HRB Health Research Board

The 2019–20 Irish National Drug and Alcohol Survey: Main findings

Deirdre Mongan, Seán R Millar, and Brian Galvin

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Copies of this report can be obtained from:
Health Research Board
Grattan House
67-72 Lower Mount St
Dublin 2

t + 353 1 234 5000
f + 353 1 661 1856
e hrb@hrb.ie
w www.hrb.ie

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Members of the Advisory Committee

Bobby Smyth (Health Service Executive, Chair); Brian Woods (An Garda Síochana); Sarah Waters (Department of Health); Joseph Doyle (Health Service Executive); Therese M. Molyneux (Department of Justice); Seán Millar (Health Research Board/School of Public Health, University College Cork); Barry P. Quinn (Department of Justice); Dara Murphy (Health Research Board).

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Glossary

Alcohol use disorder (AUD) – defined according to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) criteria. It is a maladaptive pattern of alcohol use leading to clinically significant impairment or distress, as manifested by 2 or more of the following 11 criteria occurring at any time in the last 12 months: role impairment; hazardous use; social problems; tolerance; withdrawal; longer or more use than intended; unsuccessful attempts to quit/cut down; much time spent using alcohol; reduced activities because of drinking; continued drinking despite psychological or physical problems; and alcohol cravings.

Area deprivation level – based on the Irish Pobal HP deprivation index that was developed by Haase and Pratschke. The index is a method of measuring the relative affluence or deprivation of a geographical area using data compiled from various censuses. A score is given to the area based on a national average of 0 and ranging from −35 (being the most deprived) to +35 (being the least deprived). For the purposes of this report, these data are presented in five quintiles, from most deprived (1) to least deprived (5).

Cannabis use disorder (CUD) – defined as any cannabis abuse or dependence in the 12 months prior to the survey, and classified according to the ***Diagnostic and Statistical Manual of Psychiatric Disorders, Fourth Edition*** (DSM-IV). 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 in 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.

Ex-drinker – a person who has consumed alcohol beyond sips or tastes in their lifetime, but who has not consumed alcohol in the last year.

Heavy episodic drinking (HED) – sometimes referred to as 'binge drinking' and defined as consuming six or more standard drinks on a single occasion. This is approximately equivalent to three pints of beer or cider, six pub measures of spirits, or just under one bottle of wine.

Illegal drugs – defined as any of the following: cannabis, ecstasy, cocaine powder, magic mushrooms, amphetamines, poppers, LSD, new psychoactive substances (NPS), solvents, crack, and heroin. Poppers and solvents are not actually illegal in Ireland, however, to ensure comparability with previous surveys they have been included in this category.

Last month prevalence – refers to the proportion of the sample that reported using a named drug in the 30-day period prior to the survey. Last month prevalence is often referred to as current use. A proportion of those reporting current use may be occasional (or first-time) users who happen to have used in the period leading up to the survey. It should therefore be noted that current use is not synonymous with regular use.

Last year prevalence – refers to the proportion of the sample that reported using a named drug in the year prior to the survey. Last year prevalence is often referred to as recent use.

Lifetime prevalence – refers to the proportion of the sample that reported ever having used the named drug at the time they were surveyed. A person who records lifetime prevalence may or may not be currently using the drug. Lifetime prevalence should not be interpreted as meaning that people have necessarily used a drug over a long period of time or that they will use the drug again in future.

New psychoactive substances (NPS) – refers to a new narcotic drug or a new psychotropic drug in its pure form or in a preparation. Many of these substances mimic the most common illegal drugs, namely cocaine, ecstasy, amphetamine, and cannabis.

Never drinker – a person who has never consumed alcohol beyond sips or tastes in their lifetime.

Never smoker – a person who does not currently smoke and has never smoked in their lifetime.

Non-drinker – a person who has not consumed alcohol in the last year. This can be a person who has never consumed alcohol in their lifetime or who has most recently consumed alcohol more than a year ago.

Non-medical use of prescribable drugs – the use of these medicines without a personal prescription, taking more tablets than prescribed, or taking tablets for a longer period or for different purposes than prescribed.

Opioid pain relievers – medicines that contain opioids such as codeine or morphine. Most of these products require a prescription, although some codeine products are available from a pharmacist without a prescription (for example, Solpadeine and Nurofen Plus).

Polydrug use – the use of more than one drug. It can be simultaneous, which is the use of two or more drugs on the same occasion, or concurrent, which is the use of two or more different substances in a given time period, such as during the last month or the last year.

Prescribable drugs – drugs that can be legally purchased from a pharmacy or chemist, usually with a prescription.

Prevalence – refers to the proportion of a population that has used a drug over a particular time period.

Sedatives and tranquillisers – medicines that can be obtained from a doctor and which are sometimes prescribed to help people sleep, calm down, or to relax their muscles.

Smoker – a person who reports currently smoking either daily or occasionally.

Standard drink – a drink that contains 10 grams of alcohol; this is the equivalent of one glass of beer, one pub measure of spirits, or 100 mL of wine.

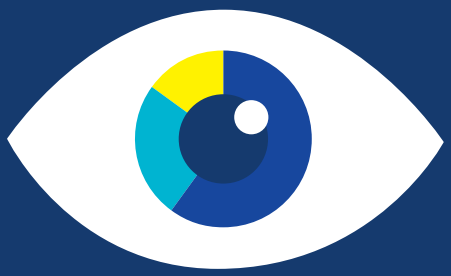
Statistically significant – a result is deemed statistically significant if it is unlikely to have occurred by chance, and hence provides enough evidence to reject the hypothesis of ‘no effect’. As used in statistics, ‘significant’ does not mean important or meaningful. A small, but important, real-world difference may fail to reach significance in a statistical test, while a statistically significant finding may have no practical consequence.

Abbreviations

AUD	alcohol use disorder
AUDIT-C	Alcohol Use Disorders Identification Test–Concise
CAPI	Computer-Assisted Personal Interviewing
CI	confidence interval
CUD	cannabis use disorder
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
DSM-IV	Diagnostic and Statistical Manual of Psychiatric Disorders, Fourth Edition
ED	electoral division
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
HED	heavy episodic drinking
HRB	Health Research Board
LSD	lysergic acid diethylamide
M-CIDI	Munich-Composite International Diagnostic Interview
NDAS	National Drug and Alcohol Survey
NPS	new psychoactive substances
OTC	over-the-counter
PSU	primary sampling unit
RDATF	Regional Drug and Alcohol Task Force

01

Introduction



The National Drug and Alcohol Survey (NDAS) collects information on alcohol and tobacco consumption and drug use among the general population in Ireland. It also surveys people's attitudes and perceptions relating to tobacco, alcohol, and other drug use and records the impact of drug use on people's communities. The 2019–20 NDAS collected information from 5,762 people aged 15 years and older across Ireland.

1.1 National drugs strategy

An Taoiseach Leo Varadkar launched *Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017–2025* on 17 July 2017. The strategy was presented as a health-led rather than a 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. The strategy defines substance misuse as "the harmful or hazardous use of psychoactive substances, including alcohol, illegal drugs and the abuse of prescription medicines".[1] 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* from 2012,[2] illegal drug use is the primary focus of many of the actions of the current strategy. The strategy covers an 8-year period (2017–2025) and is accompanied by a shorter-term action plan (2017–2020). The strategy's vision is for "A healthier and safer Ireland, where public health and safety is protected and the harms caused to individuals, families and communities by substance misuse are reduced and every person affected by substance use is empowered to improve their health and wellbeing and quality of life."

The Minister for Health continues to have overall ministerial responsibility for the national drugs strategy. The Department of Health also has a Minister of State who combines responsibility for the national drugs strategy with other policy areas within the health portfolio. Implementation of the strategy is coordinated through a National Oversight Committee, comprising senior members of the various stakeholder groups; a standing subcommittee; and various subcommittees established by the National Oversight Committee.

One of the national drugs strategy's five strategic goals is to develop sound and comprehensive evidence-informed policies and actions. The Drugs Policy and Social Inclusion Unit in the Department of Health analyses the implications of research findings for policy and the design of initiatives to tackle the drug problem, and advises on the commissioning of new research and development of new data sources.

1.2 Role of the Health Research Board

The Health Research Board (HRB) manages the commissioning of research and monitoring projects on behalf of the Department of Health and as part of its role as the Irish national focal point to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The EMCDDA provides factual, objective, reliable, and comparable information concerning

drugs, drug addiction, and their consequences. The Centre monitors the drugs situation and responses to drug-related problems in Europe. Prevalence and patterns of drug use is one of the five key epidemiological indicators used by the EMCDDA to assess the drug situation in Europe. This indicator uses a number of approaches including general population surveys and school population drug surveys, as well as innovative new approaches such as wastewater-based drug epidemiology, and targeted surveys, including web surveys. This helps with understanding patterns of use, risk perceptions, and social and health correlates, as well as the consequences of the use of illegal drugs. General population surveys are one of the key tools used by European Union member states to develop knowledge around this indicator. The 2019–20 NDAS is the fifth such study undertaken in Ireland. It will provide vital information to assess the current drug situation, map trends since 2002-03, and inform the development of responses to this situation in the coming years.

The most recent drugs strategy report, *Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017–2025*, has designated the HRB the main information hub for evidence on the drugs situation and responses.[1] Action 5.1.45 (strengthen Ireland's drug monitoring system) of this strategy gives the HRB responsibility for the EMCDDA indicators pertaining to prevalence and patterns of drug use among the general population.

1.3 About the NDAS

The rationale for the 2019–20 NDAS was to generate data that estimate the prevalence of drug use and describe patterns of use, as set out in action 5.1.45 of the national drugs strategy. The objective of the 2019–20 NDAS was to determine the prevalence and patterns of drug use (including alcohol and tobacco use) of a representative sample of the general population aged 15 years and older in Ireland, and to compare the current situation with previous surveys. The data collected provide:

1. A profile of tobacco use, including e-cigarettes, in Ireland
2. A detailed description of drinking patterns (including hazardous drinking patterns) in Ireland, and the harms associated with alcohol use
3. Prevalence estimates of lifetime, last year, and last month use of illegal and prescribable drugs
4. A description of drug use according to sex, age, and area deprivation level
5. An estimation of the prevalence of alcohol use disorder and cannabis use disorder
6. Findings on the perceptions and attitudes of people in Ireland towards tobacco, alcohol, and drug use, and
7. Information on the impact of drug use on local communities.

Previous drug prevalence surveys were undertaken in 2002–03, 2006–07, 2010–11, and 2014–15. These surveys were commissioned on an all-island basis by the National Advisory Committee on Drugs and Alcohol (NACDA) in the Republic of Ireland, and the Department of Health, Social Services and Public Safety in Northern Ireland. For the first time, the current survey was managed by the HRB and only included the Republic of Ireland. The HRB commissioned Ipsos MRBI to to organise, collect and validate the NDAS. Ipsos MRBI also

undertook this role for the first four surveys. A research advisory group supported the HRB in the management of the survey.

1.4 Report structure

1.4.1 Layout of report

This report outlines the results of the 2019–20 NDAS at a national level and compares them with those of previous surveys. Prevalence estimates will be published for the 10 Regional Drug and Alcohol Taskforce areas at a later stage. Following this introductory chapter, Chapter 2 describes the methodology employed for this survey. Chapters 3 and 4 give information on the use of tobacco and alcohol. Chapter 5 describes the use of illegal drugs with Chapter 6 providing more detailed sections on cannabis, ecstasy, and cocaine use, and Chapter 7 covers the use of prescribable drugs, including non-medical use. Chapter 8 presents findings on the perceptions and attitudes of people in Ireland towards tobacco, alcohol, and drug use, and the impact of drug use on communities is described in Chapter 9. Appendix I contains detailed tables on the lifetime, last year, and last month prevalence of use for each substance included in the survey. These are presented for the total sample, and separately by age group and sex, and 95% confidence intervals are provided for these estimates. Appendix II presents trends in lifetime, last year, and last month prevalence of use for each substance, by age group and sex, across the five surveys completed to date.

1.4.2 Understanding the results in this report

Trends over the five survey time points are presented in Appendix II and also throughout the report. As the population for the first three surveys excluded adults aged 65 years and older, trends are only presented for adults aged 15–64 years. All tables in Appendix II have been tested for statistically significant changes between each survey but this has not been done for other comparisons throughout the report (such as between sex or age). Where it is stated in the text that there has been a significant change in prevalence, this means that the change is statistically significant.

All prevalence rates presented in this report are based on weighted responses and are rounded to one decimal place. Percentages may not always sum to 100 due to either the effect of rounding or where respondents could give more than one answer.

When the figure 0.0% is reported in the prevalence tables it can mean that either no respondents reported use of the drug or that a very low number reported use and that due to rounding it is presented as 0.0%. This does not mean that no-one in the population has used the drug, rather it means that the sample was too small to detect prevalence. In Appendix I, confidence intervals are only provided after 0.0% if there are observations in the category. Where there are no confidence intervals, this means that there were no observations.

Where population estimates are provided, they are presented to the nearest thousand.

Main Findings

Tobacco

17.4%
of respondents indicated current tobacco use

2019 was the first time that the proportion of **ex-smokers was found to be greater than current smokers.**

The main reasons reported for quitting smoking were

27.8%
health or fitness

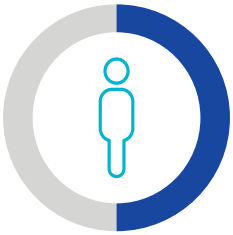
13.3%
cost

12.7%
health warning labels

Current E-cigarette use has increased from 3.1% of the population in 2014–15 to **4.3% in 2020**

Alcohol

One-third
of drinkers typically consume at least **6 standard drinks** per drinking occasion;



for **male drinkers** this increases to **one-half**

The prevalence of Alcohol Use Disorder (AUD) in the general population was found to be

14.8%
corresponding to **578,000 adults** in Ireland.

15–24-year-old drinkers

17+

median age
at which alcohol consumption initiated, increase from 16 to 17 years since 2002–03.

males

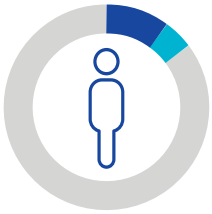
63.1%
engage in monthly heavy episodic drinking

37%
have an Alcohol Use Disorder

Main Findings

Illegal drug use

7.4%
(289,000 adults) reported recent or last year use of any illegal drug



Males more likely to report last year illicit drug use
10.2% Males vs. **4.7%** Females

Median age
of first drug use has decreased for most illegal drugs since 2002-03

19 Years
Median age of first **cannabis** use

21 Years
Median age of first **cocaine** use

Use of cannabis, ecstasy and cocaine

Of those who had used cannabis in the past year, **19.6%** met the criteria for **Cannabis Use Disorder**

Recent cocaine use among males aged 25–34 years increased across each survey
1.8% 2002/03 vs. **9.4%** 2019/20

Recent ecstasy use among **males aged 25–34 increased** from 2.2% in 2002/03 to **9.7% in 2019/20**

84.9% of those who have ever used cocaine, also used alcohol on the occasion of first cocaine use

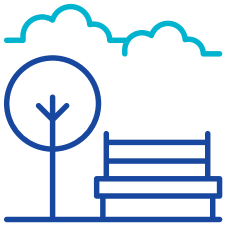
Perceptions and attitudes

of 15–35-year olds perceived smoking cannabis regularly to be associated with **great risk,** compared to 59.3% of 35–64-year olds

88.8%
supported permitting cannabis for medical use

Impact of drug use on communities

Over one-third
(37.0%) of respondents stated that there was a big or very big problem with people using or dealing drugs in their local area



44%
of those living in the most deprived quintile most likely to experience drug-related problems in their local area




02 Methodology




This chapter outlines the methodology employed to undertake the 2019–20 NDAS. It describes the survey design, questionnaire development, sampling, fieldwork, and data processing that was undertaken. A more detailed account of the NDAS methodology is provided in the survey's technical report, which may be accessed at www.drugsandalcohol.ie.

2.1 Survey design

The design of the NDAS was guided by best practice guidelines drawn up by the EMCDDA.[3] The universe for the survey was defined as all adults aged 15 years and older living in private households in the Republic of Ireland. Excluded from this survey were persons who do not normally live in private households – for example, members of the Traveller community; people who were homeless; or those in institutions, such as prisons or nursing homes. The survey did not make a specific provision for interviews to be conducted in languages other than English. The survey data were recorded face-to-face in respondents' homes using the Computer-Assisted Personal Interviewing (CAPI) technique. Compared with the pen-and-paper method, CAPI reduces the number of missed questions and logical errors at the time of data collection, as the programme automatically guides interviewers to the correct question. It also reduces the time required to complete each interview, as it skips to the next appropriate question for each interviewee.

2.2 Questionnaire development

Similar to the four previous surveys, the 2019–20 NDAS was based on the EMCDDA model questionnaire.[3] In order to enable comparisons over time, the questionnaire for the 2014–15 survey was used for the current survey, with a number of new questions added. These new questions were as follows:

- A module on the non-medical use of sedatives/tranquillisers and opioid pain relievers was added; the included questions were proposed by the EMCDDA in 2018.
- A question on polydrug use – defined as the use of two or more substances at one time (simultaneous use) – was asked of those who reported last year use of alcohol, cannabis, ecstasy, or cocaine.
- A set of questions was included on the impact of drug use and drug dealing – including drug-related intimidation – on local communities.
- For each respondent, the deprivation level of the area they live in was recorded for the first time in the NDAS. The deprivation index used in the NDAS is based on the Irish Pobal HP deprivation index that was developed by Haase and Pratschke.[4] The index is a method of measuring the relative affluence or deprivation of a geographical area using data compiled from various censuses. For the purposes of this report, these data are presented in five quintiles, from most deprived (1) to least deprived (5).

Prior to the fieldwork, cognitive testing was undertaken to evaluate questionnaire content in order to ensure that respondents would understand questions in the way that was intended by the researchers. The approach used by Ipsos MRBI to test this questionnaire involved 'think-aloud interviewing', whereby the respondent is asked to talk through their thought process as they arrive at an answer, and 'verbal probing', whereby the respondent is required to provide further information on their answer. Following this exercise, a number of minor changes to question wording and to the showcards were undertaken. The questionnaire was then converted into a CAPI script suitable for interviewing. At this stage, the questionnaire was tested using CAPI in order to ensure that all questions were included with the correct wording and in the correct order, and also to check the routing. A series of pilot interviews with members of the general public were then conducted in December 2018.

2.3 Sampling

The survey used stratified and multistage area probability sampling methods to select a representative sample of the Irish population that was aged 15 years and older and was living in private households.

2.3.1 Sampling frame

The sampling frame was An Post/Ordnance Survey Ireland's GeoDirectory, which was also used in the previous four surveys GeoDirectory is a complete database of every building in the Republic of Ireland. Each of the 2.2 million addresses contained in GeoDirectory includes an accurate standardised postal address, usage details for each building (commercial or residential), a unique 8-digit identity number, Eircode, and geo-coordinates which accurately locate the centre point of each building to within one metre. The advantages of the GeoDirectory are that it is comprehensive and regularly updated, and has a high degree of accuracy. It avoids double counting, as buildings which have alternative names are counted only once, and it also provides separate lists for businesses and residential addresses. It links every address to its electoral division (ED), allowing for the separation of data from large (e.g. Regional Drug and Alcohol Task Force (RDATF) areas) and small (e.g. EDs) geographical areas. However, using the GeoDirectory has some limitations: it does not include dwellings that have been built but not yet added to the database; addresses may be listed without dwellings; and dwellings may contain multiple households.

2.3.2 Selection of sample

As well as providing national estimates of drug use prevalence, the sample needed to be sufficiently large and structured in such a way as to facilitate comparisons between the 10 RDATF areas. Similar to the previous four surveys, sampling was undertaken by RDATF area to enable the estimation of drug use prevalence in each area and to allow for monitoring of drug prevalence trends over time. To provide reliable measurements by RDATF area, it was calculated that 650 completed interviews in each of the 10 RDATF areas would be required.

A three-stage process was used to construct the sample for this survey. Stratification techniques were used to select primary sampling units (PSUs). In this survey, EDs were

defined as PSUs. In the first stage of stratification, the number of addresses for each RDATF was agreed at between 980 and 1,344. The exact number of selected addresses was determined by the expected response rate in each area based on the achieved response rate on the previous iteration of this survey (Table 1).

Table 1 Sample selection by RDATF area

	Response rate achieved in previous wave	Target response rate for 2019–20	Selected addresses	Estimated number of eligible addresses	Completed interviews if target response rate achieved
East Coast	50.3%	55.0%	1,344	1,200	660
North Dublin	42.2%	55.0%	1,344	1,200	660
South Western	50.1%	55.0%	1,344	1,200	660
Midland	74.3%	70.0%	1,036	925	647
Mid-West	58.8%	58.0%	1,260	1,125	652
North Eastern	61.1%	60.0%	1,260	1,125	675
Southern	64.2%	64.0%	1,148	1,025	656
Northwest	71.1%	70.0%	1,036	925	647
South East	72.0%	70.0%	1,036	925	647
Western	82.6%	75.0%	980	875	656
Total	**60.4%**	**62.3%**	**11,788**		**6,560**

In the second stage of stratification, 421 PSUs were randomly selected. The decision on the number of PSUs selected was based on practical considerations (an appropriate compromise between allowing a sufficient range of coverage and the need to be practical from a data collection and field management perspective). These PSUs were then ranked by sociodemographic indicators (degree of urban/rural respondents and proportion of owner occupiers) to ensure that a representative cross-section of areas was included. In this way, PSUs of all sizes and compositions would have an equal chance of selection. Twenty-eight addresses were randomly selected from each of the 421 PSUs. A household was defined as a person, or as a group of people who normally live at the same property and who share a living room or at least one meal a day. In properties with multiple households, one was randomly selected using a Kish grid. Individuals (aged 15 years and older) within each selected household were randomly selected to take part in the survey. This was done by listing all individuals aged 15 years and older living in the household and then randomly selecting one using the CAPI device.

