [18–20].

### 6.2.4 Parental substance use

Throughout childhood and adolescence, the parent's role remains important for children's development; what happens in the home environment plays a crucial role in alcohol and drug use prevention, and parents are one of the main sources of learning norms, values, and behaviours. In line with the social learning theory which suggests that young people are more likely to imitate a behaviour to which they are exposed [179], parental substance use has been shown to be a strong predictor for adolescent alcohol and drug use [137].

Children witnessing non-dependent parental drinking was associated with early alcohol initiation and adolescent alcohol use [180]. Several Irish studies have verified this connection; Keeley et al. found that adolescents whose parents use substances had an increased risk of using alcohol and/or drugs themselves, and that the risk was even greater if both parents use substances [87]; a strong direct relationship between parental substance use and the likelihood of substance use by the young person was confirmed by a further Irish study [117].

Additionally, Murphy et al. reported an association between adolescent hazardous alcohol use and hazardous drinking by the parent [181]. In addition, a 2013 report from the Probation Service found that among young offenders who had misused a substance, 39% reported that their parents had a history of substance misuse – most commonly alcohol [119].

Results of the 2017 study using SEYLE data indicated that adolescents (surveyed in 2009–2010) who reported that their parents used drugs were more likely to use drugs themselves than those whose parents had not used drugs (23% versus 3.4%). Adolescents who reported seeing a family member drunk were over six times more likely to be regular drinkers than those who had not (11% versus 1.8%) [139]. Similarly, adolescents in the 2020 Planet Youth Survey whose parents got drunk regularly were twice as likely to report being drunk in the last month than those whose parents did not get drunk regularly (38% versus 18%). Furthermore, adolescents whose parents got drunk regularly were also more likely to report lifetime cannabis use (37%) compared to those whose parents did not get drunk regularly (14%) [18–20].



**Adolescents whose parents get drunk**  
regularly are more likely to get drunk themselves and to report cannabis use

## 6.2.5 Family composition

The influential role of the family on adolescents’ attitudes and subsequent alcohol and drug use has been highlighted in this overview, and family composition also has a part to play. A study using the MWS-1 adolescent cohort data, *Dissociable psychosocial profiles of adolescent substance users*, found that having a non-intact family (defined for the purposes of that study as having separated or divorced parents or where a parent is deceased) was moderately predictive of alcohol use, and risky alcohol use was found to be positively associated with growing up in a household with more than three children [172].

Findings from the 2019 ESPAD reported that schoolchildren living in one-parent homes were more likely to have used cannabis, cocaine, amphetamines, ecstasy, inhalants, and tranquillisers, than schoolchildren living with two parents [10]. The GUI study of 17–18-year-olds interviewed in 2015–16 also reported that young people from one-parent families were more likely than those from two-parent families to use cannabis (40% versus 29%) and other drugs (16% versus 11%) [13].

## 6.2.6 Parental conflict and violence in the home

A number of Irish and international studies have found evidence implicating parental conflict as a predictor of increased adolescent substance use. Parental conflict includes high levels of hostility, adversity, criticism, conflict (including violence), stress, ineffective communication and discipline, and relational tension within the family environment. An international systematic review of evidence found that higher levels of family conflict were related to early alcohol initiation [180]. Exposure to parental conflict of this kind in early adolescence increases the risk of substance use disorders later in adolescence and early adulthood [182].

In Ireland, young adults in the MWS-2 who reported experiencing conflict between parents were more likely to be in the moderate, substantial, or severe categories for drug use than those who had not experienced parental conflict (17% versus 11%). In addition, young adults who reported experiencing parental conflict were more likely to report risky alcohol use behaviour than young adults who had not experienced parental conflict (8% versus 6%) [16].

## 6.2.7 Parental attitudes substance use

As has been emphasised in this overview, parental behaviours play a key role in shaping children's decision-making in relation to alcohol and drug use. Parental attitudes are also influential in their children's alcohol and drug use. An international systematic review found that children whose parents had a liberal attitude towards alcohol were more likely to start drinking alcohol and to drink and get drunk more frequently than their peers whose parents did not hold such liberal attitudes [183].

Among adolescents in Galway participating in the 2020 Planet Youth Survey, those who reported that their parents were more tolerant of drunkenness were more likely to report being drunk in their lifetime (68%) or in the last month (32%) than those whose parents were disapproving of drunkenness (35% and 12%, respectively) [18].

## 6.2.8 Parental provision of alcohol

Parents often supply alcohol to their adolescents in the belief that by allowing their child to drink alcohol at home, including sips or tastes, they are protecting them from harmful alcohol use and that they can supervise their child's drinking and introduce them to alcohol in a controlled environment [184,185]. The evidence confirms that such practices are in fact potentially dangerous. Parental provision of alcohol is linked to earlier initiation of alcohol use, drunkenness, increased risk of HED, alcohol-related harm, and a greater chance of dependency later in life; it also increases the likelihood of seeking alcohol elsewhere [180,186–189].

As we saw in Chapter 4 of this overview, findings from the 2018 HBSC study indicated that a common source of alcohol among 16- and 17-year-olds was their parents/guardians [11]. The 2020 Planet Youth Survey found that adolescents who reported getting alcohol from their parents were more than 3.5 times more likely to have been drunk in the last month than those who did not get alcohol from their parents [190]. Murphy *et al.* also found that parental provision of alcohol was associated with hazardous alcohol use, and that adolescents were more likely to be hazardous drinkers when their parents felt that it was ok for them to drink alcohol on special occasions [181].



Adolescents who reported getting alcohol from their parents were more than **3.5 times more likely** to have been drunk in the last month than those who did not get alcohol from their parents

## 6.3 Social factors

Social risk and protective factors that have been recognised as contributing to/or reducing the risk of adolescent substance use include peer relationships, peer substance use, and school experiences, including relationships with teachers, absences from school, and school grades. The SES of the school and where the adolescent lives geographically have also been shown to add to a complex system of risk and protective factors that may predict adolescent substance use. Often a combination of social and familial factors interact to increase or decrease an adolescent's risk for substance use. In attempting to address harm reduction interventions, it is important to understand how these social factors can contribute to substance use.

### 6.3.1 Peer substance use

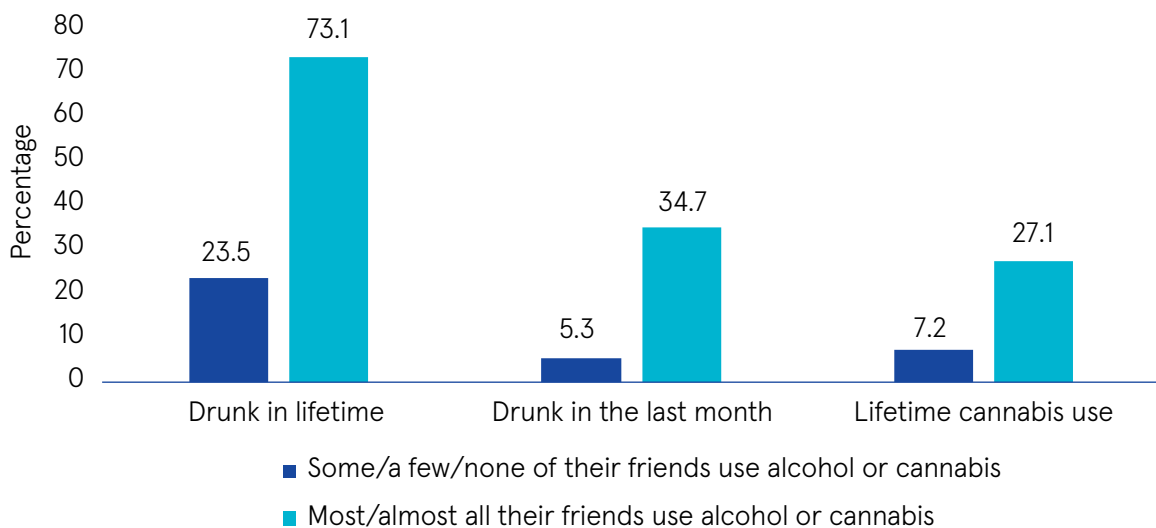
Peer influences and peer connectedness play an important role in young people's lives, particularly during adolescence, and particularly for alcohol and drug use [16,173]. Irish and international evidence highlights that young people are more likely to drink alcohol if their peers drink alcohol. According to Musher-Eizenman *et al.*, these observed associations may be a result of one of two factors: (1) adolescents with a shared disposition may come together to form a deviant group; or (2) adolescents may be influenced by their peers to use substances in order to gain social standing or to join a group [191].

Several studies have indicated that peer substance use is a risk factor for substance use among adolescents [18–20,117,192,193]. In the 2019 ESPAD in Ireland, 72% of those who reported that all of their friends get drunk had used alcohol in their lifetime; the comparable figure for those who reported that none of their friends get drunk was 66%. Schoolchildren who reported that some of their friends use cannabis were more likely to have used it themselves than schoolchildren who reported that none of their friends use cannabis (23% versus 17%) [10].

Almost one-third (31%) of schoolchildren participating in the 2020 Planet Youth Survey stated that it was important to drink so as not to feel left out of their peer group, and 8% said that

they used cannabis for the same reason [18–20]. Those who reported that most or almost all of their friends drink alcohol were more likely to report ever being drunk (73%) compared to those whose friends do not use alcohol or cannabis or that just some of their friends do (24%). Similarly, there was a higher incidence of reports of being drunk in the last month among those who reported that most or almost all their friends use alcohol or cannabis (35%) compared to those whose friends did not or rarely used alcohol or cannabis (5.3%). Lifetime cannabis use was higher among those whose friends used alcohol or cannabis (27%) compared to those who reported that some, a few, or none of their friends drink alcohol or use cannabis (7.2%) (Figure 38) [18–20].

Figure 38 Correlation between peer alcohol and cannabis use and individual alcohol or cannabis use among schoolchildren aged 15–16 years



Source: Western Region Drug and Alcohol Task Force, 2021 [18–20]



**Adolescents who reported that their friends** get drunk were more likely to drink alcohol. Adolescents who reported that their friends use cannabis were more likely to have used it themselves



## 6.3.2 School experiences

Attitudes towards school have been reported to influence alcohol and drug use; adolescents were more likely to engage in healthy behaviours (including abstaining from substance use) and succeed academically if they felt that they were a part of their school, were engaged with learning, and had good relationships with their teachers [173,194,195]. The Planet Youth Survey in 2020 reported that schoolchildren who had a negative attitude towards school (for example, finding schoolwork pointless or wanting to change schools) were consistently more likely to report alcohol and cannabis use than those who had a positive attitude towards school [18–20].

As already referred to in this overview, evidence indicates a higher level of substance use among early school leavers than among their school-attending peers [72,117]. When compared with their school-attending peers, early school leavers were 1.2 times more likely to drink alcohol, between 2.4 and 4.4 times more likely to use cannabis, and between 3.7 and 14.4 times more likely to use other drugs [117].

In a 2014 study, *Association of educational attainment and adolescent substance use disorder in a clinical sample*, those who left school early were more likely to be polysubstance users with more challenging substance use problems than their counterparts who were still in the education system [196].

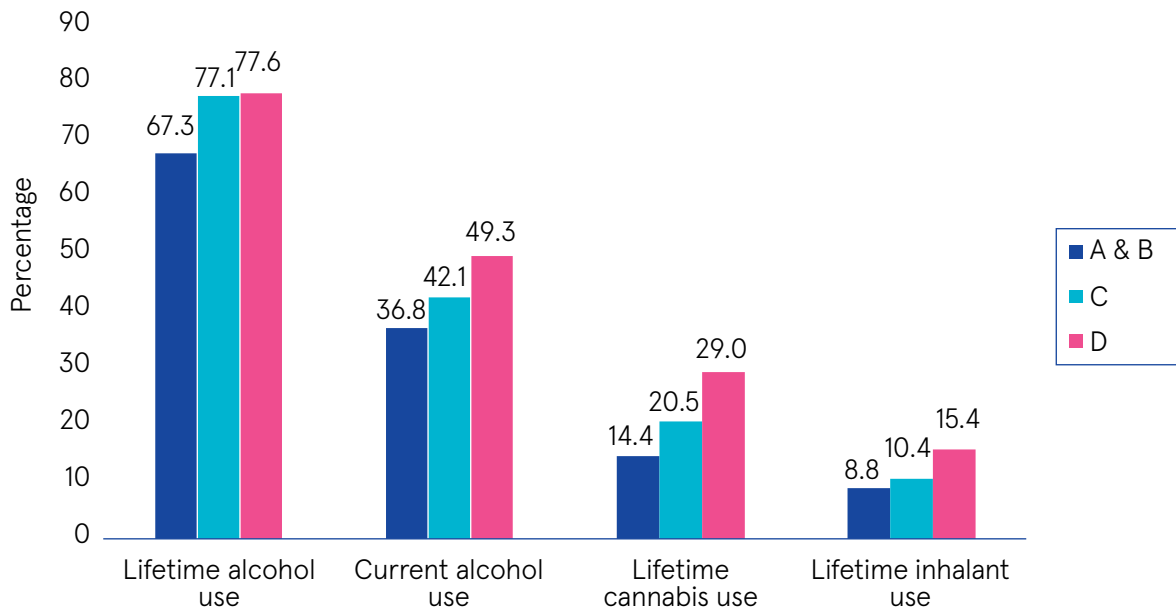
### 6.3.2.1 Skipping school

Skipping school and absence from school were associated with use of alcohol and drugs among 2019 ESPAD respondents in Ireland. Of students who had skipped school on 7 or more days in the last month, 79% were current drinkers, whereas the comparable figure for those who had not skipped school was 35%. Just 15% of schoolchildren who had not skipped school had used cannabis in their lifetime, whereas the comparable figure for those who had skipped 5 or more days of school in the last month was 50%. Similar patterns were observed for the use of other drugs [10]. This is consistent with results from the MWS-2, which found that harmful and hazardous drinkers as well as possibly alcohol dependent drinkers were more likely to report being absent from school for 6 days or more in the last month compared to low-risk drinkers [16].

### 6.3.2.2 School grades

The 2019 ESPAD reported a significant relationship between adolescent alcohol and drug use and lower academic achievement. Schoolchildren with higher grades (mostly As and Bs) were less likely to engage in alcohol and drug use behaviours than their peers with lower grades (mostly Cs and Ds), and this relationship was particularly evident between low grades and cannabis use (Figure 39) [10].

Figure 39 Correlation between use of alcohol and other drugs and average academic grade earned among schoolchildren aged 15–16 years



Source: Sunday et al. 2020 [10]

### 6.3.2.3 Socioeconomic status of school

Educational disadvantage is a risk factor for alcohol and drug use among young people [197]. It is unclear whether the school being located in an area of low SES leads to increased alcohol use or whether the association is confounded by the familial and individual factors outlined earlier.

A study, *Beyond achievement: home, school and wellbeing findings from PISA 2018 for students in DEIS and non-DEIS schools*, was conducted by the Educational Research Centre and included 57 post-primary schools in Ireland; almost 2,000 schoolchildren took part [198]. The study found that in Ireland, schools in areas of socioeconomic disadvantage (Delivering Equality of Opportunity in Schools [DEIS]), student learning was three times more likely to be hindered by student alcohol or drug use (22%) than in non-DEIS schools (7%), and this rate in Ireland was twice as high as the Organisation for Economic Co-operation and Development (OECD) average (10%) [198].

## 6.4 Summary: risk and protective factors

This chapter outlined the key risk and protective factors that influence young people in their decision-making around substance use, as well as those aspects of their personal lives that have an impact on whether they currently use or proceed to use substances in a harmful manner. As adolescence is a crucial time of both emotional and physical development, it is vital that substance use is delayed as much as possible in order to protect young people from its potential harms, and delaying alcohol use is a key element of the Public Health (Alcohol) Act 2018 and the national drugs strategy.

Alcohol use in particular, is widespread among young people and often begins at a young age. It is likely linked to frequent exposure to alcohol, including parental and peer use and alcohol marketing.

Personal attitudes and personality characteristics influence substance use. The risk of substance use is greater among those with lower levels of optimism, self-esteem, and resilience. Those who have experienced concerns due to their sexual orientation were also more likely to have used drugs and to engage in risky alcohol use behaviours.

Parents play a role in protecting their children from substance use; achieving the balance of disciplining and supporting their children to develop and mature, while at the same time monitoring and being aware of their children's behaviours and activities, are among the parental influences often associated with reduced risk. Having warm and supportive parents has been shown to be a protective factor against substance use. Parents' behaviours are evidently imitated by their children, and parental substance use has been shown to be a strong indicator for adolescent alcohol and drug use. Parental attitudes are also important to consider; children whose parents have liberal attitudes towards alcohol use and drunkenness were more likely to drink and get drunk than those whose parents disapprove of such behaviours.

Schoolchildren commonly reported that their parents provided their alcohol. This is concerning because despite some parents believing it is safer to introduce alcohol to children in their own home, the evidence is clear that the practice should be avoided. Children whose parents provided them with alcohol were more likely to drink in a hazardous manner and were at increased risk of developing an AUD; to start drinking at an earlier age; to report increased drunkenness and alcohol-related harms; and to seek additional alcohol elsewhere.

The evidence suggests that parents play a protective role in deferring their children's alcohol use in their behaviours and attitudes and can prevent or minimise the harm from substance use by talking openly to their children; by being positive role models; encouraging their children to seek support if needed; and by collectively agreeing to not give alcohol to children even if their intentions were good.

Peers are also central in the lives of young people and consequently play an important role in influencing their substance use decision-making. Where an adolescent's peers drink alcohol and/or use drugs, they are more likely to do so as well. This may be a result of peer pressure

and influence, or substance-using adolescents may be drawn together due to their shared propensity for such behaviours.

Education plays a role in influencing substance use; early school leavers are more likely to use substances and be at an increased risk of substance use problems, as are those who have a negative attitude towards school, perform poorly or are regularly absent from school.

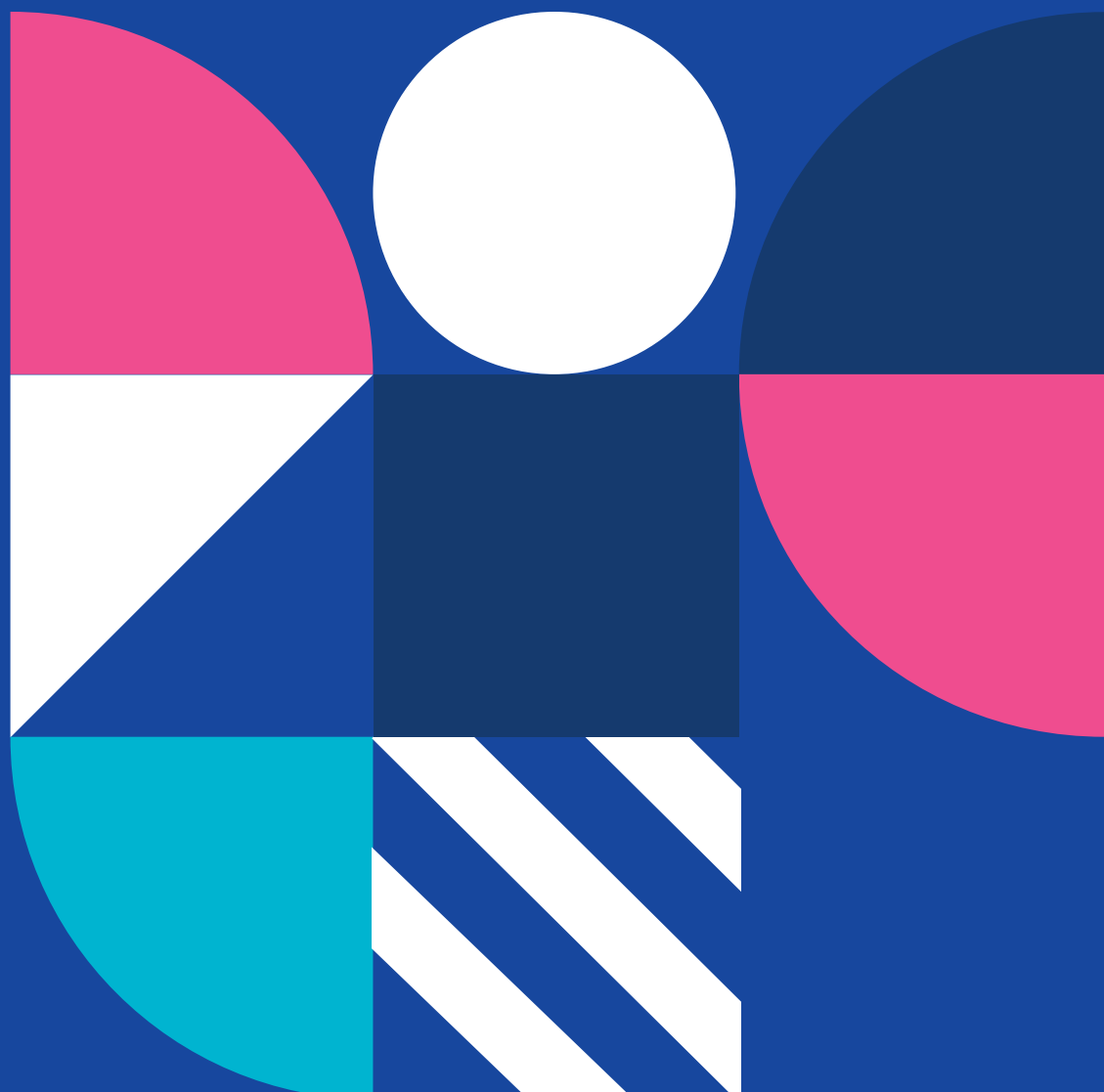
Adolescents are at a sensitive stage in their development and as such, many are particularly susceptible to outside influences, including parental, peer, or marketing. The role of explicit and subliminal alcohol advertising plays an important role in young people's perception of alcohol use, and it is important that children are protected from this form of marketing as much as possible.

Identifying factors that influence adolescent lifestyle behaviours is essential in order to develop effective prevention approaches to reduce negative health outcomes and strengthen adolescent health.

07



# Consequences of alcohol and other drug use among young people



Young people are particularly vulnerable to alcohol- and drug-related harms, as substance use during adolescence is related to changes in brain structure and function, ultimately affecting cognitive functioning [199]. Adolescents are also more likely to engage in risky behaviours, and consequently experience more harms. Often young people feel invincible to the potential damage to their health as a result of substance use however the data presented in this overview suggest that this complacency is unwarranted. This chapter describes the harms associated with substance use among young people in Ireland, including the incidence of substance use disorders; the mental health consequences of substance use, including suicide and self-harm; the social, personal, health and criminal harms experienced as a result of alcohol and drug use; risky sexual behaviour; and death as a result of substance use or among those with a history of substance misuse.

Alcohol-attributable deaths among adolescents and young people decreased by more than one-third between 2010 and 2016 worldwide, but continued to be a leading cause of death [27]. The effects of alcohol on the brain can result in reduced self-control and diminished ability to process information and assess risks and, as a consequence, for some drinkers, it can increase impulsiveness and the likelihood of engaging in risky and violent behaviour [200]. With their high rates of alcohol use and risky patterns of drinking, young people are at increased risk of violence, risky sexual behaviours, self-harm, and mental health problems.

Psychological, physical, and financial harms due to substance use can impact not only the well-being of the individual, but also impacts their family, friends, and the wider community. Several Irish surveys have investigated experiences of substance-related harms and these studies are presented in this chapter. The majority of the data presented in this chapter are from information systems that collect routine data, including national databases on drug-related deaths, hospital discharges, and criminal activity.

## 7.1 Mental health and substance use

People use substances because of how they make them feel and think, and the effect of the substance(s) depends on the individual's current mental health as well as the type, contents/potency, quantity, mix of substances used, and the amount the individual is used to taking. The use of any psychoactive substance has a short-term impact on the mental health of the user, affecting their mood, feelings, and behaviours. The impact can depend on how the individual was feeling when they initially took the substance and the setting for the substance use – whether the individual was alone, in a nightclub or outdoors, and/or who they were with. However, frequent and long-term use can impact mental health, such as increasing the risk of anxiety and/or depression.

The association between substance use and mental health is complex; pre-existing mental distress may lead to substance use as a way of coping with symptoms, or substance use may trigger or exacerbate existing mental distress by changing the way a certain chemical affects brain functions [201].

## 7.1.1 Substance use disorders

### 7.1.1.1 Alcohol use disorder

It is evident from Irish survey data (and confirmed by international research) that alcohol is the substance most frequently used among young people. The data presented in Chapter 4 demonstrate that although there has been an increase in the age of initiation of alcohol use and a decrease in the number of young people drinking, once adolescents start drinking, for many we see a pattern of drinking a lot and still at too young an age.

Under the DSM-IV, alcohol dependency and alcohol abuse were categorised separately into two distinct disorders with specific criteria for each. The updated *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) combined the two former categorisations of abnormal alcohol use (alcohol abuse and alcohol dependence) into one diagnosis: alcohol use disorder (AUD) which can be classified as mild, moderate or severe. In the 2019–20 NDAS, AUD was measured using the *DSM-5* [53]. An AUD diagnosis requires meeting at least 2 of the following 11 criteria in the last year: role impairment; hazardous use; social problems; tolerance; withdrawal; longer or more use than intended; unsuccessful attempts to quit/cut down; much time spent drinking alcohol; reduced activities because of drinking; continued drinking despite psychological or physical problems; and alcohol cravings. The 2019–20 NDAS reported that more than one-quarter (27%) of young people aged 15–24 years in the general population met the criteria for last year AUD. When limited to only those who reported drinking alcohol (in other words, excluding non-drinkers from the sample), this increased to 38%, the highest prevalence of AUD when compared with prevalence among all other age groups. Young females were more likely than young males (38% versus 37%) to be classified as having an AUD and of those young people with an AUD, 18% were classified as having a mild AUD, 11% had a moderate AUD, and 8% had a severe AUD [7].

Using the AUDIT, 3% of MWS-2 adolescents (aged 12–19 years) scored highly indicating potentially having an AUD, and more males than females reported a possible AUD (4% versus 2%) [16]. The percentage of adolescents reporting an AUD is lower than that of young people due to the wider age group used for young people in the NDAS (aged 15–24 years). It is important to note, however, that the MWS measured for dependency only and is a cohort study and therefore the findings cannot be applied to the general population of adolescents; rather, they can be used as a guide to indicate the extent of the problem among adolescents.

### 7.1.1.2 Cannabis use disorder

The 2019–20 NDAS measured the prevalence of cannabis use disorder (CUD) using the Munich-Composite International Diagnostic Interview (M-CIDI), which is based on criteria from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV) [202]. An individual who meets the *DSM-IV* criteria for either abuse or dependence in the previous year is said to have a CUD, which is defined as any cannabis abuse or dependence and is a maladaptive pattern of cannabis use that leads to clinically significant impairment or distress. Cannabis abuse is established from a positive response in one or more of the four domains in the *DSM-IV* diagnostic criteria: hazardous use; role impairment; legal problems related to use; or social or interpersonal problems. Cannabis dependence is determined from a positive response to three or more of the following seven domains: tolerance;

withdrawal; longer or more use than intended; unsuccessful attempts to quit/cut down; much time spent obtaining cannabis or recovering from its effects; giving up or reducing important social, occupational, or recreational activities in favour of use; or continued use despite psychological or physical problems.

In the 2019–20 NDAS, the prevalence of CUD among 15–24-year-olds in the general population was 2.8%, the highest rate recorded for any age group. Almost one in five (19%) respondents aged 15–24 years who had used cannabis in the last year met the criteria for a CUD [7].

The MWS-2 reported that of the 40% of the young adults aged 18–25 years surveyed in 2018–2019 who reported using drugs other than those required for medical reasons, 19% of males and 12% of females fell into the moderate to severe category for drug use. This was determined using the Drug Abuse Screening Test (DAST), developed to screen individuals for drug problems and validated as a psychometrically sound drug abuse screening measure to evaluate drug abuse severity [36,203–205].



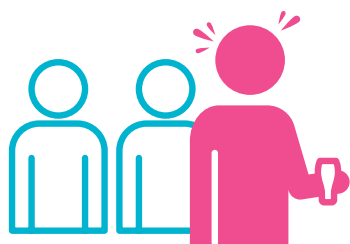
The prevalence of  
**cannabis use disorder**  
among cannabis users was  
**19%**

---

### 7.1.2 Other mental health problems related to substance use

Comorbidity of mental health and substance use disorders is a complex phenomenon among adolescents and it is not clear if one leads to the other [206]. Adolescents in the 2019 MWS-2 who were reported to have attempted suicide were more likely to have smoked cannabis than adolescents who did not report attempted suicide (36% versus 14%) [36]. Among Planet Youth Survey respondents surveyed in 2020, those who smoked cannabis six times or more in their lifetime were more likely to report poor mental health (42%) than those who had never smoked cannabis (17%). In addition, those who smoked cannabis six times or more in their lifetime were more likely to report low self-esteem (60%) compared to those who had never smoked cannabis (48%) [18–20]. Further studies indicated high levels of poor mental health and mental illness in those using both cocaine and alcohol simultaneously (46%), reducing to 37% where alcohol was the only substance being misused [207,208]. There is some indication that adolescents experiencing depression may be at higher risk for developing a substance use disorder at an earlier age after the onset of substance use [209], and research has indicated that the association between depression and cocaine use is stronger among females than among males [210].

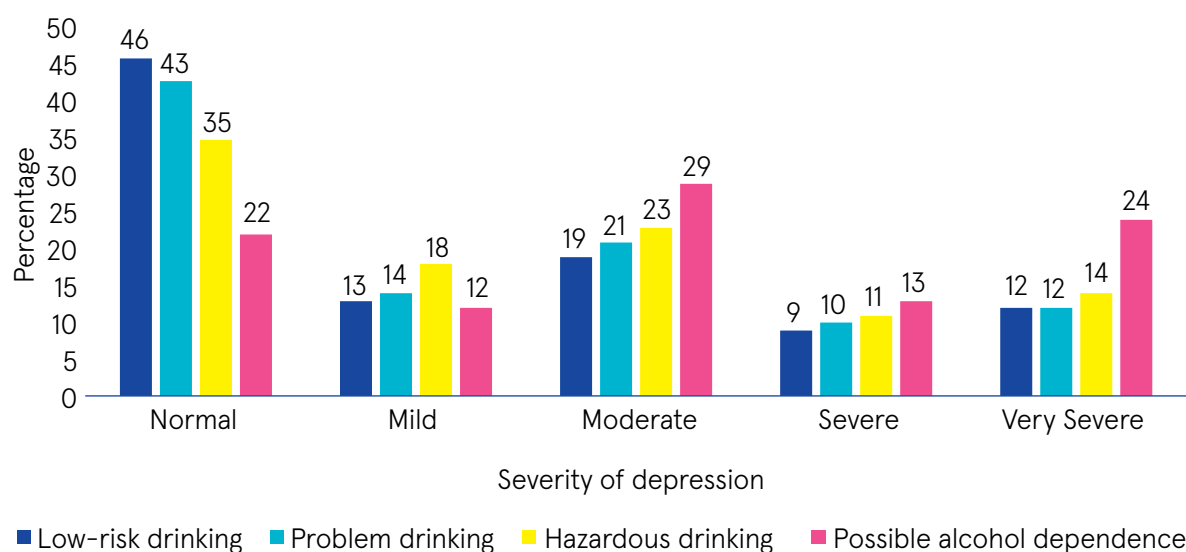




Young adults with alcohol dependence are more likely to have **severe anxiety**

Alcohol is classified as a CNS depressant; it slows down brain functioning and neural activity, and at larger quantities, alcohol reduces an individual’s ability to think rationally, lessens inhibitions, and distorts judgement. Alcohol has been linked to increased risk of self-harm and suicide, especially among young males experiencing depression [211]. Using the Depression, Anxiety and Stress Scale (DASS), an instrument to assess mental health status, the 2019 MWS-2 highlighted the link between harmful and hazardous levels of alcohol use and psychological distress among young people. Of young adults (18–25 years) in the MWS-2, those classified as having possible alcohol dependence were more likely to be in the very severe category for anxiety, and those classified as being in the problem drinking and hazardous drinking categories were more likely to be in the moderate range for anxiety. Similarly, young adults in the possible alcohol dependence category were more likely to be in the moderate (29%), severe (13%), and very severe (24%) ranges of depression than those in any other drinking behaviour category (Figure 40), and they were more likely to have engaged in deliberate self-harm and to have attempted suicide [36].

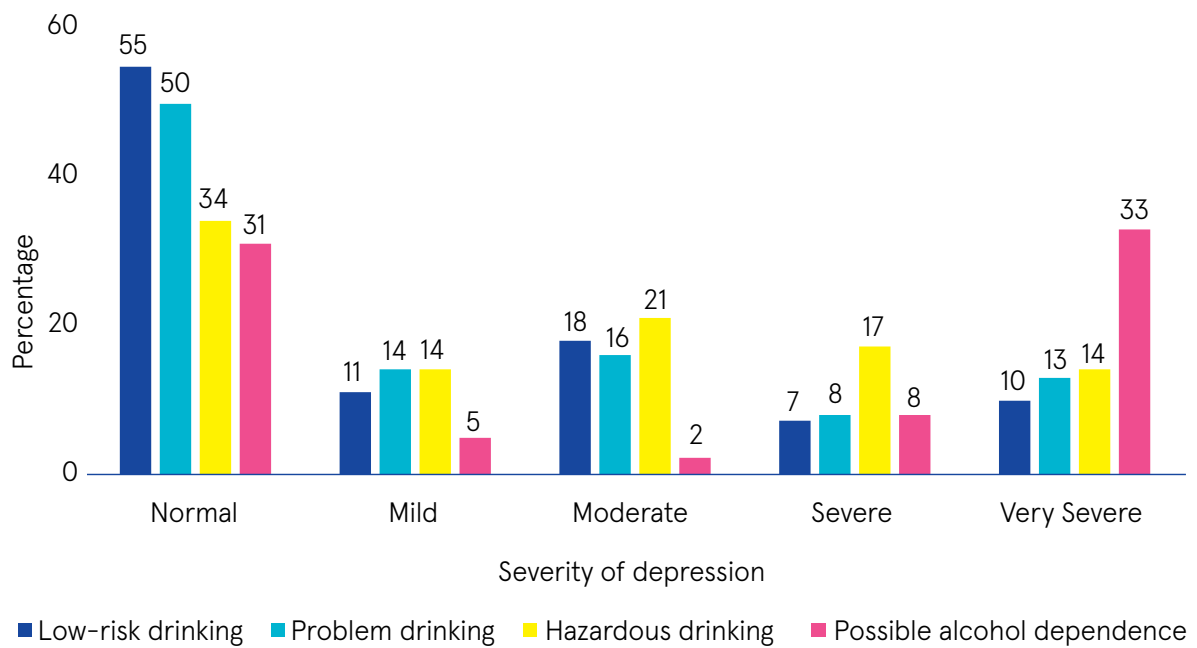
Figure 40 Experience of depression, by alcohol behaviour among young adults aged 18–25 years



Source: Dooley et al. 2019 [16]

As with young adults, adolescents (12–19 years) in the 2019 MWS-2 who were classified as hazardous drinkers were more likely to fall within the severe category for depression (17%) than those in any other drinking behaviour category. Those classified as having possible alcohol dependence were most likely to be in the very severe category for depression (33%) whereas low-risk drinkers were most likely to fall within the normal range for depression (55%) (Figure 41) [36].