2.4 Fieldwork

Fieldwork commenced in February 2019. Prior to this, a series of interviewer briefings were conducted in order to ensure that interviewers were fully prepared to conduct the survey. The initial interviewer briefing was held in Dublin on 23 January 2019. Further briefings were held throughout the fieldwork period. The briefings provided opportunities for discussion and role play, as well as a thorough run-through of the survey.

Two letters from the HRB and Ipsos MRBI were sent in advance of fieldwork to the entire selected sample, outlining that a survey was taking place and that an interviewer would call to their door. The letters contained a respondent information sheet providing information on the household selection process, the survey content, the voluntary nature of participation, contact details in case of queries pertaining to the survey, and support services should the respondent require help on issues relating to the problems caused by drug use. Signed consent was obtained from all participants. In providing this consent, respondents were informed that their participation in the survey was voluntary, anonymous, and confidential, and that they were free to refuse to answer any particular question, to stop the interview at any point, and to request that all data they provided to Ipsos MRBI be destroyed. Written consent from a parent or guardian was required for all young people aged 15–17 years. The parent or guardian also had the right to sit in on the interview if they so wished. Data collection was conducted using tablet devices. Sensitive questions, including those that measured cannabis use disorder and alcohol use disorder, were self-completed by respondents.

In order to monitor progress and calculate response rates, interviewers completed a contact sheet for each address that was issued to them. Interviewers uploaded completed interviews on a daily basis, so as to ensure that interim data files could be produced in order to check the quality and integrity of the data. Validation of 90 completed assignments was conducted by telephone.

All interviews were conducted face to face in respondents' homes. An exception to this was an exercise that was undertaken to enhance response rates among certain household types in Dublin. Lower response rates among those living in apartments is a common feature of pre-select surveys due to the difficulties in accessing these households. In order to improve the response rate, addresses that were located in apartment or shared buildings were sent a letter asking them to contact Ipsos MRBI to participate in the research. One individual in each household was then randomly selected and invited to an interview session in a central location in Dublin. Each individual who participated in this exercise received a €50 voucher to compensate them for the expenses they incurred in order to attend.

Over the course of the fieldwork period, 22,828 contacts were made with the 11,788 households that were selected. This equates to an average of 1.94 contacts per household. Most of these were in-person visits, although this also includes contact by letter after face-to-face fieldwork was halted due to Covid-19. The achieved sample was 5,762, which is 87.8% of the initial target of 6,560.

2.4.1 Impact of Covid-19 on fieldwork

Due to the onset of the Covid-19 crisis in March 2020 and the restrictions on movement that followed, the decision was made to halt interviewing in the interest of the safety of interviewers and respondents. At that point, 5,640 interviews had been completed. There were also various incomplete sample assignments that were already in progress, and those that had not yet commenced. In order to maximise the number of completed interviews, a letter was sent to all remaining households, as well as selected non-responding households, that introduced the survey and asked a member of each household to contact Ipsos MRBI on a freephone telephone number in order to participate. Upon making contact, a member of Ipsos MRBI completed the respondent selection process within the household and then invited the selected individual to complete an interview over the telephone. The self-completion modules were not administered to respondents completing the survey over the phone. Those participating in the survey received a €20 voucher to compensate them for their time. Over the course of this exercise in April and May 2020, 2,278 letters were issued, resulting in 127 interviews.

2.5 Ethical approval

Ethical approval for the survey was obtained from the Royal College of Physicians of Ireland.

2.6 Response rate

Table 2 details the response rate for the households that were sampled.

Table 2 Overview of fieldwork response rate

Category	Outcome	Number of households
Complete interview	Full interview	5,762
Unproductive addresses	No reply after five contacts	646
	Appointment not maintained by respondent	260
	Partial interview	31
	Other reason address was unproductive	224
Refusal	Refusal to interviewer	1,948
	Refusal by contacting office	149

Category	Outcome	Number of households
Ineligible addresses	Property vacant	760
	Occupied but not main residence (e.g. holiday home)	163
	Non-residential address	280
	Address inaccessible	825
	Address not found	70
	Communication difficulties	220
	No response to letter following curtailment of fieldwork	450
Total		11,788

The response rate was calculated by dividing the number of complete interviews by the sum of all addresses minus ineligible addresses. The response rate was therefore 63.9%. However, two significant issues should be noted here. First, the proportion of ineligible addresses was higher in this wave than in the four previous survey waves. Overall, 2,768 out of 11,788 addresses were classified by interviewers as being ineligible. This accounts for 23.5% of the total sample, compared with 12.4% of the total sample for the 2014–15 survey. Part of this is accounted for by differences in the way the sample was created, as this wave's sample contained a higher proportion of non-residential addresses and vacant addresses than would normally be expected. Also, 450 addresses that did not receive any interviewer contact before fieldwork was curtailed due to Covid-19 restrictions, and that also did not respond to a follow-up letter are classified as ineligible because their eligibility has not been established. It is likely that most of these addresses would have been eligible, but it is not known how many would have agreed to participate in the survey. As a result they are classified as ineligible. This has the effect of inflating the response rate.

Further analysis of the response rate indicates a much lower response rate in the North Dublin RDATF (41.0%) compared with in the Western RDATF (84.8%) and in the Midland RDATF (83.1%) (Table 3). This is comparable to other surveys and is addressed through the post-survey weighting structure that is applied.

Table 3 Fieldwork response rate by RDATF area

	East Coast	North Dublin	South Western	Midland	Mid-West	North Eastern	Northwest	South East	Southern	Western
Complete interview	537	399	587	745	467	592	619	556	574	686
Unproductive addresses	104	203	114	47	86	129	82	84	245	67
Refusal	348	372	240	104	314	228	98	167	170	56
Ineligible addresses	348	375	405	140	393	311	237	229	159	171
Response rate	54.3%	41.0%	62.4%	83.1%	53.9%	62.4%	77.5%	68.9%	58.0%	84.8%

2.7 Weighting

Weighting of the achieved sample was required in order to account for differential response rates and the sampling approach used in this survey. Younger males and those living in large urban areas were under-represented, while the sampling approach whereby one individual was selected at random within a household meant that those living in households with fewer people were more likely to be selected than those living in households with more people.

The first stage in the weighting process was to generate a selection weight in order to address any issues that may arise due to those living in smaller households being more likely to be selected. In doing so a weight was calculated that was the inverse of the selection probabilities – i.e. those living in larger households had a higher weight applied than those living in smaller households.

The second stage in this process was to overcome discrepancies arising from differential response rates. In doing so, the weighting variables should relate to both the likelihood of participating and health behaviours. Weights were produced according to the following variables: age by sex; education; working status; and region. Population information was taken from the Central Statistics Office, and a rim weighting process was used.

A small number (around 0.5%) of high weights were capped in order to prevent extreme weights. The final weights were scaled to give a mean of 1 and ensure that the weighted sample size matches the unweighted sample size. The weighting scheme resulted in a design effect of 1.54 and an effective base size of 3,743.

2.8 Data analysis

The data were analysed by age and sex, by age within sex, and by area deprivation level. Data are presented using weighted proportions. Confidence intervals of 95% were calculated for key statistics and are presented in Appendix I. They provide a range of likely prevalence rates for all categories of drug use. The confidence interval calculation takes into account the effects of the weighting, stratification, and clustering. In order to identify whether or not changes in prevalence since the 2014–15 survey could be considered statistically significant, a straightforward p-value test was conducted. A p-value was calculated for each variable using the survey result and associated standard error. All changes with a p-value of less than 0.05 were considered to be statistically significant. The prevalence of cannabis use disorder and alcohol use disorder were measured using DSM criteria. The sampling procedures employed in this survey facilitate the estimation of drug prevalence at RDATF level. In this report we have concentrated mainly on national estimates. Drug prevalence estimates for each RDATF area will be published at a later stage in 2021.

03

Tobacco use

3.1 Tobacco: Main findings

The main findings from the 2019–20 NDAS regarding tobacco use include the following:

- 17.4% of respondents indicated current tobacco use, corresponding to 680,000 of the general population in Ireland aged 15 years and older; 1 in 4 (25.6%) respondents, or 1,000,000 of the general population, were ex-smokers.
- This was the first NDAS where the proportion of ex-smokers was found to be greater than the proportion of current smokers.
- The main reasons reported for quitting smoking were its effect on health or fitness (27.8%), cost (13.3%), and health warning labels (12.7%).
- Males (20.6%) were more likely than females (14.3%) to report current smoking.
- 24.7% of smokers reported smoking at least 20 cigarettes per day.
- 4.3% (167,000) of the adult population reported current e-cigarette use; this has increased from 3.1% reported in 2014–15.
- The average age of first smoking tobacco was 17.4 years (median: 16 years).
- The average age of current smokers was 42.4 years (median: 41 years).
- The median age at which 15–24-year-olds initiated smoking has increased from 15 years to 16 years since 2002–03.

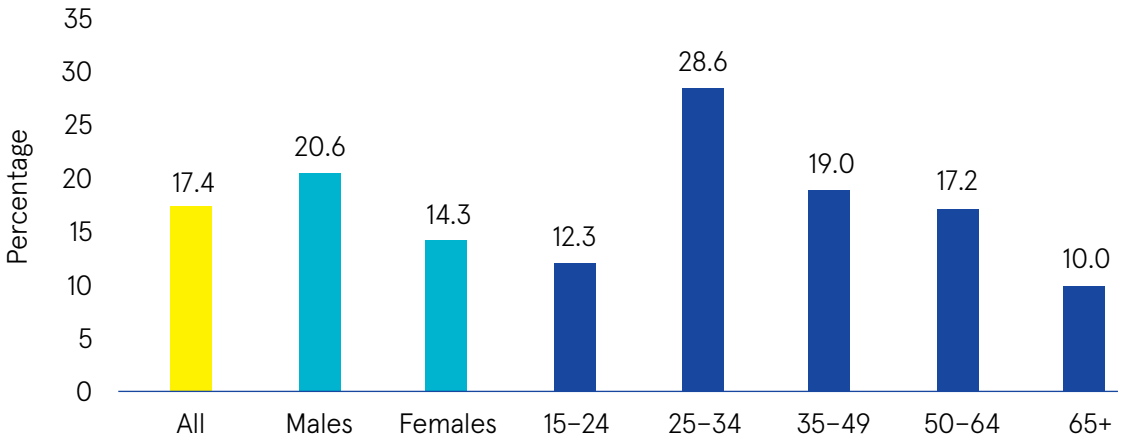
3.2 Tobacco use in Ireland

In 2019–20, 17.4% of respondents reported current smoking, corresponding to 680,000 of the general population in Ireland aged 15 years and older; 13.9% of respondents reported daily smoking and 3.5% reported occasional smoking. A further 25.6%, or 1,000,000 of the general population, were ex-smokers. There has been a statistically significant decrease in current tobacco use since 2014–15 (from 24.4%).

3.2.1 Profile of current tobacco use

Males (20.6%) were more likely than females (14.3%) to smoke. Smoking levels were highest among 25–34-year-olds (28.6%) and lowest among those aged 65 years and older (10.0%) (Figure 1). Of those who smoked, 79.9% reported daily smoking and one-quarter (24.7%) smoked at least 20 cigarettes per day (Table 6). Those living in the most deprived quintile were more likely to report current smoking, daily smoking, and smoking at least 20 cigarettes per day, with 28.3% reporting current smoking compared with 10.2% in the least deprived quintile (Table 8).

Figure 1 Current tobacco use in Ireland, by sex and age group



3.2.2 Age of first tobacco use

Among survey respondents who reported ever smoking, the mean age of first tobacco use was found to be 17.4 years (median: 16 years) and was 16.4 (median: 16 years) for those aged 15–24 years. There has been an increase in age at first use of tobacco among those aged 15–24 years across survey time points; in 2002–03, the mean age of first use was 14.6 years (median: 15 years), and this has increased with each survey to 16.4 years in 2019–20.

3.2.3 Non-smokers

In 2019–20, more than four-fifths (82.6%) of survey participants were non-smokers; this included 57.0% who had never smoked and 25.6% who had stopped using tobacco. Females were more likely than males to have never smoked (61.4% versus 52.4%). For both males and females, respondents aged 15–24 years were most likely to report never smoking (males: 73.9%; females: 82.1%). Older adults were more likely to be ex-smokers; 35.7% of respondents aged 65 years and older had ceased their tobacco use. More than one-half of ex-smokers (57.7%) stated that they had last smoked more than 10 years ago. The main reason given for stopping tobacco use was its effects on health or fitness (27.8%). Cost (13.3%) and health warnings on tobacco packets (12.7%) were the next most common reasons cited. For 16.4% of females, pregnancy or planning to start a family was the second most common reason given for quitting smoking (Table 4).

Table 4 Main reasons for stopping tobacco use, by sex (%)

Weighted responses=1,463	All	Males	Females
I think it was affecting my health or fitness	27.8	29.6	25.9
It was costing too much	13.3	15.2	11.3
Health warnings on tobacco packets	12.7	12.7	12.6
I was pregnant or planning to start a family	9.0	2.0	16.4
I was worried it was affecting the health of those around me	8.1	8.5	7.7
Family and/or friends asked me to quit	6.5	6.3	6.7
I wanted to get fit	6.4	8.4	4.2
My doctor advised me to give it up	5.9	7.4	4.4
Got sick of them/did not like them anymore	2.9	2.3	3.6
Only occasional/social smoker	1.7	1.5	1.8
Smoking restrictions in public areas	1.4	1.7	1.1
Just gave them up/no reason	1.0	0.9	1.1
Diagnosed with illness	0.9	0.8	0.9
Smoking restrictions in the workplace	0.5	0.5	0.5
Quit.ie website or quit smoking mobile device app	0.3	0.5	0.1
Government advertisements on TV	0.2	0.2	0.2
Death/illness of family member	0.2	0.2	0.3
Press or radio advertising for products	0.2	0.1	0.3
Pamphlets or brochures on how to quit	0.0	0.1	0.0
Other	1.0	1.1	1.0

3.2.4 E-cigarette use

This was the second survey that included questions on e-cigarette use. Lifetime e-cigarette use was reported by 14.9% of respondents and current use was reported by 4.3% (Table 6), which represents a statistically significant increase since 2014–15, when current use was found to be 3.1%. Current e-cigarette use was highest among males aged 35–49 years (7.2%) and females aged 35–64 years (6.2%) (Table 7), and among those living in the most deprived

quintile (7.3%) (Table 8). More than one-half (55.9%) of e-cigarette users were ex-smokers, 39.6% were current smokers, and 4.5% had never smoked tobacco. The main reason cited for starting e-cigarette use was to help quit smoking (59.9%) (Table 5).

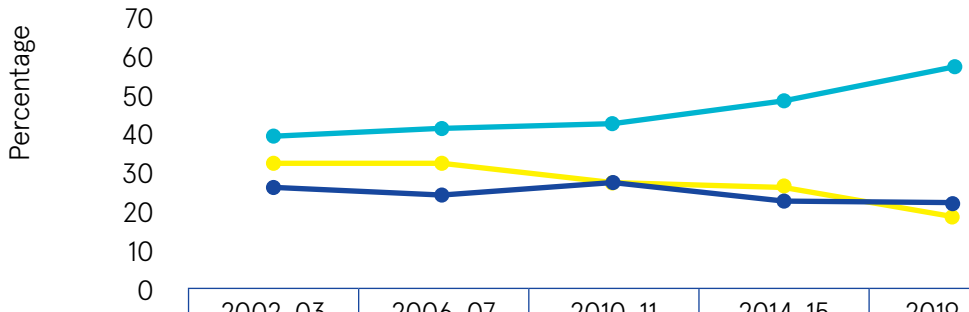
Table 5 Main reason for starting e-cigarette use, by sex (%)

Weighted responses=847	All	Males	Females
To help me quit smoking	59.9	59.6	60.3
To try to cut down on the number of cigarettes I smoke	11.9	12.1	11.6
Out of curiosity	10.4	11.6	9.0
To try to stop me going back to smoking	5.1	5.7	4.5
They are cheaper than regular cigarettes	4.3	3.3	5.5
I think they are less harmful than regular cigarettes	3.8	3.1	4.5
They seem more acceptable than regular cigarettes	1.8	2.1	1.6
I think they taste better than regular cigarettes	1.5	1.2	1.9
You can smoke in places where regular cigarettes are banned	0.0	0.1	0.0
Other	1.2	1.3	1.2

3.2.5 Trends in tobacco use

Tobacco use among 15–64-year-olds has reduced with each wave of the NDAS, from 33.2% in 2002–03 to 19.5% in 2019–20. In addition, the proportion of never smokers has increased with each survey, from 39.9% in 2002–03 to 57.6% in 2019–20 (Figure 2). The 2019–20 survey is the first conducted in Ireland where the proportion of ex-smokers was found to be higher than the proportion of current smokers.

Figure 2 Trends in last month tobacco use among 15–64-year-olds, 2002–03 to 2019–20



	2002-03	2006-07	2010-11	2014-15	2019-20
Current smoker	33.2	32.6	28.3	27.4	19.5
Ex-smoker	26.9	25.3	28.3	23.4	22.9
Never smoker	39.9	42.1	43.4	49.2	57.6

3.3 Tables – tobacco use

Table 6 Tobacco use, by sex and age group (%)

	All	Males	Females	15–24	25–34	35–49	50–64	65+
Weighted responses	*5,751*	*2,821*	*2930*	*901*	*902*	*1,634*	*1,272*	*1,033*
Current smoker	17.4	20.6	14.3	12.3	28.6	19.0	17.2	10.0
Ex-smoker	25.6	27.0	24.3	9.8	15.1	28.5	32.5	35.7
Never smoker	57.0	52.4	61.4	77.9	56.3	52.5	50.3	54.3
Daily smoking	13.9	15.8	12.2	8.3	21.9	15.6	14.1	9.2
20+ cigarettes per day	4.3	5.1	3.4	1.1	4.9	5.0	5.7	3.5
E-cigarettes – lifetime use	14.9	16.4	13.4	14.2	21.0	19.5	13.3	5.2
E-cigarettes – current use	4.3	4.7	3.8	3.0	3.3	6.7	5.1	1.5

All figures are based on weighted data, are rounded to the nearest decimal place, and are based on valid responses.

Table 7 Tobacco use, sex by age group (%)

	Males (N=2,821)					Females (N=2,930)				
	15–24	25–34	35–49	50–64	65+	15–24	25–34	35–49	50–64	65+
Current smoker	16.3	39.0	20.5	19.2	10.0	8.1	18.5	17.5	15.3	10.0
Ex-smoker	9.8	12.7	29.8	32.8	44.4	9.8	17.4	27.3	32.2	28.0
Never smoker	73.9	48.3	49.7	48.0	45.7	82.1	64.1	55.2	52.5	62.0
Daily smoking	9.3	29.7	16.3	15.1	9.0	7.2	14.4	14.8	13.1	9.4
20+ cigarettes per day	1.1	8.1	5.9	6.3	3.4	1.2	1.7	4.1	5.2	3.6
E-cigarettes – lifetime use	17.4	24.6	20.7	13.0	5.2	10.8	17.4	18.2	13.5	5.2
E-cigarettes – current use	5.6	3.8	7.2	3.9	1.6	0.3	2.8	6.2	6.2	1.3

All figures are based on weighted data, are rounded to the nearest decimal place, and are based on valid responses.

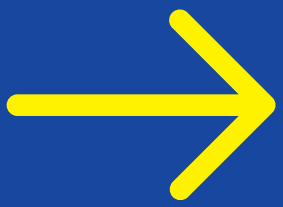
Table 8 Tobacco use by area deprivation quintile (%)

	1 (most deprived)	2	3	4	5 (least deprived)
Weighted responses	*1,004*	*1,364*	*1,363*	*1,101*	*920*
Current smoker	28.3	17.7	14.8	16.3	10.2
Ex-smoker	22.8	27.1	26.6	24.8	26.0
Never smoker	48.9	55.2	58.6	58.9	63.8
Daily smoking	24.8	14.7	12.1	11.4	6.6
20+ cigarettes per day	7.6	4.3	3.8	3.5	2.1
E-cigarettes – lifetime use	20.4	15.1	13.2	13.6	12.7
E-cigarettes – current use	7.3	4.0	5.0	3.0	1.7

All figures are based on weighted data, are rounded to the nearest decimal place, and are based on valid responses.

04

Alcohol



4.1 Alcohol: main findings

The main findings from the 2019–20 NDAS regarding alcohol use include the following:

- 74.2% of respondents reported having consumed alcohol in the last 12 months (defined as current drinking), corresponding to 2,904,000 of the general population in Ireland aged 15 years and older.
- The proportion of the adult population aged 15–64 years who have consumed alcohol in the last year has decreased since the 2002–03 survey, from 83.8% to 77.7% in 2019–20.
- The median age at which 15–24-year-olds initiated alcohol consumption has increased from 16 years to 17 years since 2002–03.
- One-third (34.1%) of current drinkers typically consume at least 6 standard drinks per drinking occasion; this increases to one-half for male drinkers.
- Two-fifths (39.9%) of drinkers engaged in heavy episodic drinking (HED) at least once per month.
- The prevalence of alcohol use disorder (AUD) in the general population was found to be 14.8%, corresponding to one in every seven or 578,000 adults in Ireland.
- Young males were most likely to have hazardous or harmful drinking patterns. Among male drinkers aged 15–24 years, 63.1% engaged in monthly HED and 37.0% had an AUD.