Figure 41 Experience of depression, by alcohol behaviour among adolescents aged 12–19 years



Source: Dooley et al. 2019 [36]



Cannabis users  
**6 times more likely**  
 to report poor mental health  
 than non-users

Of adolescents participating in the SEYLE study in 2009–2010, a mental health promotion programme for adolescents in European schools including 1,112 adolescents from 17 schools in Ireland, more regular drinkers had poorer well-being, had higher levels of depression and anxiety, and were more likely to report suicidal ideation than those who were not regular drinkers. In addition, adolescents who were drinkers were eight times more likely to have attempted suicide than their non-drinking peers [139].

A 2016 study investigating the lifestyle behaviours of student nurses (N=473, 81% of whom were aged under 26 years), *Predictors of health of pre-registration nursing and midwifery students: findings from a cross-sectional survey*, found high levels of alcohol use (92%), indicating that alcohol was often used as a coping strategy for the stress related to their course [212].

*The LGBTIreland Report: national study of the mental health and wellbeing of lesbian, gay, bisexual, transgender and intersex people in Ireland*, published in 2016, found that experiences of bullying due to sexuality among the school years sample (those aged 14–18 years) had an impact on the mental health of these young people. Increased psychological distress, along with increased alcohol and drug use, was reported by those who experienced such victimisation in school [61].

An international study found that young people who used drugs to forget their worries and forget about negative experiences were more likely to move from recreational drug use to problem drug use [213].

### 7.1.2.1 Substance use, suicide, and self-harm among young people

Alcohol is associated with suicide and self-harm; suicide was the third leading alcohol-related cause of death among those aged 15–49 years between 1990 and 2016 according to the Global Burden of Disease Study [214]. Suicide rates among young males in Ireland are among the highest in Europe [215], and alcohol has been found to play a role in suicide mortality among young males in Ireland aged 15–24 years [216].

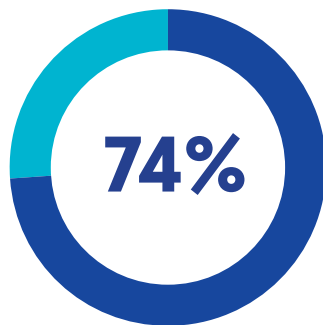


Alcohol was present in **28%** of **self-harm hospital presentations** among young people

---

The National Self-Harm Registry Ireland (NSHRI) is a national system recording incidences of hospital-treated self-harm. A study using data from the NSHRI looked at hospital presentations, *Increasing rates of self-harm among children, adolescents and young adults: a 10-year national registry study 2007–2016*, and found that intentional drug overdose was the most common type of self-harm among 15–19-year-olds (59% of males and 72% of females). The study noted that although alcohol as the sole method of self-harm was rare, alcohol was present in 28% of self-harm incidents among those aged 10–24 years (n=10,701). A decrease in the proportion of self-harm presentations involving alcohol was observed between 2007 and 2016, although the authors note that this was likely due to alcohol information not always being recorded at the time of presentation [217].

The Suicide Support and Information System (SSIS) collects information on risk factors associated with suicide and deaths classified as open verdicts. A study, *Suicide among young people and adults in Ireland: method characteristics, toxicological analysis and substance abuse histories compared*, analysed data on individuals who had died by suicide between May 2007 and June 2012 (N=121), 61 of whom were young people aged 15–24 years (50%). Where information on alcohol and drug history was available (51% of the young people sample), 74% had a history of alcohol and/or drug misuse. Toxicological analysis of samples taken at post-mortem examination was available for 95% of the young people cohort. Almost one-quarter (24%) of the young people had only alcohol documented in their toxicology report, while a further 28% had consumed both alcohol and drugs. The study found that younger people who died at weekends were more likely to have alcohol found in their toxicology (67%) than those who died between Monday and Friday (44%) [218].



74% of those aged 15–24 years who **died by suicide** had a history of alcohol and/or drug misuse

Another study, using both the SSIS to identify suicide cases and the NSHRI for self-harm presentations to EDs, investigated factors associated with alcohol involvement in suicide and self-harm [219]. For the 307 cases analysed of all ages, only younger age (under 25 years) was associated with having consumed alcohol among suicides (51% among those aged under 25 years versus 24% among those aged 55 years or over). In self-harm cases, alcohol was less likely to be involved in presentations involving young people (aged under 25 years) than in presentations involving those in older age groups.

## 7.2 Hospitalisations as a consequence of substance use

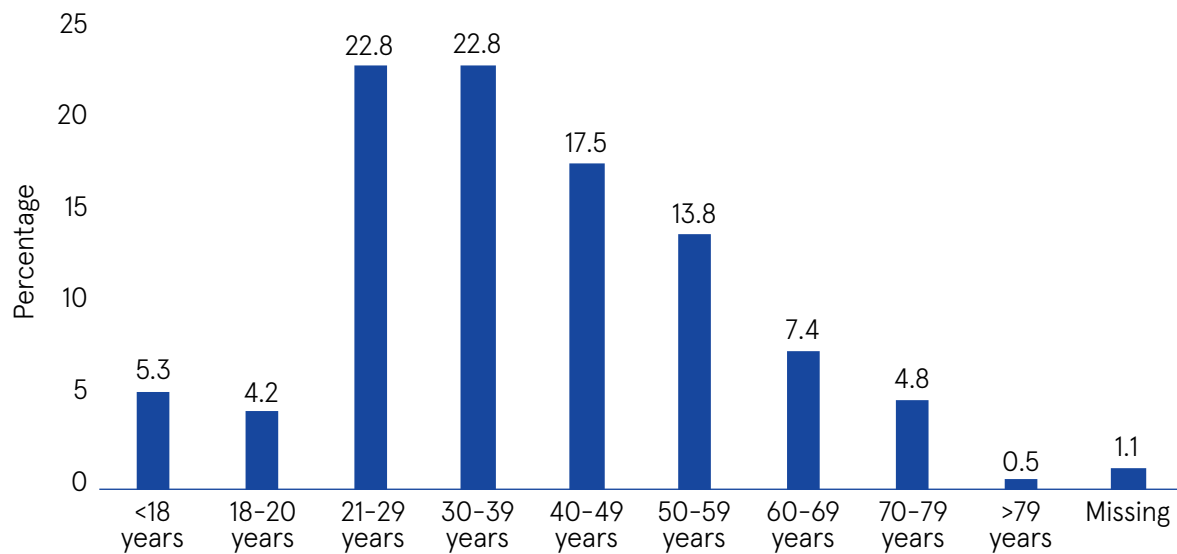
Substance use contributes to substantial societal burdens, especially healthcare costs. People respond to the use of alcohol and drugs in different ways depending on their age, sex, and body weight, and younger people are particularly susceptible due to their growing and developing bodies and brains. Alcohol, especially when consumed frequently and in a binge drinking manner, can cause physical damage to the body as well as to mental well-being, the effects of which can be short-lived or lifelong. Potential short-term effects of alcohol use include hangovers or alcohol poisoning, as well as accidents (such as falls), and potentially risky behaviours due to lower inhibitions. The longer-term consequences include harms to health, such as AUD; alcoholic liver disease; alcohol-induced pancreatitis; diabetes; cardiovascular disease; and a number of cancers, including liver, bowel, mouth, upper throat, larynx, oesophagus and female breast; these harms are in addition to alcohol's link with self-harm and suicide.

While not everyone will require hospital care for their alcohol and/or drug use, this section outlines the pressure that substance use places on hospitals in Ireland due to acute and chronic illnesses – ranging from accidents and poisoning presentations in our EDs to long-term consequences resulting in long hospital stays – all of which come at a high cost, both emotionally and financially, to the individual, their family, and to society.

### 7.2.1 Alcohol-related presentations to EDs

Alcohol-related harms spill into Irish health services, and many presentations to EDs across Ireland involve alcohol. There are limited national data on alcohol-related ED presentations, but one study, *Alcohol-related presentations to emergency departments in Ireland: a descriptive prevalence study*, examined the prevalence of alcohol-related presentations in all 29 EDs in Ireland during four specified 6-hour periods. The total number of presentations was 3,194, of which 189 (5.9%) were alcohol related. The percentages presented here are based on that total; 5.3% of all alcohol-related presentations were aged under 18 years, 4.2% of presentations were aged 18–20-years, and 23% were aged 21–29 years (Figure 42). Those in the 21–29-year-old age group and in the 30–39-year-old age group represented the highest number of alcohol-related presentations to EDs (23% each). The study gives an insight into the strain on EDs across the country due to alcohol-related presentations [220].

Figure 42 Percentage of all alcohol-related ED admissions, by age group



Source: McNicholl et al., 2018 [220]

A valuable study of alcohol-related injuries in ED's in Ireland, *Alcohol and injuries in the accident and emergency department: a national perspective*, found that over one-quarter of ED presentations due to injuries were alcohol-related. Of all presentations, the 18–29 years age group represented the highest proportion (48%) of alcohol-related presentations to ED's [221].

The study found that alcohol-related injuries were highest between the hours of 10pm and 11pm, at weekends, and fractures were the most common cause of requiring medical attention, most commonly due to a fall/trip. Over two-thirds of those aged 18–29 years (68%) had engaged in harmful drinking prior to the incident (12+ drinks) and 69% had a blood alcohol concentration (BAC) greater than 80mg/100ml. Respondents who presented with an alcohol-related injury were also asked about their typical drinking habits; 84% of male and 77% of female respondents aged 18–29 years reported hazardous drinking at least weekly; 20% of male and 13% of females reported harmful drinking at least weekly; and the mean number of drinks usually consumed on a typical drinking occasion was 15 for males and 11 for females. The data, although now dated, provides a useful insight into the burden alcohol-related injuries have on already overstretched ED's around the country and replication of the study would be valuable to examine if the situation has worsened, improved or remains unchanged.

## 7.2.2 Alcohol- and drug-related hospital discharges

Information on hospital discharges due to drug or alcohol use is collated from the HIPE scheme. HIPE is a computerised health information system designed to collect clinical and administrative data on discharges (including deaths) from acute Irish hospitals and is managed by the Healthcare Pricing Office in the HSE. Each HIPE discharge record represents one

episode of care; patients may be admitted to hospital(s) more than once with the same or different diagnoses. HIPE uses discharges, which can be considered a proxy for admissions, to measure each patient contact. For each discharge, HIPE records up to 30 diagnoses. *The International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM)* is used to code diagnosis data in HIPE [222]. ED and outpatient data are not collected by HIPE.

It should be noted that the use of HIPE for epidemiological purposes has some limitations. As the HIPE system counts each patient contact and not the number of patients, it is not possible to ascertain the incidence of drug- or alcohol-related morbidity. In this analysis, we have calculated the number of drug- and alcohol-related discharges aged 15–24 years for the years 2015–2019 (inclusive). Drug- and alcohol-related discharges are analysed separately, and it is possible that there are discharges that have been included in both analyses if they had both a drug- and alcohol-related diagnosis. Table 20 and Table 21 in Appendix 3 provide a list of the *ICD-10-AM* codes included in generating annual HIPE reports on drug-related discharges.

### 7.2.2.1 Alcohol-related hospital discharges

Table 8 presents trends in the number of alcohol-related hospital discharges among those aged 15–24 years between 2015 and 2019. The number of alcohol-related discharges increased by 12% between 2015 and 2018, from 795 to 888, and decreased by 16% in 2019, to 744. Males were more likely than females to be discharged from hospital due to alcohol-related conditions.

Table 8 Number of hospital discharges among young people aged 15–24 years with an alcohol-related diagnosis, by sex

|      | Male | Female | Total |
|------|------|--------|-------|
| 2015 | 533  | 262    | 795   |
| 2016 | 566  | 268    | 834   |
| 2017 | 574  | 294    | 868   |
| 2018 | 582  | 306    | 888   |
| 2019 | 481  | 263    | 744   |

Source: HIPE data, 2015–2019

Table 9 provides a breakdown of alcohol-related discharges by diagnosis type. There were no discharges recorded with the following diagnoses: alcohol-induced pseudo-Cushing's syndrome, degeneration of nervous system due to alcohol, alcoholic polyneuropathy, alcoholic myopathy, or alcoholic cardiomyopathy. These are chronic conditions that may take a number of years to develop, so it is not surprising that no such diagnoses were observed among 15–24-year-olds. Similarly, there were very few discharges with a diagnosis of alcoholic liver disease. For each year between 2015 and 2019, mental and behavioural disorders due to the use of alcohol was the most common diagnosis observed among alcohol-related discharges.

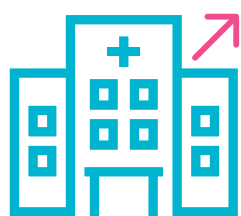
Table 9 Number of hospital discharges among young people aged 15–24 years, by alcohol-related diagnosis

| ICD-10-AM diagnosis codes   | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|------|------|------|------|------|
| Mental and behavioural disorders due to use of alcohol            | 658  | 669  | 708  | 717  | 638  |
| Alcoholic gastritis   | 8    | 6    | 7    | 12   | 12   |
| Alcohol-induced acute pancreatitis                                | 11   | 7    | 10   | 12   | 13   |
| Alcohol-induced chronic pancreatitis                              | 0    | 0    | 0    | 0    | ~    |
| Alcoholic liver disease   | 8    | 19   | 15   | 15   | ~    |
| Toxic effect of alcohol   | 78   | 80   | 75   | 93   | 79   |
| Alcohol poisoning   | 80   | 79   | 78   | 96   | 79   |
| Evidence of alcohol involvement determined by blood alcohol level | ~    | ~    | ~    | ~    | 8    |
| Alcohol problems – other*   | 54   | 79   | 86   | 70   | 53   |

Source: HIPE data, 2015–2019

\*Those with a diagnosis of Z50.2, Z71.4, Z72.1, or Z86.41 were combined into the ‘other’ category. See Table 20 and Table 21 in Appendix 2.

~ denotes less than 5 cases



## Hospitalisations

due to drug use have

**increased by 26%**

between 2015–2018. Alcohol-

related conditions increased by 12%



### 7.2.2.2 Drug-related hospital discharges

Table 10 presents trends in the number of drug-related hospital discharges as recorded on HIPE among those aged 15–24 years between 2015 and 2019. The number of drug-related discharges increased by 26% between 2015 and 2018, from 676 to 849, and decreased by 3.2% in 2019 to 822. Across the 5-year period, males were more likely than females to be discharged from hospital due to drug-related conditions.

Table 10 Number of hospital discharges among young people aged 15–24 years with a drug-related diagnosis, by sex

| Year | Male | Female | Total |
|------|------|--------|-------|
| 2015 | 442  | 234    | 676   |
| 2016 | 486  | 259    | 745   |
| 2017 | 542  | 299    | 841   |
| 2018 | 562  | 287    | 849   |
| 2019 | 545  | 277    | 822   |

Source: HIPE data, 2015–2019

The 3 most common substances for **substance-related hospitalisations** were: alcohol, cannabis and cocaine



**alcohol**



**cannabis**



**cocaine**

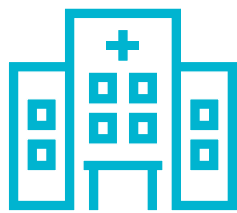
Table 11 provides a breakdown of drug-related discharges by diagnosis type. As a discharge may have more than one diagnosis, there is an element of double counting (for example, if a discharge had a diagnosis of both opiate and benzodiazepine poisoning, it is counted twice – once under each diagnosis). Drug-related discharges were divided into two broad diagnostic groupings: mental and behavioural disorders, and poisonings. In 2019, 60% of discharges had a mental and behavioural diagnosis and 40% had a poisoning diagnosis.

Table 11 Number of hospital discharges among young people aged 15–24 years, by drug-related diagnosis

| ICD-10-AM diagnosis codes  | 2015 | 2016 | 2017 | 2018 | 2019 |
|--|------|------|------|------|------|
| Mental and behavioural disorders due to opioids  | 161  | 163  | 158  | 156  | 131  |
| Mental and behavioural disorders due to cannabinoids   | 173  | 210  | 217  | 218  | 213  |
| Mental and behavioural disorders due to sedatives or hypnotics                                     | 36   | 36   | 40   | 50   | 38   |
| Mental and behavioural disorders due to cocaine  | 79   | 91   | 120  | 161  | 149  |
| Mental and behavioural disorders due to other stimulants   | 31   | 42   | 44   | 48   | 36   |
| Mental and behavioural disorders due to hallucinogens  | ~    | 9    | 13   | 16   | 10   |
| Mental and behavioural disorders due to volatile solvents  | ~    | 0    | 0    | ~    | ~    |
| Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances | 61   | 48   | 62   | 58   | 76   |
| Poisoning by heroin  | 17   | 19   | 22   | 27   | 11   |
| Poisoning by other opioids   | 39   | 48   | 60   | 46   | 57   |
| Poisoning by methadone   | 9    | 6    | 10   | 8    | 10   |
| Poisoning by other synthetic narcotics   | 13   | 29   | 22   | 20   | 22   |
| Poisoning by cocaine   | 41   | 39   | 61   | 75   | 70   |
| Poisoning by unspecified narcotics   | ~    | ~    | ~    | 6    | ~    |
| Poisoning by cannabis  | 34   | 32   | 39   | 37   | 40   |
| Poisoning by LSD   | ~    | ~    | 9    | ~    | 7    |
| Poisoning by unspecified hallucinogens   | ~    | ~    | 0    | ~    | ~    |
| Poisoning by barbiturates  | ~    | ~    | ~    | ~    | 0    |
| Poisoning by benzodiazepines   | 100  | 106  | 167  | 166  | 146  |
| Poisoning by psychotropic drugs not classified elsewhere   | 69   | 77   | 94   | 65   | 68   |
| Toxic effect of organic solvents   | 7    | 7    | ~    | ~    | ~    |

Source: HIPE data, 2015–2019

~ Denotes five or fewer discharges reported to HIPE

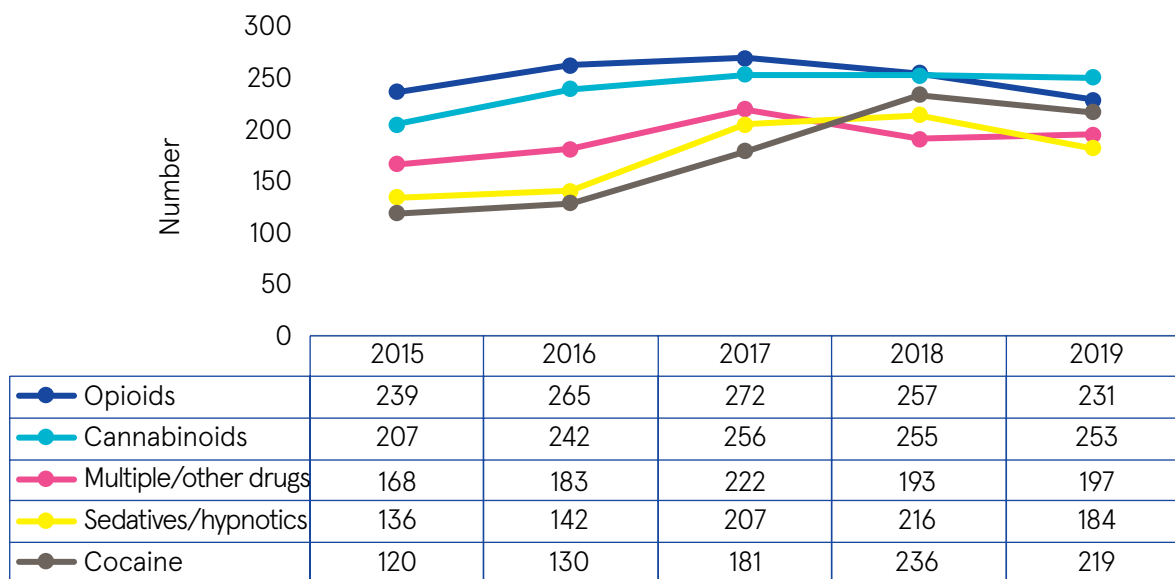


The number of hospital discharges with **cocaine diagnoses increased by 83%** between 2015–2019



Figure 43 illustrates the number of drug-related discharges for specific drug types. In 2019, cannabinoids accounted for 23% of drug-related diagnoses, opioids accounted for 21%, and cocaine for 20%. While the number of drug-related discharges increased by 18% between 2015 and 2019, the number of discharges with cocaine diagnoses increased by 83% in the same time period.

Figure 43 Number of hospital discharges among young people aged 15–24 years with a drug-related diagnosis, by drug type



Source: HIPE data, 2015–2019

## 7.3 Alcohol- and drug-related deaths

Alcohol- and drug-related deaths are reported for this overview using the NDRDI. The NDRDI is an epidemiological database recording deaths by drug and alcohol poisoning (poisoning deaths), and deaths among people who used drugs and/or those who were alcohol dependent (non-poisoning deaths) [223]. Poisoning deaths are deaths that are directly due to the toxic effect of the consumption of substance(s). Non-poisoning deaths are deaths of individuals with a history of alcohol and/or drug dependency or non-dependent use of drugs (ascertained from toxicology results and from the Central Treatment List (CTL), medical, or coronial records), irrespective of whether the use of the substance(s) was directly implicated in the death.

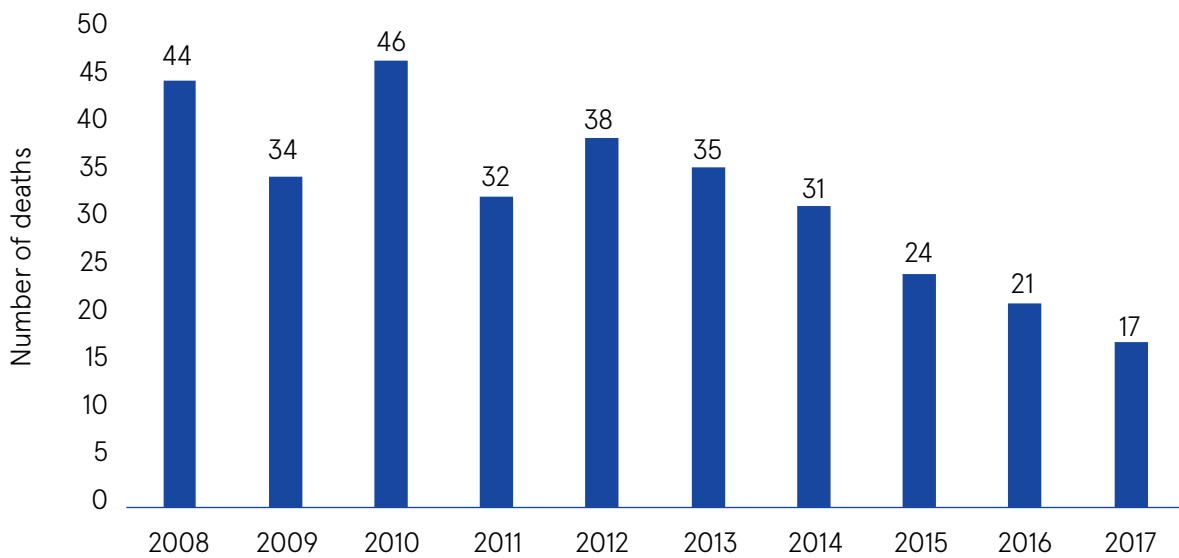
The NDRDI records data from four sources:

1. The Coroner Service
2. The HIPE scheme
3. The CTL, and
4. The General Mortality Register through the CSO.

### 7.3.1.1 Alcohol and drug poisoning deaths among young people

In Ireland, during the period 2008–2017 (inclusive), 322 people aged 15–24 years died as a result of drug and/or alcohol poisoning, accounting for 8.7% of the total 3,715 poisoning deaths among all age groups during that period [223]. The annual number of deaths decreased by 61%, from 44 in 2008 to 17 in 2017 (Figure 44). In 2017, there were 148 deaths of young people aged 15–24 recorded by the CSO, meaning that drug/alcohol poisoning deaths represent 12% of all deaths among young people in Ireland in that year [224].

Figure 44 Trends in drug and alcohol poisoning deaths among young people aged 15–24 years



Source: NDRDI data, 2008–2017

### 7.3.1.1.1 Main drugs implicated in drug and alcohol poisoning deaths

Of the drug and/or alcohol poisoning deaths, the majority (67%) involved polydrug use (including alcohol) (Table 12), and the majority (82%) were among males.

Table 12 Drug and alcohol poisoning deaths among young people aged 15–24 years

|  | n   | %    |
|--|-----|------|
| Drug poisoning deaths involving alcohol only                       | 12  | 3.7  |
| Drug poisoning deaths involving a single drug (excluding alcohol)  | 94  | 29.2 |
| Drug poisoning deaths involving multiple drugs (excluding alcohol) | 169 | 52.5 |
| Drug poisoning deaths involving drug(s) and alcohol                | 47  | 14.6 |

Source: NDRDI data, 2008–2017

Diazepam (32%), heroin (31%), and methadone (30%) were the main drugs implicated in drug poisoning deaths (Table 13).

Table 13 Main drugs implicated in poisoning deaths among young people aged 15–24 years

| ICD-10-AM diagnosis codes      | Number of deaths* | Percentage of all poisoning deaths (%) |
|--------------------------------|-------------------|--|
| Diazepam                       | 102               | 31.7                                   |
| Heroin                         | 99                | 30.7                                   |
| Methadone                      | 97                | 30.1                                   |
| Cocaine                        | 70                | 21.7                                   |
| Other benzodiazepines          | 65                | 20.2                                   |
| Alcohol                        | 59                | 18.3                                   |
| Antidepressants                | 56                | 17.4                                   |
| Other opioids                  | 53                | 16.5                                   |
| Ecstasy                        | 37                | 11.5                                   |
| Other prescription medications | 25                | 7.8                                    |
| Z-drugs                        | 25                | 7.8                                    |
| Flurazepam                     | 21                | 6.5                                    |
| Antipsychotics                 | 21                | 6.5                                    |
| NPS                            | 20                | 6.2                                    |
| Anti-epileptics                | 16                | 5.0                                    |
| Non-opioid analgesics          | 13                | 4.0                                    |
| Volatile inhalants             | 8                 | 2.5                                    |
| Other amphetamines             | 5                 | 1.6                                    |

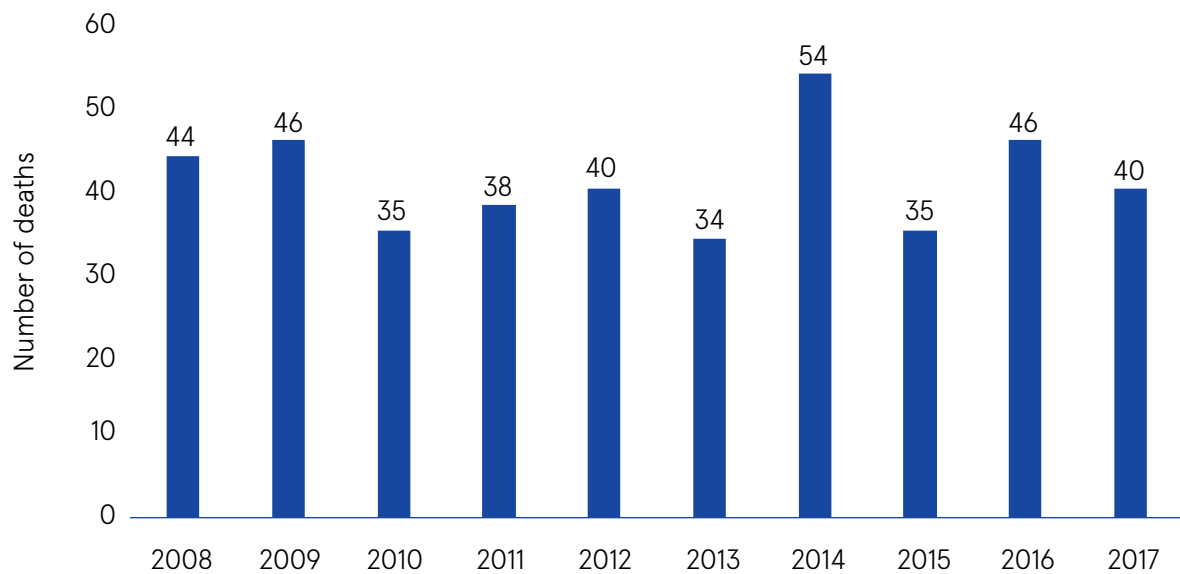
Source: NDRDI data, 2008–2017

\*This is a multi-response table taking account of up to six drugs which could be implicated in the death. Therefore, numbers in columns do not add up to the total number of deaths, as individual cases may have more than one drug implicated in their death.

### 7.3.1.2 Non-poisoning deaths among young people

Non-poisoning deaths recorded on the NDRDI include deaths due to medical conditions, and deaths due to external traumatic events among people with a lifetime history of drug use and/or alcohol dependence, whether or not the use of the substance(s) had a direct impact on the cause of death. Only deaths due to external traumatic events (trauma) are included in this analysis; medical causes of death are not included in this analysis due to low numbers.

Figure 45 Trends in non-poisoning deaths due to traumatic events among young people aged 15–24 years with a lifetime history of drug use



Source: NDRDI data, 2008–2017

Of the 412 non-poisoning deaths due to traumatic events (2008–2017), the majority (87%) were among males. The lifetime history of drug use among young people who died due to traumatic events is as follows:

- 328 young people (80%) had a lifetime history of drug use only, excluding alcohol dependence.
- Fewer than 5 young people had a history of alcohol dependency.
- 42 people (10%) had alcohol implicated as a factor related to the death, but not as the direct cause of death as recorded by the Coroner.
- 19 people (4.6%) had a lifetime history of both drug use and alcohol dependency.
- 18 people (4.3%) had a lifetime history of drug use and had alcohol implicated in the cause of death.

Over one-half (n=225, 55%) of deaths due to traumatic events were among young people with a history of cannabis use, and more than one-third (37%) had a history of cocaine use.

Table 14 Type of drug recorded for lifetime history of drug use among young people aged 15–24 years who died of non-poisoning deaths due to traumatic events

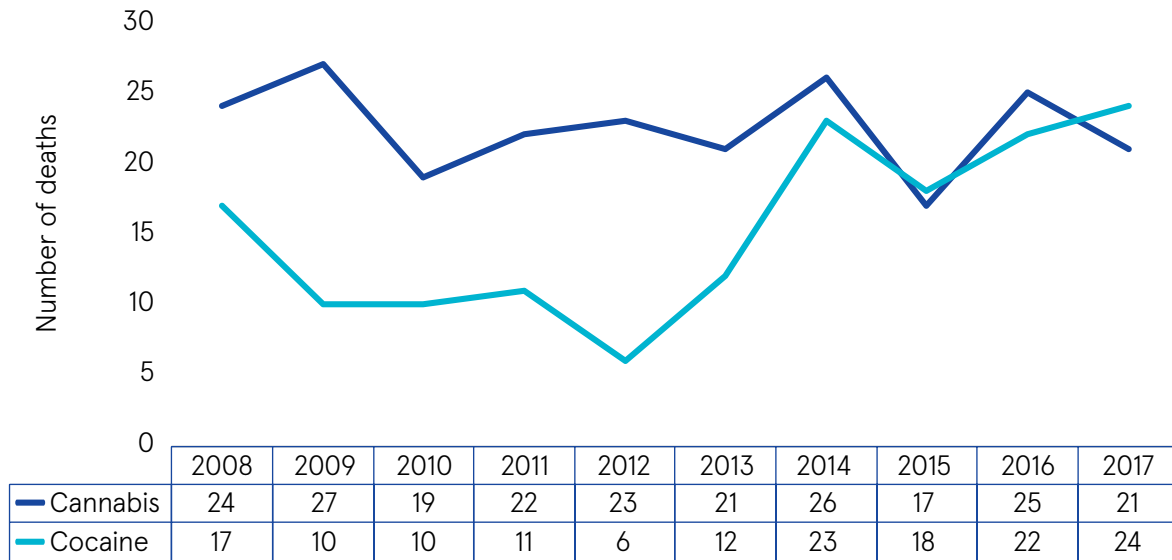
|                             | n   | %    |
|-----------------------------|-----|------|
| Cannabis                    | 225 | 54.6 |
| Cocaine                     | 153 | 37.1 |
| Ecstasy                     | 49  | 11.9 |
| Opioids                     | 39  | 9.5  |
| Benzodiazepines             | 37  | 9.0  |
| NPS                         | 23  | 5.6  |
| Other amphetamines          | 13  | 3.2  |
| Other hypnotics             | 11  | 2.7  |
| Other and unknown drug type | 10  | 2.4  |
| Hallucinogens               | 6   | 1.5  |

Source: NDRDI data, 2008–2017

This is a multi-response table taking account of up to six drugs. Therefore, numbers in columns will not add up to totals shown, as individual cases may have more than one drug implicated in their death.

Deaths among those with a lifetime history of cocaine use fluctuated over the reporting period, from a low of 6 deaths in 2012 to a high of 24 deaths reported in 2017. Deaths among those with a lifetime history of cannabis use has remained fairly stable over the 10 years of reporting, from 24 deaths in 2008 to 21 deaths to 2017 (Figure 46).

Figure 46 Trends in lifetime history of cannabis and/or cocaine drug use among young people – non-poisoning deaths due to traumatic events



Source: NDRDI data, 2008–2017

Of the young people whose main cause of non-poisoning death was due to traumatic events, deaths due to hanging accounted for just over one-half (52%) of these deaths in the period 2008–2017 (inclusive). One-fifth (20%) of trauma deaths among young people with a lifetime history of drug and/or alcohol use were due to road traffic collisions (Table 15).

Table 15 Main cause of non-poisoning deaths due to trauma among young people aged 15–24 years who had a lifetime history of drug/alcohol use

|   | n   | %    |
|---|-----|------|
| Hanging                                   | 214 | 51.9 |
| Road traffic collision                    | 82  | 19.9 |
| Drowning                                  | 49  | 11.9 |
| Assault (shooting/stabbing/other assault) | 24  | 5.8  |
| Choking                                   | 15  | 3.6  |
| Fall                                      | 15  | 3.6  |
| Other^                                    | 13  | 3.2  |

Source: NDRDI data, 2008–2017

^ ‘Other’ included deaths due to fire, railway/industrial incidents, suffocation, aspiration, other, and ill-defined trauma deaths.



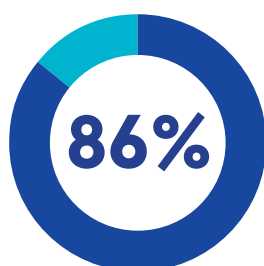
Although poisoning deaths have decreased since 2008 and non-poisoning deaths have plateaued, drug poisoning deaths continue to contribute to many deaths among young people, or there is a history of drug use, especially cannabis and/or cocaine use in non-poisoning traumatic deaths.