4.2 Alcohol consumption in Ireland

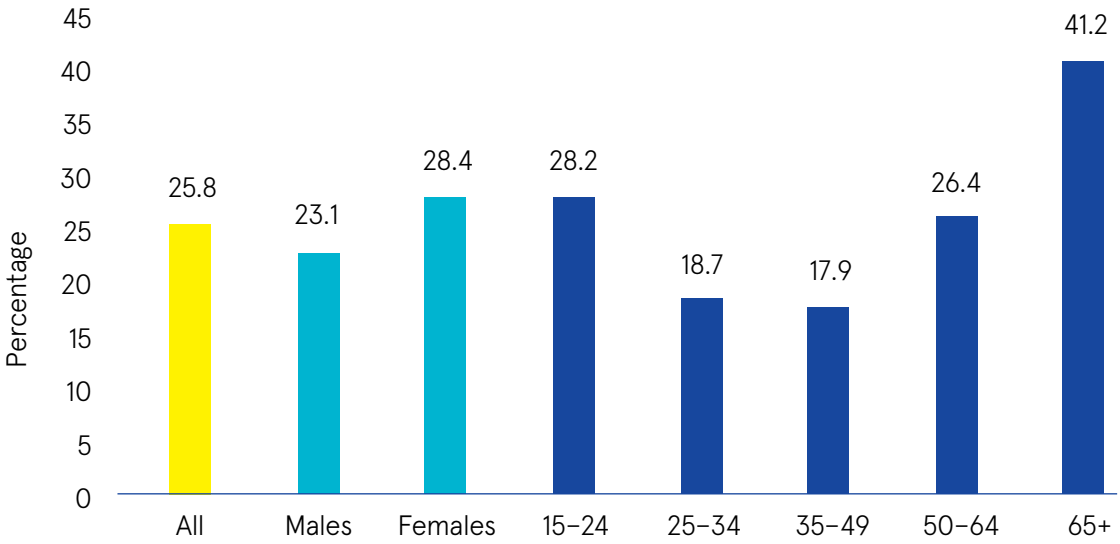
In the 2019–20 NDAS, 74.2% of survey respondents reported having consumed alcohol in the last 12 months (also defined as current drinking), corresponding to 2,903,000 of the general population in Ireland aged 15 years and older. There have been no significant changes in the prevalence of alcohol consumption since 2014–15. This section provides an overview of general patterns of consumption, harmful patterns of consumption, trends in alcohol consumption, and harms arising from alcohol use. More detailed tables on general patterns of alcohol consumption as well as on hazardous and harmful drinking patterns may be found at the end of this chapter. For the purposes of this survey, a standard drink contains 10 g of pure alcohol. This is the equivalent of one glass (or half a pint) of beer, or a pub measure of spirits (35.5 mL), or a small (100 mL) glass of wine.

4.2.1 Non-drinkers

One-quarter of respondents (25.7%) did not consume alcohol in the 12 months prior to the NDAS (defined as non-drinkers). Females (28.4%) were more likely than males (23.1%) to be non-drinkers (Table 10, Figure 3). The highest proportion of non-drinkers was in the

65 years and older age group (45.2% of females and 36.6% of males) (Table 11), followed by the 15–24-year-old age group (28.2%). The proportion of non-drinkers varied by level of deprivation – 30.0% of those in the most deprived quintile were non-drinkers, compared with 21.4% in the least deprived quintile (Table 12).

Figure 3 Proportion of non-drinkers in the year prior to the 2019–20 NDAS, by age and sex



The proportion of ex-drinkers was found to be 6.1%, corresponding to 240,000 of the general population (Table 10). The most common reason given for stopping alcohol use was health reasons (28.4%). Males also reported lifestyle reasons (19.5%) and not enjoying drinking or getting drunk (15.4%), while females also reported not enjoying drinking or getting drunk (25.3%) and being pregnant and/or breastfeeding (18.6%) as the most common reasons they stopped drinking (Table 9).

Table 9 Main reason for stopping alcohol use, by sex (%)

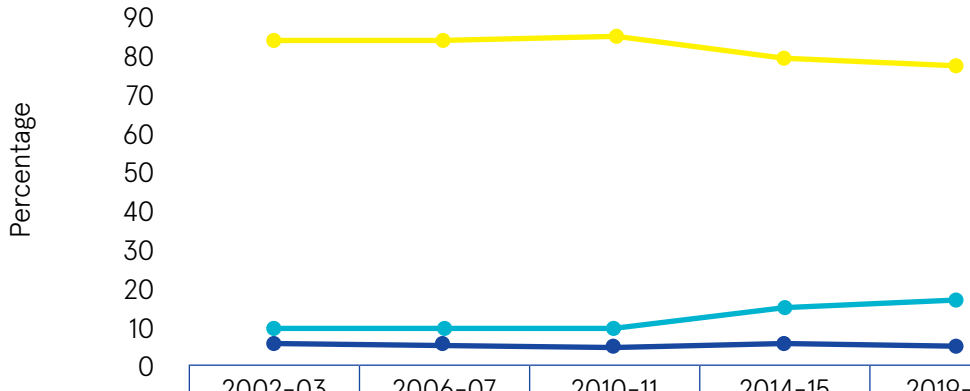
Weighted responses=350	All	Males	Females
Health reasons (e.g. weight, diabetes, avoiding hangovers)	28.4	31.4	25.7
Taste/enjoyment (e.g. I did not enjoy drinking/ getting drunk)	20.6	15.4	25.3
Lifestyle reasons (e.g. work/study commitments, less opportunity, young family)	14.0	19.5	9.0
Pregnant and/or breastfeeding	9.8	0.0	18.6
Social reasons (e.g. believe in moderation, concerned about violence, avoiding getting drunk)	5.4	5.3	5.5
I was receiving treatment for alcohol problems	4.2	6.2	2.4

Weighted responses=350	All	Males	Females
Drink driving regulations	2.9	4.4	1.5
Financial reasons	2.8	3.8	1.9
Family and/or friends asked me to give up drinking	1.5	2.4	0.7
The price of the alcohol I drank increased	0.5	0.7	0.3
Other	9.9	10.9	9.1

4.2.1.1 Trends in the proportion of the population that does not drink

There has been a decrease in the proportion of current drinkers aged 15–64 years in the general population – from 83.8% in 2002–03 to 77.7% in 2019–20. This can be explained by an increase in the proportion of never drinkers rather than an increase in the number of people quitting their alcohol use (Figure 4). The largest increases in never drinkers have been observed in the 15–24-year-old and 25–34-year-old age groups (Table 13).

Figure 4 Trends in alcohol consumption among 15–64-year-olds



	2002-03	2006-07	2010-11	2014-15	2019-20
Current drinker	83.8	84.2	85.3	79.9	77.7
Ex-drinker	6.4	6.2	5.0	5.3	5.3
Never drinker	9.8	9.7	9.7	14.8	17.0

4.2.2 Age of first use of alcohol

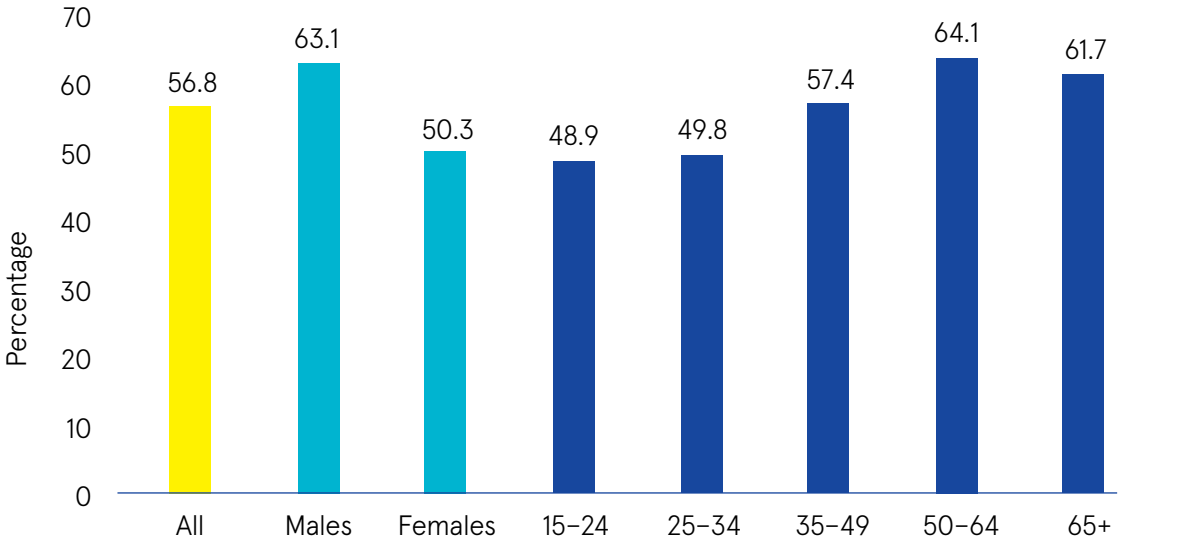
Among survey participants who had used alcohol, the mean age of first use was found to be 17.7 years (median: 17 years). There has also been an increase in the age of first use of alcohol among those aged 15–24 years; in 2002–03, the mean age of first use was 15.6 years (median: 16 years), and this increased with each survey to 16.6 years (median: 17 years) in 2019–20.

4.3 General patterns of alcohol consumption

4.3.1 Frequency of drinking in the last year

More than one-half of drinkers (56.8%) reported drinking alcohol at least once per week (Figure 5). Males consumed alcohol more frequently than females, with 63.1% of males consuming alcohol weekly compared with 50.3% of females. Older drinkers reported drinking more frequently than those in younger age groups; 13.6% of drinkers aged 65 years and older consumed alcohol at least four times per week, compared with just 1.5% of drinkers aged 15–24 years (Table 10).

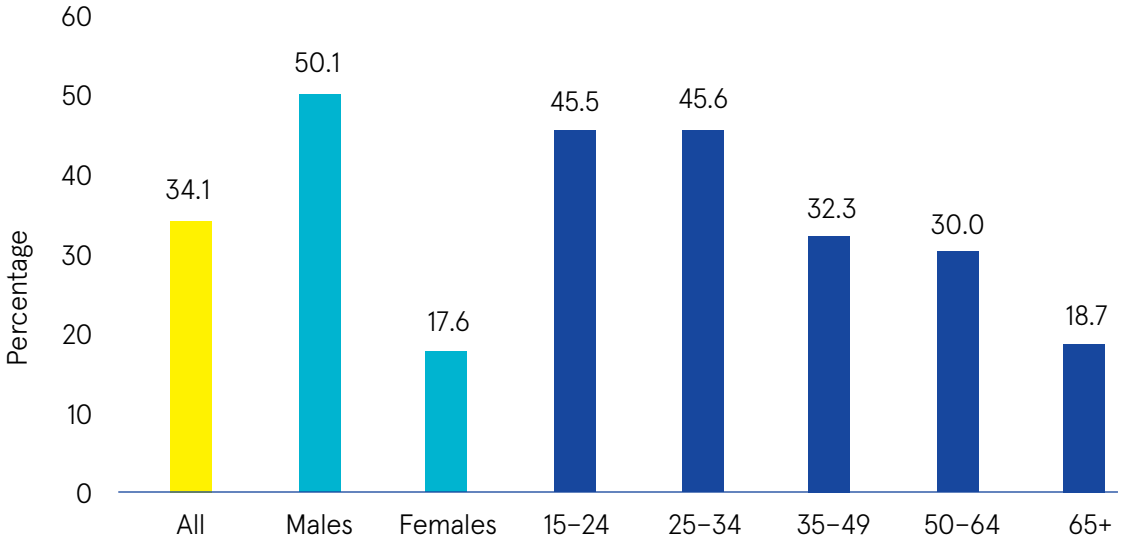
Figure 5 Proportion of drinkers who consume alcohol at least once per week, by sex and age group



4.3.2 Quantity of alcohol consumed per typical drinking occasion

The mean number of standard drinks consumed per typical drinking occasion was 5.0. This ranged from 3.8 among females to 6.2 among males and from 6.1 among 15–24-year-olds to 3.6 among those aged 65 years and older. One-third (34.1%) of respondents reported drinking at least six standard drinks per typical drinking occasion over the last year (Figure 6). While young people drank less frequently than those in older age groups, they consumed more alcohol per typical drinking occasion, with 45.5% of 15–24-year-olds and 45.6% of 25–34-year-olds consuming at least six standard drinks per drinking occasion. This level of consumption was almost twice as common among 15–24-year-old males (58.4%) than 15–24-year-old females (31.3%). A similar trend was observed among 25–34-year-olds, with 61.3% of males and 28.4% of females consuming alcohol in this way. One-fifth (19.5%) of males reported consuming 10 or more drinks per typical drinking occasion compared with just 3.3% of females (Table 10). Drinkers were also asked the highest number of standard drinks they had consumed on a single occasion in the last year; 8.3% reported consuming at least 20 drinks on a single occasion (Table 10).

Figure 6 Proportion of drinkers who consumed at least six standard drinks on a typical drinking occasion, by sex and age group



4.4 Hazardous and harmful drinking patterns in Ireland

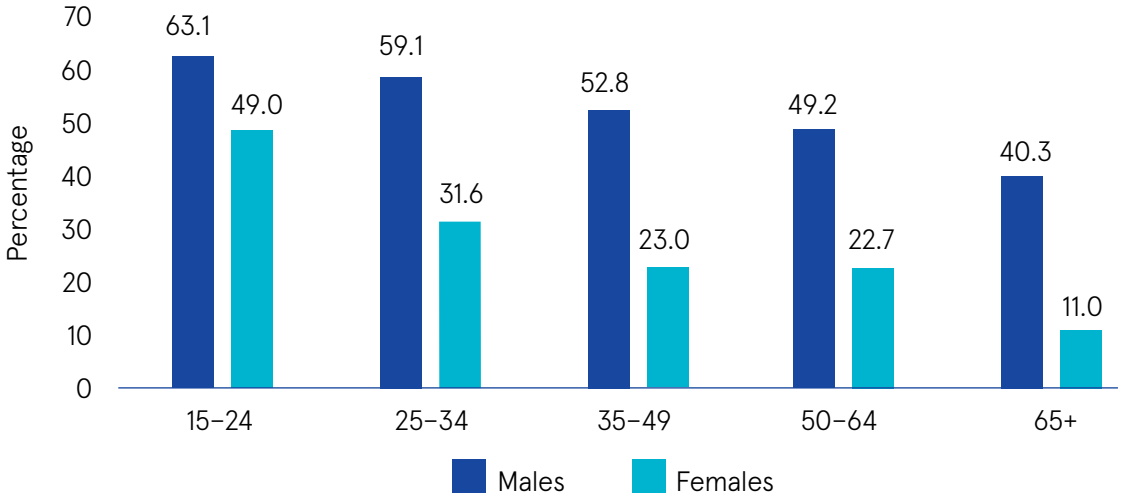
Three internationally agreed methods to measure hazardous or harmful drinking patterns are included in the current NDAS:

- Heavy episodic drinking (HED) is defined as consuming six or more standard drinks on a single occasion at least once per month in the last year. Engaging in monthly HED may be considered a hazardous pattern of drinking.[5]
- The World Health Organization's Alcohol Use Disorders Identification Test–Concise (AUDIT-C) is a three-question screening test that asks about frequency of drinking, typical volume consumed per drinking occasion, and HED. In this survey, a score of 5 or higher is considered positive for a hazardous pattern of drinking.[6]
- AUD is measured using the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5).[7] 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 using alcohol; reduced activities because of drinking; continued drinking despite psychological or physical problems; and alcohol cravings. AUD severity levels were classified as mild, moderate, or severe (2–3, 4–5, or ≥6 criteria, respectively).

4.4.1 Heavy episodic drinking

Two-fifths (39.9%) of drinkers engaged in monthly HED in the year prior to the survey, and almost one-quarter (23.7%) engaged in HED on a weekly basis (Table 10). Monthly HED was more prevalent among male than female drinkers (53.0% versus 26.4%) and among 15–24-year-old drinkers than among those aged 65 years and older (56.4% versus 25.7%). Overall, monthly HED was most prevalent among 15–24-year-old male drinkers (63.1%) and was also common among 15–24-year-old female drinkers (49.0%) (Figure 7). Although those aged 65 years and older were the least likely to engage in monthly HED, two-fifths of male drinkers (40.3%) in this age group reported monthly HED. Monthly HED was more common among drinkers living in the most deprived quintile (45.4%) compared with those living in less deprived quintiles (Table 12).

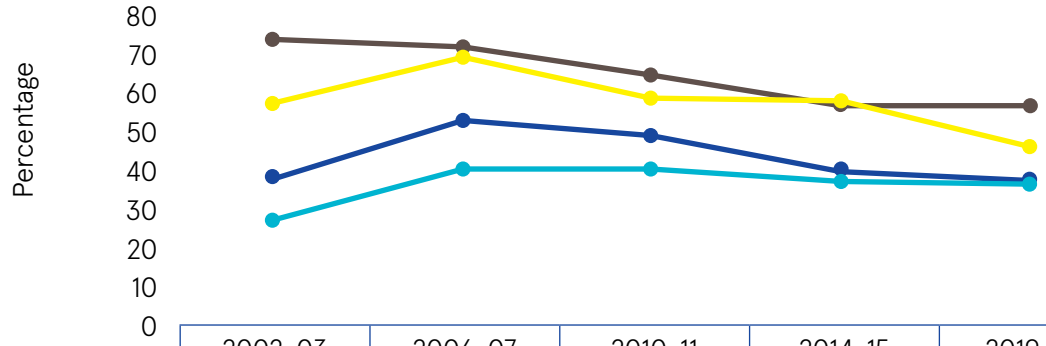
Figure 7 Proportion of drinkers who engaged in monthly HED, sex by age group



4.4.1.1 Trends in heavy episodic drinking

Although the current level of monthly HED in Ireland is high by international standards,[5] there has been a decrease in the proportion of drinkers aged 15–64 years reporting monthly HED, which peaked in 2006 (58.6%) and decreased in each subsequent survey to 42.3% in the current survey (Table 14). This coincides with a decrease in per capita alcohol consumption in Ireland since the early to mid-2000s. In 2006, per capita alcohol consumption was 13.4 L of pure alcohol per adult aged 15 years and older, but by 2019 this had decreased to 10.8 L. The largest decline in monthly HED was observed among 15–24-year-olds, from 73.7% in 2002–03 to 56.4% in 2019–20 (Figure 8).

Figure 8 Trends in proportion of drinkers (aged 15–64 years) who engage in monthly HED, by age group

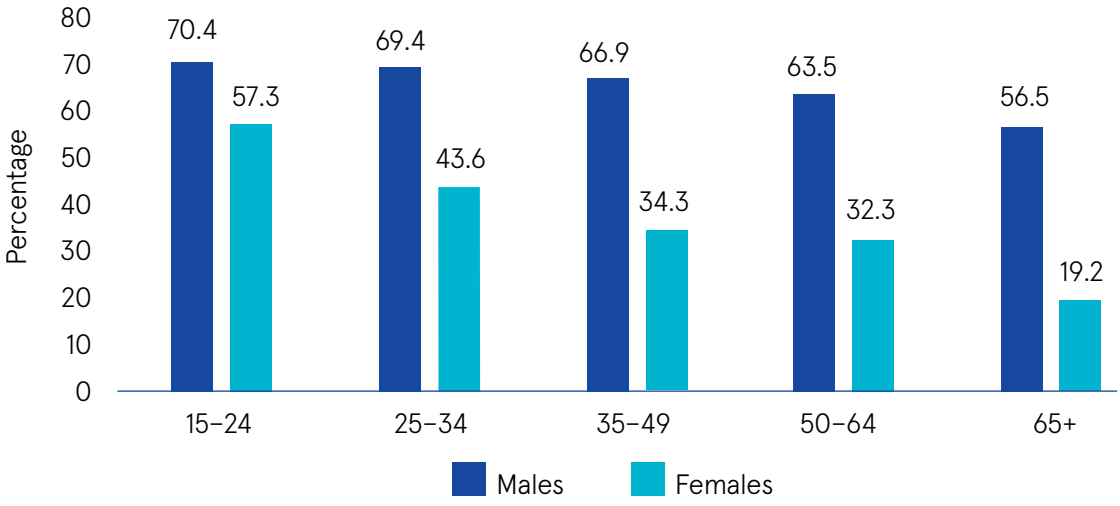


	2002-03	2006-07	2010-11	2014-15	2019-20
15–24	73.7	71.6	64.6	57.0	56.4
25–34	57.4	69.0	58.8	57.7	46.0
35–49	37.8	53.0	48.6	39.8	37.7
50–64	27.2	40.4	40.6	37.1	36.2

4.4.2 AUDIT-C

More than one-half (51.3%) of all drinkers were classified as hazardous drinkers using the World Health Organization's AUDIT-C screening tool (Table 10). This was more common among male (65.7%) than female drinkers (36.5%), particularly younger males, with 70.4% of 15–24-year-old male drinkers meeting the criteria for hazardous drinking (Table 11, Figure 9). Drinkers aged 65 years and older were least likely to have an AUDIT-C score of 5 or higher (38.2%). An AUDIT-C score of 5 or higher was most common among drinkers living in the most deprived quintile (58.5%) (Table 12).

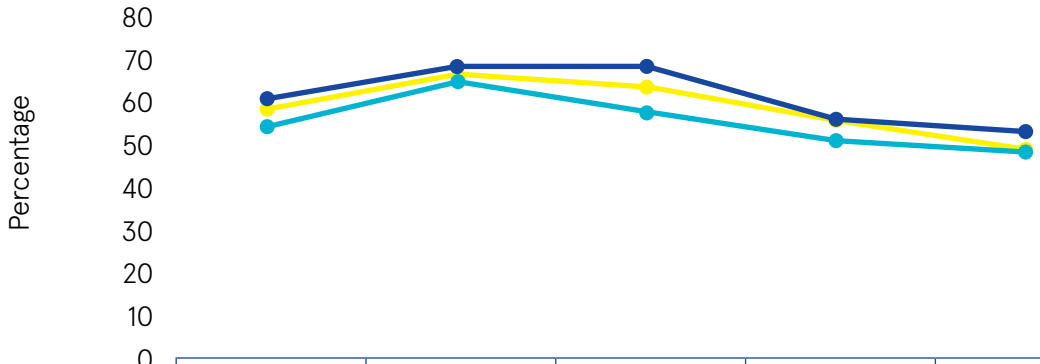
Figure 9 Proportion of drinkers with an AUDIT-C score of 5 or higher, sex by age group



4.4.2.1 Trends in AUDIT-C scores

AUDIT-C scores are also available for the 2010–11 and 2014–15 surveys. The proportion of drinkers aged 15–64 years with an AUDIT-C score of 5 or higher increased from 57.6% to 60.1% between 2010–11 and 2014–15, and decreased to 53.5% in the current survey. The largest decrease was observed among drinkers aged 25–34 years (Figure 10).