## 7.4 Substance use and crime

Crime and substance use are linked, yet the precise nature of the relationship remains elusive. Does substance use lead to crime (do people engage in criminal behaviour in order to fund the substance use and/or due to intoxication) or does criminal behaviour and resulting imprisonment lead to substance use? Perhaps the relationship is coincidental or explained by a set of common causes. The 2009 HRB alcohol overview *Social consequences of harmful use of alcohol in Ireland* provided extensive detail on the role of alcohol and crime in Ireland, and much of the information contained in that overview still stands true today [225]. An Garda Síochána and Probation Services data showed that alcohol and drug use are risk factors for violence and antisocial behaviour. Alcohol- and/or drug-related crime impacts not only on those directly affected, but also on the wider community, affecting perceptions of safety and security.

### 7.4.1 Substance use and young offenders on probation supervision

The 2021 Probation Service report, *Informing & supporting change: drug and alcohol misuse among people on probation supervision in Ireland*, examined the prevalence of substance use among those referred to probation services and provides an insight into the high levels of substance use among this population and how it is potentially linked to the offending crime [120]. The report noted that substance use was often the main offence that brought young people into contact with An Garda Síochána and Probation Services. The report included data on 3,096 Probation Service clients; of these, 5% were aged 12–17 years and 24% were aged 18–24 years. Of those aged 12–24 years, 41% were members of the Traveller community. For the purposes of this overview, only those aged under 25 years are presented here, but where age breakdown details are not available, overall references to the data are made.



**of probation  
services clients**  
aged 18–24 years reported  
alcohol and/or drug misuse

### 7.4.1.1 Drug and alcohol misuse among young offenders on probation supervision

Drug and/or alcohol misuse was common among young people on probation supervision and combined alcohol and drug misuse was the most frequently reported substance use issue [120].

Among adolescents aged 12–17 years, 70% reported drug and/or alcohol misuse\*\* as follows:

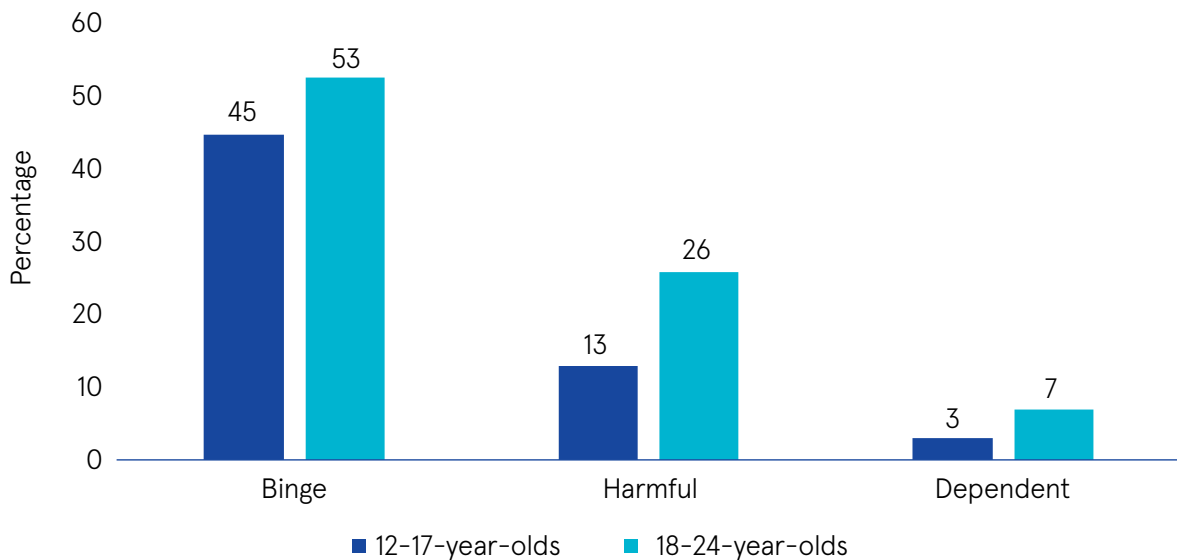
- 47% had combined drug and alcohol misuse.
- 7% misused alcohol only.
- 16% misused drugs only [120].

Of those aged 18–24 years, 86% reported drug and/or alcohol misuse (a reduction from 91% reported in the 2012 Probation Service report *Drug and alcohol misuse among adult offenders on probation supervision* [226], as follows:

- 57% had combined drug and alcohol misuse.
- 9% misused alcohol only.
- 20% misused drugs only.

Over one-half of those aged 18–24 years who misused alcohol reported binge drinking (53%), 26% reported harmful drinking and 7% were alcohol dependent. Of those aged 12–17 years who misused alcohol, 45% were binge drinkers and 3% were alcohol dependent (Figure 47) [120].

Figure 47 Type of problematic alcohol use of Probation Service clients, by age group

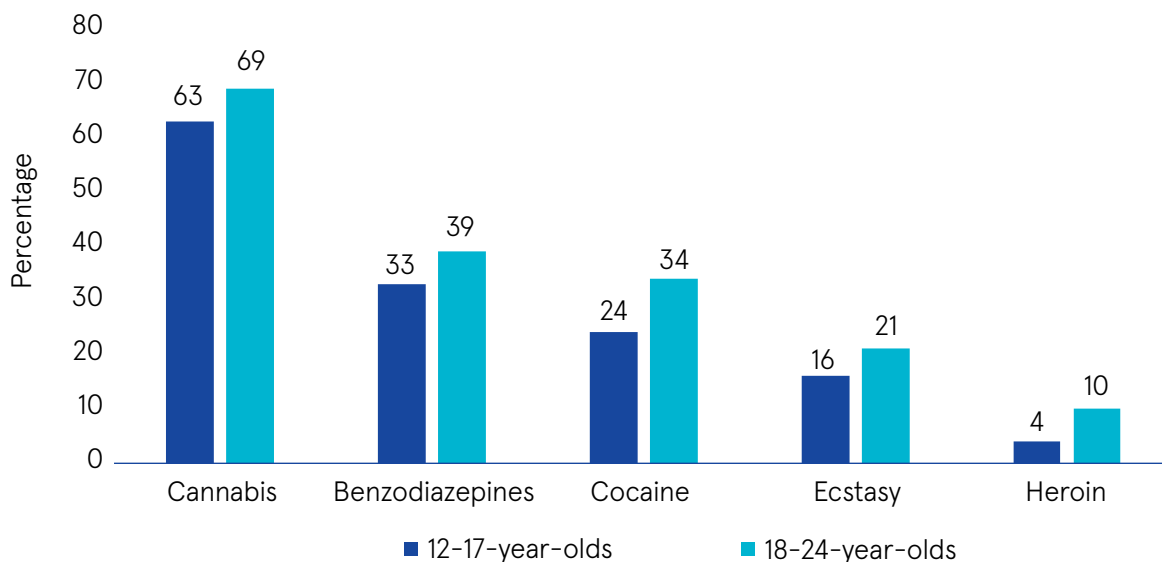


Source: Rooney, 2021 [120]

\*\* Note that for the purposes of the Probation Service report, *Informing & supporting change: drug and alcohol misuse among people on probation supervision in Ireland*, the terms ‘alcohol misuse’ and ‘problematic alcohol use’ refer to binge drinking, harmful drinking, or dependent drinking.

Cannabis was the most commonly misused drug by Probation Service clients; 63% of those aged 12–17 years and 69% of those aged 18–24 years misused cannabis (Figure 48).

Figure 48 Most commonly misused drug by Probation Service clients, by age group



Source: Rooney, 2021 [120]

### 7.4.1.2 Mental health co-morbidity of Probation Service clients

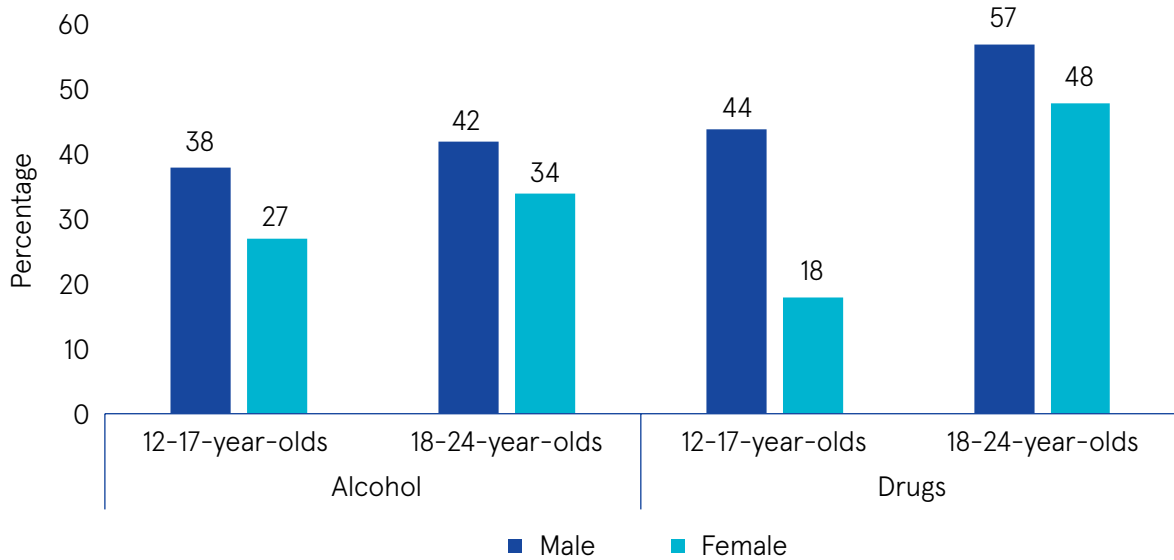
Mental health co-morbidity (mental health problems along with substance misuse problems) was common among young people on probation supervision. Over one-third (37%) of those aged 18–24 years were identified as experiencing mental health problems which moderately interfered with their lives and 15% were engaged with a service for mental health problems at the time of the assessment [227]. Mental health problems in combination with substance use issues requires careful consideration and Probation Officers require the knowledge and skills in identifying and understanding mental health to ensure that such problems are identified and that their clients’ are referred to the appropriate services for treatment.

### 7.4.1.3 Substance misuse and the relationship to offending

The Probation Service report also investigated whether drug and/or alcohol misuse was linked to the offence committed. Drug use was more likely to be connected to the offending crime than alcohol use, and particularly for males (57% of males aged 18–24 years versus 48% of females and 44% of males aged 12–17 years and 18% of females in this age group).

The link between alcohol use and the current offence was also more common among males than among females; (42% of males in the 18–24 years age group versus 34% of females, and 38% of males aged 12–17 years versus 27% of females in the same age group) (Figure 49). This information highlights the need for early intervention programmes that address substance misuse in order to reduce reoffending among young people [120].

Figure 49 Alcohol and drug use linked to current offence, by age group of Probation Service clients



Source: Rooney, 2021 [120]

Drug use was linked to the **crime committed by over one-half** of 18–24-year-olds referred to Probation Services (38% alcohol use linked to current crime)



#### 7.4.1.4 Misuse of Drugs Act 1977 conviction among young Probation Service clients

Legislation regarding the unlawful production, possession, and supply of drugs is set out in the Misuse of Drugs Act, 1977 and its subsequent amendments and additions. Two in every five Probation Services clients aged 18–24 years (40%) had a Misuse of Drugs Act conviction and 20% of those aged 12–17 years. Under the Misuse of Drugs Act 1977, possession was the most frequent conviction; 17% of those aged 12–17 years had a conviction for possession under the Act and 10% had convictions for possession, sale and supply for an amount less than €13,000. One-third of those aged 18–24 years had a possession conviction (33%) and 20% had convictions for possession, sale and supply for an amount less than €13,000 [120].

### 7.4.1.5 Existing service engagement for problematic substance use and Probation Service interventions

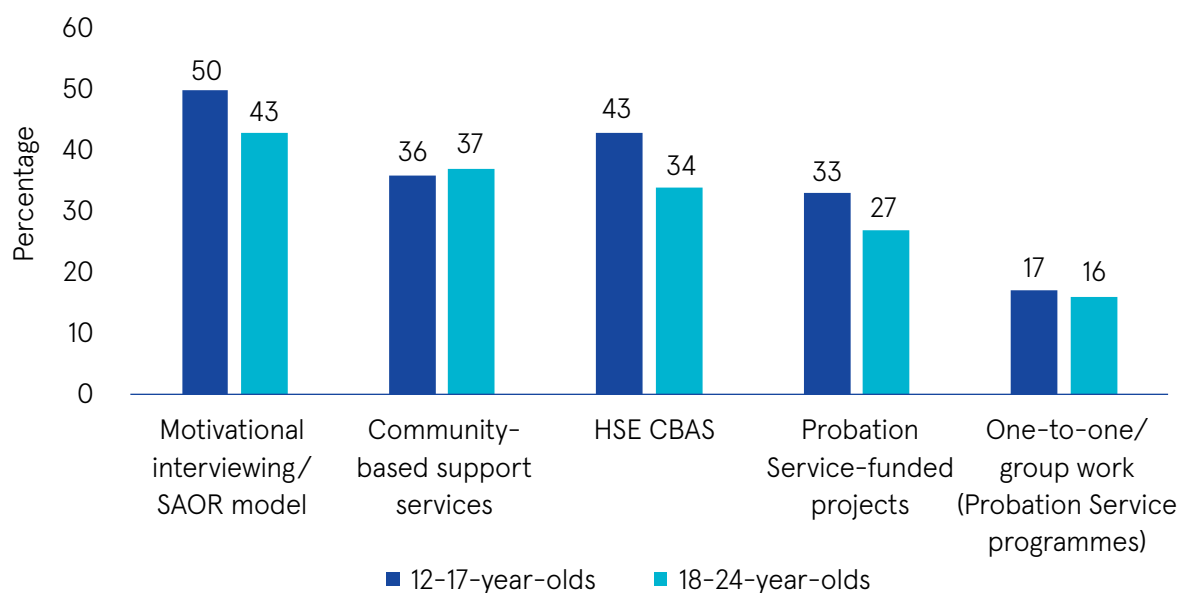
Where an offender with substance misuse was not already engaged with support services for their problematic alcohol use, probation officers commonly referred their clients to appropriate services in order to address their alcohol use issues. The most common referrals for young clients misusing alcohol were to HSE-run community-based addiction services (CBAS) (39% of 12–17-year-olds and 27% of 18–24-year-olds). Clients were also regularly referred to Probation Service-funded projects; 36% of 12–17-year-olds and 26% of 18–24-year-olds [120].

Just 8% of clients aged 12–17 years and 17% of those aged 18–24 years, who misused drugs, were engaged with medical intervention for their drug use (for example, methadone/opioid substitution treatment, GP engagement, or outpatient services) upon their referral to Probation Services. Almost one-quarter of those aged 12–17 years (23%) and 25% of clients aged 18–24 years were engaged with a community support service<sup>††</sup>.

Females had a higher rate of engagement in medical interventions and in community support services than males. This was in contrast with the drug treatment trends reported for the general population, where three times as many males as females engaged in a medical/community intervention in 2019 [228].

Young Probation Service clients who had used drugs were most commonly referred by Probation Officers for motivational interviewing/Support, Ask and Assess, Offer Assistance, Refer (SAOR) (50% of 12–17-year-olds and 43% of 18–24-year-olds) and to HSE CBAS (43% of those aged 12–17 years and 34% of those aged 18–24 years) (Figure 50) [120].

Figure 50 Probation Services referrals for substance misuse of young clients, by age group



Source: Rooney, 2021 [120]

<sup>††</sup> Note that Probation Service clients could be engaged with more than one service at a time. Community support services include counselling and psychotherapy, Narcotics Anonymous, aftercare, pharmacies, family support, and needle exchange.

## 7.4.2 Drink-driving and drug-driving

Driving under the influence of alcohol, at any level, is a major risk factor for road traffic collisions and fatalities, and the evidence shows that the risk of collision increases exponentially with BAC [4]. In Ireland, a driver can be arrested if they are found to be too intoxicated to have proper control of their vehicle, or to have consumed more than the permitted amount of alcohol. The legal limit for fully licensed drivers is 50 milligrams (mg) of alcohol per 100 millilitres (mL) of blood, and for professional and learner drivers it is 20 mg of alcohol per 100 mL of blood.

In recognition that driving is impaired even at low levels of alcohol use, the Road Traffic Act 2018 introduced a more severe penalty for drivers found to have alcohol levels of between 50 mg per 100 mL and 80 mg per 100 mL of blood and equivalent in urine or breath. Under the amendment of the Act in 2018, all drink-drivers, without exception, receive a driving disqualification (the previous legislation had allowed some drink-drivers to receive penalty points instead of a disqualification). A reduction in the number of drink-driving offences following the change in legislation was noted; however, despite the stricter penalties, drink-driving continues.

It is also illegal to drive under the influence of drugs (including prescription drugs) if your driving is impaired to such an extent that you do not have proper control of the vehicle. In addition, a person cannot drive if they are over the specified limit for cannabis, cocaine and heroin, even if your driving is not impaired.

In its annual report for 2020, the Medical Bureau of Road Safety reported that those aged 24 years or under represented 24% of arrested drivers providing blood and urine specimens for drug and/or alcohol testing [229].



**30% drug-driving arrests &  
14% of drink-driving arrests**  
were among those aged 18–24 years

---

The CSO is responsible for reporting PULSE crime statistics and the CSO provided the data for this overview, including a breakdown of the number of arrests made for alcohol- and drug-related offences for those aged 18–24 years.

Analysis of the PULSE data revealed that there were 12,580 recorded arrests made for driving/being in charge of a vehicle while over the legal alcohol limit (drink-driving), for the years 2018 and 2019 (6,449 and 6,131 respectively). Among arrests for drink-driving in 2018 and 2019, 14% were aged 18–24 years and of those young people arrested for drink-driving, the majority were male (89% in 2018 and 90% in 2019) (Table 16).

Table 16 Percentage of arrests for driving/being in charge of a vehicle while over the legal alcohol limit, by age group

|                 | 2018                     |                          |                           | 2019                     |                          |                           |
|-----------------|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|---------------------------|
|                 | Female<br>(n=916)<br>(%) | Male<br>(n=5,533)<br>(%) | Total<br>(n=6,449)<br>(%) | Female<br>(n=878)<br>(%) | Male<br>(n=5,253)<br>(%) | Total<br>(n=6,131)<br>(%) |
| 18–24-year-olds | 11.5                     | 88.5                     | 14.1                      | 9.6                      | 90.4                     | 14.2                      |
| All other ages  | 14.6                     | 85.4                     | 85.9                      | 15.1                     | 84.9                     | 85.8                      |

Source: CSO data, 2018–2019

According to PULSE data, in 2018 and 2019, 1,630 arrests were made for drug-driving, of which 490 (30%) were aged 18–24 years. Young males were more likely than females (95% versus 5%) to be arrested for drug-driving offences (Table 17).

Table 17 Percentage of arrests for driving/being in charge of a vehicle while under the influence of drugs, by age group

|                 | 2018                    |                        |                         | 2019                    |                          |                           |
|-----------------|-------------------------|------------------------|-------------------------|-------------------------|--------------------------|---------------------------|
|                 | Female<br>(n=39)<br>(%) | Male<br>(n=432)<br>(%) | Total<br>(n=471)<br>(%) | Female<br>(n=85)<br>(%) | Male<br>(n=1,074)<br>(%) | Total<br>(n=1,159)<br>(%) |
| 18–24-year-olds | 5.0%                    | 95.0%                  | 33.8%                   | 5.4%                    | 94.6%                    | 28.6%                     |
| All other ages  | 9.9%                    | 90.1%                  | 66.2%                   | 8.1%                    | 91.9%                    | 71.4%                     |

Source: CSO data, 2018–2019

### 7.4.2.1 Substance use and road user fatalities

For the period 2013–2017, Road Safety Authority (RSA) data indicated that those in the 15–24 years age group (26%) represented the second largest proportion of fatalities with a positive toxicology for alcohol following the 25–34 years age group (27%) [230].

Road traffic collision (RTC) fatalities data were analysed on our behalf by the RSA. The HRB collects RTC fatalities data annually on behalf of the RSA. These data are collected from available closed coronial files, using NDRDI methodology, and are referred to as coronial data. The RSA collaborates with the HRB and the Medical Bureau of Road Safety in relation to the interpretation and analysis of toxicology results from the coronial data. This analysis focused on the toxicology results of road user fatalities aged 15–24 years (inclusive) that occurred during 2013–2017. The RSA has coronial data for 705 road user fatalities that occurred during this time period and 139 (20%) of these fatalities were aged 15–24 years.

Of the 139 road user fatalities aged 15–24, 123 (88%) had a toxicology result available<sup>‡</sup>. Of these 123 road user fatalities:

- 57 (46%) had a positive toxicology for alcohol<sup>§§</sup>.
- 23 (19%) had a positive toxicology for cocaine<sup>\*\*\*</sup>.
- 16 (13%) had a positive toxicology for cannabis.
- 16 (13%) had a positive toxicology for at least one benzodiazepine.

Of the 123 road user fatalities aged 15–24 with a toxicology result available, 80 were driver fatalities<sup>†††</sup>. Of these 80 driver fatalities:

- 39 (49%) had a positive toxicology for alcohol.
- 19 (24%) had a positive toxicology for cocaine.
- 12 (15%) had a positive toxicology for cannabis.
- 10 (13%) had a positive toxicology for at least one benzodiazepine.

<sup>‡</sup> Ante-mortem toxicology results or post-mortem toxicology results where the deceased died  $\leq 1$  day after the collision occurred were analysed.

<sup>§§</sup> A positive toxicology for alcohol is recorded where the Blood Alcohol Concentration (BAC) of the deceased is  $>20$ mg alcohol per 100ml blood (or equivalent in urine).

<sup>\*\*\*</sup> This analysis examined 7 drug categories: benzodiazepines, cannabis, cocaine, gabapentinoids, opioids, stimulants and z-drugs. Fatalities may have had a positive toxicology for more than one drug category, and more than one drug within one drug category. Drugs administered as part of medical care were excluded. A positive toxicology for a drug does not imply impairment.

<sup>†††</sup> ‘Driver fatalities’ includes motorcycle drivers.



### 7.4.2.2 Behaviours and attitudes towards drink-driving

The RSA commissioned a national survey of driver attitudes and behaviours, analysing a number of key measures including drinking and driving [231]. Of young drivers aged 24 years and under, 8% admitted to having driven a motor vehicle after consuming alcohol in the last year and 16% of this age group said that there were times where they may have been over the limit when driving the morning after a night out. However, the majority (74%) did not agree that it was acceptable to drive short distances after consuming one drink. Awareness of the risks of drink driving was high with 83% of young drivers indicating that driving under the influence of alcohol seriously increases the risk of a collision and 68% agreed that one drink can impair driving. An earlier RSA survey in 2017 also revealed there was high support among young people for the proposal that those who are caught driving over the drink-driving limit should be automatically disqualified from driving (91%), and 62% felt that this disqualification should be for more than 12 months [232].

### 7.4.3 Controlled drug offences among young people

Analysis of PULSE system data for the HRB alcohol overview in 2009 *Social consequences of harmful use of alcohol in Ireland* revealed that alcohol and crime in Ireland were closely linked [225]. At that time, the typical profile of offenders recorded on the PULSE system for drunkenness, public order, or assault was that of a young male aged under 24 years. More up-to-date PULSE data reveal that young people, particularly young males, remain the age group that feature the most prominently in PULSE statistics of arrests made for drug-driving, drink-driving, possession of drugs for personal use and for sale and supply, and disorderly conduct.



**43%** of controlled **drug offences arrests** involved those aged 18–24 years, of which;



**46%**

of arrests were for possession of drugs for personal use

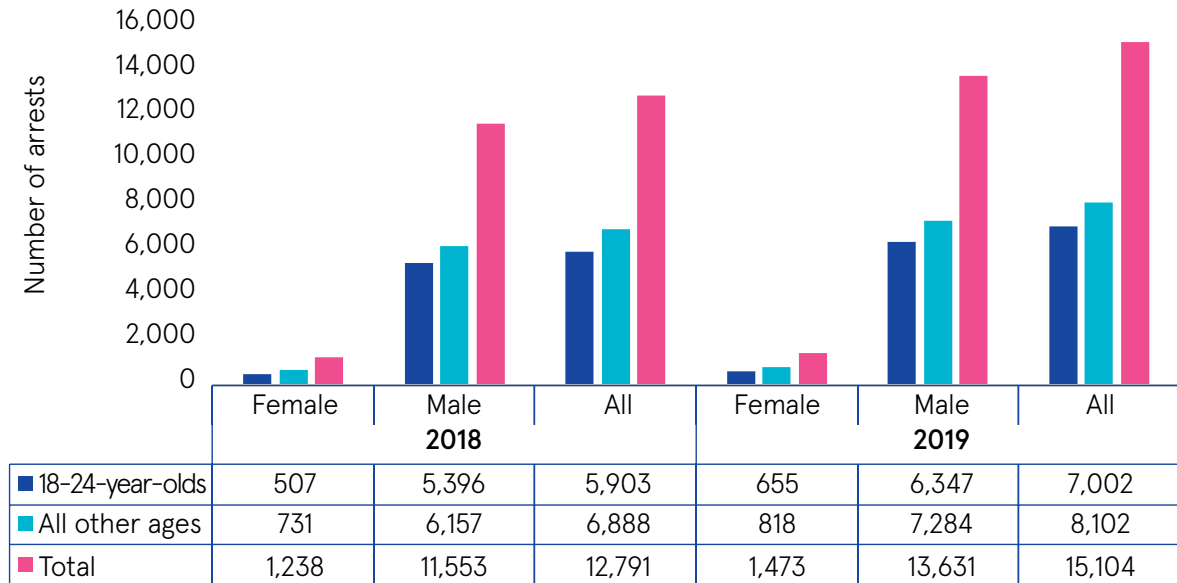


**36%**

of arrests were for possession of drugs for sale and supply

PULSE data indicated that in 2018 and 2019 there were 37,568 incidents of controlled drug offences, of which 43% involved those aged 18–24 years. Arrests for possession of drugs for personal use was the most common controlled drug offence in 2018 and 2019 (n=27,895); 46% of these arrests were young people aged 18–24 years; 78% were male. Such arrests increased from 5,903 in 2018 to 7,002 in 2019 (Figure 51).

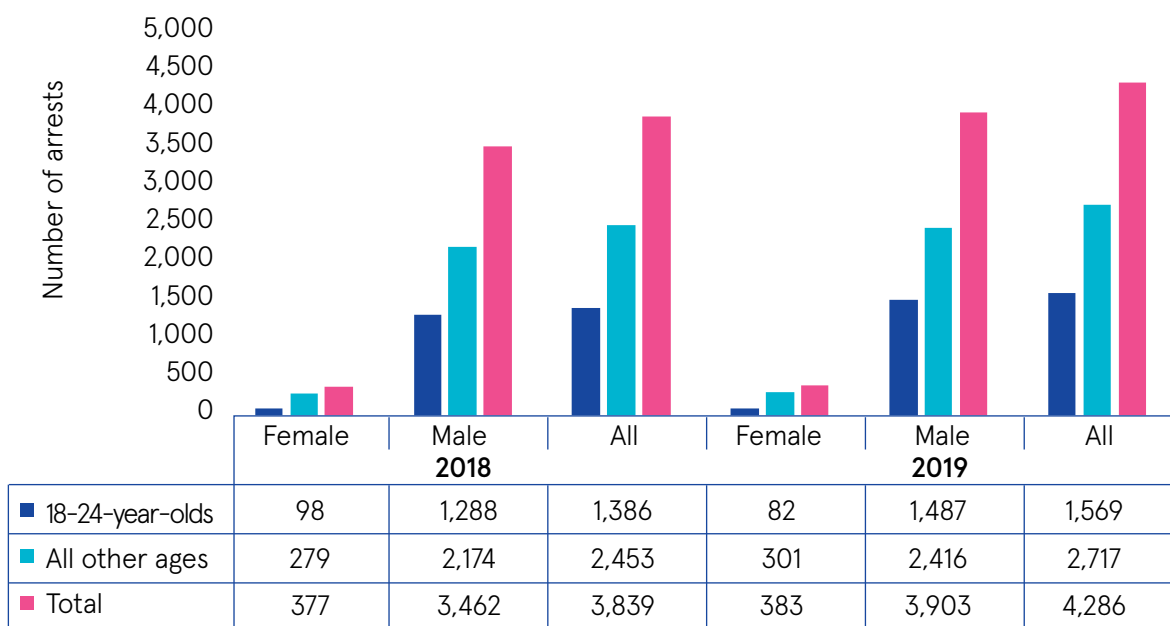
Figure 51 Number of arrests for possession of drugs for personal use, by sex



Source: CSO data, 2018–2019

In 2018–19, there were 8,125 arrests for possession of drugs for sale or supply (3,839 in 2018 and 4,286 in 2019); 36% of those arrested were aged 18–24 years, and males were more likely than females to be arrested for possession of drugs for sale and supply (91% versus 9%) (Figure 52).

Figure 52 Number of arrests for possession of drugs for sale or supply, by sex



Source: CSO data, 2018–2019

### 7.4.4 Public order offences (disorderly conduct)

In legal terminology, disorderly conduct means intentionally disturbing the public peace and order by language or other conduct as outlined in the Criminal Justice (Public Order) Act, 1994. Under this law, it is an offence for an individual to behave in a disorderly or disruptive manner (including drunkenness) in public places such as roads, public parks or recreational areas, cemeteries, churchyards, trains, buses, and other public transport vehicles.

Drunkenness and disorder in public places undermines confidence in public safety and is an indicator of alcohol-related social harms. Disorderly conduct is often concentrated in areas where alcohol is sold for consumption on-trade, for example, in or near bars, pubs, clubs, and restaurants. Noise, litter, and vandalism as a result of the congregation of people when late-night venues close can constitute a public nuisance and safety risk and can create a sense of unease.

In 2018–19, there were 51,906 incidents of disorderly conduct; the annual number of such incidents increased from 25,348 in 2018 to 26,558 in 2019. Of all arrests made for disorderly conduct, 26% (n=13,572) involved those aged 18–24 years, and young males were more likely than young females to be arrested for disorderly conduct (88% versus 12%) (Table 18).

Table 18 Percentage of arrests for disorderly conduct, by age group

|                 | 2018                     |                         |                          | 2019                     |                         |                          |
|-----------------|--------------------------|-------------------------|--------------------------|--------------------------|-------------------------|--------------------------|
|                 | Female<br>(4,047)<br>(%) | Male<br>(21,301)<br>(%) | Total<br>(25,348)<br>(%) | Female<br>(4,176)<br>(%) | Male<br>(22,382)<br>(%) | Total<br>(26,558)<br>(%) |
| 18–24-year-olds | 12.5                     | 87.5                    | 27.0                     | 12.4                     | 87.6                    | 25.3                     |
| All other ages  | 17.2                     | 82.8                    | 73.0                     | 16.9                     | 83.1                    | 74.7                     |

Source: CSO data, 2018–2019

### 7.4.5 Young people involved in the illegal drugs trade

A 2019 qualitative study *The drug economy and youth interventions: an exploratory research project on working with young people involved in the illegal drugs trade* investigating the involvement of young people in drug markets in Ireland and violence and intimidation in the illegal drug trade identified a need to explore the issue of early intervention with young people involved in drug distribution [233]. The report outlined the complexities of the Irish drug market due to the changing profile of drug use to polydrug use; the open nature of dealing and drug use in public places; the debt-based nature of drug distribution; and a greater association of the drug market with violence and intimidation. Young people and their families who had experienced drug-related problems, who were involved in some form of drug selling or holding, and who had experienced some associated violence or threat of violence were interviewed as part of the study to help understand their behaviour. The report found that the young people saw being involved in the drug economy as work (dealing or holding or carrying drugs) whereby they had access to cash and consumer goods, and this was reportedly a more attractive alternative to working in, for example, the service industry.

The report highlighted how drug distribution was based on a financial system of credit, and the recouping of debts operated under the threat of violence. Drug-related intimidation and drug debt intimidation were central to how these distribution networks were structured, and this created an environment where the dominant drug dealers ruled the community. The term ‘grooming’ was used to describe the process whereby a young person did favours for those involved in drug distribution in return for small amounts of cash. Once they were considered trustworthy, they could then progress to holding money, drugs, or weapons. Young people were sometimes paid for this, but movement into these more involved roles in the distribution network was often required to pay drug debt. Intimidation featured throughout the report, especially for young males, and a concern of the author was of young people being asked to engage in sexual activity in order to pay off debts [233].

A further report, *Lifting the Lid on Greentown*, examined the effect of a criminal network on the offending behaviour of children in a regional Garda sub-district outside Dublin referred to as Greentown [234]. The research sought to explore whether criminal networks influenced children moving into a life of crime. Using the PULSE system data for burglary and drugs

for sale and supply offences committed by young people and interviews with gardaí, the key findings revealed the presence of a criminal hierarchical network that differentiated between family and non-family members in Greentown. This hierarchical structure was supported by processes and sympathetic-embedded cultures. The report described how there was a mismatch between how the criminal justice system operated and the lived reality. For example, the network leader rarely was directly involved in criminal activities and thus was difficult to convict, and very few would complain or act as a witness against him. The power and effect of the network was shown to be strongest where the network leader lived, and his influence was thought to decline with distance. Regardless of distance, having any relationship with the network leader resulted in independence and privacy being taken away.

Child offending in Greentown was shown to be five times higher than the national average for burglary (75% versus 15%) and was likely due to the effect the network had in persuading children to offend [234]. Children were actively recruited and cultivated into the network to engage in criminal behaviour, and younger family members of existing members of the network were expected to follow suit.

Two replication case studies, the Bluetown [235] and Redtown [236]. studies, were carried out to determine whether the findings of the Greentown study could be generalised to other locations in Ireland, in order to determine what factors influence young people's engagement and retention within a criminal network and how these factors may influence their crime trajectories [235,236]. In Bluetown, a combination of risk factors was linked to young people developing more serious and prolific offending patterns across all networks. Criminal network strength and stability was enhanced by the quality of trust in relationships between network members and was influenced by fear and intimidation [235].

The Redtown study was based in a small provincial town that was chosen due to the number of youths involved in burglary and possession of drugs for sale and supply. In Redtown, involvement in crime was intergenerational and viewed as normal. The young people often came from families with criminal histories and/or had experienced financial poverty and adversity. As their families were rooted within the Redtown criminal network, they were excluded from the mainstream Redtown community. A combination of these factors influenced young people's involvement with both criminality and the Redtown criminal network. Involvement in drug-related offences centred on how vulnerable the individual was and their personal drug use [236].