Figure 10 Trends in proportion of drinkers (aged 15–64 years) with an AUDIT-C score of 5 or higher, by age group



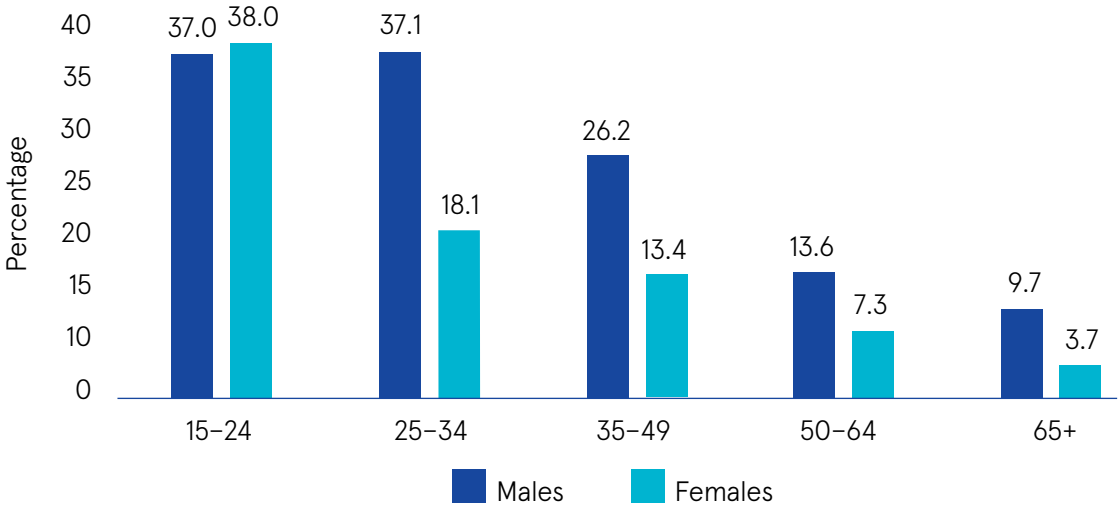
	All	15-24	25-34	35–49	50–64
2010–11	57.6	66.1	62.7	55.1	48.6
2014–15	60.1	67.9	67.7	55.2	52.7
2019–20	53.5	64.2	57.1	50.4	48.0

4.4.3 Alcohol use disorder

This is the first NDAS to measure AUD using DSM-5 criteria. The prevalence of last-year AUD in the general population was found to be 14.8%, corresponding to 578,000 of the general population in Ireland aged 15 years and older. This equates to one in five drinkers (20.0%). The proportion of drinkers with mild, moderate, and severe AUD was 11.6%, 5.4%, and 3.1%, respectively (Table 10). AUD was more common among male than female drinkers (24.8% versus 15.1%). Younger drinkers aged 15–24 years were most likely to report AUD (37.5%), whereas drinkers aged 65 years and older were least likely to report AUD (6.7%).

The highest prevalence of AUD was observed among female drinkers aged 15–24 years (38.0%), followed by male drinkers aged 25–34 years (37.1%) and male drinkers aged 15–24 years (37.0%) (Figure 11). The high prevalence among young female drinkers is somewhat surprising, given that males aged 15–24 years were much more likely to report monthly HED and to have an AUDIT-C score of 5 or higher. Similarly, 15–24-year-old females were more likely to report mild AUD (21.6%) than 15–24-year-old or 25–34-year-old males (15.0% and 14.6%, respectively) (Table 11). There were no significant differences in the prevalence of AUD across the area deprivation quintiles (Table 12).

Figure 11 Proportion of drinkers with AUD, sex by age group



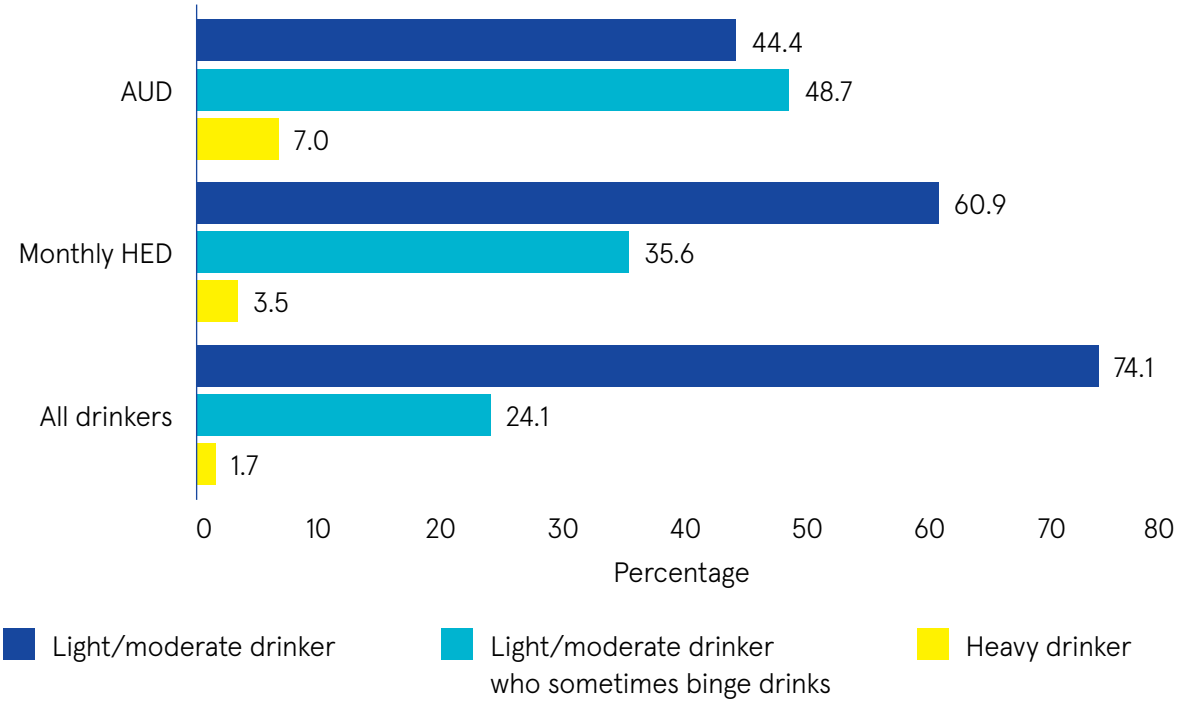
4.5 Self-perception of own drinking

Drinkers were asked to classify themselves as one of the following types of drinkers:

- Light drinker
- Light drinker who sometimes binge drinks
- Moderate drinker
- Moderate drinker who sometimes binge drinks
- Heavy drinker, or
- Heavy drinker who sometimes binge drinks.

The majority of drinkers (74.1%) classified themselves as either a light or moderate drinker (Figure 12). A further one-quarter (24.1%) of drinkers classified themselves as a light drinker who sometimes binge drinks or a moderate drinker who sometimes binge drinks, and 1.7% classified themselves as either a heavy drinker or as a heavy drinker who sometimes binge drinks. Among those with AUD, just 7.0% classified themselves as a heavy drinker, whereas 44.4% classified themselves as a light or a moderate drinker.

Figure 12 Drinkers' self-reported drinker type, by drinking pattern



4.6 Alcohol-related harm

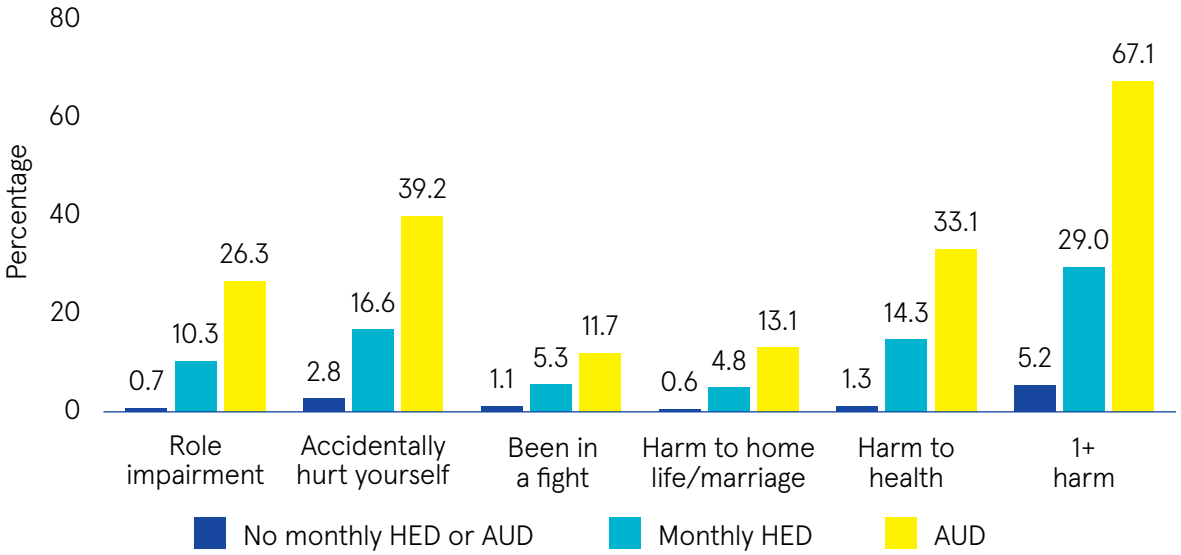
The current survey contained questions relating to both harms arising from a drinker's own alcohol consumption and harms due to others' drinking.

4.6.1 Harm from own drinking

Drinkers were asked if they had experienced any of the following negative consequences as a result of their own drinking in the last year: role impairment (for example, at work, at school, or when taking care of the household), accidentally hurt yourself, been in a fight, harm to home life or marriage, and harm to health. The proportion of drinkers who reported at least one of these harms was 13.5%, ranging from 3.1% who experienced harm to their home life or marriage to 10.2% who had accidentally hurt themselves (Table 16). Males were more likely than females to experience any harm (17.3% versus 9.8%) and those aged 15–24 years were most likely to experience harm (27.6%).

Experiencing harm was associated with drinking pattern. Low-risk drinkers (defined as those who did not engage in regular HED or meet the criteria for AUD) were least likely to experience any harm (5.2%), while those with AUD were 13 times more likely to experience harm (67.1%) (Figure 13, Table 18).

Figure 13 Harms from own alcohol consumption in the year prior to the survey, by drinking pattern

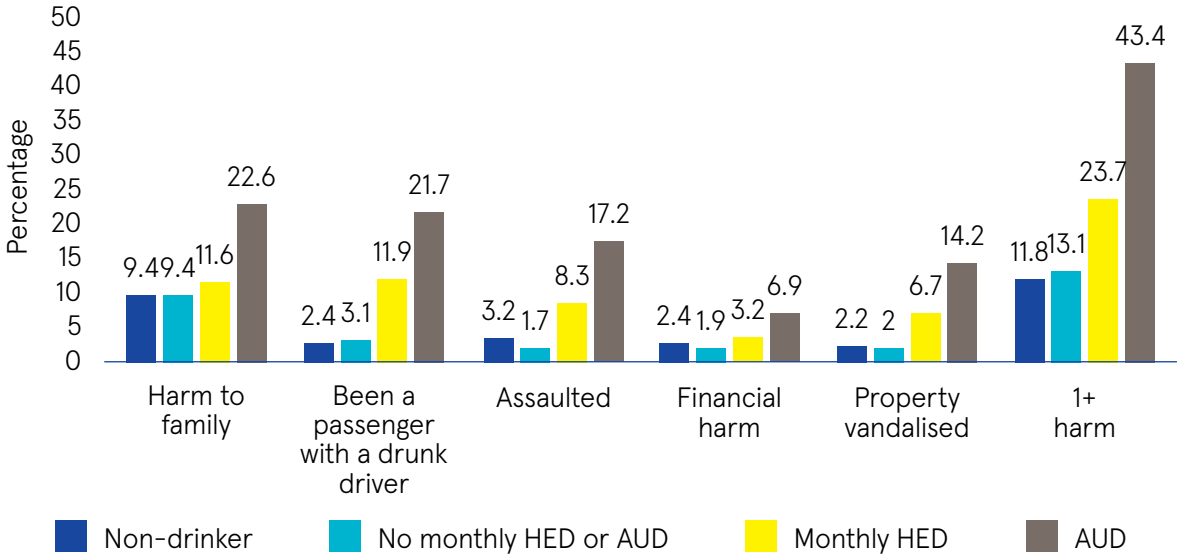


4.6.2 Harm from others' drinking

All respondents were asked if there were people in their life (family, friends, co-workers, or others) that they would consider to be a fairly heavy drinker or someone who drinks a lot sometimes, and whether this affected them. One-third (33.0%) reported that there were such people in their life and 13.8% of all respondents reported that they were affected because of this.

All respondents were also asked if they had experienced any of the following negative consequences as a result of others' drinking in the last year: harm to family, been a passenger with a drunk driver, been assaulted, financial harm, and having property vandalised. Harm from others' drinking was experienced by 17.0% of all respondents, with 18.3% of males and 15.7% of females reporting such harm (Table 16). The most commonly reported harm was harm to family (10.8%), followed by being a passenger with a drunk driver (6.0%). Females were more likely than males to report harm to family (13.1% versus 8.5%) and to report financial harm (2.9% versus 2.4%). Similar proportions of non-drinkers (11.8%) and low-risk drinkers (13.1%) reported harms from others' drinking (Figure 14, Table 19). In comparison, 23.7% of monthly HED drinkers and 43.4% of those with AUD reported harm from others' drinking. Low-risk drinkers were more than twice as likely to report harm from someone else's drinking (13.1%) than from their own drinking (5.2%).

Figure 14 Harms from others' alcohol consumption in the year prior to the survey, by drinking pattern



4.7 Alcohol tables

Table 10 Drinking patterns, by sex and age group (%)

Drinking status (all) (N=5,762)

	All	Males	Females	15–24	25–34	35–49	50–64	65+
Never drinker	19.6	17.2	22.0	26.4	13.0	12.6	18.7	31.5
Ex-drinker	6.1	5.9	6.4	1.8	5.7	5.3	7.7	9.7
Current drinker	74.2	76.9	71.6	71.8	81.3	82.1	73.6	58.8

Frequency of drinking (drinkers only) (N=4,277)

	All	Males	Females	15–24	25–34	35–49	50–64	65+
Less than monthly	16.8	14.1	19.5	16.1	18.5	15.5	14.3	21.8
1–3 times per month	26.4	22.7	30.2	35.0	31.7	27.1	21.7	16.5
1–3 times per week	51.0	55.8	46.0	47.4	46.7	52.5	56.6	48.1
4+ times per week	5.9	7.3	4.4	1.5	3.1	4.9	7.4	13.6

Number of standard drinks consumed on a typical drinking occasion (drinkers only)

	All	Males	Females	15–24	25–34	35–49	50–64	65+
1–2 drinks	25.5	16.3	34.8	12.4	17.4	26.7	27.2	43.2
3–5 drinks	40.5	33.6	47.5	42.1	37.0	41.0	42.8	38.1
6–9 drinks	22.6	30.6	14.3	27.6	28.8	21.7	20.7	14.7
10+ drinks	11.5	19.5	3.3	17.9	16.8	10.7	9.3	4.0
Mean	*5.0*	*6.2*	*3.8*	*6.1*	*6.0*	*4.9*	*4.7*	*3.6*

Highest number of standard drinks consumed on a single occasion in the last year (drinkers only)

	All	Males	Females	15–24	25–34	35–49	50–64	65+
1–5 drinks	33.1	20.5	45.9	20.1	19.9	27.6	40.4	61.5
6–9 drinks	29.1	23.9	34.5	30.1	29.9	31.6	28.9	22.3
10–19 drinks	29.5	40.9	17.8	35.6	37.9	32.3	25.0	14.6
20+ drinks	8.3	14.8	1.8	14.4	12.3	8.5	5.8	1.6

Frequency of HED among drinkers

	All	Males	Females	15–24	25–34	35–49	50–64	65+
Never	27.5	17.9	37.4	15.7	16.5	22.9	33.9	53.3
Less than monthly	32.6	29.1	36.2	27.9	37.5	39.4	29.9	21.0
1–3 times per month	16.3	19.3	13.1	23.1	21.5	16.0	13.8	6.9
Weekly	23.7	33.7	13.3	33.4	24.5	21.7	22.4	18.8

Hazardous drinking among those who drank in the last year (drinkers only)

	All	Males	Females	15–24	25–34	35–49	50–64	65+
Monthly HED	39.9	53.0	26.4	56.4	46.0	37.7	36.2	25.7
AUDIT-C score of 5+	51.3	65.7	36.5	64.2	57.1	50.4	48.0	38.2
Prevalence of AUD								
AUD (all)	14.8	19.1	10.8	26.9	22.8	16.2	7.7	3.9
AUD (drinkers only)	20.0	24.8	15.1	37.5	28.1	19.7	10.5	6.7
Mild AUD	11.6	13.0	10.1	18.1	14.5	12.8	7.2	4.8
Moderate AUD	5.4	7.6	3.1	11.2	9.2	4.7	1.8	1.6
Severe AUD	3.1	4.2	1.9	8.2	4.4	2.2	1.5	0.3

All figures are based on weighted data, are rounded to the nearest decimal place, and are based on valid responses.

Table 11 Drinking patterns, sex by age group (%)

Drinking status (all) (N=5,762)

	Males					Females				
	15–24	25–34	35–49	50–64	65+	15–24	25–34	35–49	50–64	65+
Never drinker	23.3	9.3	12.8	17.6	25.1	29.6	16.7	12.3	19.7	37.2
Ex-drinker	1.7	3.7	5.3	6.7	11.5	1.9	7.6	5.4	8.7	8.1
Current drinker	75.0	87.0	81.9	75.7	63.4	68.5	75.8	82.4	71.6	54.8

Frequency of drinking (drinkers only) (N=4,277)

	15–24	25–34	35–49	50–64	65+	15–24	25–34	35–49	50–64	65+
Less than monthly	16.7	15.0	12.0	14.2	14.7	15.4	22.4	18.9	14.4	29.1
1–3 times per month	27.1	24.4	24.7	20.9	14.3	43.8	39.9	29.4	22.5	18.7
1–3 times per week	55.2	57.1	55.4	57.5	53.2	38.6	35.1	49.7	55.7	43.0
4+ times per week	0.9	3.5	7.9	7.4	17.9	2.2	2.6	2.0	7.4	9.3

Number of standard drinks consumed on a typical drinking occasion (drinkers only)

	15–24	25–34	35–49	50–64	65+	15–24	25–34	35–49	50–64	65+
1–2 drinks	8.4	10.5	19.1	15.1	28.1	16.8	25.0	34.0	39.3	58.9
3–5 drinks	33.2	28.2	31.9	37.3	38.6	51.9	46.7	49.9	48.4	37.6
6–9 drinks	32.0	33.5	29.9	31.4	25.8	22.8	23.7	13.7	9.9	3.3
10+ drinks	26.4	27.8	19.1	16.2	7.6	8.5	4.7	2.4	2.4	0.3
Mean	*7.0*	*7.4*	*6.2*	*5.9*	*4.6*	*5.1*	*4.4*	*3.7*	*3.4*	*2.6*

Highest number of standard drinks consumed on a single occasion in the last year (drinkers only)

	15–24	25–34	35–49	50–64	65+	15–24	25–34	35–49	50–64	65+
1–5 drinks	12.5	12.1	15.9	23.4	43.2	28.5	28.2	38.7	57.5	80.3
6–9 drinks	23.8	18.7	22.7	26.6	28.4	37.1	42.0	40.1	31.3	16.0
10–19 drinks	43.9	46.6	44.5	39.9	25.3	26.2	28.6	20.7	9.8	3.7
20+ drinks	19.8	22.6	16.9	10.1	3.1	8.3	1.2	0.5	1.4	0.1

Frequency of HED among drinkers

	Males					Females				
	15–24	25–34	35–49	50–64	65+	15–24	25–34	35–49	50–64	65+
Never	11.5	10.5	12.9	22.4	38.0	20.4	23.1	32.7	45.7	68.8
Less than monthly	25.4	30.4	34.3	28.4	21.7	30.6	45.3	44.4	31.5	20.3
1–3 times per month	24.2	22.5	20.3	17.3	10.6	21.8	20.5	11.8	10.2	3.3
Weekly	38.9	36.7	32.5	31.9	29.7	27.2	11.1	11.2	12.5	7.7

Hazardous drinking among those who drank in the last year (drinkers only)

	15–24	25–34	35–49	50–64	65+	15–24	25–34	35–49	50–64	65+
Monthly HED	63.1	59.1	52.8	49.2	40.3	49.0	31.6	23.0	22.8	11.0
AUDIT-C score of 5+	70.4	69.4	66.9	63.5	56.5	57.3	43.6	34.3	32.3	19.2
Prevalence of AUD										
AUD (all)	27.8	32.2	21.5	10.3	6.1	26.1	13.7	11.1	5.3	2.0
AUD (drinkers only)	37.0	37.1	26.2	13.6	9.7	38.0	18.1	13.4	7.3	3.7
Mild	15.0	14.6	16.1	9.4	7.3	21.6	14.3	9.7	5.0	2.2
Moderate	14.1	15.3	6.5	1.9	1.9	7.9	2.4	2.9	1.8	1.3
Severe	7.9	7.1	3.7	2.3	0.4	8.6	1.4	0.8	0.6	0.2

All figures are based on weighted data, are rounded to the nearest decimal place, and are based on valid responses.

Table 12 Drinking patterns, by area deprivation quintile (%)

Drinking status (all) (N=5,762)

	1 (most deprived)	2	3	4	5 (least deprived)
Never drinker	21.2	23.4	19.0	16.0	17.7
Ex-drinker	8.8	6.7	6.0	5.3	3.7
Current drinker	70.0	70.0	74.9	78.7	78.6

Frequency of drinking (drinkers only) (N=4,277)

	1	2	3	4	5
Less than monthly	19.6	18.7	18.2	15.0	11.6
1–3 times per month	25.3	28.6	26.3	24.4	27.2
1–3 times per week	51.6	47.3	51.5	53.3	51.7
4+ times per week	3.6	5.4	4.1	7.2	9.5

Number of standard drinks consumed on a typical drinking occasion (drinkers only)

	1	2	3	4	5
1–2 drinks	17.4	20.4	25.6	30.7	33.5
3–5 drinks	38.5	41.3	41.7	37.6	42.8
6–9 drinks	27.4	24.2	22.2	21.4	17.7
10+ drinks	16.7	14.1	10.6	10.3	6.0
Mean	*6.0*	*5.5*	*4.9*	*4.7*	*4.1*

Highest number of standard drinks consumed on a single occasion in the last year (drinkers only)

	1	2	3	4	5
1–5 drinks	27.8	30.6	34.4	33.7	38.9
6–9 drinks	31.7	30.0	30.8	26.5	26.0
10–19 drinks	30.4	32.1	27.4	30.1	27.4
20+ drinks	10.1	7.3	7.4	9.7	7.7

Frequency of HED among drinkers					
	1	2	3	4	5
Never	24.7	25.8	29.9	27.0	29.4
Less than monthly	29.9	33.4	33.8	33.4	31.5
1–3 times per month	16.4	18.1	13.9	15.0	18.5
Weekly	29.1	22.7	22.4	24.5	20.6
Hazardous drinking among those who drank in the last year (drinkers only)					
	1	2	3	4	5
Monthly HED	45.4	40.8	36.3	39.6	39.1
AUDIT-C score of 5+	58.5	52.2	48.8	48.6	50.0
Prevalence of AUD					
AUD (all)	14.1	13.4	13.4	18.0	16.1
AUD (drinkers only)	20.2	19.2	17.9	22.9	20.5
Mild	11.5	10.8	9.4	13.1	13.8
Moderate	4.3	6.6	5.3	5.8	4.5
Severe	4.4	1.9	3.2	4.0	2.2

All figures are based on weighted data, are rounded to the nearest decimal place, and are based on valid responses.

Table 13 Trends in proportion of non-drinkers (aged 15–64 years), by age and sex

	All	Males	Females	15–24	25–34	35–49	50–64
2002–03	16.2	14.0	18.4	17.7	9.0	15.1	23.6
2006–07	15.8	13.6	18.2	16.8	10.6	14.5	22.7
2010–11	14.7	12.5	16.8	18.3	10.4	13.2	18.6
2014–15	20.5	17.9	23.2	22.7	19.5	17.8	23.6
2019–20	22.3	20.2	24.4	28.2	18.7	17.9	26.4

Table 14 Trends in proportion of drinkers (aged 15–64 years) reporting monthly HED, by age and sex

	All	Males	Females	15–24	25–34	35–49	50–64
2002–03	48.8	58.4	37.9	73.7	57.4	37.8	27.2
2006–07	58.6	69.1	46.2	71.6	69.0	53.0	40.4
2010–11	52.3	63.8	40.3	64.6	58.8	48.6	40.6
2014–15	46.8	60.9	31.9	57.0	57.7	39.8	37.1
2019–20	42.3	55.1	29.0	56.4	46.0	37.7	36.2

Table 15 Trends in proportion of drinkers (aged 15–64 years) with a positive AUDIT-C score, by age and sex

	All	Males	Females	15–24	25–34	35–49	50–64
2010–11	57.6	70.3	44.3	66.1	62.7	55.1	48.6
2014–15	60.1	75.4	43.8	67.9	67.7	55.2	52.7
2019–20	53.5	67.2	39.5	64.2	57.1	50.4	48.0

Table 16 Harms from alcohol consumption in the year prior to the survey, by sex and age group

	All	Males	Females	15–24	25–34	35–49	50–64	65+
Harms in the last year from own drinking (drinkers only) N=4,277								
Role impairment	5.9	8.4	3.3	14.6	9.2	5.3	1.5	0.6
Accidentally hurt yourself	10.2	12.0	8.4	25.7	13.9	7.5	4.6	3.9
Been in a fight	3.2	4.3	2.1	11.9	5.0	1.1	0.6	0.3
Harm to home life/ marriage	3.1	4.5	1.7	4.2	3.2	4.4	2.0	0.8
Harm to health	8.0	10.7	5.2	15.9	8.7	7.8	5.5	3.1
1+ harm	*13.5*	*17.3*	*9.8*	*27.6*	*19.4*	*13.6*	*7.4*	*3.5*

Harms in the last year from others' drinking (all respondents) N=5,762

	All	Males	Females	15–24	25–34	35–49	50–64	65+
Harm to family	10.8	8.5	13.1	11.0	15.6	12.5	9.4	5.5
Been a passenger with a drunk driver	6.0	8.5	3.6	11.5	8.9	5.5	3.3	2.6
Assaulted	4.5	6.4	2.7	12.6	6.2	3.8	1.6	0.6
Financial harm	2.7	2.4	2.9	3.1	3.7	3.6	1.6	1.1
Property vandalised	4.0	4.7	3.3	8.9	7.1	3.8	1.1	0.7
1+ harm	*17.0*	*18.3*	*15.7*	*24.0*	*23.9*	*18.8*	*12.5*	*7.5*

All figures are based on weighted data, are rounded to the nearest decimal place, and are based on valid responses.

Table 17 Harms from alcohol consumption in the year prior to the survey, sex by age group

	Males					Females				
	15–24	25–34	35–49	50–64	65+	15–24	25–34	35–49	50–64	65+
Harms in the last year from own drinking (drinkers only) N=4,277										
Role impairment	18.1	14.6	8.1	1.8	0.5	10.9	3.1	2.5	1.1	0.7
Accidentally hurt yourself	23.5	16.9	10.7	6.1	4.7	28.2	10.6	4.4	3.0	3.1
Been in a fight	15.6	7.1	1.4	0.4	0.0	7.9	2.6	0.7	0.7	0.5
Harm to home life/marriage	3.6	5.6	7.1	2.8	1.3	4.9	0.6	1.8	1.1	0.3
Harm to health	17.2	14.1	10.9	6.8	5.0	14.4	2.8	4.7	4.2	1.1
1+ harm	*29.5*	*26.4*	*18.7*	*9.6*	*5.3*	*25.7*	*12.6*	*8.6*	*5.3*	*2.0*
Harms in the last year from others' drinking (all respondents) N=5,762										
	15–24	25–34	35–49	50–64	65+	15–24	25–34	35–49	50–64	65+
Harm to family	6.4	14.7	8.7	8.2	4.7	15.7	16.5	16.1	10.6	6.1
Been a passenger with a drunk driver	14.5	13.7	7.7	4.7	4.3	8.4	4.2	3.5	1.9	1.1

	Males					Females				
	15–24	25–34	35–49	50–64	65+	15–24	25–34	35–49	50–64	65+
Assaulted	15.9	10.1	4.9	3.0	0.8	9.2	2.4	2.8	0.2	0.4
Financial harm	2.1	3.1	3.7	1.5	1.3	4.2	4.3	3.5	1.7	1.0
Property vandalised	10.3	10.1	3.4	1.4	0.6	7.5	4.2	4.2	0.8	0.7
1+ harm	*25.7*	*28.8*	*18.3*	*13.0*	*8.4*	*22.2*	*19.2*	*19.3*	*12.1*	*6.8*

All figures are based on weighted data, are rounded to the nearest decimal place, and are based on valid responses.

Table 18 Harms from own alcohol consumption in the year prior to the survey, by drinking pattern

	No monthly HED or AUD	Monthly HED	Any AUD
Role impairment	0.7	10.3	26.3
Accidentally hurt yourself	2.8	16.6	39.2
Been in a fight	1.1	5.3	11.7
Harm to home life/marriage	0.6	4.8	13.1
Harm to health	1.3	14.3	33.1
1+ harm	*5.2*	*29.0*	*67.1*

Table 19 Harms from others' alcohol consumption in the year prior to the survey, by drinking pattern

	Non-drinker	No monthly HED or AUD	Monthly HED	Any AUD
Harm to family	9.4	9.4	11.6	22.6
Been a passenger with a drunk driver	2.4	3.1	11.9	21.7
Assaulted	3.2	1.7	8.3	17.2
Financial harm	2.4	1.9	3.2	6.9
Property vandalised	2.2	2.0	6.7	14.2
1+ harm	*11.8*	*13.1*	*23.7*	*43.4*

05

Illegal drug use

This chapter presents data on the use of illegal drugs. In this survey, 'any illegal drug' refers to cannabis, ecstasy, cocaine powder, magic mushrooms, amphetamines, poppers, LSD, new psychoactive substances (NPS), solvents, crack, and heroin. It should be noted that poppers and solvents are not illegal in Ireland. However, they are included here to ensure consistency with previous surveys. Three recall periods are used to measure drug use prevalence:

- ***Lifetime prevalence*** refers to the proportion of the sample that reported ever having used the named drug at the time they were surveyed.
- ***Last year prevalence*** refers to the proportion of the sample that reported using a named drug in the year prior to the survey. Last year prevalence is often referred to as recent use.
- ***Last month prevalence*** refers to the proportion of the sample that reported using a named drug in the 30-day period prior to the survey. Last month prevalence may also be referred to as current use.

This chapter contains the main findings on last year (recent) illegal drug use. More detailed tables on lifetime, last year, and last month prevalence, by sex and age group, and including 95% confidence intervals for each drug, are provided in Appendix I. Tables on trends in lifetime, last year, and last month prevalence of each drug, including significance testing, are provided in Appendix II. It should be noted that the survey methodology changed in 2014–15 to include all adults aged 15 years and older (for the first three surveys, the study population only included those aged 15–64 years). To analyse trends across all five surveys, only those aged 15–64 years were included in these analyses.

5.1 Illegal drug use: Main findings

The main findings from the 2019–20 NDAS regarding illegal drug use include the following:

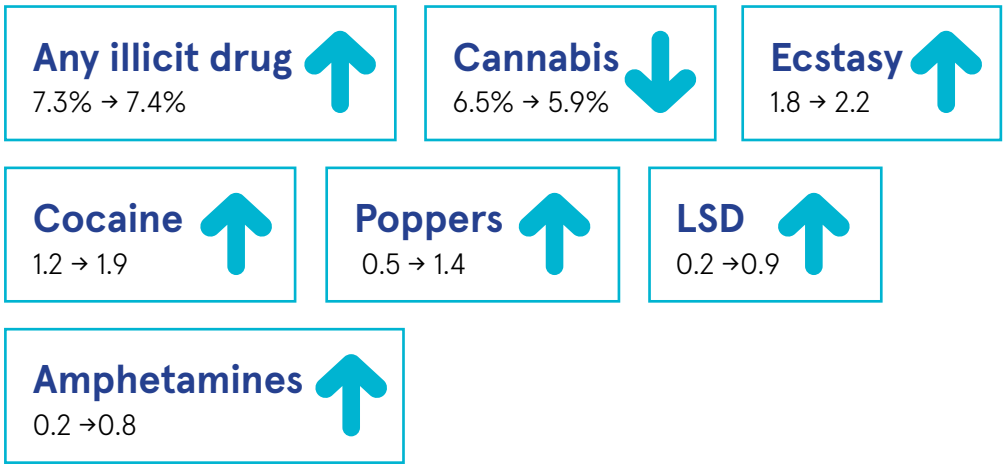
- 23.0% of respondents reported lifetime use of any illegal drug, corresponding to 899,000 adults aged 15 years and older in the general population in Ireland; 7.4% (corresponding to 289,000 adults in the general population) reported recent or last year use; and 4.1% (corresponding to 161,000 adults in the general population) reported current or last month use.
- The most commonly used illegal drugs in the 12 months prior to the survey were:
    1. Cannabis (5.9%)
    2. Ecstasy (2.2%)
    3. Cocaine (1.9%)
    4. Poppers (1.4%)
    5. LSD (0.9%)
    6. Amphetamines (0.8%)

- Males were more likely than females to report recent illegal drug use (10.2% versus 4.7%).
- Young people aged 15–24 years were most likely to report recent illegal drug use (18.5%).
- Males aged 25–34 years had the highest reported level of recent illegal drug use (25.8%).
- An increase in recent illegal drug use since 2014–15 was reported for several illegal drugs, including cocaine, ecstasy, LSD, amphetamines, and poppers. A small decrease in recent use of cannabis was reported.
- Those who used drugs were more likely to report recent use of at least three different drugs in 2019–20 (25.0%) compared with 2014–15 (15.4%).

5.2 How many people use illegal drugs and how has this changed?

In 2019–20, 23.0% of survey participants aged 15 years and older reported use of an illegal drug at some point in their lifetime, corresponding to 899,000 adults aged 15 years and older in the general population in Ireland; 7.4% (corresponding to 289,000 adults in the general population) reported last year or recent use; and 4.1% (corresponding to 161,000 adults in the general population) reported last month or current use. For adults aged 15–64 years, the equivalent prevalence rates were 27.1% for lifetime use, 9.0% for last year use, and 4.9% for last month use.

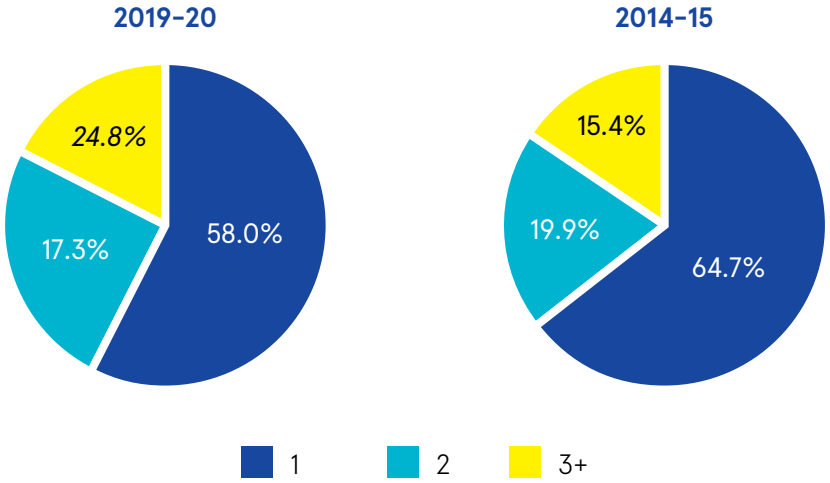
Although the prevalence of recent illegal drug use among survey participants aged 15 years and older was similar in 2019–20 (7.4%) and 2014–15 (7.3%), a statistically significant increase in recent use since 2014–15 was reported for cocaine, LSD, amphetamines, and poppers. A non-significant decrease in recent use of cannabis was also reported (from 6.5% in 2014–15 to 5.9% in 2019–20).



5.2.1 Number of drugs used

Although the prevalence of recent drug use has remained stable since the 2014–15 survey, the 2019–20 NDAS found that those who reported recent illegal drug use were more likely to report use of at least two illegal drugs. In 2019–20, one-quarter of those who reported illegal drug use reported use of at least three illegal drugs, compared with 15.4% in 2014–15 (Figure 15).

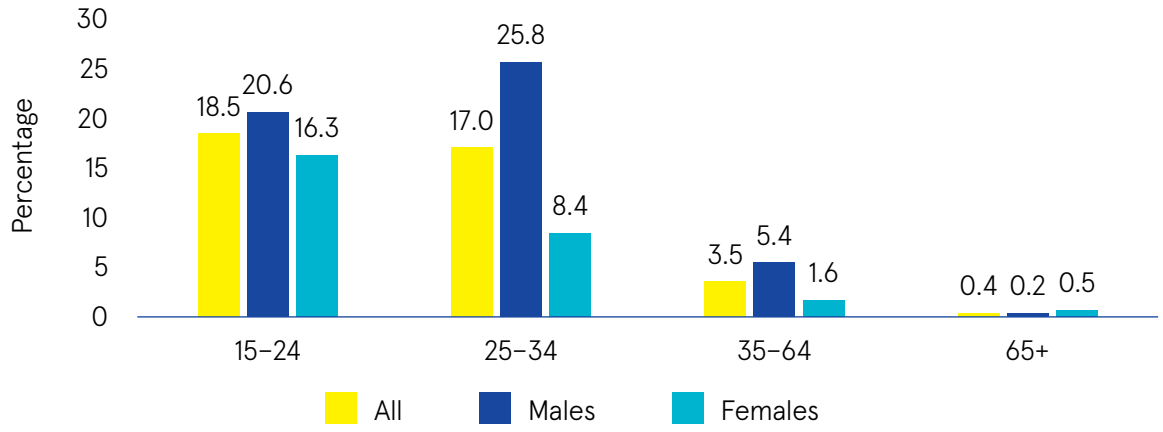
Figure 15 Number of illegal drugs used by those reporting recent use of illegal drugs in 2014–15 and 2019–20



5.3 Drug use by age group and sex

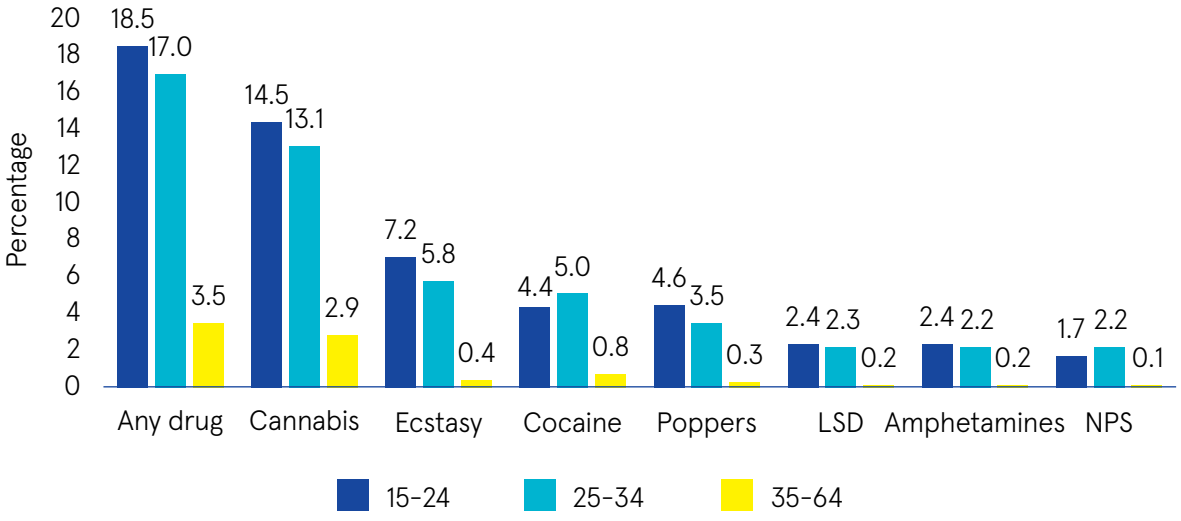
Males were more than twice as likely as females to report recent use of an illegal drug (10.2% versus 4.7%). The youngest age group (15–24 years) had the highest prevalence of drug use (18.5%), with little difference between males and females (Figure 16). There were considerable differences among male and female 25–34-year-olds, with males in this age group being three times more likely than females to report recent drug use (25.8% versus 8.4%). Males aged 25–34 years had the highest prevalence of recent drug use (25.8%). Those aged 35–64 years reported a relatively low prevalence of drug use (3.5%), with males in this age group being three times more likely than females to report recent drug use (5.4% versus 1.6%).

Figure 16 Recent use of any illegal drug, by sex and age group



For all illegal drugs except for cocaine and NPS, recent use was most common among 15–24-year-olds (Figure 17).

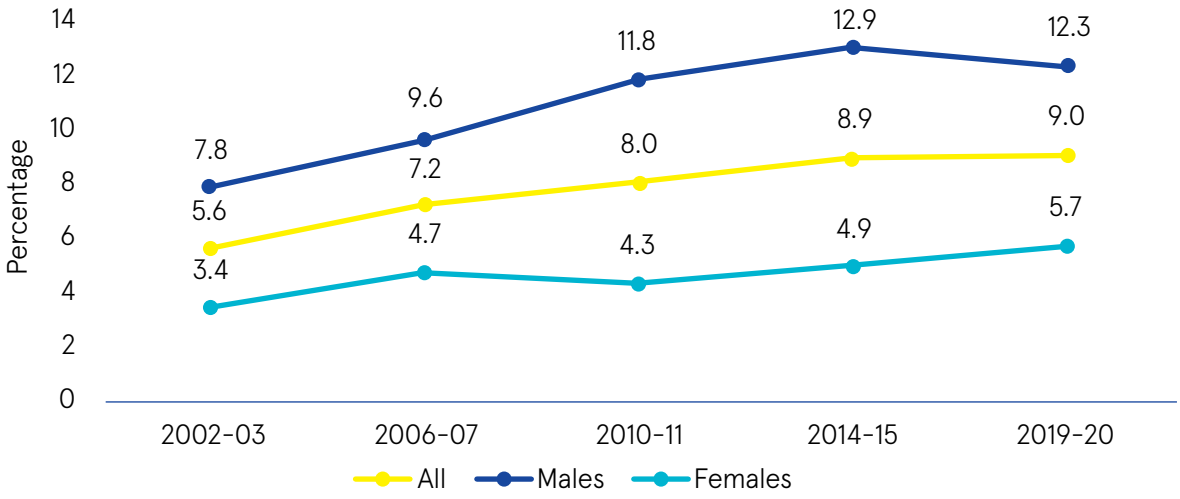
Figure 17 Recent use of illegal drugs, by drug type and age group



5.3.1 Trends in recent use of illegal drugs among 15–64-year-olds

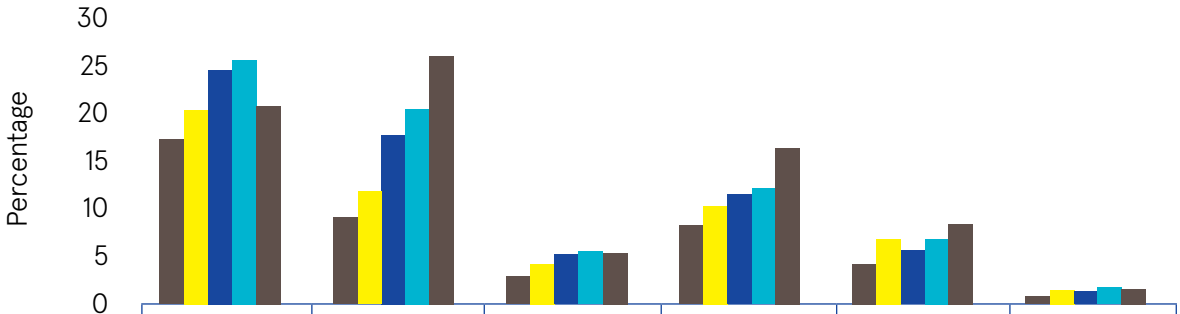
Although illegal drug use increased steadily between 2002–03 and 2014–15, no significant increase in the proportion of 15–64-year-olds reporting use of any illegal drug use was observed in the 2019–20 NDAS compared with the 2014–15 survey (Figure 18).