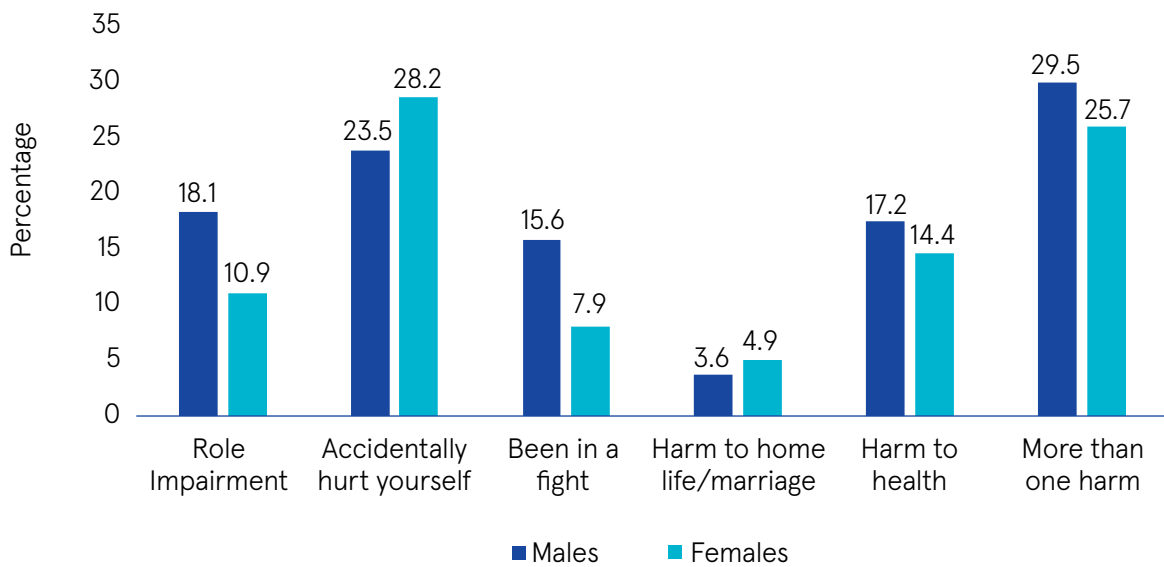
## **7.5 Social consequences of drug and alcohol use**

The negative social consequences of substance use include family problems, public disturbances, violence, and reduced work performance, impacting on all facets of society. Harmful use of alcohol and drug use has a negative effect on family well-being and can contribute to relationship and marriage problems and impact on children, who are especially vulnerable to the effects of parental substance use. The effects of substance use can undermine the fabric of family life and in many cases leave a legacy of neglect, abuse, chaos, and damaged children. The emotional cost borne by these families is considerable.

### 7.5.1 Alcohol- and drug-related harms

Younger people were more likely to experience harm as a result of their own drinking than those in older age groups [7,25]. The 2019–20 NDAS found that young males were more likely than females (30% versus 26%) to report more than one harm although females were more likely than males (28% versus 24%) to report accidentally hurting themselves. Males were more likely than females (18% versus 11%) to experience role impairment (for example, at work, at school, or when taking care of the household) (Figure 53) [7].

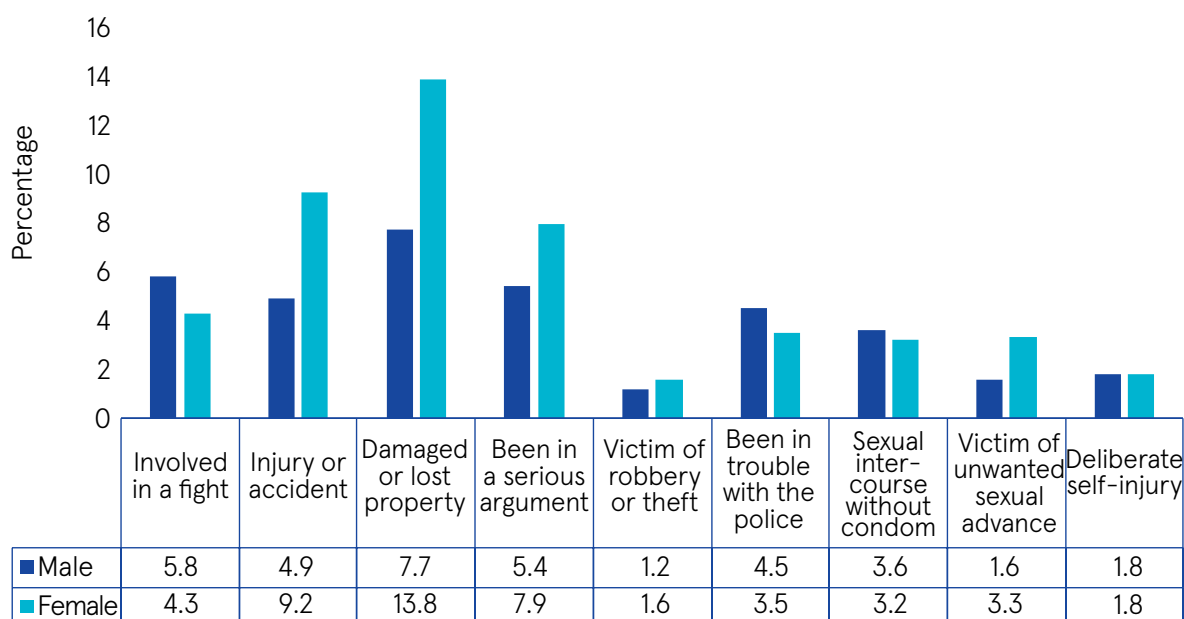
Figure 53 Harms experienced in the last year from own drinking among young people aged 15–24 years



Source: Mongan et al. 2021 [7]

More than one in ten schoolchildren surveyed in the 2019 ESPAD reported damage to, or loss of property (11%). Injury or accident was reported by 7%, serious argument (7%), being involved in a fight (5%), and being in trouble with the police (4%) in the last year as a result of alcohol use [10]. Sex differences were noted in harms experienced as a result of own drinking, as females experienced more damaged or lost property than males (14% versus 7.7%), and females were also more likely than males to be victims of an unwanted sexual advance (3.3% versus 1.6%). Males were more likely than females to report having been involved in a fight (5.8% versus 4.3%) (Figure 54).

Figure 54 Harms experienced as a result of own drinking among adolescents aged 15–16 years, by sex



Source: Sunday et al. 2020 [10]

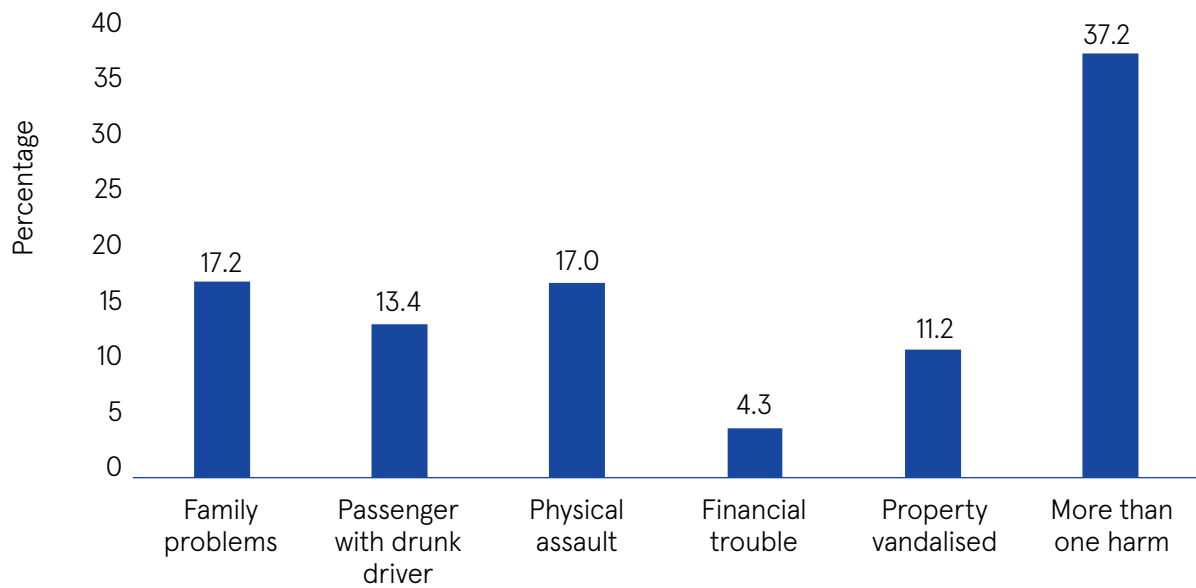
A number of other studies involving young people found similar patterns of adverse consequences as a result of alcohol use including feelings of guilt and remorse due to something they said or did because of their drinking; missing work or college because of a hangover; financial problems; arguments; damaged property; injuries; being involved in fights; accidents and injuries; and being in trouble with the police [77,132,237–239].

### 7.5.1.1 Harm from others’ drinking

Alcohol is responsible for substantial harms to others and has been examined in detail in the 2016 HRB alcohol overview *Alcohol in Ireland: consumption, harm, cost and policy response* [240]. Findings from the report, *Alcohol consumption in Ireland 2013: analysis of a national alcohol diary survey* indicated that younger people aged 18–24 years were more likely than those in older age groups to report experiencing harms from others’ drinking. Young males specifically reported a higher incidence of being involved in fights (23%), being in an accident (15%), and being a passenger with a drunk driver (9.3%) as a result of others’ drinking compared to females and those in older age groups [25].

Alcohol-related violence and harms was considered in a 2014 study, *Alcohol’s harm to others in Ireland*, and are illustrated in Figure 55 [241]. Of those aged 18–29 years, 17% reported experiencing fights and assaults. The incidence of having experienced fights and assaults increased exponentially with the frequency of risky drinking.

Figure 55 Prevalence of alcohol's harm to others among young adults aged 18–29 years



Source: Hope 2014 [241]

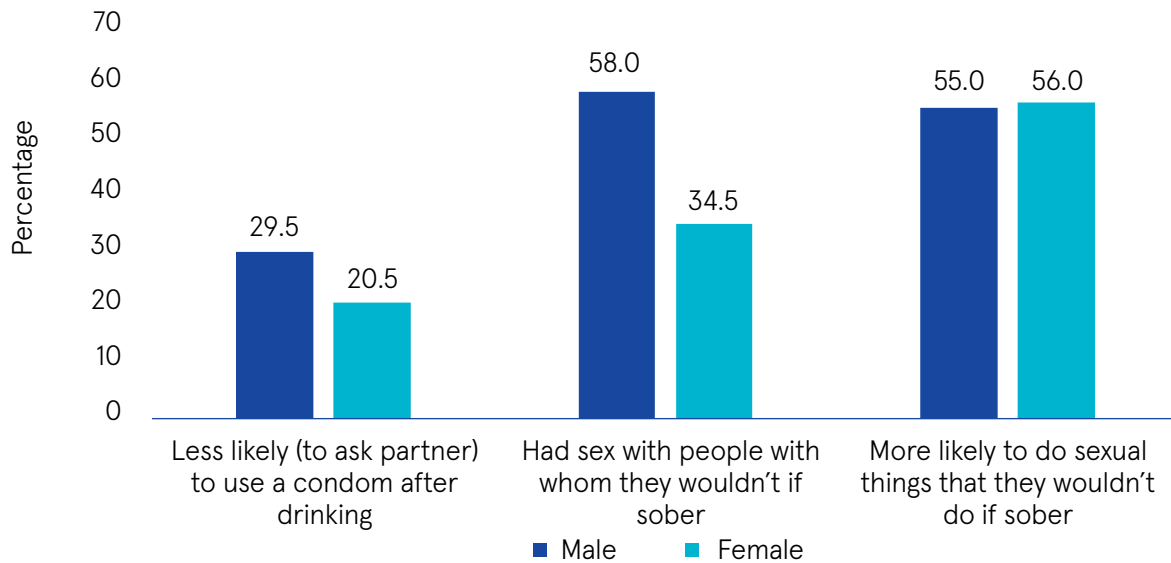
### 7.5.1.2 Sexual behaviour and substance use

Alcohol use has been linked to risky sexual behaviours due to its effects of lowering inhibitions; it increases the risk of harms such as sexually transmitted infections (STIs), regretted sexual experiences, neglecting to use contraception, and sexual assault.

The Sexual Health and Attitudes, Galway (SHAG) survey was the first of its kind undertaken in Ireland to comprehensively gather information on sexual behaviour in a third-level student population (aged 18–29 years) (N=1,691) [239]. Students were asked a series of questions about alcohol and sex in order to understand the relationship between the two. Figure 56 illustrates the attitudes towards sexual experiences after drinking; 30% of males and 21% of females felt that they were less likely to use, or ask a partner to use, condoms, after drinking and 55% of males and 56% of females agreed that they were more likely to participate in sexual behaviours they would not do if sober.



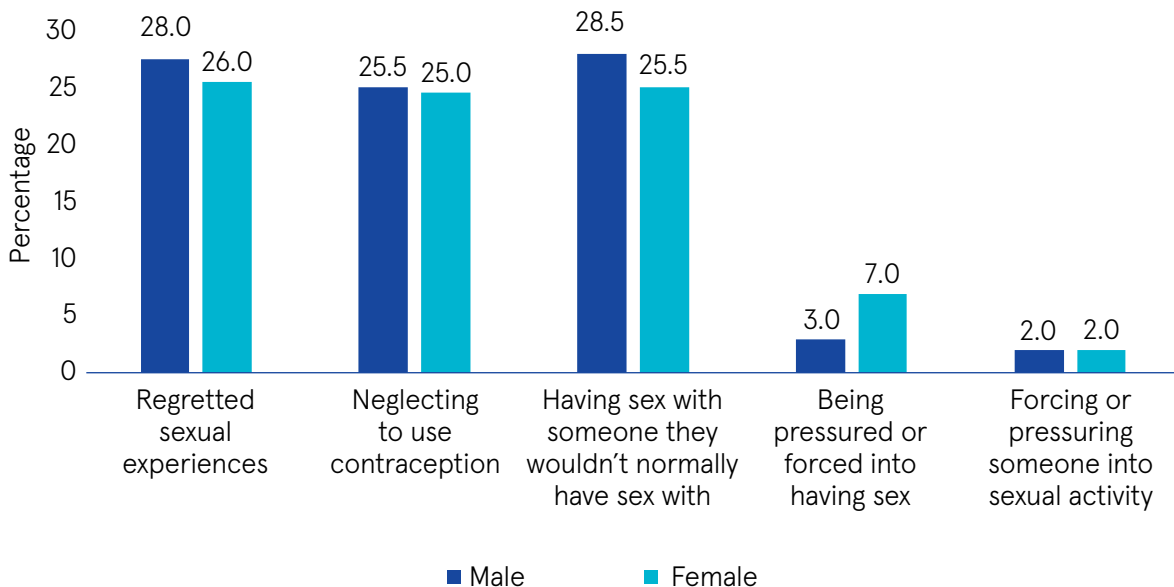
Figure 56 Attitudes towards sex after drinking among young adults aged 18–29 years



Source: Byrnes and MacNeela, 2017 [239]

The students were also asked about their own sexual experiences as a result of their alcohol use; 26% of females and 28% of males reported regretted sexual experiences (Figure 57) [239].

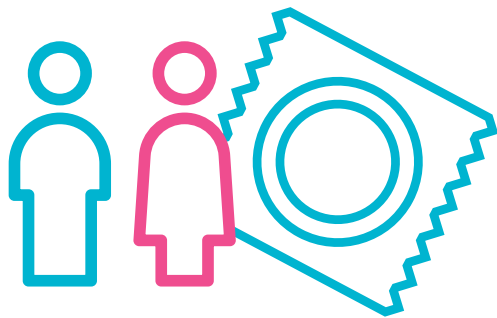
Figure 57 Sex-related alcohol consequences among young adults aged 18–29 years



Source: Byrnes and MacNeela, 2017 [239]

A study of third-level students found higher levels of unintended sex and unprotected sex among students who were hazardous drinkers than among non-hazardous drinkers [237].

A 2010 study of young people (mean age=23.9 years) and the relationship between alcohol and condom use featured a subset of participants (n=388) from the Irish Study of Sexual Health and Relationships, *Suppression effects of partner type on the alcohol-risky sex relationship in young Irish adults* [242]. The majority of respondents (70%) had consumed alcohol before casual sex and those who reported heavy drinking were less likely to report condom use than those who did not report drinking before sex.



30% of young males and 21% of females felt that they were **less likely to use,** or ask a partner to use, **condoms after drinking**

Among a sample of Irish festivalgoers (N=1,193) aged between 18 and 34 years, 40% reported having sex following the use of a drug at a festival; of these, 66% stated that the sex was unprotected [115]. Among third-level students participating in the DUHEI survey, 32% of those who said they had used drugs in the last year reported engaging in sexual activity while under the influence of drugs and of those, cocaine was the most commonly reported drug used (25%), other drugs (19%) and ketamine (8.6%) [24].

### 7.5.1.3 Substance use and sexual assault

A study, *The active\* consent / union of students in Ireland sexual experiences survey 2020: sexual violence and harassment experiences in a national survey of higher education institutions*, by NUI Galway and the Union of Students examined experiences of sexual assault among third-level students. Of the 6,026 student respondents (83% were aged under 25 years), 29% of females, 10% of males, and 28% of non-binary students reported non-consensual penetration through force or threat of force, or while incapacitated and unable to give consent. Of those students, 65% of females, 64% of males, and 33% of non-binary students reported that their perpetrator had consumed alcohol prior to the incident [243].



74% of third-level students who reported experiencing **sexual violence** said they had been using alcohol and/or drugs at the time of the incident and 64% said that the perpetrator had been using alcohol and/or drugs at the time of the incident

Findings from a 2022 study that surveyed 7,901 third-level students (81% were aged under 25 years), *Surveys of experiences of sexual violence and harassment in higher education: reports and findings*, indicated that of students who reported experiencing sexual violence, 74% said they had been using alcohol and/or drugs at the time of the incident, most commonly alcohol (69%) and 64% said that the perpetrator had been using alcohol and/or drugs at the time of the incident, most commonly, alcohol (52%) [244].

## 7.5.2 Homelessness and substance use

The issues of homelessness and substance use often overlap, and it is difficult to determine which of the experiences are causes and which are effects with those experiencing homelessness often using substances. Does homelessness lead to substance use or does substance use result in homelessness? It is not always clear although we know from international research that homelessness and drug use are connected, there is limited Irish data available.

A series of interviews and focus groups with young people aged 16–25 years who were homeless found that alcohol and/or drug misuse was not a major factor in causing their homelessness although the majority reported high exposure to alcohol and drug use from an early age and, once homeless, this exposure increased [126]. Their peer affiliations, housing instability, and struggle to cope with past and ongoing trauma propelled them towards problematic alcohol and/or drug use. Among those who reported a substance use problem, 68% reported that alcohol was the main problem substance. A theme of heavy drinking impacting on family relationships emerged, as did using alcohol as a coping strategy to counteract depression and anxiety. Some reported using alcohol and drugs to pass the time. A number of participants had attended treatment for drug or alcohol misuse at some point; however, most reverted to their prior drug or alcohol use patterns following completion of a treatment programme.

## 7.6 Summary: consequences of alcohol and drug use

Alcohol and other drug use can have a profound impact on a young person's life; mental and social well-being and increase the risk of involvement in criminal activities. Young people risk devastating health consequences, including death, through risky behaviour involving substances. Young people may feel invincible and that only a minority of (older) people are affected by substance-related harms. The information presented in this chapter shows that this is not the case, and that young people are highly susceptible to harm, as they are still developing physically, mentally, and socially. Behaviours during childhood and adolescence can have long-term consequences into adulthood, and it is not just older people that can develop a substance use disorder: more than one-third of all young drinkers were classified as having an AUD and outnumber those in older age groups for incidences of AUD and CUD. Incidences of CUD were more prevalent among young males and although also high among young males, incidences of AUD among young females were highest of all.

The association between substance use and mental health is complex and it is unclear if substance use causes or exacerbates mental health issues, or whether the presence of existing mental health problems leads to substance use. Surveys of schoolchildren revealed that those with mental health issues were more likely to have smoked cannabis regularly, to be hazardous drinkers, or to have an AUD. Among young adults, those with depression were more likely to be dependent on alcohol and were more likely to have engaged in deliberate self-harm or to have attempted suicide. Regular drinkers were more likely to report poorer mental health and suicidal ideation than those who were not regular drinkers. Experiences of bullying, particularly for those struggling with or worried about their sexuality, were linked with hazardous alcohol and drug use.

The greatest cost of substance use among young people is the number of deaths recorded. During the period 2008–2017, 322 young people died as a result of drug and/or alcohol poisoning, and although the incidence of poisoning deaths decreased during this period, non-poisoning traumatic deaths among young people remained relatively unchanged.

Suicide is the third leading alcohol-related cause of death among young people, and suicide rates among young males in Ireland are among the highest in Europe; young males are also the most likely to be hazardous drinkers. Young people also have higher rates of self-harm than those in older age groups, and alcohol was found to be present in almost one-third of self-harm hospital presentations. High rates of history of substance misuse were noted among individuals who had died by suicide and toxicology samples revealed the presence of alcohol and/or drugs in more than one-half of all suicides among young people.

Hospital presentations and discharges also reveal much about the consequences of alcohol and drug use among young people in Ireland. ED presentations showed that those in the younger age groups were more likely to present to EDs for alcohol-related incidents, and hospital data from HIPE revealed the strain on our health services due to substance use. Mental and behavioural disorders due to the use of alcohol were the most common diagnoses observed among alcohol- and drug-related discharges. Poisoning diagnoses were

most commonly caused by benzodiazepines, followed by cocaine and males accounted for the majority of alcohol-related and drug-related discharges.

Probation Service data highlight important information about the level of substance misuse among young people referred to their services and it is often their substance use that results in coming to the attention of An Garda Síochána and for many, also the first time that their substance use is addressed. The level of engagement that clients had with support services for their substance misuse issues upon referral to Probation Services was low, and Probation Officers play a key role in assessing, providing interventions for, and referring those who had substance misuse issues to appropriate services. The link between drug and alcohol misuse to the offence committed was common, especially among young males and especially for clients misusing drugs. There was a high incidence of co-existing mental health problems along with substance misuse among young people referred to Probation Services and Probation Officers need to be well-equipped to deal with such complexities.

Evidence of young people's involvement in substance-related crime and antisocial behaviour is available from the Garda PULSE system. Two-fifths of arrests made for controlled drug offences in 2018 and 2019 were among young people aged 18–24 years, and more than one-third of arrests for possession with intent to supply were from this age cohort. The mechanisms by which people are drawn into criminal behaviour and their experiences while actively engaged in the distribution of illegal drugs were outlined in qualitative studies. The speed with which young people are referred to support services for substance misuse following presentation to Probation Services may be life-changing for some young people. An understanding of the dynamics of the illegal drug market; of the shifting patterns in drug use, as stimulants and cannabis increasingly displace opiates; and of the dangers of polydrug use and risky alcohol use should inform the development of interventions and the facilities required in order to enable young people to enjoy a safe and fulfilling transition into adulthood.

**08**



**Responses to  
alcohol and  
other drug  
use among  
young people  
in Ireland**



This chapter presents information on the responses to young people’s alcohol and drug use in Ireland, including treatment where a problem has been identified and support is sought by, or on behalf of, the young person; population-level interventions focused on preventing substance use and harm; and early interventions for those at risk or when substance use initiation has begun. When substance use becomes problematic, it is important that it is responded to and acted on promptly, and that resources are available to help young people move forward with their lives.

## 8.1 Substance use treatment

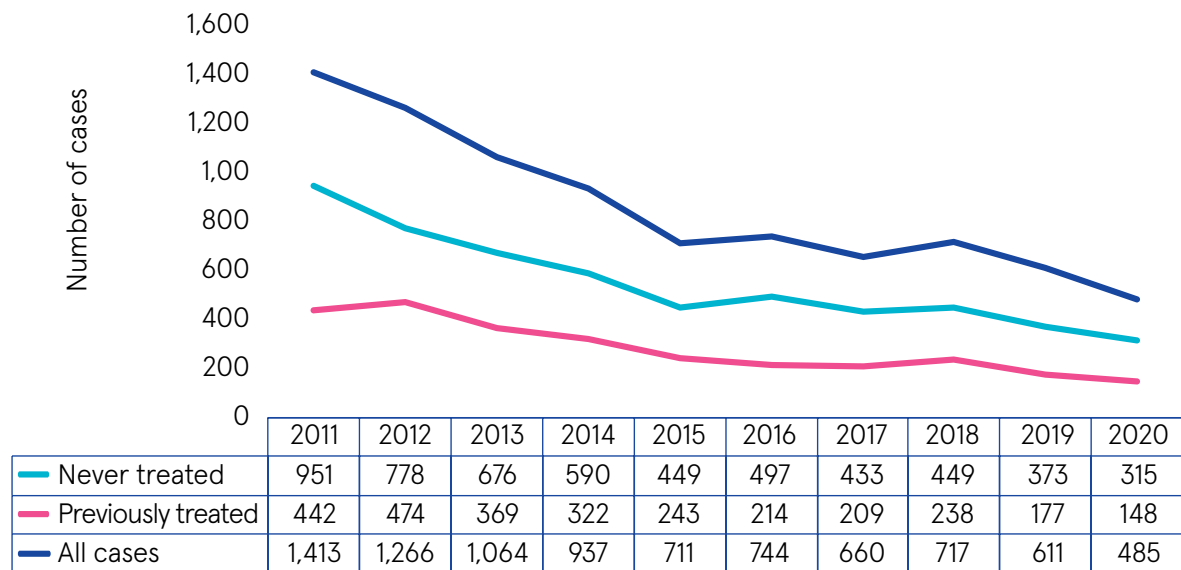
This section contains information on the number of cases of young people who have received treatment for their alcohol and drug use. It covers the number of new and previously treated cases that accessed treatment for alcohol and specific drugs, as well as the trends from 2011 to 2020. Data on treatment presented were obtained from the National Drug Treatment Reporting System (NDTRS).

The NDTRS provides information on the number of cases that entered treatment for their drug and/or alcohol use in Ireland by recording episodes of treatment during the calendar year [228,245,246]. In 2020, the NDTRS covered 71% of drug and alcohol services known to the NDTRS; the data presented here are therefore an underestimation of the actual number of cases that attended for alcohol and drug treatment. As there is no unique health identifier in Ireland, if an individual attended treatment more than once in a given year, they are represented more than once in these statistics and therefore are referred to as cases.

### 8.1.1 Alcohol treatment among young people

During the period from 2011 to 2020 (inclusive), there were 8,608 cases of young people aged 15–24 years where alcohol was the main problem substance reported. Figure 58 illustrates treatment for alcohol use reported by all new and previously treated cases in this period. There has been a decrease in the number of alcohol treatment cases, from 1,413 in 2011 to 485 in 2020, although alcohol remains the third most common substance (after cannabis and cocaine) that young people seek treatment for.

Figure 58 Number of cases of young people aged 15–24 years treated with alcohol as their main problem substance, by treatment status



Source: NDTRS data 2011–2020

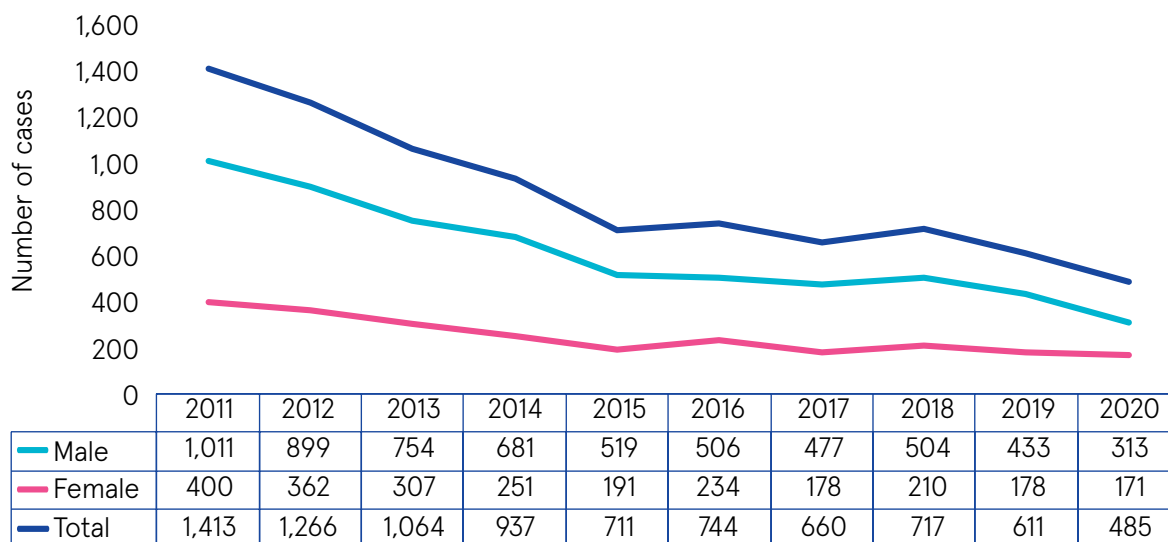
The decrease in cases entering treatment is likely due to a combination of factors, including the coverage of NDTRS data, a decrease in the demand among young people for treatment, waiting lists, and availability of treatment places. The data also indicated that median age of cases entering treatment for alcohol use for new cases was 40 years in the entire sample inclusive of all ages [246]. This was confirmed by a 2021 study, *Estimating need for alcohol treatment in Ireland using national treatment surveillance data*, which found that those attending treatment for their alcohol use had been drinking for a long time before seeking treatment and may also explain why the level of treatment among young people for alcohol use is low when compared with the prevalence of AUD and hazardous and harmful drinking patterns among young people [247]. The reduction in cases presenting for treatment in 2020 is due to the COVID-19 pandemic, as many services temporarily closed and introduced measures to comply with restrictions, and this reduction is not an indication of a decline in demand for treatment [246].

More young males than females presented for treatment due to alcohol each year<sup>###</sup> (Figure 59).

<sup>###</sup> Note that the NDTRS wording is ‘self-defined gender’



Figure 59 Number of cases of young people aged 15–24 years entering treatment due to alcohol, by sex



Source: NDTRS data, 2011–2020<sup>§§§</sup>

Of the cases of young people aged 15–24 years entering treatment in 2020, 39% were classified as alcohol dependent<sup>\*\*\*\*</sup> by the healthcare professional treating them. A further 23% of cases were classified as hazardous drinkers, and 34% of cases as harmful drinkers.

Many of those who entered treatment for their alcohol use also required treatment for additional substances. Among the 611 cases of young people who entered treatment with alcohol as their main problem substance, 44% reported problem use of at least one other substance. The most common additional substances reported (along with alcohol) in 2019 were cannabis (216 cases, 35%), followed by cocaine (171 cases, 28%) and benzodiazepines (64 cases, 11%).

### 8.1.1.1 Sociodemographic characteristics of young people entering treatment for alcohol use

Among cases of young people aged 15–24 years treated for alcohol as their main problem substance between 2011 and 2020, 51% were unemployed at the time of treatment, 14% were in regular employment, 3.9% were members of the Traveller community, 4.5% were homeless, 18% had left school before they were aged 16 years, and 3.9% had child(ren) aged under 18 years who were living with them.<sup>†††</sup>

<sup>§§§</sup> Note that sex was missing for a number of cases entering treatment, so totals do not always add up.

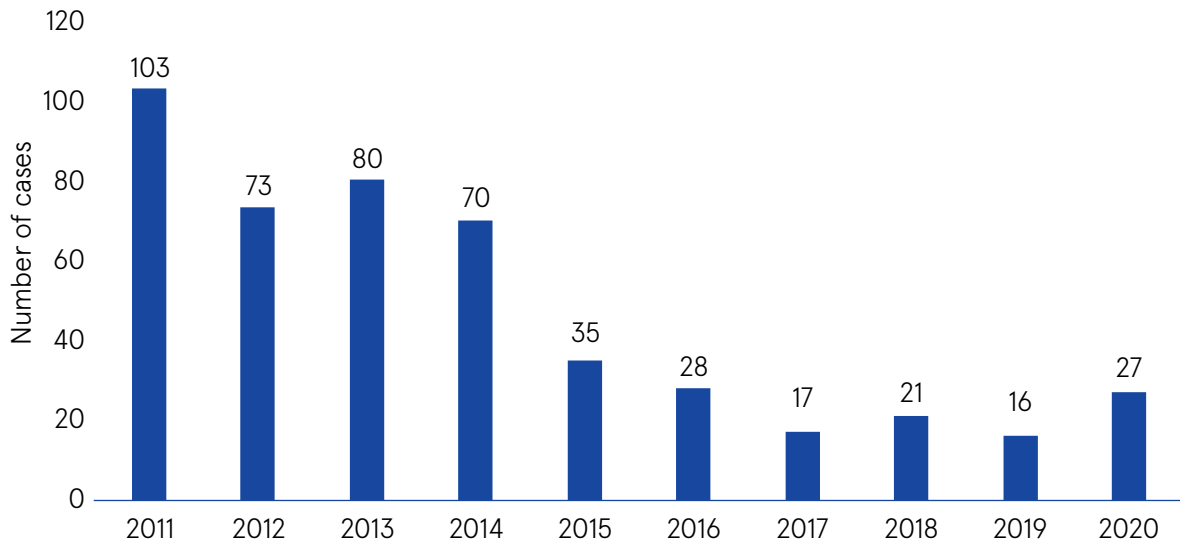
<sup>\*\*\*\*</sup> See glossary for definitions of dependent drinkers, hazardous drinking and harmful drinking.

<sup>†††</sup> Data are available for 2016 onwards for ‘children currently living with service user’.

### 8.1.1.2 Young people treated in prison for alcohol as the main problem substance

Between 2011 and 2020, 470 cases of young people were treated in prison for alcohol as their main problem substance. The numbers have decreased steadily since 2011 (103 cases), although an increase was noted between 2019 (16 cases) and 2020 (27 cases)<sup>####</sup> (Figure 60).