Figure 18 Trends in recent use of any illegal drug among 15–64-year-olds, by sex



Since 2002–03, there has been a steady increase in each survey in the proportion of males aged 25–34 years who reported recent illegal drug use (from 9.1% in 2002–03 to 25.8% in 2019–20). Among males aged 15–24 years, recent illegal drug use increased from 17.1% in 2002–03 to 25.4% in 2014–15, but decreased to 20.6% in 2019–20 (Figure 19). While females were much less likely to use illegal drugs, the prevalence of illegal drug use among females aged 15–24 years and 25–34 years has doubled since 2002–03. The prevalence of illegal drug use among 35–64-year-olds has been fairly stable since 2006–07 for both males and females.

Figure 19 Trends in recent use of any illegal drug, sex by age group



	15-24	25-34 Males	35-64	15-24	25-34 Females	35-64
2002-03	17.1	9.1	2.9	8.2	4.2	0.8
2006-07	20.2	11.7	4.2	10.2	6.7	1.5
2010-11	24.4	17.6	5.2	11.4	5.6	1.3
2014-15	25.4	20.3	5.5	12.0	6.7	1.7
2019-20	20.6	25.8	5.4	16.3	8.4	1.6

5.4 Age at which people start using illegal drugs

The median age at first use of the most commonly used illegal drugs was higher in 2019–20 when compared with the 2002–03 survey, except for poppers. The median age at first use of each drug was found to be similar in 2019–20, ranging from 19 years for cannabis and poppers to 21 years for cocaine (Table 20).

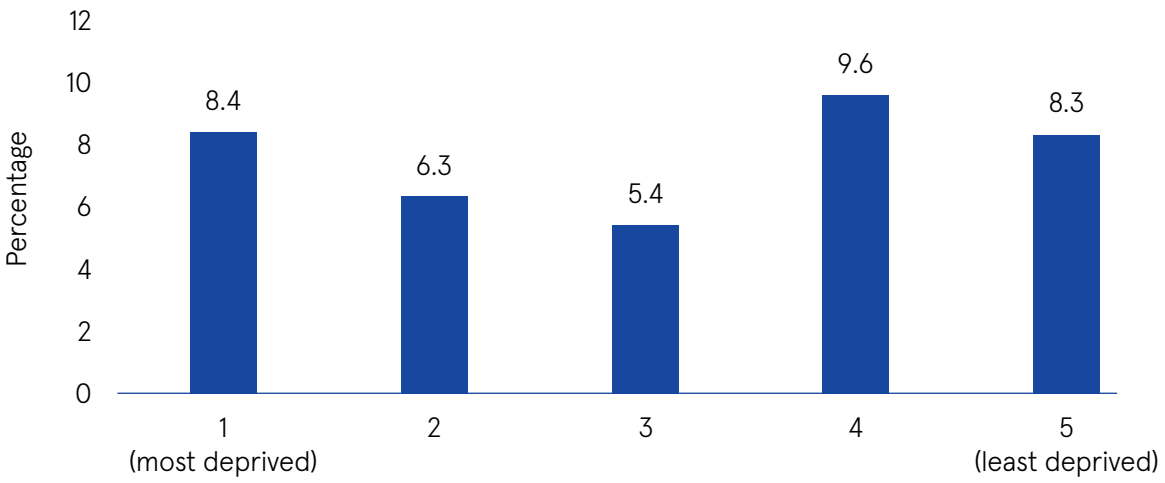
Table 20 Comparison of mean and median age at which respondents first used illegal drugs (years)

	2002–03 mean (median)	2019–20 mean (median)
Cannabis	19.2 (18)	19.7 (19)
Ecstasy	19.4 (18)	19.9 (20)
Cocaine	21.5 (20)	21.9 (21)
Poppers	20.2 (19)	20.1 (19)
LSD	18.4 (18)	20.6 (20)
Amphetamines	19.9 (19)	20.7 (20)

5.5 Illegal drug use by area deprivation level

There were differences in recent drug use according to area deprivation level (Figure 20). Those living in the fourth least deprived quintile reported the highest rate of drug use (9.6%) while those in the third least deprived reported the lowest (5.4%). Similar rates of drug use were reported by the most (8.4%) and least (8.3%) deprived areas.

Figure 20 Recent use of any illegal drug, by area level deprivation



5.6 Polydrug use

The 2019–20 survey contained new questions on polydrug use, which was defined as the use of at least two drugs on the same occasion (simultaneously) in the last year. Table 21 presents the drugs that were used in addition to cannabis, cocaine, and ecstasy. Alcohol was the substance most commonly used with cannabis, cocaine, and ecstasy; 29.8% of recent cannabis users did not use any additional substances with cannabis at any time in the last year, compared with 4.5% of recent cocaine users.

Table 21 Polydrug use among recent users of cannabis, cocaine, and ecstasy (%)

	Cannabis (N=340)	Cocaine (N=107)	Ecstasy (N=128)
None	29.8	4.5	13.0
Alcohol	68.1	93.4	86.0
Cannabis	–	22.3	5.0
Cocaine	7.3	–	6.6
Ecstasy	4.9	9.2	–
LSD	2.5	0.0	0.0
Poppers	2.3	2.6	0.0
Amphetamines	2.2	0.0	0.0
Magic mushrooms	2.2	0.0	0.9
Opioid pain relievers	1.7	0.0	0.5
Sedatives or tranquillisers	0.7	0.0	0.0

5.7 Factors associated with using drugs

This section presents recent illegal drug use in relation to a number of socioeconomic and demographic variables. These were education, employment, marital status, housing, and region of residence. Results are also presented for 15–34-year-olds, as drug use is most prevalent in this age group (Table 22). For those aged 15–34 years, the prevalence of recent drug use was higher among those who had only completed lower secondary school education (30.7%) compared with those with higher educational attainment or who were still in education. There was little difference in prevalence between 15–34-year-olds who were employed (18.7%), unemployed (20.8%), or students (17.2%). Single 15–34-year-olds had a higher prevalence of recent drug use (21.2%) compared with those who were married (9.3%).

Those aged 15–34 years living in rented accommodation (21.0%) or with their parents/family (19.9%) were more likely to report recent drug use than those who owned their own housing (11.1%). Respondents aged 15–34 years who lived in Dublin had the highest prevalence of recent drug use (22.9%), while those living in the rest of Leinster had the lowest (13.7%).

Table 22 Factors associated with recent drug use among all adults and 15–34-year-olds (%)

Employment	All adults	15–34 years	Education	All adults	15–34 years
Employed	7.6	18.7	Primary/none	0.7	0.0
Unemployed	14.0	20.8	Lower secondary	3.7	30.7
Student	17.0	17.2	Higher secondary	6.1	18.5
Home duties	2.4	11.5	Third level	6.9	17.1
Retired	0.4	–	Still in education	14.0	17.1
Housing	**All adults**	**15–34 years**	**Marital status**	**All adults**	**15–34 years**
Owned outright or with mortgage	3.3	11.1	Single/never married	16.5	21.2
Rented	13.1	21.0	Married	3.4	9.3
Live with parents/ family	19.1	19.9	Divorced/ separated	4.8	3.5
			Widowed	0.4	–
Region	**All adults**	**15–34 years**			
Dublin	10.4	22.9			
Rest of Leinster	5.8	13.7			
Munster	6.1	16.9			
Connacht/Ulster	6.9	16.9			

5.8 Why do some people decide not to use drugs?

Respondents who did not report lifetime use of any illegal drug were asked what was the main reason that influenced their decision not to use illegal drugs. The most common reason respondents gave for not ever using drugs was that they were 'just not interested' (39.9%). Young respondents were more likely to cite concerns around health problems and becoming addicted, whereas older respondents were more likely to cite no opportunity or illegal drugs available (Table 23).

Table 23 Reasons why people decide not to use illegal drugs, sex by age group (%)

Weighted responses=4,408	All	Males			Females		
	15+	15–34	35–64	65+	15–34	35–64	65+
Just not interested	39.9	31.0	40.2	45.8	35.1	41.7	45.5
I think drug taking is wrong	14.1	12.5	13.0	13.5	18.0	13.3	15.1
Worry about health problems	12.8	17.1	14.5	8.1	14.7	11.6	9.3
Did not want to become addicted	10.3	15.9	11.3	8.4	10.1	9.2	6.5
No opportunity or illegal drugs available	4.6	0.5	4.1	11.3	0.5	4.0	10.3
Did not like to feel out of control	3.2	2.4	1.4	2.1	2.3	6.0	3.4
Fear of death	3.0	3.0	1.7	1.1	5.7	3.5	2.1
Family/friends/peer pressure	2.8	5.5	2.8	1.3	4.3	2.1	0.4
Did not think it would be enjoyable	2.5	2.3	3.1	2.5	1.8	2.7	2.1
Fear of legal consequences	2.2	2.5	2.2	1.2	3.6	2.1	1.5
Did not want to break the law	1.6	1.4	2.1	1.8	1.3	1.5	1.7
Other	3.2	5.8	3.8	2.9	2.5	2.3	2.2

06

Use of cannabis, ecstasy, and cocaine

This section contains a more detailed analysis of the three most commonly used illegal drugs in Ireland: cannabis, ecstasy, and cocaine. As the prevalence of these drugs is very low among those aged 65 years and older, results are predominantly presented for respondents aged 15–64 years. Tables describing the availability of cannabis, ecstasy, and cocaine are presented at the end of this chapter.

6.1 Cannabis: Main findings

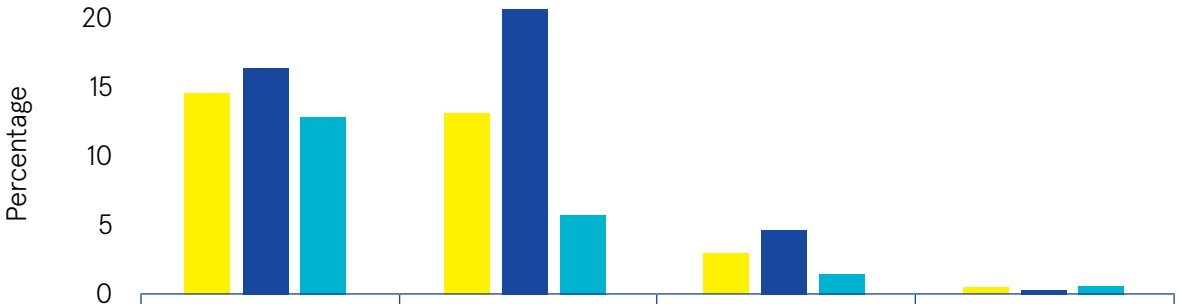
The main findings from the 2019–20 NDAS regarding cannabis use include the following:

- 20.7% of respondents had used cannabis in their lifetime, corresponding to 809,000 of the general population in Ireland aged 15 years and older.
- 5.9% of respondents (231,000 of the general population) and 2.9% of respondents (113,000 of the general population) had used cannabis in the last year and last month, respectively.
- 1.2% of respondents (45,000 of the general population) met the criteria for cannabis use disorder. This corresponds to 19.6% of those who reported last year cannabis use.
- The average age of first cannabis use was 19.7 years (median: 19 years).
- The average age of participants who reported recent cannabis use was 29.9 years (median: 27 years).
- The average age of first regular cannabis use was 20.6 years (median: 20 years).
- The proportion of survey respondents who personally knew somebody who used cannabis was 40.3%.

6.1.1 Cannabis use by age group and sex

Recent (last year) use of cannabis was reported by 5.9% of the adult population (7.1% among 15–64-year-olds) and was higher among males (8.2%) than females (3.6%). Those aged 15–24 years were most likely to report recent cannabis use (14.5%). There were notable differences according to sex in the prevalence of recent cannabis use among those aged 25–34 years, with a higher percentage of males reporting recent use (20.6%) compared with females (5.7%) in the same age group (Figure 21).

Figure 21 Recent use of cannabis, by sex and age group

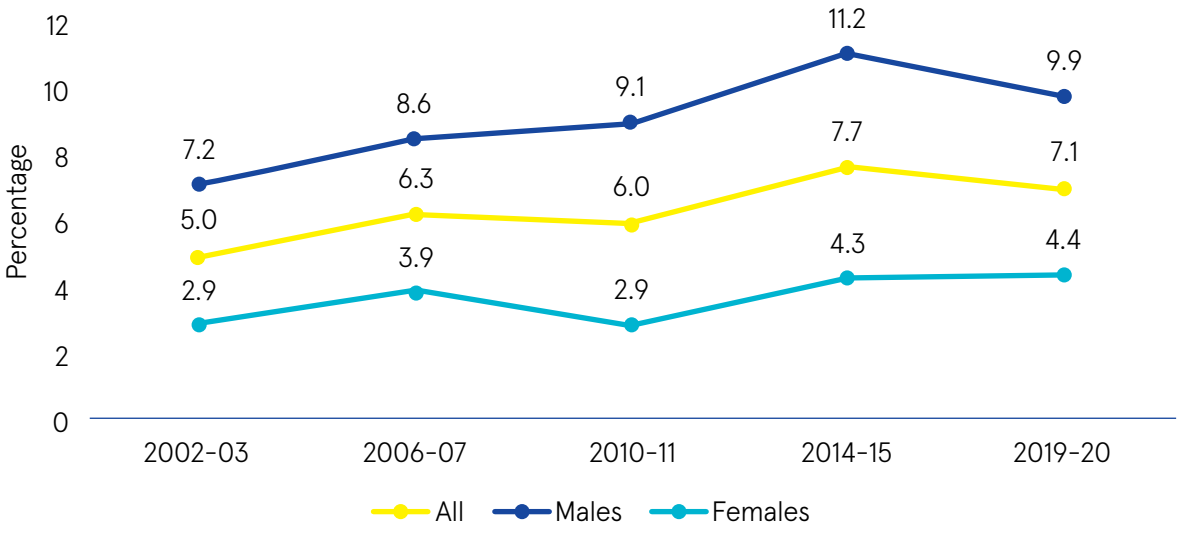


	15–24	25–34	35–64	65+
All	14.5	13.1	2.9	0.4
Males	16.3	20.6	4.6	0.2
Females	12.8	5.7	1.4	0.5

6.1.1.1 Trends in recent cannabis use

Between 2002–03 and 2014–15, recent cannabis use among 15–64-year-olds increased from 5.0% to 7.7%, and was 7.1% in the current survey. Between 2014–15 and 2019–20, recent cannabis use among males decreased from 11.2% to 9.9%, while remaining stable among females (Figure 22).

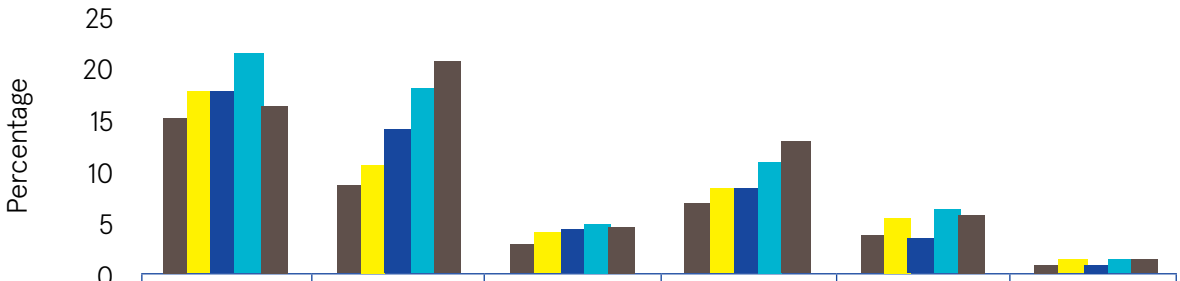
Figure 22 Trends in recent use of cannabis among 15–64-year-olds, by sex



Recent cannabis use among males aged 25–34 years increased across each survey, from 8.6% in 2002–03 to 20.6% in 2019–20. In comparison, there has been a decrease in recent

use among males aged 15–24 years since 2014–15, from 21.5% to 16.3%. Among females aged 15–24 years, recent use has increased from 6.8% in 2002–03 to 12.8% in 2019–20 (Figure 23).

Figure 23 Trends in recent use of cannabis, sex by age group



	15-24	25-34 Males	35-64	15-24	25-34 Females	35-65
2002-03	15.0	8.6	2.8	6.8	3.7	0.8
2006-07	17.8	10.4	3.9	8.3	5.5	1.4
2010-11	17.7	13.9	4.2	8.1	3.3	0.9
2014-15	21.5	18.0	4.8	10.9	6.1	1.2
2019-20	16.3	20.6	4.6	12.8	5.7	1.4

6.1.2 Frequency of cannabis use

One-fifth (22.7%) of current users used cannabis on 20 days or more in the previous month, which is considered to be daily or almost daily use. This was more common among males (29.4%) than females (7.5%) and among older (30.5%) than younger (19.8%) respondents (Table 24).

Table 24 Frequency of cannabis use in the last month among current users, by sex and age group

N=159	All	Males	Females	15–34	35–64
20 days	22.7	29.4	7.5	19.8	30.5
10–19 days	12.3	17.4	0.6	10.9	17.3
4–9 days	30.1	27.2	36.7	33.8	16.0
1–3 days	34.9	26.0	55.2	35.5	36.2

6.1.3 Cannabis use disorder

Cannabis use disorder (CUD) is defined as any cannabis abuse or dependence in the 12 months prior to survey. It was measured using an instrument called the Munich-Composite International Diagnostic Interview (M-CIDI). The M-CIDI instrument was completed by all respondents reporting cannabis use in the last year. The M-CIDI combines the four cannabis abuse and the seven cannabis dependence criteria from the *Diagnostic and Statistical Manual of Psychiatric Disorders, Fourth Edition* (DSM-IV).[8, 9] A person who meets the criteria for either abuse or dependence in the 12 months prior to the survey is said to have a CUD. A person can be diagnosed as having either cannabis abuse or cannabis dependence. If the respondent meets the criteria for both abuse and dependence, then they are assigned to the dependence category only. In previous publications relating to the 2010–11 and 2014–15 surveys, prevalence estimates were presented differently; those who met the criteria for both cannabis abuse and cannabis dependence were counted in each category. Consequently, the cannabis abuse results presented here for the 2010–11 and 2014–15 surveys differ to what was published previously.

The prevalence of CUD in 2019–20 was 1.2%, representing 45,000 of the Irish population; this included 0.5% with cannabis abuse and 0.6% with cannabis dependence (Table 25). The prevalence of CUD was 1.6% for males and 0.8% for females. The highest prevalence was observed among 15–34-year-olds (2.8%). Of those who had used cannabis in the last year, 19.6% met the criteria for CUD, including 19.0% of male and 20.9% of female cannabis users.

Table 25 Prevalence of CUD in the general population, by sex and age group (%)

	All adults	Males	Females	15–34	35–64
Cannabis abuse	0.5	0.5	0.5	1.3	0.3
Cannabis dependence	0.6	1.0	0.2	1.6	0.3
CUD	1.2	1.6	0.8	2.8	0.5

All figures are based on weighted data, are rounded to the nearest decimal place, and are based on valid responses.

6.1.3.1 Trends in CUD

The prevalence of CUD among 15–64-year-olds increased substantially between 2010–11 and 2014–15, from 1.5% to 3.0%, and decreased in 2019–20 to 1.4%. A decrease in CUD was particularly apparent among males and 15–34-year-olds (Table 26). The proportion of last year cannabis users with CUD was 19.6% in 2019–20, 39.2% in 2014–15, and 24.0% in 2010–11.