Figure 60 Number of cases of young people aged 15–24 years treated in prison due to alcohol use



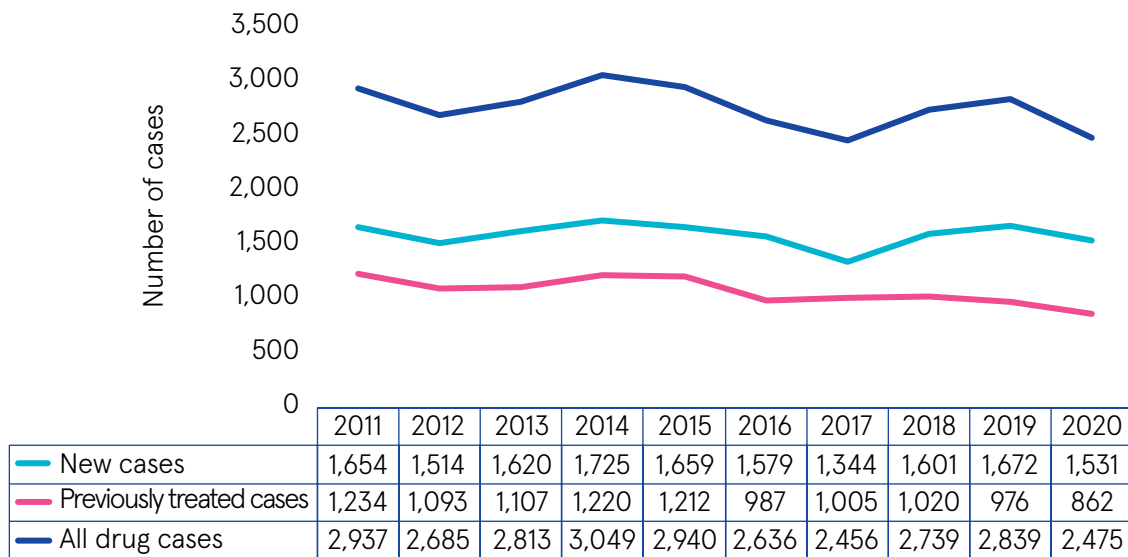
Source: NDTRS data, 2011–2020

### 8.1.2 Drug treatment among young people

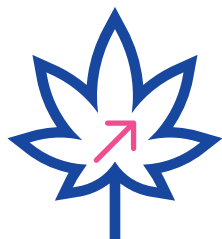
Between 2011 and 2020, 27,569 cases of young people aged 15–24 years were treated for drug use as the main problem substance. Figure 61 shows the trends in cases treated for drug use by new and previously treated cases; the total number of cases decreased from 2,937 in 2011 to 2,839 in 2019 (and to 2,475 in 2020). The number of new cases (not previously treated), however, increased from 1,654 in 2011 to 1,672 in 2019.

<sup>####</sup> Note that the figures included in the prison NDTRS data are also included in the overall figures presented.

Figure 61 Number of cases of young people aged 15–24 years treated with drug use as main problem, by treatment status



Source: NDTRS data, 2011–2020<sup>§§§§</sup>



**Cannabis** was the substance that **treatment was most commonly required** in 2020, followed by **cocaine**

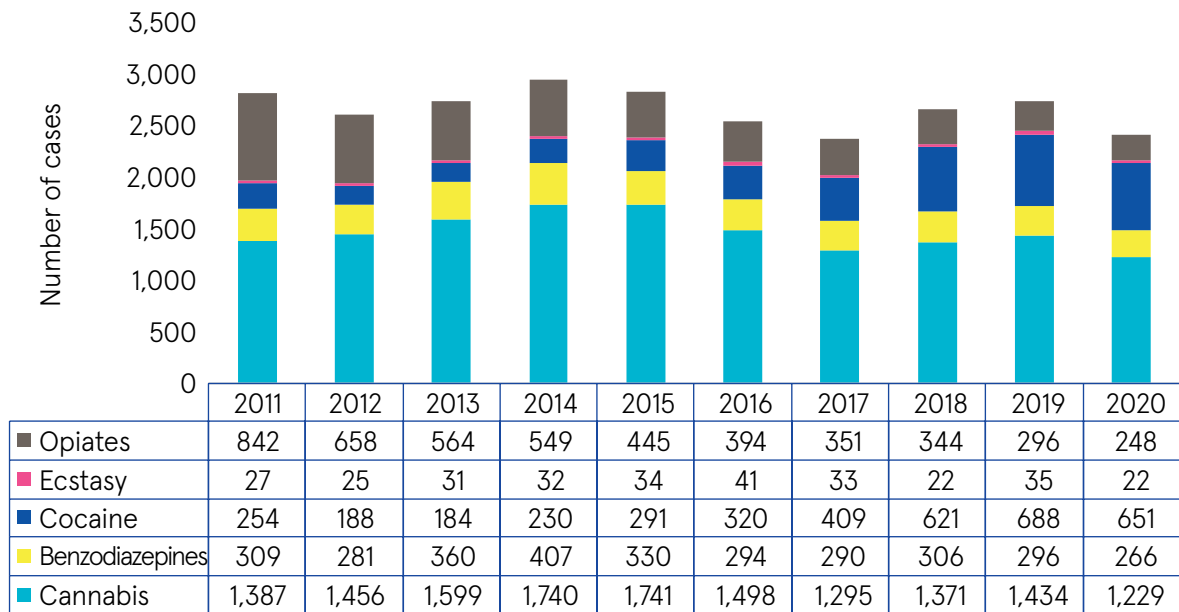
Figure 62 illustrates the number of cases treated by drug type between 2011 and 2020 among young people aged 15–24 years. The most common main drugs for which treatment was required during that period were:

- Cannabis (increased by 3.4% from 1,387 cases in 2011 to 1,434 cases in 2019)
- Opiates (decreased by 65% from 842 cases in 2011 to 296 cases in 2019)
- Cocaine (increased by 171% from 254 cases in 2011 to 688 cases in 2019)
- Benzodiazepines (decreased by 4.2% from 309 cases in 2011 to 296 cases in 2019)
- NPS (decreased by 40% from 63 cases in 2011 to 34 cases in 2019)

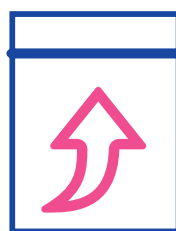
<sup>§§§§</sup> Note that the total number of new cases and previously treated cases does not sum to the total number of treatment cases, as the treatment status is unknown for a number of cases.

- Volatile substances (decreased from 17 cases in 2011 to <5 cases in 2019)
- Amphetamines (decreased by 61% from 18 cases in 2011 to 7 cases in 2019)
- Ecstasy (increased by 30% from 27 cases in 2011 to 35 cases in 2019).

Figure 62 Number of new and previously treated cases of young people aged 15–24 years, by drug type



Source: NDTRS data, 2011–2020

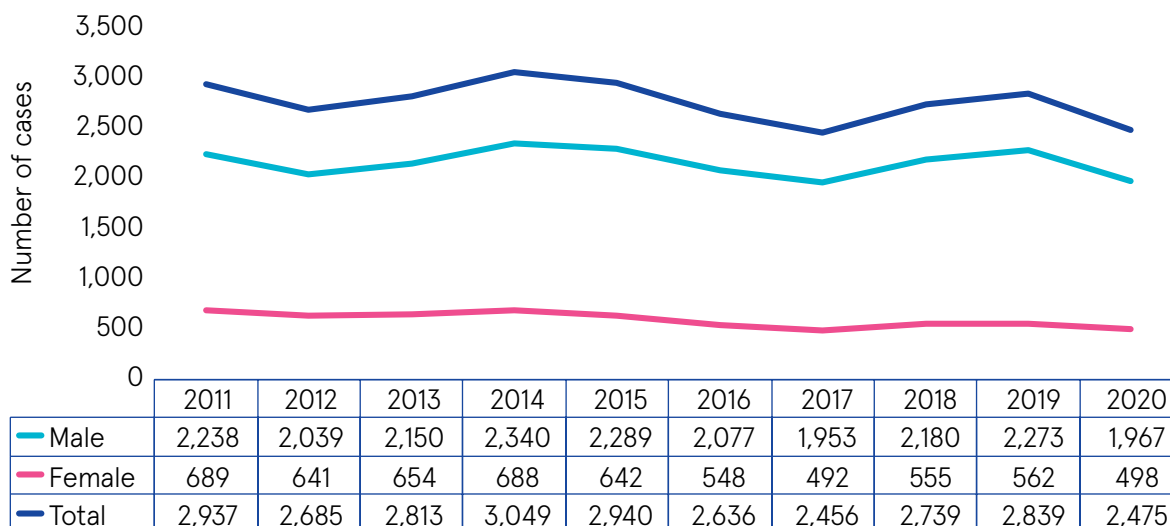


## Treatment for cocaine

increased by 171% between 2011 and 2019

Although cannabis was the main substance for which treatment was received, the cases who received treatment for cannabis use represent a minority of those classified as having a CUD [291]. As with treatment for alcohol use, more young males than young females received treatment for drug use (Figure 63); in 2020, males accounted for 80% of all treatment cases while females accounted for 20%.

Figure 63 Number of cases of young people aged 15–24 years who attended treatment due to drug use, by sex



Source: NDTRS data, 2011–2020\*\*\*\*

Young people attending treatment for their drug use commonly reported problem use of more than one substance, and over the period from 2011 to 2020, 62% of cases entering treatment reported polydrug use.

In 2019, of the 2,839 who received treatment for their drug use, alcohol (763 cases, 27%) was the most common additional substance reported by cases with polydrug use, followed by cocaine (634 cases, 22%), cannabis (620 cases, 22%), and benzodiazepines (521 cases, 18%).

### 8.1.2.1 Sociodemographic characteristics of young people entering treatment for drug use

Of the cases of young people who were treated for drugs as their main problem substance during the period 2011–2020, 53% were recorded as being unemployed at the time of treatment, 9.6% were in regular employment, 2.9% of cases were members of the Traveller community, 5.5% were recorded as being homeless, 25% had left school before they were aged 16 years, and 3.4% had child(ren) aged under 18 years who were living with them.<sup>†††</sup>

\*\*\*\* Note that sex was not available for a number of cases, so totals do not always add up.

††† Data are available for 2016 onwards for ‘children currently living with service user’



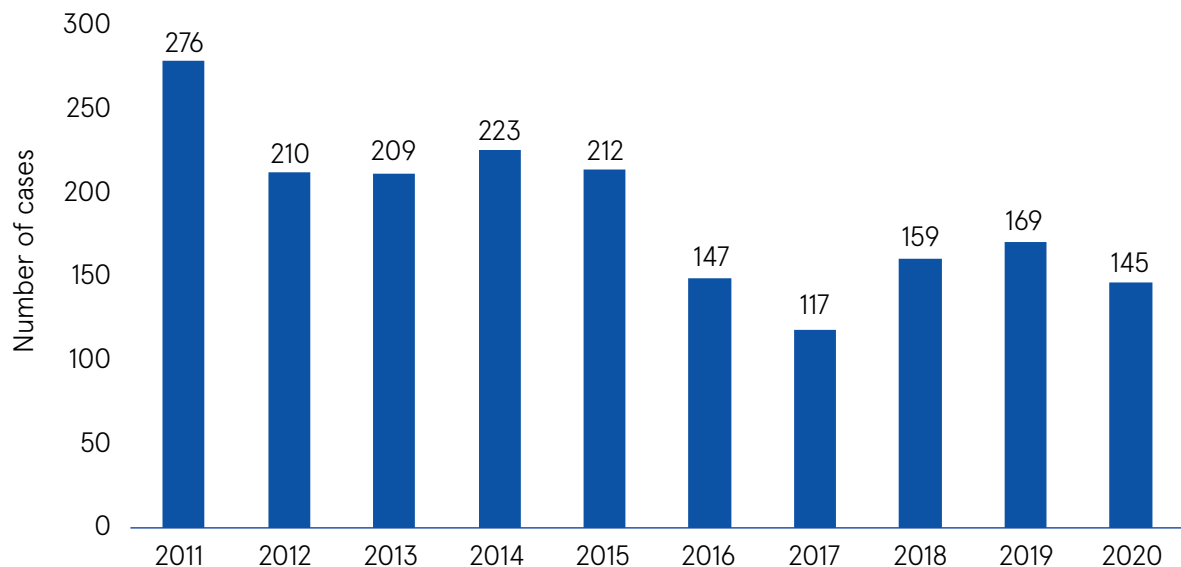
Over one-half of cases of young people who were treated for drug use were **unemployed**

**25% had left school** before they were aged 16 years

### 8.1.2.2 Young people treated in prison for drug use

Between 2011 and 2020, 1,867 cases were treated in prison for their drug use<sup>####</sup> decreasing by 39% from 2011 (276 cases) to 2019 (169 cases) (Figure 64). The main problem drugs that cases in prison required treatment for between 2011 and 2020 were opiates (516 cases, 27%), followed by benzodiazepines (434 cases, 23%) and cannabis (388 cases, 21%).

Figure 64 Number of cases of young people aged 15–24 years treated in prison due to drug use



Source: NDTRS data, 2011–2020

#### Note that the cases treated in prison for their drug use are also included in the overall number of cases treated for drug use.

### 8.1.3 Adolescents attending treatment

The HSE Adolescent Addiction Service reported that in 2020, the service worked with 40 young people with a mean age of 15.4 years (range: 14–19 years) and their families. Referrals to the service reduced by 18% since 2019 likely due to the COVID-19 pandemic and the closure of many services. Although cannabis continued to be the primary substance for which treatment was required (100%), alcohol use featured among 69% of attendees, compared with 67% in 2019 and 95% in 2018 [248–250].

In 2020, as well as cannabis and alcohol, the substances most commonly used among the adolescents attending the service included cocaine (26%), benzodiazepines (24%) and amphetamines (7%). Amphetamine use saw the largest decrease, reducing from 22% in 2019 [250].

A 2015 study, *Treatment outcome for adolescents abusing alcohol and cannabis: how many 'reliably improve?'*, examined the outcomes for adolescents who attended treatment and found that reductions in alcohol use were modest and abstinence levels were low when patients were followed up at subsequent appointments [251]. The majority of adolescents who had attended for treatment for their alcohol use were unchanged in their use of alcohol at follow-up (71%), 25% were abstinent or reliably improved at follow-up.

Where information was available for the cannabis users, 11% were abstinent at follow-up, 36% had reliably improved, 7% had reliably deteriorated, while 45% remained unchanged in their cannabis use. There were no statistically significant findings between those who had improved or were abstinent compared to those who had not changed their cannabis use behaviour or had deteriorated. The study reported that motivation was very poor, when compared with adult treatment-attending groups, particularly regarding alcohol problems. Where drug and alcohol problems co-occurred, patients were more motivated to address their drug use than to address the alcohol problem. The author suggested that the lack of motivation in addressing problem drinking may impede progress in tackling drug use, and they also noted that our harmful drinking habits in Ireland resulted in adolescents being unable to recognise their own unhealthy drinking and to change it when they do.

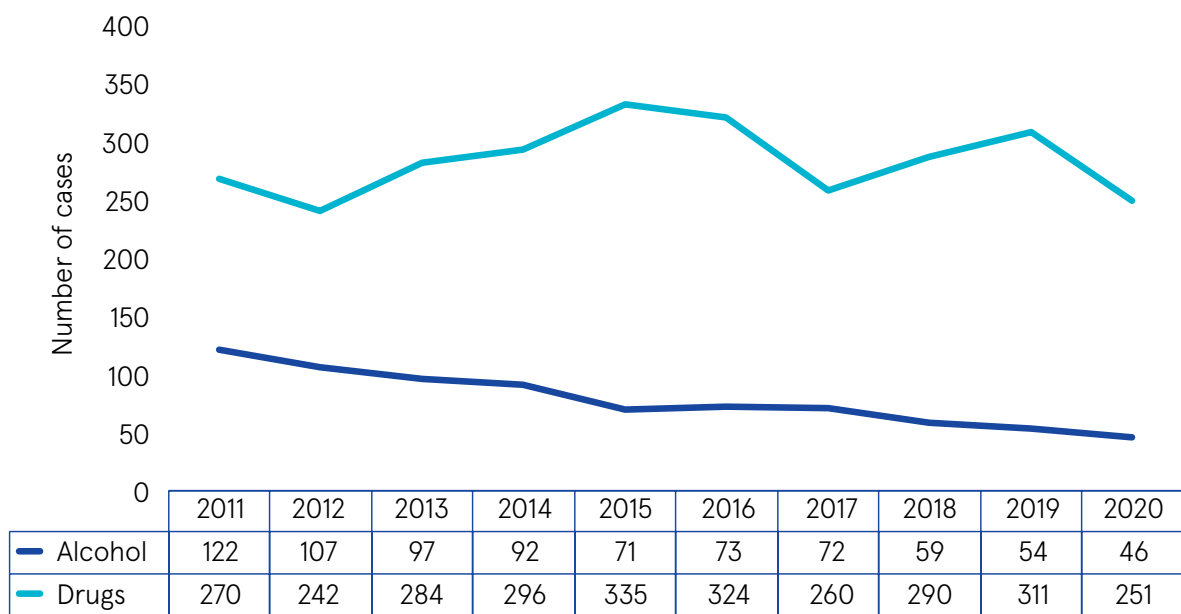
## 8.2 Psychiatric admissions and discharges for drug and/or alcohol related disorders

The National Psychiatric Inpatient Reporting System (NPIRS) provides detailed information on all admissions to and discharges from inpatient psychiatric services in Ireland. Data are collected from psychiatric hospitals, general hospital psychiatric units, private hospitals, children's centres, and the Central Mental Hospital. Each admission and discharge represents one episode or event, and not an individual patient; while a single individual may have several admissions in any given year, each one is recorded as a separate event. Diagnoses are categorised in accordance with the WHO's *International Classification of Diseases, Tenth Revision* (ICD-10) categories (Appendix 1) [252,253].

Since the publication of *A Vision for Change: Report of the Expert Group on Mental Health Policy* in 2006 which advised that those with drug or alcohol disorders be treated in outpatient settings rather than in psychiatric inpatient settings, there has been a sizeable decrease in the number of cases admitted to psychiatric services as a result of drug and/or alcohol disorders [254]. In 2020, a new mental health policy was published, *Sharing the Vision*, which recognises the ongoing challenges in addressing the needs of people with a dual diagnosis (those who experience mental health problems alongside substance misuse problems). In *Sharing the Vision*, those with a dual diagnosis can access the support of a mental health team [255].

Despite the previous emphasis on outpatient services for those with drug or alcohol related disorders, 3,656 cases of young people aged 15–24 years were admitted to psychiatric hospitals with drug or alcohol related disorders during the period 2011–2020; 297 of these cases were admitted in 2020, representing 2% of all psychiatric admissions in that year (Figure 65) [252].

Figure 65 Number of cases of young people aged 15–24 years admitted to psychiatric hospitals with alcohol- and drug-related disorders



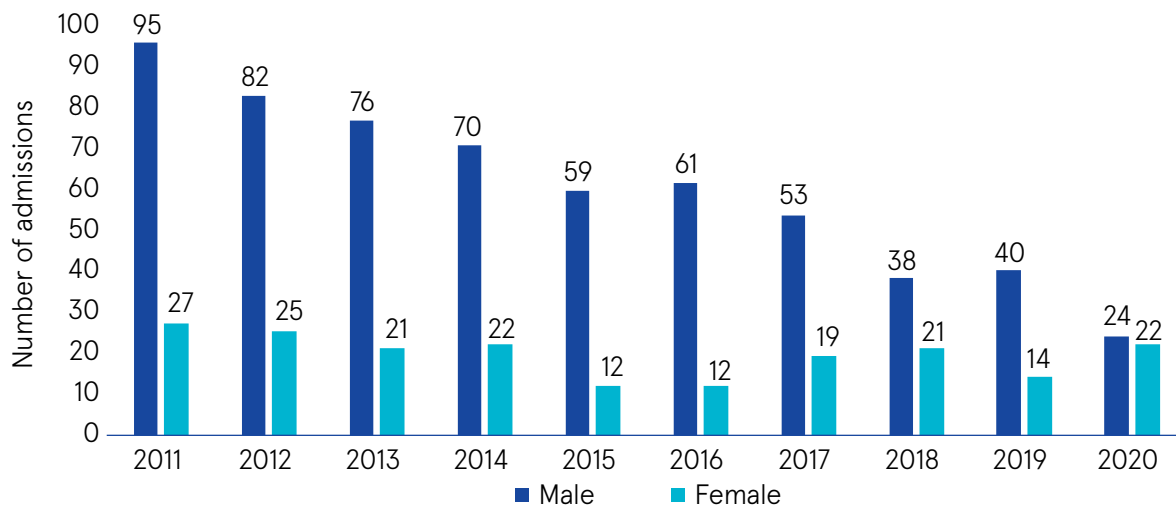
Source: NPIRS data, 2011–2020

### 8.2.1 Psychiatric hospital admissions for alcohol-related disorders

There were 793 cases of alcohol-related disorders among young people aged 15–24 years, accounting for 22% of the drug and alcohol-related admissions to psychiatric treatment between 2011 and 2020. NPIRS data showed a yearly reduction in the number of cases admitted with alcohol-related disorders, from 122 cases in 2011 to 46 cases in 2020 due to the aforementioned mental health strategy that recommended that those with alcohol-related diagnoses be treated in the community rather than in psychiatric settings (Figure 65). Young males were more likely than females to be admitted to psychiatric services for alcohol-related disorders (Figure 66).



Figure 66 Number of cases of young people aged 15–24 years admitted to psychiatric hospitals with alcohol-related disorders, by sex

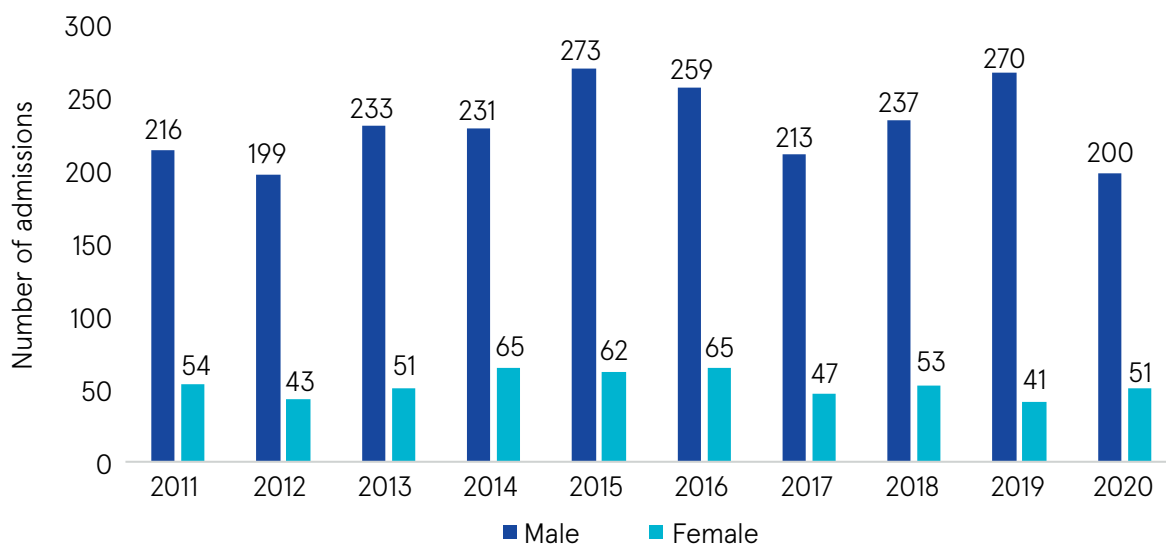


Source: NPIRS data, 2011–2020

### 8.2.2 Psychiatric hospital admissions for drug-related disorders

Drug-related disorders accounted for 2,863 admissions 78% of substance-related admissions between 2011 and 2020. In 2020, 251 cases of young people were admitted to psychiatric hospitals for treatment for drug-related disorders (Figure 67), a 19% decrease from 2019, likely due to the COVID-19 pandemic.

Figure 67 Number of cases of young people aged 15–24 years admitted to psychiatric hospitals with drug-related disorders, by sex



Source: NPIRS data, 2011–2020

## 8.3 Alcohol and drug prevention programmes

Preventing, delaying, or reducing young people's use of alcohol and drugs is a major part of the Government's drug strategies. Unlike other interventions, which might be resisted for moral or ideological reasons, prevention programmes aimed at young people are widely supported by the general public. Adolescence is also the period in people's lives when prevention programmes are most likely to be effective. However, many of the most common prevention programmes are supported by a very narrow evidence base, and evaluation of most of the prevention options in place is infrequent both in Ireland and internationally. Those that have been evaluated are largely concentrated in school settings that facilitate research opportunities and the possibility to collect follow-up information on the participants in these programmes.

The earliest prevention programmes were based on theoretical assumptions around pointing out the dangers of substance use, followed by programmes aimed at building resilience to peer pressure and building self-esteem. While these programmes may have had some beneficial outcomes, they proved largely ineffective in preventing substance use and some had iatrogenic effects. Current thinking around prevention recognises the mix of factors involved in decision-making around substance use, including parental and peer factors, as well as challenging young people's assumptions around what they regard as norms in their social group.

Based on contemporary development theories, substance prevention is often seen as fitting into a broader approach to well-being, encompassing attitudes around general health, pro-social behaviours, and social competencies. The national drugs strategy continues with the common prevention threads that ran through previous strategies.<sup>2</sup> These threads include delaying the onset of use, increasing awareness, and improving understanding among the general population of the dangers and problems related to using drugs, and promoting positive health choices. The objectives also recognise that certain groups and communities may be at a higher risk of using drugs than the general population, and therefore may require additional resources and supports.

### 8.3.1 Categories of prevention

Adapting a classification system from disease prevention, substance use prevention programmes are usually categorised as universal, selective, or indicated. The latter two encompass interventions targeted at those who are at increased risk of, or have already initiated, potentially harmful substance use. These broad categories can be applied in different settings. For instance, while universal prevention is often associated with school-based programmes, some family-based interventions can also be included in this category.

Environmental prevention, which involves using regulations and legal changes to reduce or prevent consumption of substances, can overlap with universal prevention as it does not target a specific part of the population or an at-risk group. Environmental prevention interventions in Ireland include relatively high taxes on alcohol; drink-driving restrictions; local authority bye-laws prohibiting the consumption of alcohol in public spaces; and

age restrictions on the purchase and sale of alcohol. The Public Health (Alcohol) Act 2018 provides for a number of evidence-based measures that are designed to reduce alcohol consumption at a population level [30]. One example of an environmental prevention programme in an educational setting is the Responding to Excessive Alcohol Consumption in Third Level (REACT) programme, which is based in third-level institutions. Other examples of policy and legislative changes that have contributed to the landscape of environmental prevention in Ireland include the area of NPS and how Ireland proposes to deal with the possession of small amounts of drugs for personal use.

### **8.3.1.1 Universal prevention programmes**

A range of universal prevention programmes are run at both local and national levels in Ireland. At a national level, these include online resources, substance misuse awareness campaigns, and whole-school prevention programmes. Community programmes continue to take the form of alternative leisure-time activities, including youth cafés, and recreational arts and sports activities. Internationally recognised family interventions also continue to be delivered.

#### **8.3.1.1.1 Universal prevention in mainstream education**

The Social, Personal and Health Education (SPHE) programme is the main vehicle through which substance use prevention is delivered in both primary and post-primary (Junior Cycle) schools in Ireland [256]. The programme modules aim to help schoolchildren understand the nature of social influences that impact on their development and decision-making, and to help them develop adequate life skills to improve their self-esteem, develop resilience, and build meaningful and trusting relationships. The Walk Tall and On My Own Two Feet programmes, which are substance misuse prevention programmes, have been integrated into the SPHE curriculum for primary and post-primary schools, respectively.

*Know the Score: Substance Use Resource Materials for Senior Cycle SPHE* is a resource for Senior Cycle teachers to support their delivery of the SPHE programme substance use module [257]. The resource aims to provide factual information to guide and support schoolchildren (aged 15–18 years) in making informed and conscious decisions about alcohol and drugs as well as developing the skills necessary to make healthy choices and minimise the risk associated with substance use and it complements the HSE’s guide for parents on how to communicate with their children about alcohol and drugs [258].

The SPHE and well-being programme in the Junior Cycle aims to support and develop the mental resilience and personal well-being of schoolchildren [259]. The six indicators of the well-being programme encompass being active, responsible, collective, resilient, respected, and aware.

Substance use is also addressed as part of the Garda Schools Programme, which focuses on educating young people about the role of the gardaí and promoting responsible behaviour. The programme consists of a series of presentations given to schoolchildren by their local gardaí on the role of the gardaí, road/cycle safety, bullying, vandalism, personal safety, drugs, crime prevention, and respectful online communication although their effectiveness is questionable..

The National Educational Psychological Service (NEPS) is concerned with learning, behaviour, and the social and emotional development of schoolchildren at both primary and post-primary level [260]. The NEPS works with teachers and parents to enable them to intervene effectively to meet pupils' needs and also to work directly with schoolchildren where necessary. It is particularly focused on children with special educational needs, but it also works with children who are at risk of marginalisation (for example, those from socioeconomically disadvantaged groups, immigrant/migrant populations, and members of the Traveller community) and children and young people with social, emotional, or behavioural difficulties.

The NEPS psychologists also provide training for teachers to implement evidence-based programmes and practices that promote resilience as well as social and emotional competence in children and young people; these include the Incredible Years Teacher Classroom Management programme [261] and the FRIENDS programmes [262].

#### **8.3.1.1.2 Environmental prevention interventions in third-level institutions**

REACT was developed through a collaboration between the Health Matters team at University College Cork, the Irish Student Health Association, and the Union of Students in Ireland. Its aim is to tackle the harms associated with alcohol use among third-level students [263].

REACT awards and accredits third-level institutions' efforts to reduce alcohol-related harms among their students and encourages them to implement and evaluate a multifaceted, strategic, evidence-based, stakeholder-led action plan. In 2019, several universities were recognised for their efforts to reduce alcohol-related harm experienced by third-level students through training staff in brief intervention, developing a college alcohol policy, and forming a cross-institutional, dedicated REACT steering committee.

A 2021 study involving two third-level institutions participating in the Responding to Excessive Alcohol Consumption in Third Level (REACT) programme, *College students' perspectives on an alcohol prevention programme and student drinking*, observed how alcohol use was perceived to be endemic in third-level institutions, facilitated by numerous community-level factors, such as easy access to cheap alcohol in supermarkets, a high density of pubs in the environs of campuses, and a culture of pre-drinking (drinking cheap alcohol at home before going out). The students involved in the study perceived heavy drinking to be a transient phase and were open to change; alcohol-free events had been organised by some college societies, indicating a possible shift in the drinking culture among students [264].

#### **8.3.1.1.3 Universal prevention online**

The HSE public information site ([www.hse.ie/alcohol/](http://www.hse.ie/alcohol/)) is an evidence-based information source including alcohol risks, enabling people to better manage their own health. The site provides information on the physical and mental health effects of alcohol; tools to help users assess their drinking, including an alcohol test; and links to service providers.

Another website, [www.drugs.ie](http://www.drugs.ie), also aims to help individuals, families, and communities prevent and/or address problems arising from drug and alcohol use. The website provides information on drugs and alcohol, including an online drug self-assessment and brief intervention resource, as well as an online directory of related services and information campaigns as a response to emerging drug trends [84].

The HSE also runs a confidential drugs and alcohol helpline that provides an active listening helpline and email support service offering non-directive support, information, guidance, and referral to anyone with a question or concern related to their own or another person's drug or alcohol use.

### **8.3.1.2 Selective prevention programmes**

A range of selective prevention programmes delivered by Drug and Alcohol Task Forces (DATFs) include, for example, local and regional awareness initiatives and community actions on alcohol and drug use in socially and economically disadvantaged communities. Since July 2020, these projects have been funded under a single scheme, UBU Your Place Your Space, which aims to prevent drug misuse through the development of youth facilities, including sport and recreational facilities [265]. UBU Your Place Your Space targets young people who are marginalised, disadvantaged, or vulnerable and provides out-of-school supports, including health, education, employment, and social connectedness.

#### ***8.3.1.2.1 Programmes targeting educational disadvantage***

The Delivering Equality of Opportunity in Schools (DEIS) programme addresses educational disadvantage and aims to improve attendance, participation, and retention in designated schools located in disadvantaged areas [266].

The School Completion Programme is a support under DEIS that targets those most at risk of early school leaving and children of school-going age who are not currently attending school. It aims to retain a young person in school until completion of the Leaving Certificate, equivalent qualification, or suitable level of educational attainment which enables them to transition into further education, training, or employment.

The Home School Community Liaison Scheme, another support under DEIS, is a school-based intervention working with families in disadvantaged areas by supporting parents to enable their children to attend school, participate in education, and develop positive attitudes to lifelong learning.

There are a number of other programmes and initiatives to improve school retention rates:

- Meitheal, Tusla – the Child and Family Agency's national practice model, is a standardised approach to assessing the needs of children and families who have come to the attention of practitioners and community members due to a child welfare or safety concern [267].
- The Department of Rural and Community Development's Social Inclusion and Community Activation Programme provides supports to children and young people from target groups who are at risk of early school leaving, and/or to children and young people aged 15–24 years who are not in employment, education, or training [268].

#### ***8.3.1.2.2 Prevention programmes in education centres outside mainstream schooling***

A number of prevention programmes are delivered to those attending centres of education that are outside mainstream schooling:

- Youth Encounter Projects provide non-residential educational facilities for children who have either become involved in, or who are at risk of becoming involved in, minor

delinquency. The projects provide young people with a lower pupil–teacher ratio than mainstream schooling, as well as a personalised education plan [269].

- Youthreach is the Irish Government’s primary response to early school leaving, providing educational training and work experience programmes for early school leavers. An evaluation of Youthreach found that while there had been a notable decline in the number of early school leavers, those who had left school early were presenting to Youthreach with greater levels of need, increased prevalence of mental health and emotional problems, and learning difficulties [270]. Among the challenges faced was substance misuse – either by the young people themselves or by a family member. The evaluation’s findings indicated that the programme works well as second-chance provision for often vulnerable young people with complex needs.

#### **8.3.1.2.3 Selective prevention programmes targeting families and at-risk young people**

The national drugs strategy identifies three family support programmes that should receive continued support: the Strengthening Families Programme, Parenting Under Pressure (PuP), and the 5-Step Method (the Stress–Strain–Coping–Support Model) [271,272]. Children leaving care are also targeted by the national drugs strategy. The needs of children living with, and affected by, parental alcohol and drug use are the target of the National Hidden Harm Project to bridge the gap between adults’ and children’s services in favour of a more family-focused approach to the identification, assessment, and treatment of alcohol and substance use [273].

### **8.3.1.3 Indicated prevention programmes**

Indicated prevention tends to take the form of mental health services and brief interventions. Under the Health Diversion Approach, those found in possession of drugs for personal use would engage with the HSE to attend a health screening and brief intervention. Another area receiving increased attention is community-based projects that target young people involved in the drug economy. There are also programmes that work with young people who have come into contact with the criminal justice system. Child and Adolescent Mental Health Services teams are the first line of specialist mental health services for children and young people and are provided by multidisciplinary teams.

#### **8.3.1.3.1 Brief interventions**

There are two main brief intervention programmes in Ireland that address substance use: Making Every Contact Count and the SAOR Screening and Brief Intervention for Problem Alcohol and Substance Use [84]; which provide a self-assessment and brief intervention resource.

Making Every Contact Count supports the implementation of Healthy Ireland priority programmes whereby health and social care staff engage patients in a conversation and a possible brief intervention on whatever lifestyle issue is the most important for that patient [274].

SAOR is a HSE screening and brief intervention for problem substance use in health, social care, social, and recreational settings, and for all levels of need. It supports workers from their first point of contact with a service user in order to enable them to deliver brief

interventions and to help those presenting with more complex needs to access treatment programmes [275].

The drugs website (www.drugs.ie) contains an interactive drug self-assessment and brief intervention resource enabling individuals aged over 18 years to complete an online test to identify harmful drug use: the Drug Use Disorders Identification Test, a parallel instrument to the AUDIT for identification of individuals with drug-related problems. On completing the test, the user receives personalised video feedback based on their specific responses, with suggestions on what to do to change any risks relating to their drug use.

### **8.3.1.3.2 Community-based outreach projects**

Young people's involvement in the drug economy is an ongoing issue in Ireland. A number of community-based projects deliver services to address the needs of these young people, including the Easy street programme in Ballymun and the Targeted Response with Youth (TRY) project [276,277]. Both projects take an outreach and bridging approach in which youth workers make contact at street level, build trust, and then act as a 'connecting node' or 'host' in order to enable young people to extend their social networks beyond those associated with the drug economy and to build on positive traits. The youth workers engage with individual young people and broader networks of young people in the community. They also support young people in accessing education or work pathways, with the aim of either preventing them from engaging in, or enabling them to desist from, the drug economy.

### **8.3.1.3.3 Diversion programmes in the criminal justice system**

In order to provide an opportunity to divert young offenders from criminal activity, a number of diversion programmes – such as the Garda Juvenile Diversion Programme and the Garda Youth Diversion Projects – avail of restorative justice and restorative practices to try to target offending behaviour in young people aged under 18 years [278]. These programmes engage with young people through a range of supports, including education, training, and employment support; social enterprise initiatives; and personal development and supports such as mentoring and personal development activities. Similarly, the Irish Probation Service has a Young Persons Probation division of trained staff who work specifically with children and young people who come before the courts, or those who are in children detention schools or centres, to support and motivate young people to address the cause of their offending behaviour and to make positive changes in their lives in order to avoid further offending.

## **8.4 Summary: responses to alcohol and illegal drug use among young people in Ireland**

In Ireland, there are several interventions in place to prevent young people from initiating alcohol and illegal drug use; early interventions to reduce harms; and interventions to support young people who have developed a problem with alcohol and other drugs. The treatment data indicated that between 2011 and 2020 there was a decrease in the numbers who received treatment for their alcohol use, even though alcohol remains the

most widely used and abused substance, although alcohol remains the third most common substance for which treatment was required, after cocaine and cannabis. There are several possible explanations for this decrease, including NDTRS coverage, the availability of places, reluctance to attend treatment, the stigma attached to attending or seeking treatment for their alcohol and/or drug use.

It was also noted from the treatment data that the age of initiation of substance use compared to the age of first treatment is delayed, it may take many years before use becomes problematic and before treatment is sought. Sex differences were noted for those attending for treatment, with males more likely than females to present for treatment. Treatment for additional substances was common and one-quarter of those who received treatment for drug use were early school leavers.

The most common substances for which treatment was sought were cannabis, cocaine, alcohol, opioids, and benzodiazepines, but the majority of young people reported problem use of more than one substance. The NDAS prevalence data in this overview have highlighted the increase in cocaine use among young people, particularly since the 2010–11 NDAS. This increase in cocaine use is reflected in the 171% increase in the number of cases of young people aged 15–24 years presenting for treatment for cocaine use, as shown in the NDTRS data between 2011 and 2019. Furthermore, the HIPE data have shown an 89% increase in the number of cocaine-related hospitalisations among young people in the period 2015–2019, and although the numbers are low for cocaine-related deaths, an increase of 41% was noted in the period 2007–2017.

A study using NDAS and NDTRS data showed a disparity between the prevalence of CUD and the number of people that present for treatment for their cannabis use, with only a minority of those with CUD seeking treatment.

A study following the outcomes of adolescents who attended treatment for their substance use found poor reductions in substance use following treatment, with the majority reporting unchanged behaviours and low motivation, particularly for their alcohol use.

This chapter also looked at the number of young people admitted to psychiatric hospitals due to a diagnosis of alcohol- and/or drug- related disorders. The data showed that psychiatric admissions decreased between 2011 and 2020, and males were more likely than females to be admitted for alcohol- and drug-related disorders, particularly for drug-related disorders.

In addition, this chapter outlined the drug and alcohol prevention programmes and interventions that exist in Ireland to delay the onset of substance use and to increase awareness and improve understanding of the dangers and problems related with the use of drugs and alcohol. Prevention programmes are categorised into universal programmes, including online resources, school-based programmes, and family-based interventions; and selective or indicated programmes that target those who are at increased risk of, or have already initiated, potentially harmful substance use. However, there is limited evidence of the effectiveness of these interventions due to a lack of evaluations of these programmes.



**09**



**Ireland's  
policy and  
legislation  
governing  
alcohol and  
other drugs**



This chapter outlines the existing strategies in Ireland that are intended to address drug and alcohol use, as well as strategies that focus on children, young people, and potentially vulnerable populations including the LGBTI+ community. The current laws that govern alcohol and drug use and sale are also presented here. Ireland's policies regarding substance use among young people are shaped by a number of complementary strategies, policy documents, and legislation supporting various environmental, prevention, and harm reduction measures to promote well-being and prevent harm. *The Steering Group Report On a National Substance Misuse Strategy* published in 2012, marked an important shift in official thinking regarding alcohol use [161]. Alcohol use was now seen as a phenomenon that would be most clearly understood, and responded to, from a population health perspective. The Steering Group recommended a series of measures based on public health principles to reduce alcohol consumption through the tools of pricing and restrictions on both availability and marketing.

Like the Government's approach to reducing alcohol-related harms, policy on illegal drugs is informed by a public health perspective. The national drugs strategy introduced in 2017 differed in nuance from its two predecessors in that it explicitly adopted a health-led approach to drug policy. Ireland's national drugs strategy is set out in *Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017–2025* [2]. The strategy covers an 8-year period (2017–2025) and is accompanied by a shorter-term action plan. It is the first integrated drugs and alcohol strategy in Ireland, although alcohol is not considered as comprehensively as drugs are. Rather, the strategy complements the Public Health (Alcohol) Act 2018 and reinforces some of the key elements of the alcohol-focused National Substance Misuse Strategy from 2012 [30].

While the difference in the actual content of the current drugs strategy and previous strategies appears subtle, the emphasis on health prepared the ground for initiatives such as a health diversion programme supporting alternatives to prosecution for drug possession offences. Reducing the supply of drugs requires a rigorous and ever vigilant law enforcement and judicial system, but the impact of the drug market on both communities and individuals is not a separate security issue; rather, it is very much a matter of public health.

In terms of their contributions to prevention, the alcohol and drug strategies largely concentrate on separate domains. Alcohol policy is focused on environmental protection, and the legislation provides for enforcement of detailed measures designed to reduce alcohol's affordability, accessibility, and influence through marketing and advertising. The prevention objectives and actions of the national drugs strategy cover both alcohol and illegal drug use, and they are concerned with universal prevention programmes in school and in out-of-school settings, as well as with targeted prevention activities when a risk of harm from using substances is already apparent. The national drugs strategy emphasises synergy with other strategies, in particular the one on which alcohol legislation is based.

## 9.1 Ireland's drug and alcohol strategies

Overall responsibility for the national drugs strategy rests with the Minister for Health and the Minister of State with responsibility for Public Health, Wellbeing and the National Drugs Strategy, Department of Health. Several other Government Departments and agencies have responsibility for implementing particular actions in the strategy, with the Department of Education and the Department of Children, Equality, Disability, Integration and Youth having particular responsibility for actions relating to substance use and young people.

The national drugs strategy is structured around five goals; Goal 1 focuses on preventing children and young people from early use of alcohol and drugs and minimising harm for those who have already started to use substances. The objectives of Goal 1 are to promote healthier lifestyles within society through an integrated public health approach to substance use, to develop substance use education across all sectors, and to prevent substance use at a young age through supporting the well-being of children and young people. The actions associated with the objectives include supporting the SPHE programme in schools; building on school–community links; implementing and delivering a well-being programme in mainstream education settings; improving supports for those at risk of early substance use; averting early school leaving; supporting local communities by facilitating school buildings for after-school care; and improving services for young people in socially and economically disadvantaged communities. A further objective of Goal 1 is to develop harm reduction interventions targeting at-risk groups, including children who live with parents who misuse substances; children leaving care; LGBTI young people; users of image- and performance-enhancing drugs; and NPS users. In order to achieve this, the strategy advocates for programmes with high-risk families, building awareness of hidden harm, developing protocols between stakeholders to facilitate a coordinated response to the needs of children in these families, and ensuring that adult substance use services identify those who have children and contribute actively to meeting their needs. Further actions linked to this objective are reducing the risk of substance use problems among young people leaving care by strengthening their life skills and strengthening early harm reduction responses to current and emerging trends and patterns of drug use.

### 9.1.1 Ireland's broader youth policy context

While Ireland's national drugs strategy is the main driver for substance use prevention policy, there is a complementary youth strategy supporting the policy environment in which many prevention interventions are delivered. The national policy framework for children and young people is referenced throughout the national drugs strategy, and links with the national drugs strategy are made in the LGBTI+ Strategy. The strategies outlined below that were due to be completed by end 2020 have been extended:

- *Better Outcomes, Brighter Futures: The National Policy Framework for Children & Young People, 2014–2020* was Ireland's first national policy framework for children and young people aged 0–24 years [279]. This policy framework captures all children and youth policy commitments across all Government Departments and agencies.
- *The National Youth Strategy 2015–2020* was Ireland's first ever national youth strategy and

set out the Government's aims and objectives for young people aged 10–24 years [280]. The strategy focuses particularly on young people who are experiencing, or who are at risk of experiencing, the poorest outcomes.

- *The Youth Justice Strategy 2021–2027* is designed to provide a developmental framework to address key ongoing challenges, as well as new and emerging issues, in the youth justice area [281]. This includes preventing offending behaviour from occurring and diverting children and young adults who commit a crime away from further offending and involvement with the criminal justice system. A priority within the strategy is to enhance engagement with children and young people who are most at risk of involvement in criminal activity by strengthening the services available through the existing network of Garda Youth Diversion Projects across the State, and this is supported by an Action Research Project led by the Research Evidence into Policy, Programmes and Practice research partnership with the University of Limerick.
- *The National Strategy on Children and Young People's Participation in Decision-making, 2015–2020* was aimed at enabling young people to become directly involved in the design, development, implementation, and evaluation of services that affect them, including some of those that are delivered under the actions of the national drugs strategy [282].
- *The LGBTI+ National Youth Strategy 2018–2020*, the world's first LGBTI+ youth strategy, is structured around three goals, one of which sets out to improve the mental, physical, and sexual health and well-being of the entire LGBTI+ community [283].

## 9.2 Alcohol and other drugs, and the law

### 9.2.1 Public Health (Alcohol) Act 2018

Following a lengthy process to introduction, the Public Health (Alcohol) Act 2018 was finally signed into law in October 2018 [30]. Many of the components of the Act are specifically aimed at reducing alcohol consumption and related harms among young people, which marks an important recognition of alcohol-related harms in the population. The legislation seeks to limit the damage to the nation's health, society, and economy by reducing alcohol consumption; delaying the initiation of alcohol consumption by children and young people; reducing the harms caused by alcohol use; and ensuring that the supply and price of alcohol are regulated and controlled to minimise the possibility and incidence of alcohol-related harm. To date, several components of the Act have commenced:

- From November 2019, it is illegal for alcohol advertisements to be shown in cinemas where the film is rated as suitable for those aged under 18 years.
- From November 2019, it is illegal to advertise alcohol in or on public transport vehicles, stops, or stations, or within 200 metres of a school, a crèche, or a local authority playground.
- From November 2019, the Act restricts the sale of children's clothing that promotes alcohol consumption or bears the brand name or emblem, the corporate name or emblem, or the trademark logo of an alcohol brand or product.

- From November 2020, Section 22 (structural separation) of the Act requires that alcohol products be kept separate from other grocery products in mixed retail outlets such as supermarkets, grocery stores, convenience stores, and petrol stations. It also requires that alcohol products and advertisements for alcohol products are not visible outside of these designated areas. Structural separation is intended to ensure that access to alcohol products and the advertising of same is more controlled and less likely to be on display near grocery products, thereby discouraging their purchase as part of everyday household grocery shopping and making these products less visible to children.
- In January 2021, four regulations under Section 23 of the Act (sale and supply of alcohol products) came into effect. These regulations are intended to prohibit promotions encouraging risky drinking, including:
  - The award or use of bonus or loyalty card points in relation to the sale of alcohol products
  - The sale and advertisement of alcohol products at a reduced price or free of charge when sold with one or more alcohol products, or another product or service (for example, 'buy one, get one free' or 'buy one, get one half price' sales, or a free glass of wine offered at, for example, a nail bar, hairdresser, or barber, are not permitted)
  - The sale and advertisement of alcohol products at a reduced price for a period of 3 days or less (for example, a 'Student Night' or 'Happy Hour'), and
  - Advertising any of the discount promotions outlined above.
- From November 2021, Section 15 of the Act prohibits advertising in sports grounds for events where the majority of competitors or participants are children, or directly on a sports area for all events. Alcohol sponsorship of events aimed at children, or where most of the participants are children, is also prohibited.
- From January 2022, Section 11 (minimum unit price [MUP]), whereby the price of 1 g of alcohol in a product is set at 10 cent, was commenced. One standard drink in Ireland contains 10 g of alcohol, and an MUP applies per standard drink. The MUP is designed to stop strong alcohol being sold at very low prices in the off-trade, particularly supermarkets, where alcohol was frequently sold below cost. Under the MUP policy of 10 cent per gram of alcohol or €1 per standard drink, the average bottle of wine cannot be sold for less than €7.50, a bottle of spirits cannot be sold for less than €20.71, and a 500 mL can of lager cannot be sold for less than €1.97.

A number of components of the Public Health (Alcohol) Act 2018 have yet to be commenced, including:

- Section 12 of the Act, which stipulates that all alcohol products to be sold in Ireland include health warning labels displaying information about the dangers of alcohol consumption, the dangers of alcohol consumption when pregnant, warnings of the link between alcohol and a number of cancers, the quantity of grams of alcohol and calories in the drink, and details of a HSE website providing public health information about alcohol consumption, and
- Sections 13, 18, and 19 of the Act, which refer to advertising restrictions on alcohol (Section 13 restricts the content of alcohol advertisements, Section 18 limits advertising in print media, and Section 19 stipulates a 9.00 pm broadcast watershed on alcohol advertising).

Key components of the Public Health (Alcohol) Act 2018 to reduce alcohol-related harms, specifically reducing the availability of alcohol and safeguarding vulnerable groups (such as children), focussed on addressing the (previously) low cost of many alcohol products and the ease with which it can be accessed. Prior to the commencement of minimum unit price (MUP) in January 2022, the weekly low-risk guidelines for alcohol could be bought for ‘pocket money’ prices (€4.84 for women and €7.48 for men). MUP was implemented as the price of alcohol is an important modifiable policy lever for young people and structural separation was commenced in Irish retail outlets selling alcohol in 2020, and its objective is to reduce children’s exposure to alcohol. The impact of these, and other commencements will be evident in time.

## 9.2.2 Intoxicating Liquor Act 1927

### 9.2.2.1 Alcohol sales

Under the Intoxicating Liquor Act, amended in 2008, it is illegal to sell or supply alcohol to those aged under 18 years, to buy alcohol on behalf of someone who is aged under 18 years, or for an individual aged under 18 years to represent themselves as being aged 18 years or over in order to purchase alcohol. It is also an offence to give alcohol to a person who is aged under 18 years, unless it is in someone’s home and the child has the explicit consent of their parents [284].

### 9.2.2.2 Licensed premises

It is illegal for anyone aged under 18 years to be in an off-licence premises unless with a parent or guardian, and those aged under 18 years are, by law, not permitted to be in a pub after 9.00 pm from 1 October to 30 April, or after 10.00 pm from 1 May to 30 September. Those aged under 15 years are not permitted to be on licensed premises without a parent or guardian and must be supervised at all times. Exceptions are made for those aged between 15 and 17 years who may attend a private function in a licensed premise after the times above if a substantial meal is being served.

### 9.2.2.3 Alcohol in public spaces

Gardaí can seize alcohol in the possession of an individual aged under 18 years who is drinking in a public place where the gardaí have reasonable cause to believe that the alcohol will be consumed by a child aged under 18 years in a public place, and gardaí can also contact the individual’s parents.

Section 14 of the Intoxicating Liquor Act 2008 added a provision to the Intoxicating Liquor Act, 1988 permitting An Garda Síochána to employ juveniles aged 15–18 years to act as test purchasers in licensed premises.

### **9.2.3 Misuse of Drugs Act 1977**

Under Irish law, the importation of, manufacture of, trade in, and possession of (other than by prescription) most psychoactive substances is a criminal offence, and the Misuse of Drugs Acts 1977 and 1984 are the main pieces of legislation that aim to protect society from the impact of drugs in Ireland [285]. The Misuse of Drugs Act has been amended several times (1999, 2006, 2007, and 2015) to accommodate the transient nature of drug markets and supply.

### **9.2.4 Misuse of Drugs (Supervised Injecting Facilities) Act 2017**

The Misuse of Drugs (Supervised Injecting Facilities) Act 2017 provides for the establishment and regulation of supervised injecting facilities aimed to reduce harm to people who inject drugs, reduce the number of people injecting drugs in public places, and reduce drug litter in public places [286]. However, these facilities have not yet been established.

### **9.2.5 Criminal Justice Act 1994**

The Criminal Justice Act 1994 provided for the seizure and confiscation of assets derived from the proceeds of drug trafficking and other offences [287]. In 1999, the Act was amended to make it an offence to be in possession of drugs for sale and supply. In 2006 it was further amended to include provisions for creating criminal offences in relation to participation in criminal organisations. The 2006 amendments included the creation of a drug offenders register, a minimum sentence for drug trafficking, and new offences for supplying drugs to prisoners. In 2007, a further amendment provided increased Garda detention powers.

#### **9.2.5.1 Criminal Justice (Psychoactive Substances) Act 2010**

The Criminal Justice (Psychoactive Substances) Act 2010 covers substances which are not specifically prohibited under the Misuse of Drugs Acts, but which have psychoactive effects [288]. This legislation was introduced in response to the growing number of head shops that opened around the country in the preceding years.

### **9.2.6 Medical Cannabis Access Programme 2019**

In June 2019, the Minister for Health signed legislation to allow for the operation of the Medical Cannabis Access Programme on a pilot basis [289]. The Programme allows medical consultants to prescribe cannabis-based products for medical use in cases where the patient has failed to respond to standard treatments, in line with legislation and following the clinical guidance for the scheme.

### **9.2.7 Road Traffic Act 1961**

The Road Traffic Act, 1961 is the main legislation responsible for road safety in Ireland [290]. This law has been updated over the years, including the following changes:

- 2006 – This change gave gardaí powers to reduce and eliminate the offence of drink-driving through allowing the gardaí to breathalyse any driver stopped at a mandatory

alcohol checkpoint without the need to form any opinion in relation to the driver of the vehicle.

- 2011 – Gardaí were now required to conduct a preliminary breath test where they believe that a driver has consumed alcohol or at the scene of a crash where someone has been injured and requires medical attention.
- 2014 – It became legal to take a specimen of blood from a driver who was incapacitated following a serious road traffic collision and to test that specimen for intoxicants.
- 2016 – This update to the law stipulated that it is illegal to drive under the influence of drugs (including prescription drugs) if driving is impaired. For certain drugs (cannabis, cocaine, and heroin), it is illegal to drive if you are over the specified limit, even if your driving is not impaired. The 2016 amendments allow gardaí to conduct preliminary drug tests at the roadside or in Garda stations. Drug testing devices test saliva for cannabis, cocaine, opiates, and benzodiazepines; in some instances, blood samples may be taken at a Garda station. Impairment tests can also be carried out.
- 2018 – Under the amendment in 2018, drivers who previously got penalty points for certain drink-driving offences are now routinely disqualified from driving.

## 9.3 Summary: Ireland's policy and legislation governing alcohol and drugs

The national drugs strategy is a health-led (rather than criminal justice) approach to drug use and was the first strategy in Ireland to adopt an integrated public health approach to drug and alcohol use. While the strategy complements the Public Health (Alcohol) Act 2018 and strengthens some of the key parts of the alcohol-focused *Steering Group Report On a National Substance Misuse Strategy* published in 2012, illicit drug use is the primary focus of many of the actions of the strategy.

A number of other strategies complement the national drugs strategy, including the youth strategy, the Youth Justice Strategy, the National Strategy on Children and Young People's Participation in Decision-making, and the LGBTI+ National Youth Strategy.

The legislation that govern drug and alcohol use are the Public Health (Alcohol) Act 2018, which aims to tackle alcohol-related harm at a population level by reducing overall alcohol use and delaying alcohol use initiation, and to regulate the supply, price, and marketing of alcohol; the Road Traffic Act 1961, which oversees road safety in Ireland, including drink-driving and drug-driving; the Misuse of Drugs Act 1977, which aims to protect society from the impact of drugs in Ireland; the Criminal Justice Act 1994, governing possession of drugs for sale and supply; and the Intoxicating Liquor Act which stipulates that the legal age for sale to and consumption of alcohol is 18 years.



10



# Conclusion



This report presents the most recent information from a number of indicators measuring the extent of substance use among children and young people in Ireland and identifying the social and environmental factors that impact on this use. It also examines the indicators relating to the harmful health, social and criminal consequences of substance use and the preventative and treatment interventions that form part of the response to substance use. The focus, therefore, is on aspects of young people's behaviour that cause concern. We look at the immediate effects of using alcohol and other drugs at a young age and the possibility of harmful patterns of behaviour being established by early adulthood, a key period for social, psychological, and physical development. It is important to keep this phenomenon in perspective. Children and young adults in Ireland express a high degree of satisfaction with their lives, are generally happy, enjoy good health and warm relationships with their families and peers, and have mainly positive experiences in the educational system. Exploration and experimentation are normal, healthy and essential aspects of development from childhood into adulthood. We live in a society where substance use, especially alcohol use, is closely associated with many aspects of our social, cultural, and working lives. Many adults often have difficulty negotiating this environment, and it is inevitable that young people sometimes engage in behaviours that have detrimental consequences that may impair their capacity to live fulfilling lives. While we celebrate the overwhelming positive lives of our young population it is also essential to consider the extent of drug and alcohol use among young people, the harms associated with this use and the factors that increase or decrease the likelihood of these harms occurring. This awareness will support policy makers, service providers, parents, law enforcement and all those working to protect and support young people to respond effectively to this phenomenon.

Although drinking habits among schoolchildren in Ireland seem to be slowly changing, the data presented in this overview indicate that there is still a worryingly high level of alcohol use among children and young people. The increase in the age of initiation of alcohol use is welcome, as is the number of young people who do not drink, however once young people do start drinking, many do so in a hazardous and harmful manner. Heavy episodic or binge drinking and drunkenness among adolescents in Ireland is higher than the European average and girls are as likely as boys to drink in this way. The incidence of AUD among young people in Ireland is extremely high, reflecting the harmful and hazardous drinking patterns that are commonplace among our youth and young females are more likely than males to be classified as having an AUD. This is a troubling finding as the evidence indicates that the neurotoxic effects of alcohol on the developing adolescent brain is more pronounced in girls than boys. Young people also reported experiencing alcohol-related harms due to their drinking and HED or binge drinking, which is commonplace, and particularly increases the level of harm. While concerning, it is perhaps an unsurprising finding, as alcohol use is such an integral part of Irish social and cultural life and hazardous alcohol is common across all age groups but particularly so among young people. We live in an alcogenic environment where alcohol is freely available, at relatively low cost and young people are regularly exposed to alcohol marketing, all of which have been shown to influence alcohol use among children. Children also observe alcohol use from an early age and see the adults in their lives drinking on special occasions and routinely at home. Young people drink for social reasons, to relieve boredom and, worryingly, many report drinking due to anxiety, stress, or other mental health problems. As a society, we must accept that alcohol use remains a problem in Ireland and consider forms of socialising that do not have to revolve around alcohol.

Almost one in every five of young people have used illegal drugs in the last year and although use of cannabis has plateaued among young people overall, other drug use, particularly stimulants, has increased. While males reported a decrease in last year use of any illegal drug, there was an increase in last year use among young females, especially cocaine use. The increasing likelihood of risky behaviour among young females seen in alcohol consumption data may also be emerging in drug use patterns. Trends need to be observed carefully as problematic substance use poses particular health problem for girls and young females.

Cocaine and cannabis feature frequently throughout this report. Cannabis is the most widely used illegal drug among young people and the harmful consequences of its use are presented in this overview. Cannabis was the most common drug involved in drug-related hospital admissions, the most common drug for which treatment was required and the most common substance misused by clients referred to the Probation Services. Over one-half of non-poisoning deaths due to traumatic events were among young people with a history of cannabis use. These findings need to be carefully considered in the context of recent regulatory changes internationally and their impact on future debate on the topic in Ireland. Although the prevalence of cocaine use was lower than that of cannabis, its use was also not without consequences. Cocaine was the fourth most common drug implicated in drug poisoning deaths, was the second most common drug among drug-related hospitalisations, and treatment for cocaine use has increased by 171% between 2011 and 2019.

The continuing decline in young people's initiation into opiate use is encouraging. It seems that even among young people engaged in polydrug use, there is a wariness with regard to heroin as the impact on earlier generations is apparent. Also, community-based treatment services have contributed to the reduction in the numbers of those actively using heroin and so routes for initiation are lessened. The decline is reflected in numbers of those entering treatment with opiates as the primary drug, far fewer than those who seek treatment for cannabis or cocaine use.

The widespread substance use in Ireland places a sizeable burden on resources. Hospitalisations due to both alcohol and drug use increased yearly from 2015–2018. In 2017, drug/alcohol poisonings represented over one in ten deaths or 12% of all deaths of young people aged 15–24 years that year. The period 2015–2018 saw a 12% increase in alcohol-related hospitalisations and a 26% increase in drug-related hospitalisations and although there was a reduction in hospitalisations in 2019, the financial cost to a healthcare system already under significant strain, and the personal costs to the individuals and their families are immense.

As well as health services, criminal justice services are impacted by substance use among young people. The data available demonstrated the overrepresentation of young people in drug and alcohol-related arrests, particularly for arrests for drug-driving and possession of drugs. Having a criminal record, especially from a young age, often carries a stigma and can have enormous lifelong implications, impacting employment prospects and life plans including buying or renting a home or travelling abroad. The data highlighted that the young people referred to Probation Services reported high levels of substance misuse and that this misuse was, in many cases, linked to the crime committed. Probation clients are often vulnerable, socially excluded individuals, frequently presenting with co-occurring mental health issues. Unfortunately, it is not until they come to the attention of the gardaí and

Probation Services, that these issues are addressed. Early intervention, harm reduction and integrated care pathways are key to deter reoffending. Probation Officers are well placed to refer their clients to support services and work to ensure that diversion is not just away from criminal justice system but towards treatment.

There is strong evidence of links between mental health problems in young people and their substance use. While the causal connection is complex and it is often difficult to determine whether mental health concerns pre-exist and are exacerbated by substance use or are a result of substance use, their co-occurrence worsens behavioural problems and can prove intractable for treatment. The evidence indicates that mental health issues are more common among those who use cannabis regularly, drink alcohol in a hazardous manner or have an AUD, than those who do not. Similarly, self-harm and suicide attempts are more prevalent among young people who are alcohol dependent.

Teachers and schools play a part by being alert for potential warning signs that children may be struggling or may be experiencing psychological distress, by supporting them, speaking to parents, or seeking further advice if necessary. School is a refuge for many children and in their role, they may be influential in preventing substance use or helping them overcome problematic behaviours related to substance use.

Responding to this situation involves a combination of regulations to limit availability of harmful substances, prevention intervention models that have proven effective, treatment interventions and personal support from parents, educators, health professionals and others in direct contact with children and young people in their daily lives to ensure that intervention is sought as early as possible and brief interventions are delivered that could make a significant impact on the individual's life. The Public Health (Alcohol) Act 2018 aims to reduce alcohol use at a population level, but specifically among younger people as many of the components of the Act intend to delay early alcohol initiation. Structural separation and MUP are important steps towards recognising that alcohol is no ordinary commodity. It will take time to establish the full impact of the measures introduced as part of the Act and whether they have been successful in reducing harmful alcohol use and delaying alcohol use but having baseline data to compare is crucial to quantify their effectiveness and comprehensively determine the impact of the legislation.

Overall, treatment data indicated a yearly decrease in cases presenting for treatment for alcohol use despite the fairly consistent high levels of use noted from the various sources presented in this overview. Treatment for drug use has remained constant although an increase was noted for treatment for cannabis and especially cocaine, which has seen a yearly increase particularly since 2014. Although not all illegal drug use requires treatment, this inconsistency between use and treatment presentations requires further consideration. The evidence points towards gaps in treatment whereby young people with substance misuse issues are not being identified or intervention is not sought early enough, or it may reflect that use has not yet reached the level where treatment is felt required or sought. Young people are more likely to enter treatment for their drug use than their alcohol use, a reflection of how we view alcohol use as customary in our culture and are tolerant of alcohol-related harm. More males received treatment for substance use, and CUD is more pronounced among males. If women are reluctant to seek and attend treatment, the situation could potentially be improved if gender specific services were more freely

available that accommodate for the distinct needs of women, especially where they have caring responsibilities. Also of note is the number of cases of young people re-entering treatment for substance use. Each year, approximately one-half of the cases of young people had previously attended treatment. The availability of services tailored towards young people could encourage more young people to seek support and to maintain their goal of abstinence or reduced use following treatment including e-health interventions, as might raising awareness of treatment or proactive engagement and the pathways to treatment, especially for alcohol use. As alcohol use is normalised in Ireland, we need to ensure that young people understand that there is a point where their alcohol use is not 'normal', we need to ensure that they are aware that there is help available, to remove any stigma that may be attached to seeking help, to ensure that treatment support services accommodate for co-occurring mental health issues and also that where a young person seeks help for drug use, that their alcohol use is focussed on too.

When attempting to tackle the issues surrounding substance use, it is crucial that children and young people are engaged in the conversations and the decision-making that inform policies and practices. Stakeholders such as those who provide treatment services, Probation Officers, advocacy organisations representing groups of young people, and parents also should be involved in decision-making about addressing substance use in this population. In addressing drug use, the Government remain committed to reducing the harms caused by substance use, for both the individual, their family and the wider community and also focusing on rehabilitation and recovery as per the national drugs strategy.

The Public Health (Alcohol) Act is a huge step forward in tackling our unhealthy relationship with alcohol in Ireland. Recognising that alcohol is a public health issue protects both children and adults from the harmful effects of its use. The aim of the Act is to change our behaviours and lives can be improved and even saved if all components of the Act are enacted and equally important, are monitored to ensure they are being implemented. The COVID-19 pandemic has impacted greatly on everyone's lives and livelihoods have been seriously affected. Although the proposed Sale of Alcohol Bill seeks to extend the number of venues that are alcohol free, it also proposes to extend opening hours and increase the number of venues selling alcohol. Careful consideration must be given to the social and health consequences of this approach. The Public Health (Alcohol) Act was passed following a protracted debate and there were long delays in introducing its provision and sections of the Act remain to be commenced over two years since its passing. We must not lose sight of the fundamental issue, that is, protecting our young people from the harms caused by alcohol. The Act is a landmark piece of legislation and establishes Ireland as a leader in tackling harmful alcohol use. Monitoring the drug and alcohol situation among young people is required to ensure that policymakers, service providers and families understand the continually shifting nature of substance use.

## Research gaps

This report has highlighted that we have multiple sources of information, from routine surveys, national information systems, administrative data and published literature meaning that we know a lot about the prevalence of the alcohol and drug use among children and young people in Ireland. There are also a wide range of responses to addressing the issue of substance misuse and prevention programmes and interventions to delay or deter young people from using substances and programmes to help if problematic use develops. The overview has highlighted that some important gaps in our knowledge base remain, namely the lack of data on numbers of emergency department presentations and ambulance callouts that are related to alcohol and drug use. A gap also exists in evaluating the effectiveness of prevention programmes and interventions. There are potentially vulnerable groups where there is limited or no information available or a lack of up-to-date information available, so we do not know the extent of substance use among these populations, for example, ethnic minorities including members of the Traveller community and those living in Ireland as asylum seekers or refugees. The findings presented in this overview are predominantly based on binary reporting of gender due to studies not reporting on people who do not identify as male or female. Further exploration into why there has been a decline in the number of young people receiving treatment for alcohol use is also necessary.

International evidence points to other risk factors that can result in children and young people being at greater risk of substance misuse. For example, those who have caring responsibilities (either children of their own or caring for a family member with a disability) are not examined in the literature to the best of our knowledge. There are also vulnerable periods in some young people's lives that could potentially place them at increased risk of substance use, such as children expelled from school or children who are in, or have left, State care and young people who are unemployed.

International research highlights the impact of adverse childhood experiences (ACE) on children and adults and how for many, it can impact their own substance use and mental health. Experiencing violence, abuse, or neglect, witnessing violence in the home or community, having a family member attempt, or die by, suicide and/or growing up in a household where parents misuse substances are a number of experiences that are considered ACEs and can be an important risk factor for substance misuse. There is limited published Irish evidence available for this hugely important area although the Silent Voices initiative of Alcohol Action Ireland reveals the impact of living with a family member with substance abuse.

We also need to understand more about polydrug use and how drug use has changed in the last number of years. There are now a wider range of drugs used and considerably more polydrug use. In this overview, the prevalence of each substance is described independently of each other, but we know that polydrug use is common especially among young people. Additional analysis is required of existing data sources to establish if the same respondents are using multiple drugs, (including alcohol) as this has even greater implications for substance related harms and for the policies and strategies that guide prevention. The decrease in alcohol use among younger adolescents is certainly a positive finding of the last 10–15 years but has alcohol been replaced with other drugs such as cocaine which has seen an increase? It is important to ensure real-time drug monitoring so that we are informed and understand what combinations of drugs are being used in order to be proactive in tackling the issue.