Table 26 Trends in CUD among 15–64-year-olds, by sex and age group (%)

	All	Males	Females	15–34	35–64
2010–11	1.5	2.7	0.4	2.8	0.5
2014–15	3.0	4.9	1.2	5.9	0.8
2019–20	1.4	1.9	0.9	2.8	0.5

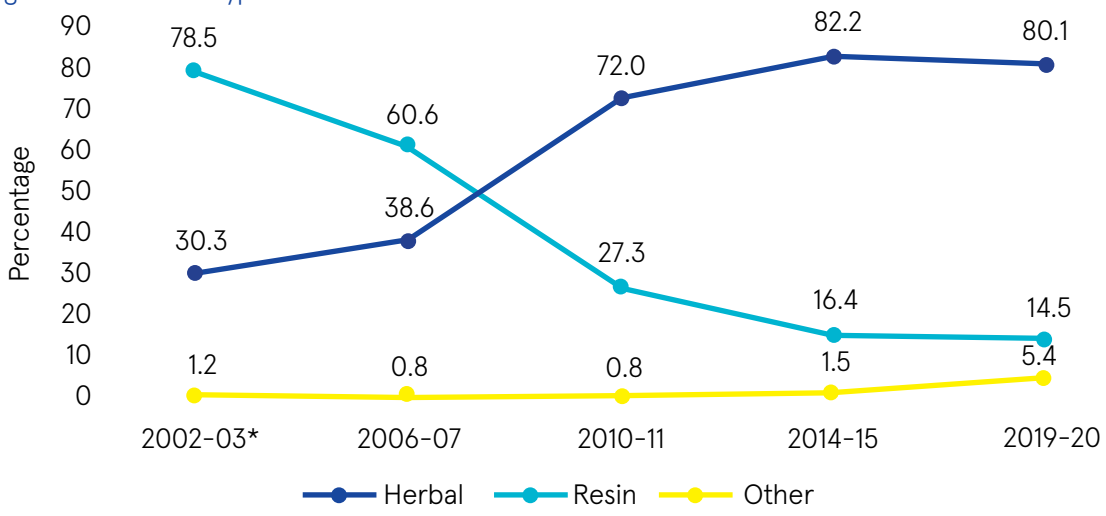
6.1.4 Type of cannabis used

Among current (last month) users of cannabis, herbal cannabis was the most common type of cannabis used (80.1%), followed by resin (14.5%), hash oil (3.0%), and other types of cannabis (2.4%). One-quarter (25.5%) of respondents stated that the cannabis they used was Irish grown, 8.4% stated it was not Irish grown, and 66.1% did not know where the cannabis they used was grown. A joint was the most common method used to take cannabis (86.2%), followed by a pipe (6.5%), vaping (4.7%), eating (1.6%), and other (1.0%).

6.1.4.1 Trends in type of cannabis used

There have been changes in the type of cannabis used since earlier surveys. In the 2002–03 and 2006–07 surveys, the majority of current users reported using resin. Between 2006–07 and 2010–11, there was a notable increase in the use of herbal cannabis and 'other' cannabis types (Figure 24).

Figure 24 Trends in type of cannabis used



*Respondents could select more than one option in the 2002–03 survey.
Herbal includes grass, weed, skunk, and herb.
Resin includes hash and resin.

6.1.5 Availability of cannabis

Regarding cannabis availability for people aged 15 years and older in Ireland, respondents reported the following in the 2019–20 survey:

- Among all adults, 17.5% had been offered cannabis either free of charge or to buy in the previous 12 months; 4.8% were offered cannabis on at least 10 occasions.
- Recent users were asked how they got their cannabis on the last occasion they used it; 31.2% reported sharing cannabis among a group of friends, 30.2% got it from a family member or a friend, and 18.0% bought it from a friend. In comparison, just 5.0% obtained

their cannabis from a stranger (Table 27).

- On the last occasion they used cannabis, recent users most frequently reported obtaining it at the house of a friend (38.4%), followed by obtaining cannabis in the street/park (18.9%), a disco/bar/club (15.3%), or a music festival (7.4%) (Table 28).
- The majority of recent cannabis users (89.8%) stated that it would be very or fairly easy to access cannabis within a 24-hour period, while 6.8% stated that it would be very or fairly difficult (Table 29).

6.1.6 Regular use of cannabis and efforts to stop

Among lifetime cannabis users, 32.3% stated that they had ever used cannabis regularly (participants defined what the term 'regular' meant for themselves). Respondents who had used cannabis regularly at some point in their lifetime were also asked about attempts to stop using cannabis. Of this group, 73.1% said they have managed to stop. The most common reason given by respondents for stopping cannabis use was that it was no longer a part of their social life (23.6%), followed by not wanting to use any longer (19.1%) and concerns about health (14.2%) (Table 30).

6.2 Ecstasy: Main findings

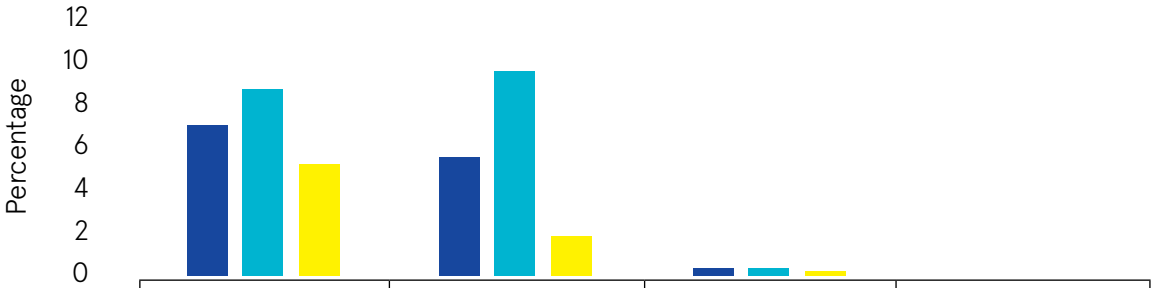
The main findings from the 2019–20 NDAS regarding ecstasy use include the following:

- 8.5% of respondents had ever used ecstasy in their lifetime, corresponding to 333,000 of the general population in Ireland aged 15 years and older.
- 2.2% of respondents (87,000 of the general population) and 1.0% of respondents (41,000 of the general population) had used ecstasy in the last year and the last month, respectively.
- The average age of first ecstasy use was 19.9 years (median: 20 years).
- The average age of participants who reported recent ecstasy use was 25.8 years (median: 24 years).
- The average age of first regular ecstasy use was 20.1 years (median: 20 years).
- The proportion of respondents who personally knew somebody who used ecstasy was 20.8%.

6.2.1 Ecstasy use by age group and sex

Ecstasy was the second most commonly used illegal drug in the year prior to the survey. Males were more likely than females to report recent use of ecstasy (3.2% versus 1.3%). Those aged 15–24 years were most likely to report recent ecstasy use (7.2%). There were significant sex differences in the prevalence of recent ecstasy use among those aged 25–34 years, with 9.7% of males reporting recent use compared with 1.9% of females in the same age group (Figure 25).

Figure 25 Recent ecstasy use, by sex and age group

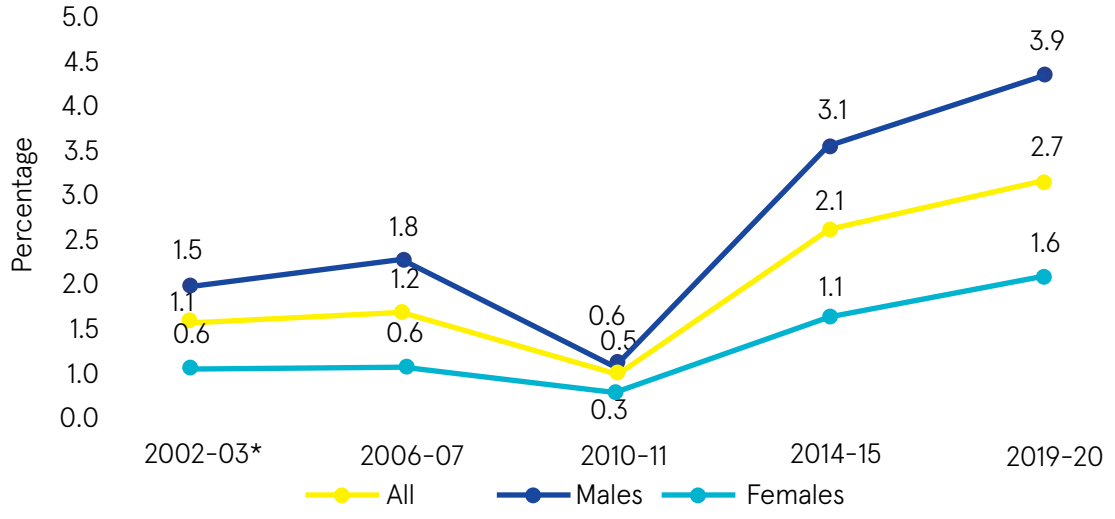


	15-24	25-34	35-64	65+
All	7.2	5.8	0.4	0.0
Males	8.9	9.7	0.4	0.0
Females	5.4	1.9	0.3	0.0

6.2.1.1 Trends in recent ecstasy use

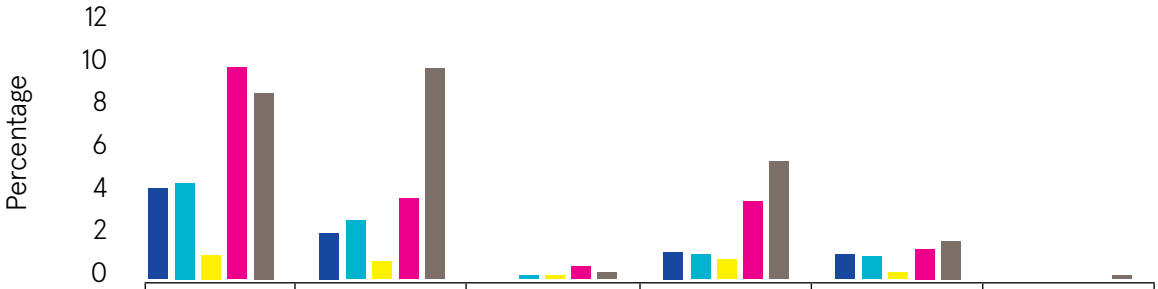
Recent ecstasy use increased from 1.1% in 2002–03 to 2.7% in 2019–20 (Figure 26). With the exception of the 2010–11 survey, recent ecstasy use increased at each survey. There was a significant decrease in 2010–11 (to 0.5%), but recent use increased to 2.1% in 2014–15. In the 2010–11 survey, NPS were the second most commonly used illegal substance, with 3.5% of 15–64-year-olds reporting recent use. It is possible that ecstasy was replaced by stimulant-like NPS in the year prior to that survey. Following the introduction of the Criminal Justice (Psychoactive Substances) Act 2010, recent use of NPS was found to have decreased in the 2014–15 survey to 0.8%, while recent use of ecstasy increased.

Figure 26 Trends in recent ecstasy use among 15–64-year-olds, by sex



Recent ecstasy use among males aged 25–34 years increased from 2.2% in 2002–03 to 9.7% in 2019–20, with the largest increase observed between the 2014–15 and 2019–20 surveys. A large increase in recent ecstasy use was also observed among females aged 15–24 years; in the first three surveys, recent use ranged from 1.0% to 1.4%, and this increased to 3.7% in 2014–15 and 5.4% in 2019–20 (Figure 27).

Figure 27 Trends in recent ecstasy use, sex by age group



	Males			Females		
	15-24	25-34	35-64	15-24	25-34	35-64
2002-03	4.2	2.2	0.0	1.4	1.2	0.0
2006-07	4.5	2.8	0.3	1.2	1.1	0.1
2010-11	1.3	0.9	0.3	1.0	0.4	0.1
2014-15	9.7	3.8	0.6	3.7	1.5	0.1
2019-20	8.9	9.7	0.4	5.4	1.9	0.3

6.2.2 Frequency of ecstasy use

No current users used ecstasy on 20 days or more in the previous month, which is considered to be daily or almost daily use. Three quarters (75.6%) had used ecstasy on 1–3 days in the previous month, 16.4% used ecstasy on 4–9 days, while 8.0% used ecstasy on 10–19 days. It should be noted that just 56 respondents answered this question.

6.2.3 Availability of ecstasy

Regarding ecstasy availability for people aged 15 years and older in Ireland, respondents reported the following in the 2019–20 survey:

- Among all adults, 11.7% had been offered ecstasy either free of charge or to buy in the previous 12 months; 3.1% were offered ecstasy on at least 10 occasions.
- Recent users were asked how they got their ecstasy on the last occasion they used it; 33.6% bought it from a contact they did not know personally, 22.5% shared it among a group of friends, and 15.2% were given it by a family member or a friend (Table 27).
- On the last occasion they used ecstasy, recent users most frequently reported obtaining

it at a disco/bar/club (47.7%), followed by in the street/park (10.7%) or at a music festival (10.6%) (Table 28).

- The majority of recent users (85.9%) stated that it would be very or fairly easy to access ecstasy within a 24-hour period, while 2.3% stated that it would be very difficult (Table 29).

6.2.4 Regular use of ecstasy and efforts to stop

Among lifetime ecstasy users, 38.3% stated that they had ever used ecstasy regularly (participants defined what the term 'regular' meant for themselves). Respondents who had used ecstasy regularly at some point in their lifetime were also asked about attempts to stop using ecstasy. Of this group, 64.9% said they have managed to stop. The most common reason given by respondents for stopping ecstasy use was that it was no longer a part of their social life (44.9%), followed by not wanting to take it anymore (15.8%) and concerns about health (15.1%) (Table 30).

6.3 Cocaine: Main findings

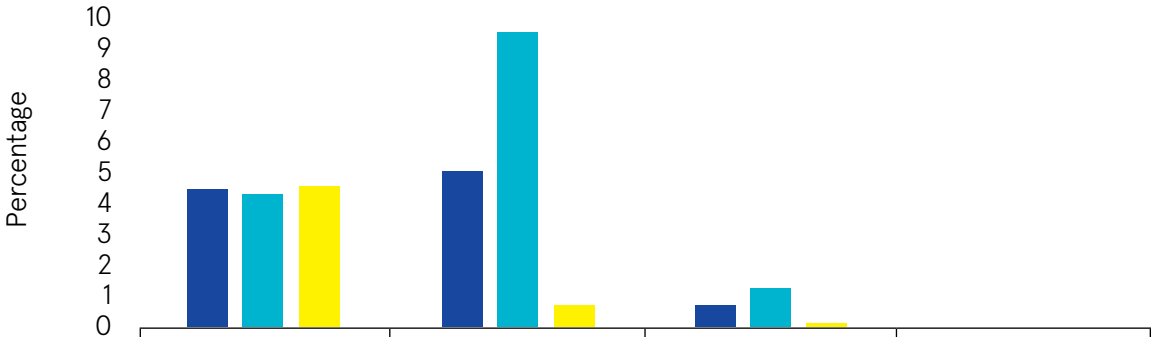
The main findings from the 2019–20 NDAS regarding cocaine use include the following:

- 6.6% of respondents had ever used cocaine in their lifetime, corresponding to 260,000 of the general population in Ireland aged 15 years and older.
- 1.9% of respondents (72,000 of the general population) and 0.6% of respondents (23,000 of the general population) had used cocaine in the last year and last month, respectively.
- The average age of first cocaine use was 21.9 years (median: 21 years).
- The average age of participants who reported recent cocaine use was 28.4 years (median: 27 years).
- The average age of first regular cocaine use was 23.5 years (median: 22 years).
- The proportion of respondents who personally knew somebody who used cocaine was 26.7%.
- 84.9% of lifetime users also used alcohol on the occasion of first cocaine use.

6.3.1 Cocaine use by age and sex

Males were more likely than females to report recent use of cocaine (2.8% versus 0.9%). Those aged 25–34 years were most likely to report recent cocaine use (5.0%). There were sex differences in the prevalence of recent cocaine use among those aged 25–34 years, with 9.4% of males reporting recent use compared with 0.7% of females in the same age group Figure 28).

Figure 28 Recent cocaine use, by sex and age group

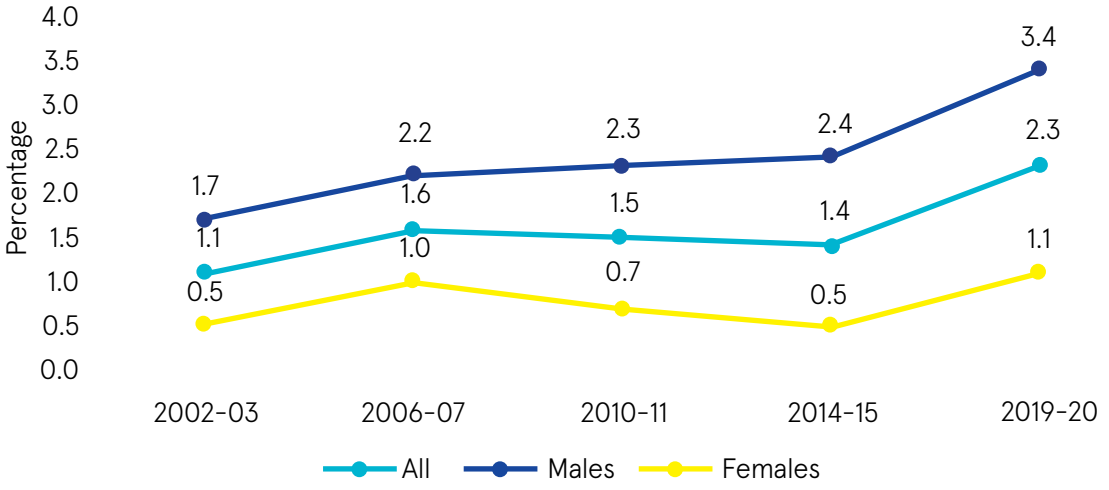


	15-24	25-34	35-64	65+
All	4.4	5.0	0.7	0.0
Males	4.2	9.4	1.3	0.0
Females	4.5	0.7	0.2	0.0

6.3.1.1 Trends in recent cocaine use

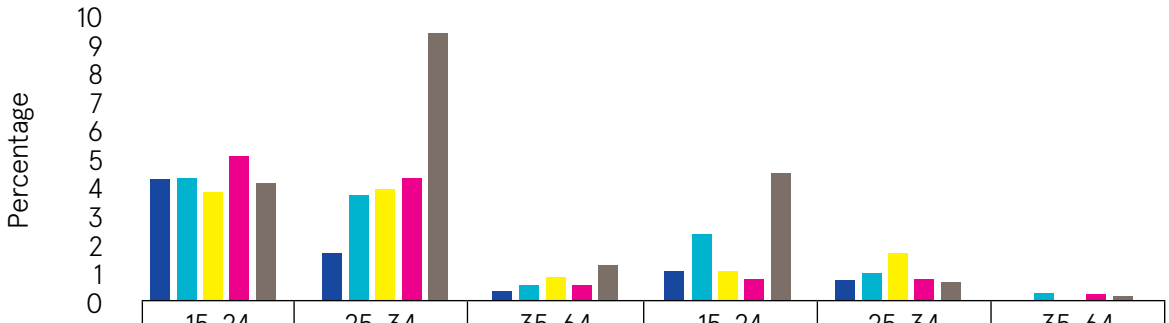
In the current survey, a statistically significant increase in recent cocaine use was observed for 15–64-year-olds, 15–34-year-olds, and females. Recent cocaine use among 15–64-year-olds has increased from 1.1% in 2002–03 to 2.3% in 2019–20, although cocaine use remained stable between 2006–07 and 2014–15. Since the 2014–15 survey, recent cocaine use among males increased from 2.4% to 3.4%, and use among females increased from 0.5% to 1.1% (Figure 29).

Figure 29 Trends in recent cocaine use among 15–64-year-olds, by sex



Recent cocaine use among males aged 25–34 years increased across each survey, from 1.8% in 2002–03 to 9.4% in 2019–20, with the largest increase observed in the current survey. A large increase was also observed among females aged 15–24 years, with recent use increasing from 0.8% in 2014–15 to 4.5% in 2019–20 (Figure 30).

Figure 30 Trends in recent cocaine use, sex by age group



	Males			Females		
	15-24	25-34	35-64	15-24	25-34	35-64
2002-03	4.3	1.8	0.4	1.1	0.8	0.1
2006-07	4.4	3.8	0.6	2.4	1.0	0.3
2010-11	3.9	4.0	0.9	1.1	1.7	0.1
2014-15	5.1	4.4	0.6	0.8	0.8	0.3
2019-20	4.2	9.4	1.3	4.5	0.7	0.2

6.3.2 Frequency of cocaine use

One-half (51.9%) of current users used cocaine on 4–9 days in the previous month, while 46.2% used cocaine on 1–3 days, and 1.9% used cocaine on 10–19 days. It should be noted that just 29 respondents answered this question.

6.3.3 Availability of cocaine

Regarding cocaine availability for people aged 15 years and older in Ireland, respondents reported the following in the 2019–20 survey:

- Among all adults, 13.0% had been offered cocaine either free of charge or to buy in the previous 12 months; 3.5% were offered cocaine on at least 10 occasions.
- Recent users were asked how they got their cocaine on the last occasion they used it; 36.1% got it from a family member or a friend, 20.5% bought it from a contact they did not know personally, and 18.9% shared it among a group of friends (Table 27).
- On the last occasion they used cocaine, recent users most frequently reported obtaining it at the house of a friend (34.5%), followed by a disco/bar/club (28.5%), ordering it by phone for collection (14.4%), or in the street/park (13.2%) (Table 28).

- The majority of recent users (94.5%) stated that it would be very or fairly easy to access cocaine within a 24-hour period, while 0.9% stated that it would be very difficult (Table 29).

6.3.4 Regular use of cocaine and efforts to stop

Among lifetime cocaine users, 23.5% stated that they had ever used cocaine regularly (participants defined what the term 'regular' meant for themselves). Respondents who had used cocaine regularly at some point in their lifetime were also asked about attempts to stop using cocaine. Of this group, 66.8% said they have managed to stop. The most common reason given by respondents for stopping cocaine use was that it was no longer part of their social life (28.4%), followed by concerns about health (23.5%), cost (15.1%), and impact on job/friends/family (13.1%) (Table 30).