# Appendices



## Appendix 1 National Psychiatric Inpatient Reporting System (NPIRS) codes

Table 19 ICD-10 codes used for NPIRS drug- and alcohol-related admissions to psychiatric hospitals

| ICD-10 code | Description  |
|-------------|--|
| F10         | Mental and behavioural disorders due to use of alcohol   |
| F11         | Mental and behavioural disorders due to use of opioids   |
| F12         | Mental and behavioural disorders due to use of cannabinoids  |
| F13         | Mental and behavioural disorders due to use of sedatives or hypnotics                              |
| F14         | Mental and behavioural disorders due to use of cocaine   |
| F15         | Mental and behavioural disorders due to use of other stimulants                                    |
| F16         | Mental and behavioural disorders due to use of hallucinogens                                       |
| F18         | Mental and behavioural disorders due to use of volatile solvents                                   |
| F19         | Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances |

Source: World Health Organization [253]



## Appendix 2 ICD-10-AM codes used for HIPE

Table 20 ICD-10-AM codes used for drug-related discharges for HIPE

| ICD-10-AM code | Description  |
|----------------|--|
| F11            | Mental and behavioural disorders due to opioids              |
| F12            | Mental and behavioural disorders due to cannabinoids         |
| F13            | Mental and behavioural disorders due to sedatives/hypnotics  |
| F14            | Mental and behavioural disorders due to cocaine              |
| F15            | Mental and behavioural disorders due to other stimulants     |
| F16            | Mental and behavioural disorders due to hallucinogens        |
| F18            | Mental and behavioural disorders due to volatile solvents    |
| F19            | Mental and behavioural disorders due to multiple/other drugs |
| T40.0          | Poisoning by opium   |
| T40.1          | Poisoning by heroin  |
| T40.2          | Poisoning by other opioids                                   |
| T40.3          | Poisoning by methadone                                       |
| T40.4          | Poisoning by other synthetic narcotics                       |
| T40.5          | Poisoning by cocaine   |
| T40.6          | Poisoning by unspecified narcotics                           |
| T40.7          | Poisoning by cannabis  |
| T40.8          | Poisoning by LSD   |
| T40.9          | Poisoning by unspecified hallucinogens                       |
| T42.3          | Poisoning by barbiturates                                    |
| T42.4          | Poisoning by benzodiazepines                                 |
| T43.6          | Poisoning by psychostimulants                                |
| T52            | Toxic effect of organic solvents                             |

Source: World Health Organization [222]

Table 21 ICD-10-AM codes used for alcohol-related discharges for HIPE

| ICD-10-AM code | Description   |
|----------------|---|
| F10            | Mental and behavioural disorders due to use of alcohol              |
| T51            | Toxic effect of alcohol   |
| X45, X65, Y15  | Alcohol poisoning   |
| R78, Y90       | Evidence of alcohol involvement determined by blood alcohol level   |
| Y91            | Evidence of alcohol involvement determined by level of intoxication |
| K70            | Alcoholic liver disease   |
| E24.4          | Alcohol-induced pseudo-Cushing's syndrome                           |
| G31.2          | Degeneration of nervous system due to alcohol                       |
| G62.1          | Alcoholic polyneuropathy  |
| G72.1          | Alcoholic myopathy  |
| I42.6          | Alcoholic cardiomyopathy  |
| K29.2          | Alcoholic gastritis   |
| K86.0          | Alcohol-induced chronic pancreatitis                                |
| K85.2          | Alcohol-induced acute pancreatitis                                  |
| Z50.2          | Alcohol rehabilitation  |
| Z71.4          | Alcohol abuse counselling and surveillance                          |
| Z72.1          | Problems related to lifestyle – alcohol                             |
| Z86.41         | Personal history of alcohol use disorder                            |

Source: World Health Organization [222]

## References

- 1 Murray CJL, Aravkin AY, Zheng P, *et al.* Global burden of 87 risk factors in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019. *The Lancet* 2020;**396**:1223–49. doi:10.1016/S0140-6736(20)30752-2
- 2 Department of Health. Reducing harm, supporting recovery. A health-led response to drug and alcohol use in Ireland 2017 – 2025. Dublin: Department of Health 2017. <https://www.drugsandalcohol.ie/27603/>
- 3 Health Research Board. HRB National Drugs Library. [www.drugsandalcohol.ie](http://www.drugsandalcohol.ie) (accessed 22 Dec 2021).
- 4 Babor T, Caetano R, Casswell S, *et al.* *Alcohol: No Ordinary Commodity: Research and Public Policy*. 2nd ed. Oxford, UK: Oxford University Press 2010.
- 5 European Monitoring Centre for Drugs and Drug Addiction. EMCDDA statistical bulletin 2021. 2021. <https://www.drugsandalcohol.ie/34351/> (accessed 15 Mar 2022).
- 6 United Nations Office on Drugs and Crime. World Drug Report 2018. Drugs and age: Drugs and associated issues among young people and older people. Vienna: UNODC 2018. <https://www.unodc.org/wdr2018/en/drugs-and-age.html>
- 7 Mongan D, Millar S, Galvin B. The 2019–20 Irish National Drug and Alcohol Survey: main findings. Dublin: Health Research Board 2021. <https://www.drugsandalcohol.ie/34287/>
- 8 Ipsos MRBI. Healthy Ireland survey 2021 summary of findings. Dublin: Department of Health 2021. <https://www.drugsandalcohol.ie/35296/>
- 9 O’Dwyer C, Mongan D, Doyle A, *et al.* Alcohol consumption, alcohol-related harm and alcohol policy in Ireland. Dublin: Health Research Board 2021. <https://www.drugsandalcohol.ie/33909/>
- 10 Sunday S, Keogan S, Hanafin J, *et al.* ESPAD 2019 Ireland. Dublin: TobaccoFree Research Institute Ireland 2020. <https://www.drugsandalcohol.ie/33347/>
- 11 Kolto A, Gavin A, Molcho M, *et al.* The Irish Health Behaviour in School-aged Children (HBSC) Study 2018. Dublin: Department of Health & Galway Health Promotion Research Centre, National University of Ireland, Galway. 2020. <https://www.drugsandalcohol.ie/31531/>
- 12 Gavin A, Grogan C, Nic Gabhainn S. HBSC Ireland 2018: Alcohol use, procurement and location of alcohol use and cannabis use among school-aged children in Ireland. Galway: Health Promotion Research Centre, NUI Galway 2020. <https://www.drugsandalcohol.ie/34986/>
- 13 McNamara E, Murphy D, Murray A, *et al.* Growing up in Ireland: the Lives of 17/18-year-olds. Dublin: ESRI; Trinity College Dublin; Department of Children and Youth Affairs 2020. <https://www.drugsandalcohol.ie/32535/>
- 14 ESRI and Trinity College Dublin. Growing Up in Ireland. Wave 4 at 20-years. Dublin: ESRI; Trinity College Dublin; and Department of Youth and Community Affairs 2019. <https://www.drugsandalcohol.ie/31381/>
- 15 Dooley B, Fitzgerald A. My world survey: national study of youth mental health in Ireland. Dublin: Headstrong – The National Centre for Youth Mental Health; UCD School of Psychology 2012. <https://www.drugsandalcohol.ie/17589/>
- 16 Dooley BA O’Connor, C, Fitzgerald, A, & O’Reilly, A. My World Survey 2. The National Study of Youth Mental Health in Ireland. Dublin: University College Dublin School of

- Psychology, Dublin, Ireland & Jigsaw, the National Centre for Youth Mental Health, Dublin, Ireland 2019. <https://www.drugsandalcohol.ie/31343/>
- 17 Western Region Drug and Alcohol Task Force. Planet youth strategy & implementation framework: Galway, Mayo & Roscommon. Galway: Western Region Drug and Alcohol Task Force 2020. <https://www.drugsandalcohol.ie/31961/>
- 18 Western Region Drug and Alcohol Task Force, Planet Youth. Growing up in the West. Planet Youth county report Galway 2020. Galway: WRDATF 2021. <https://www.drugsandalcohol.ie/34107/>
- 19 Western Region Drug and Alcohol Task Force, Planet Youth. Growing up in the West. Planet Youth county report Mayo 2020. Galway: WRDATF 2021. <https://www.drugsandalcohol.ie/34108/>
- 20 Western Region Drug and Alcohol Task Force, Planet Youth. Growing up in the West. Planet Youth county report Roscommon 2020. Galway: WRDATF 2021. <https://www.drugsandalcohol.ie/34109/>
- 21 Central Statistics Office. Irish health survey 2019 – main results. Cork: Central Statistics Office 2020. <https://www.drugsandalcohol.ie/33531/>
- 22 Central Statistics Office. Social Impact of COVID-19 Survey April 2020. Central Statistics Office 2020. <https://www.cso.ie/en/releasesandpublications/ep/p-covid19/covid-19informationhub/socialandwellbeing/socialimpactofcovid-19survey/>
- 23 Central Statistics Office. Social impact of COVID-19 survey November 2020 well-being and lifestyle under level 5 restrictions. Dublin: Central Statistics Office 2020. <https://www.drugsandalcohol.ie/33458/>
- 24 Byrne M, Dick S, Ryan L, *et al.* The Drug Use in Higher Education in Ireland (DUHEI) survey 2021: main findings. Cork: University College Cork 2022. <https://www.drugsandalcohol.ie/35515/>
- 25 Long J, Mongan D. Alcohol consumption in Ireland 2013: analysis of a national alcohol diary survey. Dublin: Health Research Board 2014. <https://www.drugsandalcohol.ie/22138/>
- 26 Morgan K, McGee H, Dicker P, *et al.* SLÁN 2007: Survey of Lifestyle, Attitudes and Nutrition in Ireland. Alcohol use in Ireland: A profile of drinking patterns and alcohol-related harm from SLAN 2007. Dublin: Department of Health and Children 2009. <https://www.drugsandalcohol.ie/12664/>
- 27 WHO Regional Office for Europe. Making the European region safer: developments in alcohol control policies, 2010–2019. Copenhagen: WHO Regional Office for Europe 2021. <https://www.drugsandalcohol.ie/34060/>
- 28 Degenhardt L, Stockings E, Patton G, *et al.* The increasing global health priority of substance use in young people. *Lancet Psychiatry* 2016;**3**:251–64.
- 29 World Health Organization. Global strategy to reduce the harmful use of alcohol. Geneva: World Health Organization 2010. <https://www.drugsandalcohol.ie/14845/>
- 30 Office of the Attorney General. Public Health (Alcohol) Act. Dublin: Irish Statute Book 2018. <https://www.drugsandalcohol.ie/33698/>
- 31 World Health Organization Regional Office for Europe. Spotlight on adolescent health and well-being. Findings from the 2017/2018 Health Behaviour in School-aged Children (HBSC) survey in Europe and Canada. International report. Denmark: World Health Organization Regional Office for Europe 2020. <https://www.drugsandalcohol.ie/32013/>

- 32 ESPAD Group. ESPAD report 2019 results from the European School Survey Project on Alcohol and Other Drugs. Luxembourg: EMCDDA Joint Publications, Publications Office of the European Union 2020. <https://www.drugsandalcohol.ie/33331/>
- 33 Azzopardi PS, Hearps SJ, Francis KL, *et al.* Progress in adolescent health and wellbeing: tracking 12 headline indicators for 195 countries and territories, 1990–2016. *The Lancet* 2019;**393**:1101–18. <https://www.drugsandalcohol.ie/30368/>
- 34 Bräker AB, Soellner R. Alcohol drinking cultures of European adolescents. *Eur J Public Health* 2016;**26**:581–6. <https://www.drugsandalcohol.ie/25801/>
- 35 Davoren MP, Demant J, Shiely F, *et al.* Alcohol consumption among university students in Ireland and the United Kingdom from 2002 to 2014: a systematic review. *BMC Public Health* 2016;**16**:173. <https://www.drugsandalcohol.ie/25221/>
- 36 Dooley B, O'Connor C, Fitzgerald A, *et al.* My world survey 2: national study of youth mental health in Ireland. Dublin: UCD and Jigsaw 2019. <https://www.drugsandalcohol.ie/31343/>
- 37 O'Mahony D, McNamara E, McClintock R, *et al.* Growing Up in Ireland: The lives of 20-year-olds: making the transition to adulthood. Dublin: ESRI; Trinity College Dublin; Department of Children Equality, Disability, Integration and Youth 2021. <https://www.drugsandalcohol.ie/35334/>
- 38 National Advisory Committee on Drugs. Drug use in Ireland and Northern Ireland: first results from the 2010/2011 drug prevalence survey. Bulletin 1. Dublin: National Advisory Committee on Drugs & Public Health Information and Research Branch 2011. <https://www.drugsandalcohol.ie/16353/>
- 39 National Advisory Committee on Drugs and Alcohol, Northern Ireland. Department of Health. Prevalence of drug use and gambling in Ireland & drug use in Northern Ireland. Bulletin 1. Dublin: National Advisory Committee on Drugs and Alcohol 2016. <https://www.drugsandalcohol.ie/26364/>
- 40 National Advisory Committee on Drugs, Public Health Information and Research Branch, Research Branch. Drug use in Ireland & Northern Ireland 2006/2007: drug prevalence survey bulletin 2: Regional Drugs Task Force (Ireland) & Health and Social Services Board (Northern Ireland) results. Dublin: National Advisory Committee on Drugs & Public Health Information and Research Branch 2008. <https://www.drugsandalcohol.ie/11535/>
- 41 National Advisory Committee on Drugs, Drug and Alcohol Information and Research Unit. Drug use in Ireland & Northern Ireland: 2002/2003 drug prevalence survey: Health Boards (Ireland) and Health and Social Services Board (Northern Ireland): updated results: bulletin 2: updated confidence intervals. Dublin: National Advisory Committee on Drugs 2009. <https://www.drugsandalcohol.ie/11584/>
- 42 Morgan M, Brand K. European Schools Survey Project on Alcohol and Other Drugs (ESPAD): Results for ESPAD 2007: Ireland. Dublin: Stationery Office 2009. <https://www.drugsandalcohol.ie/11860/>
- 43 Taylor K, Babineau K, Keogan S, *et al.* ESPAD 2015: European Schools Project on Alcohol and Other Drugs in Ireland. Dublin: Department of Health 2016. <https://www.drugsandalcohol.ie/26116/>
- 44 Oldham M, Callinan S, Whitaker V, *et al.* The decline in youth drinking in England—is everyone drinking less? A quantile regression analysis. *Addiction* 2020;**115**:230–8.
- 45 Oldham M, Holmes J, Whitaker V, *et al.* Youth drinking in decline. Sheffield: University

- of Sheffield 2018. [https://www.sheffield.ac.uk/polopoly\\_fs/1.806889!/file/Oldham\\_Holmes\\_Youth\\_drinking\\_in\\_decline\\_FINAL.pdf](https://www.sheffield.ac.uk/polopoly_fs/1.806889!/file/Oldham_Holmes_Youth_drinking_in_decline_FINAL.pdf)
- 46 Pape H, Rossow I, Brunborg GS. Adolescents drink less: how, who and why? A review of the recent research literature. *Drug Alcohol Rev* 2018;**37**:S98–114.
- 47 Törrönen J, Roumeliotis F, Samuelsson E, *et al.* Why are young people drinking less than earlier? Identifying and specifying social mechanisms with a pragmatist approach. *Int J Drug Policy* 2019;**64**:13–20. doi:10.1016/j.drugpo.2018.12.001
- 48 Rossow I, Pape H, Torgersen L. Decline in adolescent drinking: Some possible explanations. *Drug Alcohol Rev* 2020;**39**:721–8.
- 49 Petticrew M, Shemilt I, Lorenc T, *et al.* Alcohol advertising and public health: systems perspectives versus narrow perspectives. *J Epidemiol Community Health* 2017;**71**:308–12.
- 50 Atkinson A Sumnail, H, Begley, E, Jones, L. A rapid narrative review of literature on gendered alcohol marketing and its effects: exploring the targeting and representation of women. Institute of Alcohol Studies 2019. <https://www.drugsandalcohol.ie/31219/>
- 51 Babor T, Higgins-Biddle JC, Saunders JB, *et al.* AUDIT - The alcohol use disorders identification test: guidelines for use in primary care. Geneva: World Health Organization Department of Mental Health and Substance Abuse 2001. <https://www.drugsandalcohol.ie/14104/>
- 52 World Health Organisation. Global status report on alcohol and health 2018. Geneva: World Health Organization 2018. <https://www.drugsandalcohol.ie/29701/>
- 53 American Psychiatric Association. Diagnostic and statistical manual of mental disorders (5th ed.). *Am Psychiatr Assoc* 2013;**21**.
- 54 Ipsos MRBI. Healthy Ireland Survey 2016: summary of findings. Dublin: Stationery Office 2016. <https://www.drugsandalcohol.ie/26278/>
- 55 Ewing SWF, Sakhardande A, Blakemore S–J. The effect of alcohol consumption on the adolescent brain: A systematic review of MRI and fMRI studies of alcohol-using youth. *NeuroImage Clin* 2014;**5**:420–37.
- 56 Western Region Drug and Alcohol Task Force, Planet Youth, Planet Youth. Growing up in the west: county report Galway. WRDATF 2019. <https://www.drugsandalcohol.ie/30528/>
- 57 Mongan D, Millar S, O’Dwyer C, *et al.* Drinking in denial: a cross-sectional analysis of national survey data in Ireland to measure drinkers’ awareness of their alcohol use. *BMJ Open* 2020;**10**. <https://www.drugsandalcohol.ie/32429/>
- 58 UNICEF Ireland. Changing the future: experiencing adolescence in contemporary Ireland: alcohol and drugs. Dublin: UNICEF Ireland 2011. <https://www.drugsandalcohol.ie/16346/>
- 59 Clement C, Thirlaway K, Smith A, *et al.* Vulnerable young people and alcohol use: a qualitative exploration. *J Subst Use* 2014;**19**:112–7. doi:10.3109/14659891.2012.750694
- 60 European Monitoring Centre for Drugs and Drug Addiction. EMCDDA 2008 selected issue - Drugs and vulnerable groups of young people. Luxembourg: Office for Official Publications of the European Communities 2008. <https://www.drugsandalcohol.ie/11594/>
- 61 Higgins A, Doyle L, Downes C, *et al.* The LGBT Ireland report: national study of the

- mental health and wellbeing of lesbian, gay, bisexual, transgender and intersex people in Ireland. Dublin: GLEN and BelongTo 2016. <https://www.drugsandalcohol.ie/25323/>
- 62 SpunOut.ie, Ireland. Department of Children and Youth Affairs. How's your head: young voices during COVID-19. Report of a national consultation with young people on mental health and wellbeing. Dublin: Department of Children and Youth Affairs 2020. <https://www.drugsandalcohol.ie/33132/>
- 63 ESRI and Trinity College Dublin, Trinity College Dublin. Growing Up in Ireland. Key findings: special COVID-19 survey. ESRI; Trinity College Dublin; Department of Children and Youth Affairs 2021. <https://www.drugsandalcohol.ie/34254/>
- 64 Carbia C, Garcia-Cabrerizo R, Cryan JF, *et al.* Associations between mental health, alcohol consumption and drinking motives during COVID-19-second lockdown in Ireland. *Alcohol Alcohol* 2022;**57**:211-8. <https://www.drugsandalcohol.ie/35897/>
- 65 Ipsos MORI. Alcohol: public knowledge, attitudes and behaviours. Dublin: Health Research Board 2012. <https://www.drugsandalcohol.ie/18022/>
- 66 Buykx P, Li J, Gavens L, *et al.* Public awareness of the link between alcohol and cancer in England in 2015: a population-based survey. *BMC Public Health* 2016;**16**. <http://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-016-3855-6>
- 67 Puddey IB, Mori TA, Barden AE, *et al.* Alcohol and hypertension—new insights and lingering controversies. *Curr Hypertens Rep* 2019;**21**:1-10.
- 68 Berkey CS, Willett WC, Frazier AL, *et al.* Prospective study of adolescent alcohol consumption and risk of benign breast disease in young women. *Pediatrics* 2010;**125**:e1081-7. doi:10.1542/peds.2009-2347
- 69 Liu Y, Tamimi RM, Berkey CS, *et al.* Intakes of alcohol and folate during adolescence and risk of proliferative benign breast disease. *Pediatrics* 2012;**129**:e1192-8.
- 70 Critchlow N, Moodie C. Consumer protection messages in alcohol marketing on Twitter in Ireland: a content analysis. *Drugs Educ Prev Policy* 2022;**Early online**. <https://www.drugsandalcohol.ie/35588/>
- 71 Critchlow N, Jones D, Moodie C, *et al.* Awareness of product-related information, health messages and warnings on alcohol packaging among adolescents: a cross-sectional survey in the United Kingdom. *J Public Health* 2020;**42**:e223-30. doi:10.1093/pubmed/fdz080
- 72 Redmond S, Devaney E. Drug and alcohol-related knowledge, attitudes and behaviour: a study of early school leavers in the West of Ireland. *Youth Stud Irel* 2010;**5**. <https://www.drugsandalcohol.ie/15896/>
- 73 McAleer A, Daly A, Leary S, *et al.* A peer-led survey of student alcohol behaviours and motives in undergraduate students. *Ir J Med Sci* 2021;Early online. <https://www.drugsandalcohol.ie/33644/>
- 74 O'Coinneide Cullen C, Mannix McNamara P. An exploration into the prevalence of alcohol use and the values, beliefs and needs of adolescents who engage in regular alcohol use within the Limerick and North Tipperary regions. *NIHS Res Bull* 2014;**7**:40 p. <https://www.drugsandalcohol.ie/22640/>
- 75 Okakpu E, McDonnell S, McHugh R. Alcohol study 2016. A study commissioned by Ballyfermot Local Drugs and Alcohol Task Force to understand current pattern of alcohol use within the area. Dublin: Ballyfermot Local Drugs Task Force 2016. <https://www.drugsandalcohol.ie/27662/>
- 76 Costello L. Turnaround youth: young adults (18-24) in the criminal justice system - the

- case for a distinct approach. Dublin: Irish Prison Reform Trust 2015.  
<https://www.drugsandalcohol.ie/23921/>
- 77 Hope A, Dring C, Dring J, *et al.* *The health of Irish students: College Lifestyle and Attitudinal National (CLAN) Survey; a qualitative evaluation of the College Alcohol Policy Initiative.* Dublin: Health Promotion Unit, Department of Health and Children 2005. <https://www.drugsandalcohol.ie/3877/>
- 78 European Monitoring Centre for Drugs and Drug Addiction. European drug report 2021: trends and developments. Luxembourg: Publications Office of the European Union 2021. <https://www.drugsandalcohol.ie/34349/>
- 79 Hibell B, Guttormsson U, Ahlstrom S, *et al.* The 2007 ESPAD report. Substance use among students in 35 countries. Stockholm: The Swedish Council for Information on Alcohol and Other Drugs (CAN); EMCDDA; Council of Europe 2009.  
<https://www.drugsandalcohol.ie/11930/>
- 80 European Monitoring Centre for Drugs and Drug Addiction. Cannabis legislation in Europe: an overview. Luxembourg: Publications Office of the European Union 2017.  
<https://www.drugsandalcohol.ie/27071/>
- 81 Gavin A, Kolto A, Kelly C, *et al.* Trends in health behaviours, health outcomes and contextual factors between 1998–2018: findings from the Irish Health Behaviour in School-aged Children Study. Dublin: Department of Health 2021.  
<https://www.drugsandalcohol.ie/33868/>
- 82 Barrett P, Bradley C. Attitudes and perceived risk of cannabis use in Irish adolescents. *Ir J Med Sci* 2016;**185**:643–7. <https://www.drugsandalcohol.ie/25818/>
- 83 European Monitoring Centre for Drugs and Drug Addiction. MDMA ('Ecstasy') drug profile. *Eur. Monit. Cent. Drugs Drug Addict.* <https://www.emcdda.europa.eu/publications/drug-profiles/mdma> (accessed 21 Dec 2021).
- 84 Health Service Executive. HSE drugs.ie. [www.drugs.ie](http://www.drugs.ie) (accessed 22 Dec 2021).
- 85 European Monitoring Centre for Drugs and Drug Addiction. European drug report 2020: trends and developments. Luxembourg: Publications Office of the European Union 2020. <https://www.drugsandalcohol.ie/33049/>
- 86 Houghton F, Keane N, Murphy N, *et al.* 12 month prevalence of drug use among third-level students in Limerick City. *Ir Med J* 2011;**104**.  
<https://www.drugsandalcohol.ie/15300/>
- 87 Keeley H, Mongwa T, Corcoran P. The association between parental and adolescent substance misuse: findings from the Irish CASE study. *Ir J Psychol Med* 2015;**32** 1:107–16.
- 88 European Monitoring Centre for Drugs and Drug Addiction. Cocaine and crack drug profile. *Eur. Monit. Cent. Drugs Drug Addict.* <https://www.emcdda.europa.eu/publications/drug-profiles/cocaine> (accessed 21 Dec 2021).
- 89 O'Reilly L, Mac Cionnaith C. Crack cocaine use in Ballymun: an evidence base for interventions. Dublin: Ballymun Youth Action Project 2019.  
<https://www.drugsandalcohol.ie/31345/>
- 90 Connolly J, Foran S, Donovan AM, *et al.* Crack cocaine in the Dublin region: An evidence base for a crack cocaine strategy. Health Research Board 2008.  
<https://www.drugsandalcohol.ie/11512/>
- 91 European Monitoring Centre for Drugs and Drug Addiction. Problem amphetamine and methamphetamine use in Europe. Luxembourg: Publications Office of the European Union 2010. <https://www.drugsandalcohol.ie/14181/>



- 92 United Nations Office on Drugs and Crime. World drug report 2019. Vienna: United Nations Office on Drugs and Crime 2019. <https://www.drugsandalcohol.ie/30717/>
- 93 European Monitoring Centre for Drugs and Drug Addiction. New benzodiazepines in Europe - a review. Luxembourg: Publications Office of the European Union 2021. <https://www.drugsandalcohol.ie/34350/>
- 94 Duffin T, Keane M, Millar SR. Street tablet use in Ireland: a Trendspotter study on use, markets, and harms. Dublin: Ana Liffey Drug Project 2020. <https://www.drugsandalcohol.ie/31872/>
- 95 Bellerose D, Lyons S, Carew AM, *et al.* Problem benzodiazepine use in Ireland: treatment (2003 to 2008) and deaths (1998 to 2007). Appendix. HRB Trends Series 9. Dublin: Health Research Board 2010. <https://www.drugsandalcohol.ie/14288/>
- 96 European Monitoring Centre for Drugs and Drug Addiction. Lysergide (LSD) drug profile. Eur. Monit. Cent. Drugs Drug Addict. <https://www.emcdda.europa.eu/publications/drug-profiles/lsd> (accessed 21 Dec 2021).
- 97 European Monitoring Centre for Drugs and Drug Addiction. Hallucinogenic mushrooms. Lisbon: European Monitoring Centre for Drugs and Drug Addiction 2006. <https://www.drugsandalcohol.ie/11656/>
- 98 European Monitoring Centre for Drugs and Drug Addiction. Report on the risk assessment of ketamine in the framework of the joint action on new synthetic drugs. Luxembourg: Office for Official Publications of the European Communities 2002. <https://www.drugsandalcohol.ie/11640/>
- 99 European Monitoring Centre for Drugs and Drug Addiction. European drug report 2020: key issues summary. Luxembourg: Publications Office of the European Union 2020. <https://www.drugsandalcohol.ie/33051/>
- 100 Hay G, Jaddoa A, Oyston J, *et al.* Estimating the prevalence of problematic opiate use in Ireland using indirect statistical methods. Dublin: National Advisory Committee on Drugs and Alcohol 2017. <https://www.drugsandalcohol.ie/27233/>
- 101 Thanki D, Vicente J. PDU (Problem drug use) revision summary. Lisbon: European Monitoring Centre for Drugs and Drug Addiction 2013. <https://www.drugsandalcohol.ie/27693/>
- 102 Comiskey C. Estimating the prevalence of opiate drug use in Dublin, Ireland during 1996. Dublin: Department of Health and Children 1998. <https://www.drugsandalcohol.ie/5080/>
- 103 Kelly A, Carvalho M, Teljeur C, *et al.* Prevalence of opiate use in Ireland 2000–2001: a 3-source capture recapture study. Dublin: National Advisory Committee on Drugs 2003. <https://www.drugsandalcohol.ie/5942/>
- 104 Kelly A, Teljeur C, Carvalho M, *et al.* Prevalence of opiate use in Ireland 2006: a 3-source capture recapture study. Dublin: National Advisory Committee on Drugs 2009. <https://www.drugsandalcohol.ie/12695/>
- 105 European Monitoring Centre for Drugs and Drug Addiction. European drug report 2018 trends and developments. Luxembourg: Publications Office of the European Union 2018. <https://www.drugsandalcohol.ie/29135/>
- 106 European Monitoring Centre for Drugs and Drug Addiction. Volatile substances drug profile. Eur. Monit. Cent. Drugs Drug Addict. <https://www.emcdda.europa.eu/publications/drug-profiles/volatile> (accessed 21 Dec 2021).
- 107 Blanchardstown Local Drug and Alcohol Task Force. Drug and Alcohol Trends Monitoring System (DATMS) 2020: year 5. Dublin: Blanchardstown Local Drug and

- Alcohol Task Force 2020. <https://www.drugsandalcohol.ie/33563/>
- 108 Van Hout MC, Connor S. Solvent use among young Irish adolescents: a growing concern for youth workers, teachers and parents? *Drugs Alcohol Today* 2008;**8**:27–37. <https://www.drugsandalcohol.ie/12290/>
- 109 European Monitoring Centre for Drugs and Drug Addiction. EMCDDA operating guidelines for the European Union Early Warning System on new psychoactive substances. Luxembourg: Publications Office of the European Union 2019. <https://www.drugsandalcohol.ie/31486/>
- 110 Smyth BP. Head shops and new psychoactive substances: a public health perspective. *Ir J Psychol Med* 2021;**Early online**:1–8. <https://www.drugsandalcohol.ie/33687/>
- 111 Smyth BP, Daly A, Elmusharaf K, *et al.* Legislation targeting head shops selling new psychoactive substances and changes in drug-related psychiatric admissions: a national database study. *Early Interv Psychiatry* 2020;**14**:53–60. <https://www.drugsandalcohol.ie/30436/>
- 112 Smyth BP, James P, Cullen W, *et al.* ‘So prohibition can work?’ Changes in use of novel psychoactive substances among adolescents attending a drug and alcohol treatment service following a legislative ban. *Int J Drug Policy* 2015;**26**:887–9. <https://www.drugsandalcohol.ie/24190/>
- 113 Smyth BP, O’Farrell A, Cullen W. Drug-related medical hospital admissions during and after a period of head shop expansion. *Eur J Public Health* 2021;**31**:285–91. <https://www.drugsandalcohol.ie/33275/>
- 114 Smyth BP, Lyons S, Cullen W. Decline in new psychoactive substance use disorders following legislation targeting headshops: Evidence from national addiction treatment data. *Drug Alcohol Rev* 2017;**36**:609–17. <https://www.drugsandalcohol.ie/27172/>
- 115 Ivers J-H, Killeen N, Keenan E. Drug use, harm-reduction practices and attitudes toward the utilisation of drug safety testing services in an Irish cohort of festival-goers. *Ir J Med Sci* 2021;**Early online**. <https://www.drugsandalcohol.ie/34860/>
- 116 Gamage N, Darker CD, Smyth BP. Improvement in psychological wellbeing among adolescents with a substance use disorder attending an outpatient treatment programme. *Ir J Psychol Med* 2021;**Early online**. <https://www.drugsandalcohol.ie/34026/>
- 117 Haase T, Pratschke J, National Advisory Committee on Drugs. Risk and protection factors for substance use among young people: a comparative study of early school-leavers and school-attending students. Dublin: Stationery Office 2010. <https://www.drugsandalcohol.ie/14100/>
- 118 Drummond A, Codd M, Donnelly N, *et al.* Study on the prevalence of drug use, including intravenous drug use, and blood-borne viruses among the Irish prisoner population. Dublin: National Advisory Committee on Drugs and Alcohol 2014. <https://www.drugsandalcohol.ie/21750/>
- 119 Horgan JJ, Probation Service. Drug and alcohol misuse among young offenders on probation supervision in Ireland: findings from the Drugs and Alcohol Survey 2012. Dublin: Probation Service 2013. <https://www.drugsandalcohol.ie/21333/>
- 120 Rooney L. Informing & supporting change: drug and alcohol misuse among people on probation supervision in Ireland. Dublin: Probation Service 2021. <https://www.drugsandalcohol.ie/35133/>
- 121 Oberstown Children Detention Campus. Key characteristics of young people in detention: a snapshot (Q1, 2019). Dublin: Oberstown Children Detention Campus 2019.

- <https://www.drugsandalcohol.ie/31176/>
- 122 Sarma K. Drug use amongst lesbian, gay, bisexual and transgender young adults in Ireland. Dublin: BeLong to Youth Project 2007. <https://www.drugsandalcohol.ie/6202/>
- 123 Barrett P, O'Donnell K, Fitzgerald M, *et al.* Drug use among men who have sex with men in Ireland: Prevalence and associated factors from a national online survey. *Int J Drug Policy* 2019;**64**:5–12. <https://www.drugsandalcohol.ie/30028/>
- 124 O'Reilly F, Barror S, Hannigan A, *et al.* Homelessness: an unhealthy state. Health status, risk behaviours and service utilisation among homeless people in two Irish cities. Dublin: The Partnership for Health Equality 2015. <https://www.drugsandalcohol.ie/24541/>
- 125 Good Shepherd Services; Cork Simon Community, Cork Simon Community. Women's health and homelessness in Cork. A joint snapshot study of the health and related needs of women who are homeless in Cork 04 – 10 July 2011. Cork: Cork Simon Community 2011. <https://www.drugsandalcohol.ie/16071/>
- 126 Mayock P, Carr N. Not just homelessness... A study of 'out of home young people in Cork.' Cork: Health Service Executive South 2008. <https://www.drugsandalcohol.ie/6377/>
- 127 Bruton L, Featherstone T, Gibney S, *et al.* Impact of COVID-19 on drug and alcohol services and people who use drugs in Ireland: a report of survey findings. Dublin: Government of Ireland 2021. <https://www.drugsandalcohol.ie/34128/>
- 128 Research Evidence into Policy, Programmes and Practice project, University of Limerick. How are young people participating in Garda Youth Diversion Projects responding to the Covid-19 public health measures ? A local to national qualitative profile: report 1. Dublin: Department of Justice and Equality and Department of Children 2020. <https://www.drugsandalcohol.ie/32053/>
- 129 Steinberg L. A Social Neuroscience Perspective on Adolescent Risk-Taking. *Dev Rev DR* 2008;**28**:78–106. doi:10.1016/j.dr.2007.08.002
- 130 Smyth E, Darmody M. Risk and protective factors in adolescent behaviour: The role of family, school and neighbourhood characteristics in (mis)behaviour among young people. Dublin: Economic and Social Research Institute 2021. <https://www.drugsandalcohol.ie/34177/>
- 131 Delaney L, Harmon C, Milner C, *et al.* Perception of excessive drinking among Irish college students: a mixed methods analysis. Dublin: University College Dublin 2007. <https://www.drugsandalcohol.ie/14258/>
- 132 Palmer D, O'Reilly G. Young people, alcohol and drugs. Dublin: Juvenile Mental Health Matters 2008. <https://www.drugsandalcohol.ie/5983/>
- 133 Cosco TD, Morgan K, Currie L, *et al.* Early-onset drinking in Ireland: negative outcomes and behaviours. *Public Health* 2013;**127**:788–90. <https://www.drugsandalcohol.ie/21702/>
- 134 Smyth BP, Hannigan A, Cullen W. Cocaine use in young adults: correlation with early onset cannabis, alcohol and tobacco use. *Ir Med J* 2016;**109**. <https://www.drugsandalcohol.ie/26254/>
- 135 Houghton F, Keane N, Murphy N, *et al.* Alcohol use among third-level students in Limerick City. *NIHS Res Bull* 2010;**5**:104–5. <https://www.drugsandalcohol.ie/15365/>
- 136 Economic, Social Research Institute TCD. Growing up in Ireland. Key findings: child cohort at 17/18 years. No. 4: risky health behaviours and sexual activity. Dublin:

- Economic and Social Research Institute 2016. <https://www.drugsandalcohol.ie/26344/>
- 137 Ipsos MRBI. Healthy Ireland survey 2018 summary of findings. Dublin: Government Publications 2018. <https://www.drugsandalcohol.ie/29851/>
- 138 All Ireland Traveller Health Study Team; School of Public Health, Physiotherapy and Population Science, University College Dublin, School of Public Health Physiotherapy, Population Science University College Dublin. All Ireland Traveller Health Study summary of findings. Our Geels. Dublin: Department of Health and Children 2010. <https://www.drugsandalcohol.ie/13791/>
- 139 McMahon EM, O'Regan G, Corcoran P, *et al.* Young lives in Ireland: a school-based study of mental health and suicide prevention. Cork: National Suicide Research Foundation 2017. <https://www.drugsandalcohol.ie/27153/>
- 140 Cotter P, Corcoran P, McCarthy J, *et al.* Victimization and psychosocial difficulties associated with sexual orientation concerns: a school-based study of adolescents. *Ir Med J* 2014;**107**:310–3. <https://www.drugsandalcohol.ie/23090/>
- 141 Dash GF, Slutske WS, Martin NG, *et al.* Big Five personality traits and alcohol, nicotine, cannabis, and gambling disorder comorbidity. *Psychol Addict Behav* 2019;**33**:420–9. doi:10.1037/adb0000468
- 142 Adan A, Forero DA, Navarro JF. Personality Traits Related to Binge Drinking: A Systematic Review. *Front Psychiatry* 2017;**8**. doi:10.3389/fpsy.2017.00134
- 143 Redmond S. *Exploration into the drug and alcohol related knowledge, attitudes and behaviours of early school leavers aged 15–20 years in the west of Ireland.* 2008. <https://www.drugsandalcohol.ie/4539/>
- 144 Okakpu E, McDonnell S. Alcohol survey 2015. A study of pattern and trend of alcohol use within Canal Communities Drug & Alcohol Task Force areas (Bluebell, Inchicore and Rialto). Dublin: Canal Communities Local Drugs and Alcohol Task Force 2015. <https://www.drugsandalcohol.ie/31303/>
- 145 Mays D, DePadilla L, Thompson NJ, *et al.* Sports Participation and Problem Alcohol Use: A Multi-Wave National Sample of Adolescents. *Am J Prev Med* 2010;**38**:491–8. doi:10.1016/j.amepre.2010.01.023
- 146 Kwan M, Bobko S, Faulkner G, *et al.* Sport participation and alcohol and illicit drug use in adolescents and young adults: a systematic review of longitudinal studies. *Addict Behav* 2014;**39**:497–506. <https://www.drugsandalcohol.ie/24326/>
- 147 Lorente FO, Souville M, Griffet J, *et al.* Participation in sports and alcohol consumption among French adolescents. *Addict Behav* 2004;**29**:941–6. doi:10.1016/j.addbeh.2004.02.039
- 148 O'Farrell A, Allwright S, Kenny S, *et al.* Alcohol use among amateur sportsmen in Ireland. *BMC Res Notes* 2010;**3**. <https://www.drugsandalcohol.ie/14227/>
- 149 Brellenthin AG, Lee D. Physical activity and the development of substance use disorders: current knowledge and future directions. *Prog Prev Med* 2018;**3**:e0018.
- 150 Western Region Drug and Alcohol Task Force, Planet Youth, Planet Youth. Growing up in the west: county report Mayo. Galway: WRDATF 2019. <https://www.drugsandalcohol.ie/30531/>
- 151 Millar SR, Mongan D, O'Dwyer C, *et al.* Correlates of patterns of cannabis use, abuse and dependence: evidence from two national surveys in Ireland. *Eur J Public Health* 2021;**31**:441–7. <https://academic.oup.com/eurpub/advance-article/doi/10.1093/eurpub/ckab007/6149005?searchresult=1>

- 152 North Inner City Drug and Alcohol Task Force. Just saying... the views of young people about drugs and alcohol. Dublin: North Inner City Drug and Alcohol Task Force 2015. <https://www.drugsandalcohol.ie/24680/>
- 153 van Schalkwyk MCI, Petticrew M, Maani N, *et al.* Distilling the curriculum: an analysis of alcohol industry-funded school-based youth education programmes. *PLoS ONE* 2022;**17**. <https://www.drugsandalcohol.ie/35481/>
- 154 Madden M, McCambridge J. Alcohol marketing versus public health: David and Goliath? *Glob Health* 2021;**17**:45. doi:10.1186/s12992-021-00696-2
- 155 Bellis MA, Phillips-Howard PA, Hughes K, *et al.* Teenage drinking, alcohol availability and pricing: a cross-sectional study of risk and protective factors for alcohol-related harms in school children. *BMC Public Health* 2009;**9**:380. doi:10.1186/1471-2458-9-380
- 156 Raitasalo K, Kraus L, Bye EK, *et al.* Similar countries, similar factors? Studying the decline of heavy episodic drinking in adolescents in Finland, Norway and Sweden. *Addiction* 2021;**116**:62–71. doi:10.1111/add.15089
- 157 Van Hout MC, Connor S. An analysis of adolescent drug and alcohol use in County Carlow, commissioned by CANDO Community Partnership. Carlow: CANDO Community Partnership 2006. <https://www.drugsandalcohol.ie/6070/>
- 158 Jernigan D, Noel J, Landon J, *et al.* Alcohol marketing and youth alcohol consumption: a systematic review of longitudinal studies published since 2008. *Addiction* 2017;**112**:7–20.
- 159 Sargent JD, Babor TF. The Relationship Between Exposure to Alcohol Marketing and Underage Drinking Is Causal. *J Stud Alcohol Drugs Suppl* 2020;;113–24. doi:10.15288/jsads.2020.s19.113
- 160 Brown K. Association between alcohol sports sponsorship and consumption: a systematic review. *Alcohol Alcohol* 2016;**51**:747–55.
- 161 Department of Health. Steering Group Report on a National substance misuse strategy. Dublin: Department of Health 2012. <https://www.drugsandalcohol.ie/16908/>
- 162 Department of Community, Rural and Gaeltacht Affairs. National Drugs Strategy (interim) 2009–2016. Dublin: Department of Community, Rural and Gaeltacht Affairs 2009. <https://www.drugsandalcohol.ie/12388/>
- 163 Purves RI, Critchlow N. Alcohol marketing during the 2020 Six Nations Championship: a frequency analysis. Stirling: Scottish Health Action on Alcohol Problems; Institute of Alcohol Studies; and Alcohol Action Ireland 2021. <https://www.drugsandalcohol.ie/34911/>
- 164 Jernigan D, Ross CS. The Alcohol Marketing Landscape: Alcohol Industry Size, Structure, Strategies, and Public Health Responses. *J Stud Alcohol Drugs Suppl* 2020;;13–25. doi:10.15288/jsads.2020.s19.13
- 165 Russell AM, Davis RE, Ortega JM, *et al.* #Alcohol: Portrayals of Alcohol in Top Videos on TikTok. *J Stud Alcohol Drugs* 2021;**82**:615–22. doi:10.15288/jsad.2021.82.615
- 166 Houghton F. Easter eggs & ‘Easter eggs’: alcohol branded chocolate eggs & intoxicogenic environments in Ireland. *South East J Public Health* 2021;**XVI**. <https://www.drugsandalcohol.ie/35108/>
- 167 Critchlow N, Moodie C. Awareness of alcohol marketing one year after initial implementation of Ireland’s Public Health (Alcohol) Act and during the COVID-19 pandemic. *J Public Health* 2021;**Early online**. <https://academic.oup.com/jpubhealth/advance-article/doi/10.1093/pubmed/fdab353/6385006>

- 168 Fox CA, Kelly C, Molcho M. Alcohol marketing and young people's drinking behaviour in Ireland. Dublin: Alcohol Action Ireland 2015. <https://www.drugsandalcohol.ie/24854/>
- 169 Alcohol Action Ireland. Ireland thinks. Alcohol Action Ireland poll. Dublin: Alcohol Action Ireland 2021. <https://alcoholireland.ie/strong-public-supports-for-action-on-alcohol-advertising/>
- 170 Mills R, Mann M, Smith M, *et al.* Parental support and monitoring as associated with adolescent alcohol and tobacco use by gender and age. *BMC Public Health* 2021;**21**. doi:10.1186/s12889-021-12119-3
- 171 Kuntsche S, Kuntsche E. Parent-based interventions for preventing or reducing adolescent substance use – A systematic literature review. *Clin Psychol Rev* 2016;**45**:89–101. doi:10.1016/j.cpr.2016.02.004
- 172 Fitzgerald A, Mac Giollabhui N, Dolphin L, *et al.* Dissociable psychosocial profiles of adolescent substance users. *PLoS ONE* 2018;**13**:e0202498. <https://www.drugsandalcohol.ie/29577/>
- 173 Gavin A, Molcho M, Kelly C, *et al.* Family, peer and school relationships as predictors of tobacco, alcohol and cannabis use in Irish adolescents: differences between sustained and experimental substance use behaviour. *Natl Inst Health Sci Res Bull* 2008;**4**:s50–1. <https://www.drugsandalcohol.ie/14266/>
- 174 Whitesell M, Bachand A, Peel J, *et al.* Familial, social, and individual factors contributing to risk for adolescent substance use. *J Addict* 2013;**2013**:579310–579310. doi:10.1155/2013/579310
- 175 Calling S, Ohlsson H, Sundquist J, *et al.* Socioeconomic status and alcohol use disorders across the lifespan: A co-relative control study. *PLoS ONE* 2019;**14**:e0224127–e0224127. doi:10.1371/journal.pone.0224127
- 176 Mohamed S, Ajmal M. Multivariate analysis of binge drinking in young adult population: data analysis of the 2007 Survey of Lifestyle, Attitude and Nutrition (SLAN) in Ireland. *Psychiatry Clin Neurosci* 2015;**69**:483–8. <https://www.drugsandalcohol.ie/23535/>
- 177 Kerr RA. Adolescent males in secondary school in Ireland: alcohol use and depressed mood. *Ir J Appl Soc Stud* 2013;**13**. <https://www.drugsandalcohol.ie/21266/>
- 178 Probst C, Kilian C, Sanchez S, *et al.* The role of alcohol use and drinking patterns in socioeconomic inequalities in mortality: a systematic review. *Lancet Public Health* 2020;**5**:e324–32. doi:10.1016/S2468-2667(20)30052-9
- 179 Bandura A, McClelland DC. *Social learning theory*. Englewood Cliffs Prentice Hall 1977.
- 180 Yap MB, Cheong TW, Zaravinos-Tsakos F, *et al.* Modifiable parenting factors associated with adolescent alcohol misuse: a systematic review and meta-analysis of longitudinal studies. *Addiction* 2017;**112**:1142–62.
- 181 Murphy E, O'Sullivan I, O'Donovan D, *et al.* The association between parental attitudes and alcohol consumption and adolescent alcohol consumption in Southern Ireland: a cross-sectional study. *BMC Public Health* 2016;**16**:821. <https://www.drugsandalcohol.ie/26014/>
- 182 Skeer M, McCormick MC, Normand S-LT, *et al.* A prospective study of familial conflict, psychological stress, and the development of substance use disorders in adolescence. *Drug Alcohol Depend* 2009;**104**:65–72. doi:10.1016/j.drugaldep.2009.03.017
- 183 Tael-Öeren M, Naughton F, Sutton S. The relationship between parental attitudes and children's alcohol use: a systematic review and meta-analysis. *Addiction* 2019;**114**:1527–46. doi:10.1111/add.14615

- 184 Friese B, Grube JW, Moore RS, *et al.* Parents' rules about underage drinking: a qualitative study of why parents let teens drink. *J Drug Educ* 2012;**42**:379–91. doi:10.2190/DE.42.4.a
- 185 Jackson C, Ennett ST, Dickinson DM, *et al.* Letting children sip: understanding why parents allow alcohol use by elementary school-aged children. *Arch Pediatr Adolesc Med* 2012;**166**:1053–7. doi:10.1001/archpediatrics.2012.1198
- 186 Aiken A, Clare PJ, Boland VC, *et al.* Parental supply of sips and whole drinks of alcohol to adolescents and associations with binge drinking and alcohol-related harms: A prospective cohort study. *Drug Alcohol Depend* 2020;**215**:108204.
- 187 Sharmin S, Kypri K, Khanam M, *et al.* Parental supply of alcohol in childhood and risky drinking in adolescence: systematic review and meta-analysis. *Int J Environ Res Public Health* 2017;**14**:287.
- 188 Mattick RP, Clare PJ, Aiken A, *et al.* Association of parental supply of alcohol with adolescent drinking, alcohol-related harms, and alcohol use disorder symptoms: a prospective cohort study. *Lancet Public Health* 2018;**3**:e64–71. doi:10.1016/S2468-2667(17)30240-2
- 189 McLaughlin A, O'Neill T, McCartan C, *et al.* Parental Alcohol Use and Resilience in Young People in Northern Ireland: A study of family, peer and school processes. *Policy* 2015;**12**:13.
- 190 Western Region Drug and Alcohol Task Force. Guidelines for parents. Galway: Western Region Drug and Alcohol Task Force 2021. <https://www.drugsandalcohol.ie/34502/>
- 191 Musher-Eizenman DR, Holub SC, Arnett M. Attitude and peer influences on adolescent substance use: The moderating effect of age, sex, and substance. *J Drug Educ* 2003;**33**:1–23.
- 192 Darker CD, Palmer D, O'Reilly G, *et al.* Young people in drug treatment in Ireland: their views on substance use aetiology, trajectory, parents' role in substance use and coping skills. *Ir J Psychol Med* 2015;**32**:247–58. <https://www.drugsandalcohol.ie/23180/>
- 193 Fitzgerald A, Maguire J, Dooley B. Substance misuse and behavioral adjustment problems in Irish adolescents: examining contextual risk and social proximal factors. *Subst Use Misuse* 2016;**51**:1790–809. <https://www.drugsandalcohol.ie/26022/>
- 194 Scheer SD, Borden LM, Donnermeyer JF. The relationship between family factors and adolescent substance use in rural, suburban, and urban settings. *J Child Fam Stud* 2000;**9**:105–15.
- 195 Bond L, Butler H, Thomas L, *et al.* Social and school connectedness in early secondary school as predictors of late teenage substance use, mental health, and academic outcomes. *J Adolesc Health* 2007;**40**:357–e9.
- 196 Apantaku-Olajide T, James P, Smyth BP. Association of educational attainment and adolescent substance use disorder in a clinical sample. *J Child Adolesc Subst Abuse* 2014;**23**:169–76. <https://www.drugsandalcohol.ie/21868/>
- 197 Wright C, Kipping R, Hickman M, *et al.* Effect of multiple risk behaviours in adolescence on educational attainment at age 16 years: a UK birth cohort study. *BMJ Open* 2018;**8**:e020182.
- 198 Nelis SM, Gilleece L, Fitzgerald C, *et al.* Beyond Achievement: home, school and wellbeing findings from PISA 2018 for students in DEIS and non-DEIS schools. Dublin: Educational Research Centre 2021. <https://www.drugsandalcohol.ie/34499/>
- 199 Lees B, Meredith LR, Kirkland AE, *et al.* Effect of alcohol use on the adolescent brain

- and behavior. *Pharmacol Biochem Behav* 2020;**192**:172906–172906. doi:10.1016/j.pbb.2020.172906
- 200 World Health Organization. Preventing youth violence: an overview of the evidence. Geneva: World Health Organization 2015. <https://www.drugsandalcohol.ie/24701/>
- 201 Goodman A. Substance use and common child mental health problems: examining longitudinal associations in a British sample. *Addiction* 2010;**105**:1484–96.
- 202 American Psychiatric Association. *Diagnostic and statistical manual of mental disorders* : DSM-IV-TR. American Psychiatric Publishing, Inc 2000.
- 203 Shirinbayan P, Salavati M, Soleimani F, *et al*. The Psychometric Properties of the Drug Abuse Screening Test. *Addict Health* 2020;**12**:25–33. doi:10.22122/ahj.v12i1.256
- 204 Giguère C-É, Potvin S, Signature Consortium. The Drug Abuse Screening Test preserves its excellent psychometric properties in psychiatric patients evaluated in an emergency setting. *Addict Behav* 2017;**64**:165–70.
- 205 Evren C, Can Y, Yilmaz A, *et al*. Psychometric properties of the Drug Abuse Screening Test (DAST-10) in heroin dependent adults and adolescents with drug use disorder. *Dusunen Adam J Psychiatry Neurol Sci* 2013;**26**:351–9. doi:10.5350/DAJPN2013260404
- 206 Libby AM, Orton HD, Stover SK, *et al*. What came first, major depression or substance use disorder? Clinical characteristics and substance use comparing teens in a treatment cohort. *Addict Behav* 2005;**30**:1649–62.
- 207 Lyne J, O'Donoghue B, Clancy M, *et al*. Concurrent cocaine and alcohol use in individuals presenting to an addiction treatment program. *Ir J Med Sci* 2009;**179**:233–7. <https://www.drugsandalcohol.ie/12709/>
- 208 Lyne J, O Donoghue B, Clancy M, *et al*. Comorbid psychiatric diagnoses among individuals presenting to an addiction treatment program for alcohol dependence. *Subst Use Misuse* 2011;**46**:351–8. <https://www.drugsandalcohol.ie/14717/>
- 209 Rochford S, Morgan M, Quinn D, *et al*. Youth mental health in Ireland and Northern Ireland. An AcCESs evidence report. Dublin: Centre for Effective Services 2018. <https://www.drugsandalcohol.ie/29188/>
- 210 Schaffalitzky E, Leahy D, Armstrong C, *et al*. 'Nobody really gets it': a qualitative exploration of youth mental health in deprived urban areas. *Early Interv Psychiatry* 2015;**9**:406–11. <https://www.drugsandalcohol.ie/22191/>
- 211 Galaif ER, Sussman S, Newcomb MD, *et al*. Suicidality, depression, and alcohol use among adolescents: a review of empirical findings. *Int J Adolesc Med Health* 2007;**19**:27.
- 212 Deasy C, Coughlan B, Pironom J, *et al*. Predictors of health of pre-registration nursing and midwifery students: findings from a cross-sectional survey. *Nurse Educ Today* 2016;**36**:427–33. <https://www.drugsandalcohol.ie/25129/>
- 213 MacDonald R, Marsh J. Crossing the Rubicon: Youth transitions, poverty, drugs and social exclusion. *Int J Drug Policy* 2002;**13**:27–38.
- 214 Griswold MG, Fullman N, Hawley C, *et al*. Alcohol use and burden for 195 countries and territories, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016. *The Lancet* 2018;**392**:1015–35.
- 215 Murphy OC, Kelleher C, Malone K. Demographic trends in suicide in the UK and Ireland 1980–2010. *Ir J Med Sci* 2015;**184**:227–35. <https://www.drugsandalcohol.ie/21500/>
- 216 Walsh BM, Walsh D. Suicide in Ireland: the influence of alcohol and unemployment. *Econ Soc Rev* 2011;**42**:27–47. <https://www.drugsandalcohol.ie/15042/>



- 217 Griffin E, McMahon E, McNicholas F, *et al.* Increasing rates of self-harm among children, adolescents and young adults: a 10-year national registry study 2007–2016. *Soc Psychiatry Psychiatr Epidemiol* 2018;**53**:663–71. <https://www.drugsandalcohol.ie/29041/>
- 218 Arensman E, Bennardi M, Larkin C, *et al.* Suicide among young people and adults in Ireland: method characteristics, toxicological analysis and substance abuse histories compared. *PLoS ONE* 2016;**11**:e0166881.
- 219 Larkin C, Griffin E, Corcoran P, *et al.* Alcohol involvement in suicide and self-harm. *Crisis* 2017;**38**:413–22. <https://www.drugsandalcohol.ie/28375/>
- 220 McNicholl B, Goggin D, O'Donovan D. Alcohol-related presentations to emergency departments in Ireland: a descriptive prevalence study. *BMJ Open* 2018;**8**. <https://www.drugsandalcohol.ie/29070/>
- 221 Hope A, Gill A, Costello G, *et al.* Alcohol and injuries in the accident and emergency department: a national perspective. Dublin: Health Promotion Unit, Department of Health and Children 2005. <https://www.drugsandalcohol.ie/6006/>
- 222 National Centre for Classification in Health (Australia). *The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM)*. National Centre for Classification in Health 2004.
- 223 Health Research Board. National Drug-Related Deaths Index 2008 to 2017 data. Health Research Board 2019. <https://www.drugsandalcohol.ie/31275/>
- 224 Central Statistics Office. Vital Statistics Annual Report 2017: Central Statistics Office, 2017. Available from: <https://www.cso.ie/en/releasesandpublications/ep/p-vsar/vitalstatisticsannualreport2017/deaths2017>.
- 225 Mongan D, Hope A, Nelson M, *et al.* Social consequences of harmful use of alcohol in Ireland. HRB Overview series 9. Dublin: Health Research Board 2009. <https://www.drugsandalcohol.ie/12653/>
- 226 Martyn M. Drug and alcohol misuse among adult offenders. Findings from the drugs and alcohol survey 2011. Meath: Probation Service 2012. <https://www.drugsandalcohol.ie/18746/>
- 227 Power CL. Moving forward together: mental health among persons supervised by the Probation Service. Dublin: Probation Service 2021. <https://www.drugsandalcohol.ie/33861/>
- 228 Kelleher C, Carew AM, Lyons S. National Drug Treatment Reporting System 2014 – 2020 drug treatment data. Dublin: Health Research Board 2021. <https://www.drugsandalcohol.ie/34162/>
- 229 Medical Bureau of Road Safety. Medical Bureau of Road Safety annual report 2020. Dublin: Medical Bureau of Road Safety 2022. <https://www.drugsandalcohol.ie/35452/>
- 230 Road Safety Authority. Road deaths and alcohol 2013–2017. Dublin: Road Safety Authority 2020. <https://www.drugsandalcohol.ie/33937/>
- 231 O'Mahony J. Driver attitudes & behaviour survey 2020. Dublin: Road Safety Authority 2021. <https://www.drugsandalcohol.ie/35077/>
- 232 O'Mahony J. RSA alcohol and driving research 2017. Dublin: Road Safety Authority 2017. <https://www.drugsandalcohol.ie/28415/>
- 233 Bowden M. The drug economy and youth interventions: an exploratory research project on working with young people involved in the illegal drugs trade. Dublin:

- Citywide 2019. <https://www.drugsandalcohol.ie/30487/>
- 234 Department of Children and Youth Affairs. Lifting the lid on Greentown. – Why we should be concerned about the influence criminal networks have on children’s offending behaviour in Ireland. Dublin: Government Publications 2016. <https://www.drugsandalcohol.ie/26850/>
- 235 O’Meara Daly E, Redmond S, Naughton C. Lifting the lid on Bluetown: a replication case study, which investigates the contribution of engagement in a local criminal network to young people’s more serious and persistent offending patterns. Limerick: School of Law, University of Limerick 2020. <https://www.drugsandalcohol.ie/33694/>
- 236 Naughton C, Redmond S, O’Meara Daly E. Lifting the lid on Redtown: a replication case study, which investigates the contribution of engagement in a local criminal network to young people’s more serious and persistent offending patterns. Limerick: School of Law, University of Limerick 2020. <https://www.drugsandalcohol.ie/33693/>
- 237 Davoren MP, Shiely F, Byrne M, *et al.* Hazardous alcohol consumption among university students in Ireland: a cross-sectional study. *BMJ Open* 2015;5:e006045. <https://www.drugsandalcohol.ie/23350/>
- 238 Cahill E, Byrne M. Alcohol and drug use in students attending a student health centre. *Ir Med J* 2010;**103**:230–3. <https://www.drugsandalcohol.ie/14043/>
- 239 Byrnes E, MacNeela P. SHAG report 2017. Sexual health and attitudes, Galway. Galway: NUI Galway 2017. <https://www.drugsandalcohol.ie/28382/>
- 240 Mongan D, Long J. Alcohol in Ireland: consumption, harm, cost and policy response. Dublin: Health Research Board 2016. <https://www.drugsandalcohol.ie/25697/>
- 241 Hope A. Alcohol’s harm to others in Ireland. Dublin: Health Service Executive 2014. <https://www.drugsandalcohol.ie/21590/>
- 242 Cousins G, McGee H, Layte R. Suppression effects of partner type on the alcohol-risky sex relationship in young Irish adults. *J Stud Alcohol Drugs* 2010;**71**:357–65. <https://www.drugsandalcohol.ie/13412/>
- 243 Burke L O’Higgins, S, Mclvor, C, Dawson, K, O’Donovan, R, MacNeela, P. The Active\*Consent/Union of Students in Ireland Sexual Experiences Survey 2020: Sexual violence and harassment experiences in a national survey of higher education institutions. 2020. <https://www.drugsandalcohol.ie/32244/>
- 244 MacNeela P, Dawson K, O’Rourke T, *et al.* Surveys of experiences of sexual violence and harassment in higher education: reports and findings. Dublin: Higher Education Authority 2022. <https://www.drugsandalcohol.ie/35563/>
- 245 Health Research Board. National Drug Treatment Reporting System (NDTRS) data [Ireland]. Published Online First: 2020. <https://www.drugsandalcohol.ie/29240/>
- 246 O’Neill D, Carew AM, Lyons S. National Drug Treatment Reporting System 2014 – 2020 alcohol treatment data. Dublin: Health Research Board 2021. <https://www.drugsandalcohol.ie/34164/>
- 247 Carew AM, O’Neill D, Lyons S, *et al.* Estimating need for alcohol treatment in Ireland using national treatment surveillance data. *Ir J Med Sci* 2021;**Early online**. <https://link.springer.com/article/10.1007/s11845-021-02788-9>
- 248 Adolescent Addiction Service. Adolescent addiction service report 2018. Dublin: Health Service Executive 2018. <https://www.drugsandalcohol.ie/29358/>
- 249 Adolescent Addiction Service. Adolescent Addiction Service report 2020. Dublin: Health Service Executive 2020. <https://www.drugsandalcohol.ie/31890/>

- 250 Adolescent addiction service. Adolescent addiction service report 2021. Dublin: Health Service Executive 2021. <https://www.drugsandalcohol.ie/34099/>
- 251 Smyth BP. Treatment outcome for adolescents abusing alcohol and cannabis: how many 'reliably improve'? *Ir Med J* 2015;**108**:137–9. <https://www.drugsandalcohol.ie/23955/>
- 252 Daly A, Craig S. Annual report on the activities of Irish psychiatric units and hospitals 2020. Dublin: Health Research Board 2021. <https://www.drugsandalcohol.ie/34575/>
- 253 World Health Organization. World Health Organization ICD-10. 2019. <https://icd.who.int/browse10/2019/en>
- 254 Expert Group on Mental Health Policy. A vision for change: report of the Expert Group on Mental Health Policy. Dublin: Stationery Office 2006. <https://www.drugsandalcohol.ie/6154/>
- 255 Department of Health. Sharing the vision: a mental health policy for everyone. Dublin: Government of Ireland 2020. <https://www.drugsandalcohol.ie/32228/>
- 256 Department of Education. Social, Personal and Health Education (SPHE) programme. [https://www.curriculumonline.ie/Junior-Cycle/Junior-Cycle-Subj.-Pers.--Health-Educ.Social,PersonalandHealthEducation\(SPHE\)](https://www.curriculumonline.ie/Junior-Cycle/Junior-Cycle-Subj.-Pers.--Health-Educ.Social,PersonalandHealthEducation(SPHE))
- 257 HSE Alcohol Programme. Know the Score: substance use resource materials for senior cycle SPHE. Dublin: Health Service Executive 2019. <https://www.drugsandalcohol.ie/31359/>
- 258 HSE Alcohol Programme. Alcohol and drugs: a parent's guide. Practical advice to help you communicate with your child about alcohol and other drugs. Dublin: HSE Alcohol Programme 2018. <https://www.drugsandalcohol.ie/29435/>
- 259 Public Service Reform Programme Management Office. End Year Review of Action Plan for Education 2017. Dublin: Department of Education and Skills 2018. <https://assets.gov.ie/24350/3e3c7829d21e456094b213a654c0a69b.pdf>
- 260 Department of Education and Skills, Skills. Action plan for education 2016–2019. Dublin: Department of Education and Skills 2016. <https://www.drugsandalcohol.ie/27665/>
- 261 Davenport J, Tansey A. Outcomes of an incredible years classroom management programme with teachers from multiple schools. Dublin: National Educational Psychological Service 2009. <https://www.drugsandalcohol.ie/25601/>
- 262 Henefer J, Rodgers A. 'FRIENDS for Life': a school-based positive mental health programme. Research project overview and findings. Dublin: National Behaviour Support Service 2013. <https://www.drugsandalcohol.ie/25603/>
- 263 Davoren MP, Calnan S, Mulcahy J, *et al.* Responding to excessive alcohol consumption in third-level (REACT): a study protocol. *BMC Health Serv Res* 2018;**18**:364. <https://www.drugsandalcohol.ie/29015/>
- 264 Calnan S, Davoren MP. College students' perspectives on an alcohol prevention programme and student drinking – A focus group study. *Nord Stud Alcohol Drugs* 2021;**Early online**. doi:10.1177/14550725211007078
- 265 Department of Children, Equality, Disability, Integration and Youth. Welcome to your place your space. Your Place Your Space. <https://ubu.gov.ie/> (accessed 15 Mar 2022).
- 266 Department of Education. DEIS Delivering Equality of Opportunity in Schools. Gov. Irel. <https://www.gov.ie/en/policy-information/4018ea-deis-delivering-equality-of-opportunity-in-schools/> (accessed 15 Mar 2022).
- 267 TUSLA Child and Family Agency. Services: family & community support. TUSLA Child

- Fam. Agency. <https://www.tusla.ie/services/family-community-support/prevention-partnership-and-family-support-programme/meitheal-national-practice-model/> (accessed 15 Mar 2022).
- 268 Department of Rural and Community Development. Social Inclusion and Community Activation Programme (SICAP). gov.ie. <https://www.gov.ie/en/policy-information/6609f4-social-inclusion-and-community-activation-programme-sicap/> (accessed 15 Mar 2022).
- 269 Health Research Board. Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction. Ireland: national report for 2021 - prevention. Dublin: Health Research Board 2022. <https://www.drugsandalcohol.ie/25264/>
- 270 Smyth E, Banks J, O'sullivan J, *et al.* Evaluation of the national Youthreach programme. Dublin: ESRI 2019. <https://www.drugsandalcohol.ie/30687/>
- 271 National Strengthening Families Council of Ireland. Strengthening Families Programme 10 year outcomes in Ireland. Dublin: NSFCI 2018. <https://www.drugsandalcohol.ie/28737/>
- 272 Ivers J-H, Harris A, McKeown P, *et al.* Mothers experiences of the Parenting Under Pressure Program (PuP) in a residential therapeutic community: A qualitative study. *J Psychoactive Drugs* 2021;**53**:230-7. <https://www.drugsandalcohol.ie/33549/>
- 273 Health Service Executive, Tusla Child and Family Agency. Hidden harm practice guide. Seeing through Hidden Harm to brighter futures. Dublin: Health Service Executive and Tusla Child and Family Agency 2019. <https://www.drugsandalcohol.ie/30190/>
- 274 Health Service Executive. Making every contact count. hse.ie. <https://www.hse.ie/eng/about/who/healthwellbeing/making-every-contact-count/about/about.html> (accessed 15 Mar 2022).
- 275 O'Shea J, Goff P, Armstrong R. SAOR screening and brief intervention for problem alcohol and substance use. Dublin: Health Service Executive 2017. <https://www.drugsandalcohol.ie/27443/>
- 276 Mulcahy J. Relentless caring: trying something new. An evaluation of the targeted response with youth TRY project. Dublin: Slaintecare, Pobal and Government of Ireland 2021. <https://www.drugsandalcohol.ie/34556/>
- 277 Dillon L. The drug economy and youth interventions. *Drugnet Irel* 2019;**Issue 70, Summer 2019**:12-4. <https://www.drugsandalcohol.ie/31007/>
- 278 Irish Youth Justice Service. Garda Diversion Programme. Ir. Youth Justice Serv. <http://www.iyjs.ie/en/iyjs/pages/gardadiversionprogramme> (accessed 15 Mar 2022).
- 279 Department of Children and Youth Affairs. Better outcomes brighter futures. The national policy framework for children & young people 2014 - 2020. Dublin: Stationery Office 2014. <https://www.drugsandalcohol.ie/21773/>
- 280 Department of Children and Youth Affairs. National youth strategy 2015-2020. Dublin: Government Publications 2015. <https://www.drugsandalcohol.ie/24606/>
- 281 Department of Justice. Youth justice strategy 2021 - 2027. Dublin: Department of Justice 2021. <https://www.drugsandalcohol.ie/34061/>
- 282 Department of Children and Youth Affairs. National strategy on children and young people's participation in decision-making 2015 - 2020. Dublin: Government Publications 2015. <https://www.drugsandalcohol.ie/24612/>
- 283 Department of Children and Youth Affairs. LGBTI+ national youth strategy. Report of the consultations with young people in Ireland. Dublin: Department of Children and Youth Affairs 2017. <https://www.drugsandalcohol.ie/29130/>

- 284 Office of the Attorney General. Intoxicating Liquor Act. 2008.  
<https://www.irishstatutebook.ie/eli/2008/act/17/enacted/en/html>
- 285 Office of the Attorney General. Misuse of Drugs Act. 1984.  
<https://www.irishstatutebook.ie/eli/1984/act/18/enacted/en/html>
- 286 Office of the Attorney General. Misuse of Drugs (Supervised Injecting Facilities) Act. 2017. <https://www.irishstatutebook.ie/eli/2017/act/7/enacted/en/html>
- 287 Office of the Attorney General. Criminal Justice Act. 1994.  
<https://www.irishstatutebook.ie/eli/1994/act/15/enacted/en/html>
- 288 Office of the Attorney General. Criminal Justice (Psychoactive Substances) Act. 2010.  
<https://www.irishstatutebook.ie/eli/2010/act/22/enacted/en/html>
- 289 Department of Health. Medical cannabis access programme. Dublin: Department of Health 2020. <https://www.drugsandalcohol.ie/31653/>
- 290 Office of the Attorney General. Road Traffic Act. 1961.  
<https://www.irishstatutebook.ie/eli/1961/act/24/enacted/en/html>
- 291 Mongan D, Carew AM, O'Neill D, et al. Comparing Cannabis Use Disorder in the General Population with Cannabis Treatment Seekers Using Multi-Source National Datasets: Who Receives Treatment? Eur Addict Res 2021;:1-10.  
<https://www.drugsandalcohol.ie/34957/>