6.4 Cannabis, ecstasy, and cocaine tables: Availability and regular use

Table 27 How cannabis, ecstasy, and cocaine were obtained on last occasion used (recent users) (%)

	Cannabis (N=-327)	Ecstasy (N=124)	Cocaine (N=103)
Shared among group of friends	31.2	22.5	18.9
Given by family/friend	30.2	15.2	36.1
Bought from a friend	18.0	14.9	18.0
Bought from a contact I did not know personally	6.5	33.6	20.5
Given by a contact I did not know personally	3.6	4.8	5.5
Given by a stranger	2.8	1.1	0.0
Bought from a stranger	2.2	7.9	1.1
Other	5.4	0.0	0.0

Table 28 Where cannabis, ecstasy, and cocaine were obtained on last occasion used (recent users) (%)

	Cannabis (N=-327)	Ecstasy (N=125)	Cocaine (N=105)
House of a friend	38.4	9.3	34.5
Street/park	18.9	10.7	13.2
Disco/bar/club	15.3	47.7	28.5
Music festival	7.4	10.6	6.8
Ordered by phone for collection	5.3	4.8	14.4
School/college	2.1	8.7	1.3
Internet	1.9	3.1	0.0
House of a dealer	0.7	0.0	0.4
Office/workplace	0.4	0.4	0.0
Other	9.6	4.8	0.9

Table 29 Ease of obtaining cannabis, ecstasy, and cocaine in a 24-hour period (recent users) (%)

	Cannabis (N=-307)	Ecstasy (N=123)	Cocaine (N=101)
Very easy	62.6	73.6	52.9
Fairly easy	27.3	12.3	41.6
Neither easy nor difficult	3.3	5.8	4.6
Fairly difficult	3.8	6.1	0.0
Very difficult	3.0	2.3	0.9

Table 30 Reasons for stopping cannabis, ecstasy, and cocaine use (regular users who stopped using) (%)

	Cannabis (N=290)	Ecstasy (N=121)	Cocaine (N=59)
No longer part of social life	23.6	44.9	28.4
Did not want to take anymore	19.1	15.8	0.0

	Cannabis (N=290)	Ecstasy (N=121)	Cocaine (N=59)
Concern about health/health reasons	14.2	15.1	23.5
Did not enjoy the after-effects	11.3	8.2	3.3
Cost/could no longer afford it	6.6	4.1	15.1
Less available supply	4.3	0.0	0.0
Pregnancy	4.2	1.9	1.6
Impact on job/friends/family	3.3	2.5	13.1
Concern regarding legal implications if caught using by gardaí*	3.0	–	–
The pros of taking did not outweigh the cons	2.4	4.5	4.5
Gave up smoking cigarettes*	2.1	–	–
Persuaded by friends/family	2.0	3.1	7.7
Put on rehabilitation programme	0.2	0.0	1.6
Other	3.6	0.0	1.2

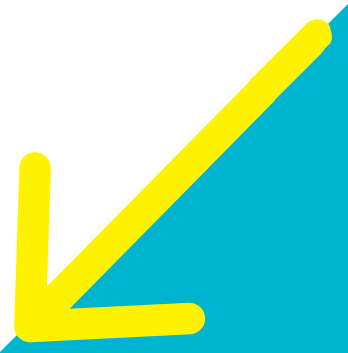
*Options only provided to those who reported regular use of cannabis

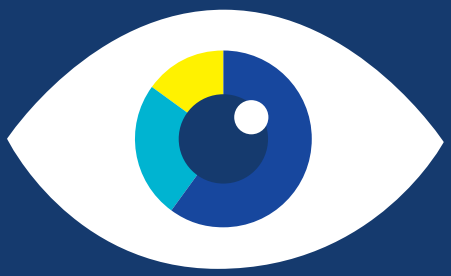
Table 31 Proportion who personally know people who use cannabis, ecstasy, or cocaine, by sex and age group (%)

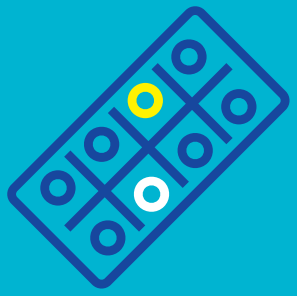
	All	Males	Females	15–34	35–64	65+
Cannabis	40.3	45.6	35.3	59.3	38.2	13.0
Ecstasy	20.8	24.4	17.3	40.6	14.8	2.2
Cocaine	26.7	31.4	22.1	44.3	23.2	5.0

07

Prescribable drugs







This chapter presents data on the use of prescribable drugs. These are drugs that can be legally purchased from a pharmacy or chemist, usually with a prescription. The current survey includes questions about the use of sedatives/tranquillisers (including benzodiazepines), opioid pain relievers (including over-the-counter opioids such as codeine), anabolic steroids, and methadone. Prevalence estimates of anabolic steroid and methadone use are presented here, but they are not described in further detail in this section due to the low numbers reporting their use.

Sedatives and tranquillisers are commonly used terms for the same group of medicines which depress, slow down, or calm the brain and central nervous system. They are mainly benzodiazepines ('benzos'), but other drugs with the same effects (e.g. zolpidem and zopiclone) are included in this group. Medically they are often referred to as hypnotics, which induce sleep, and as anxiolytics or anti-anxiety agents.

The term 'opioid pain relievers' includes a number of drugs that are used to treat short-term and chronic pain. They are examples of opioid drugs, from the same family as morphine and heroin. These medicines generally require a prescription, although some codeine products are available over the counter from a pharmacist without a prescription; for example, Solpadeine and Nurofen Plus.

A question on pregabalin use is also included in the current survey. While pregabalin is prescribed as a pain reliever, it is not opioid based. However, there has been concern in Ireland in recent years around pregabalin use due to its involvement in a relatively high number of fatal overdoses.[10]

For the first time, this survey contained questions on the non-medical use of sedatives, tranquillisers, and opioid pain relievers. The subset of questions included was suggested by the EMCDDA. Non-medical use was defined 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.

Data on sedative/tranquilliser use are not presented for 2002–03, as that survey asked about the use of either sedatives, tranquillisers, or antidepressants; subsequent surveys have asked about the use of sedatives/tranquillisers separately from the use of antidepressants.

The results for opioid pain relievers are not comparable with the 2002–03 and the 2006–07 surveys and are therefore not presented here. In these surveys, the showcard for opioid pain relievers simply contained the word 'codeine', without providing any description or examples. Since 2010–11, the showcard for opioid pain relievers contains a comprehensive list of the codeine products used in Ireland.

7.1 Prevalence of prescribable drugs

Last year prevalence (recent use) among all adults aged 15 years and older was 5.5% for sedatives and tranquillisers, 32.2% for opioid pain relievers, 0.1% for anabolic steroids, and 0.0% for methadone. More detailed tables on prevalence, with confidence intervals (including by sex and age group), are presented in Appendix I. The prevalence figures presented here and in Appendix I for sedatives/tranquilisers and opioid pain relievers relate to any use, including both medical and non-medical use, unless stated otherwise.

7.2 Sedatives and tranquillisers

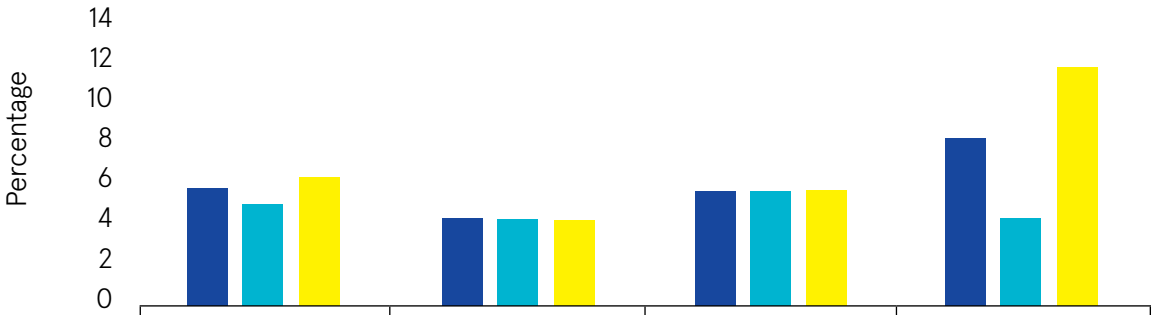
The main findings from the 2019–20 NDAS regarding sedative/tranquilliser use include the following:

- 12.7% of respondents had ever used sedatives/tranquillisers in their lifetime, corresponding to 499,000 of the general population in Ireland aged 15 years and older.
- 5.5% of respondents (213,000 of the general population) and 3.2% of respondents (125,000 of the general population) had used sedatives/tranquillisers in the last year and last month, respectively.
- 0.5% of respondents (19,000 of the general population) had used sedatives/tranquillisers in a non-medical way in the last 12 months.
- There was a statistically significant decrease in recent use reported by all adults (from 7.1% in 2014–15 to 5.5% in 2019–20).
- The average age of first sedative/tranquilliser use was 36.7 years (median: 34 years).
- The average age of participants who reported recent sedative/tranquilliser use was 50.9 years (median: 49 years).

7.2.1 Sedative/tranquilliser use by age and sex

Females were more likely than males to report recent use of sedatives/tranquillisers (6.1% versus 4.8%). Those aged 65 years and older were more likely than younger age groups to report recent sedative/tranquilliser use (8.0%). Females aged 65 years and older had the highest prevalence of recent use (11.5%) (Figure 31). Of those who had used sedatives/tranquillisers in the last year, 87.2% stated that all were prescribed, 10.2% stated that none were prescribed, and 2.7% stated that some were prescribed while others were not.

Figure 31 Recent use of sedatives/tranquillisers in 2019–20, by sex and age group

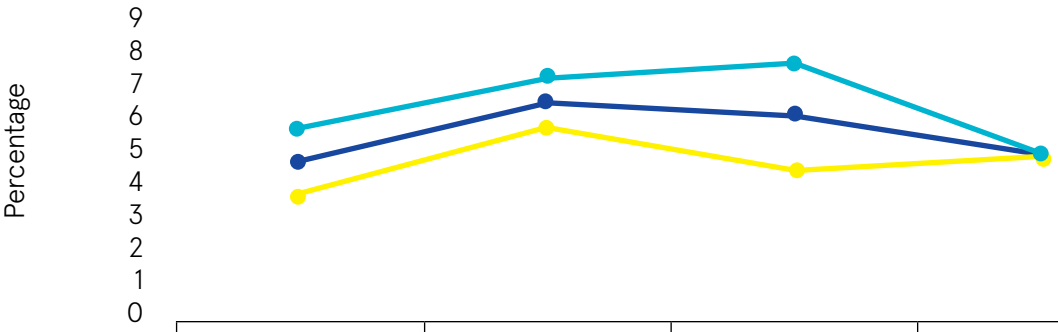


	All	15–34	35–64	65+
All	5.5	4.0	5.5	8.0
Males	4.8	4.1	5.5	4.1
Females	6.1	3.9	5.4	11.5

7.2.1.1 Trends in recent sedative/tranquilliser use

Recent use of sedatives/tranquillisers among 15–64-year-olds decreased in 2019–20 and is currently at 2006–07 levels. There was a small increase in recent use among males in 2019–20. Between 2006–07 and 2014–15, females were more likely than males to use sedatives/tranquillisers; however, following a significant decrease in female use in 2019–20, use among males and females is now similar (Figure 32).

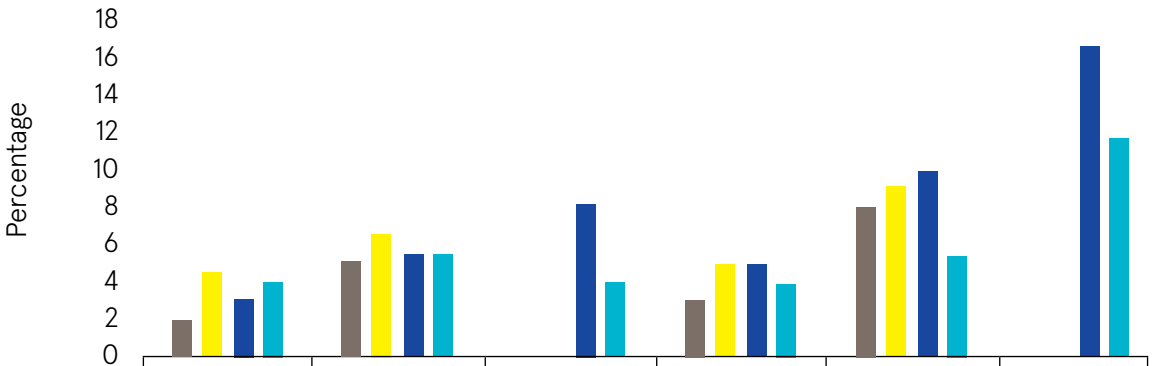
Figure 32 Trends in recent use of sedatives/tranquillisers among 15–64-year-olds, by sex



	2006-07	2012-11	2014-15	2019-20
All	4.7	6.5	6.1	4.9
Males	3.7	5.7	4.4	5.0
Females	5.7	7.3	7.7	4.8

The main changes in recent use have occurred in males aged 65 years and older, with recent use almost halving between 2014–15 and 2019–20, from 8.1% to 4.1%. Among females, recent use decreased since 2014–15 for those aged 35–64 years (from 9.9% to 5.4%) and for those aged 65 years and older (from 16.5% to 11.5%) (Figure 33).

Figure 33 Trends in recent sedative/tranquilliser use, sex by age group



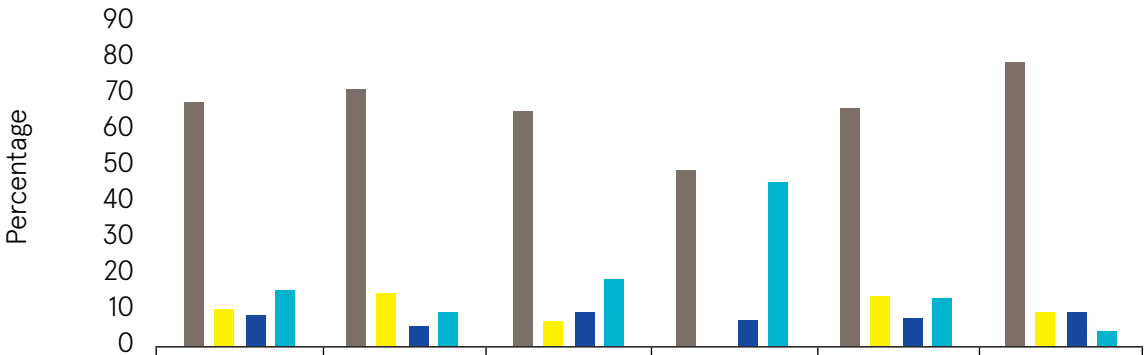
	Males			Females		
	15–34	35–64	65+	15–34	35–64	65+
2006–07	2.0	5.1		3.1	7.9	
2010–11	4.6	6.5		5.0	9.1	
2014–15	3.1	5.5	8.1	5.0	9.9	16.5
2019–20	4.1	5.5	4.1	3.9	5.4	11.5

In the 2006–07 and 2010–11 surveys, those aged 65 years and older were not included

7.2.2 Frequency of sedative/tranquilliser use

Two-thirds (66.7%) of those who used sedatives/tranquillisers in the last month did so on at least 20 days. This frequency of use was more common among those aged 65 years and older (77.7%) compared with those aged 15–34 years (47.9%) (Figure 34).

Figure 34 Frequency of sedative/tranquilliser use in the last month among current users, by sex and age group

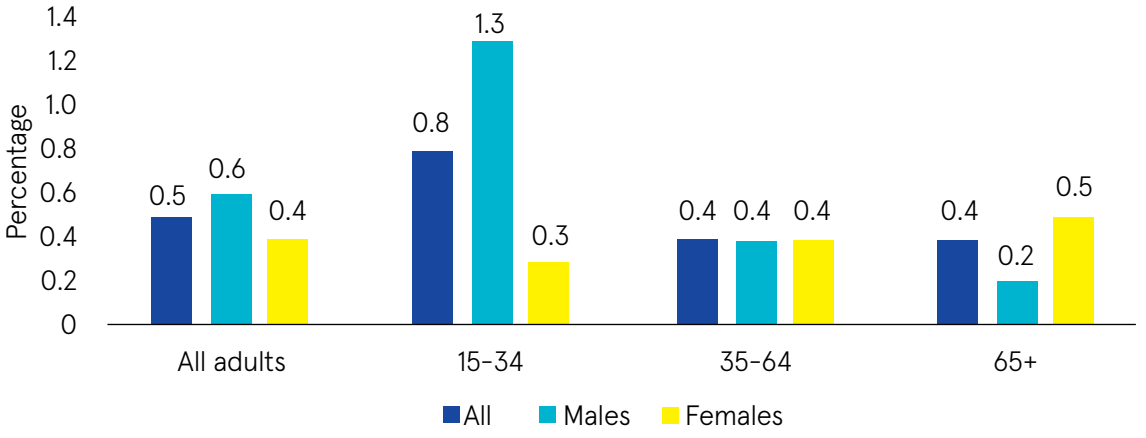


	All adults	Males	Females	15-34	35-64	65+
20 days	66.7	70.4	64.5	47.9	64.8	77.7
10-19 days	9.8	14.5	7.0	0.0	14.3	9.1
4-9 days	8.2	5.8	9.6	7.3	7.8	9.1
1-3 days	15.3	9.3	18.9	44.9	13.2	4.0

7.2.3 Non-medical use of sedatives/tranquillisers

The proportion of people reporting non-medical use of sedatives/tranquillisers in the last year was 0.5%, with similar rates reported by males (0.6%) and females (0.4%). Males aged 15–34 years were most likely to report non-medical use (1.3%) (Figure 35). On the last occasion that respondents used sedatives/tranquillisers in a non-medical way, 54.4% obtained them from a friend, spouse, or relative, and 33.6% got them with a prescription that had been written for them.

Figure 35 Recent non-medical use of sedatives/tranquillisers 2019–20, by sex and age group



7.3 Opioid pain relievers

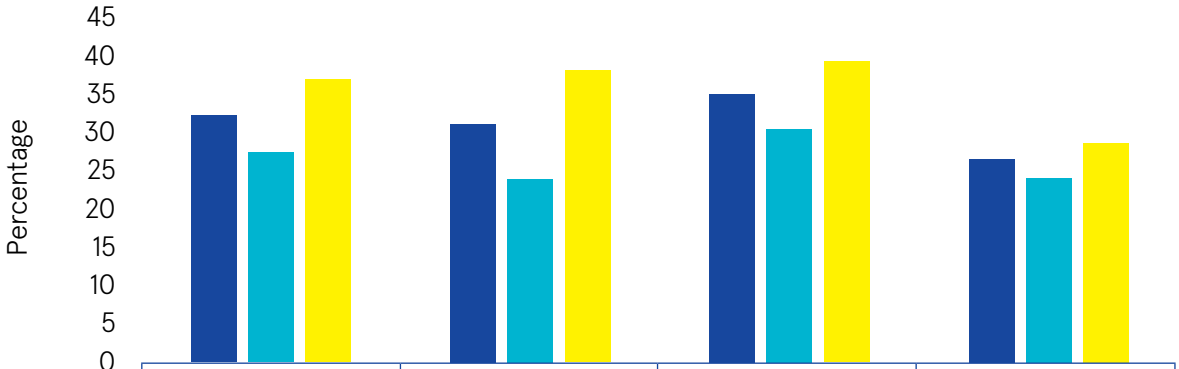
The main findings from the 2019–20 NDAS regarding opioid pain reliever use include the following:

- 53.1% of respondents had ever used opioid pain relievers in their lifetime, corresponding to 1,834,000 of the general population in Ireland aged 15 years and older.
- 32.2% of respondents (or 1,258,000 of the general population) and 13.1% of respondents (or 512,000 of the general population) had used opioid pain relievers in the last year and last month, respectively.
- 1.8% of respondents (or 70,000 of the general population) had used opioid pain relievers in a non-medical way in the last 12 months.
- The average age of first opioid pain reliever use was 25.1 years (median: 20 years).
- The average age of participants who reported recent opioid pain reliever use was 44.4 years (median: 43 years).

7.3.1 Opioid pain reliever use by age and sex

Females were more likely than males to report recent use of opioid pain relievers (36.8% versus 27.3%). Recent use was most common among 35–64-year-olds (34.9%) and lowest among those aged 65 years and older (26.5%) (Figure 36).

Figure 36 Recent use of opioid pain relievers in 2019–20, by sex and age group

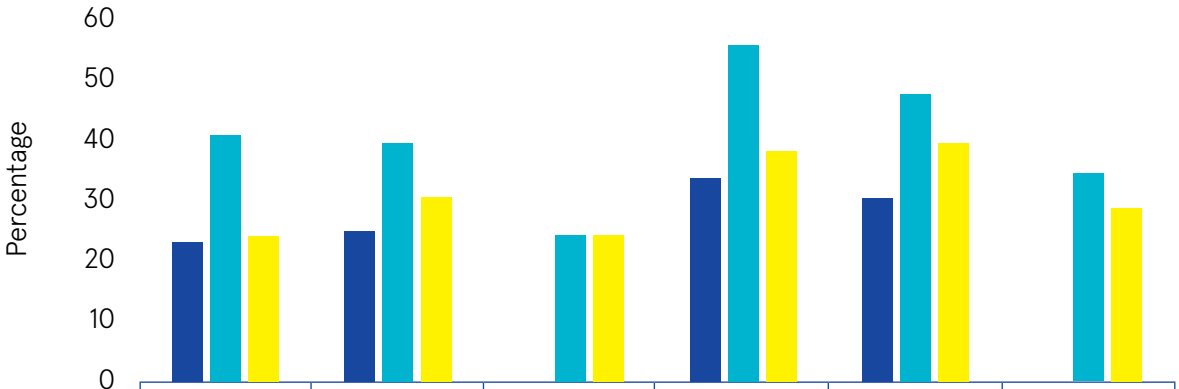


	All	15–34	35–64	65+
All	32.2	31.0	34.9	26.5
Males	27.3	24.0	30.4	24.1
Females	36.8	38.0	39.3	28.6

7.3.1.1 Trends in opioid pain reliever use

Recent use of opioid pain relievers significantly increased between 2010–11 and 2014–15, but significantly decreased in 2019–20, especially among those aged 15–34 years. However, there was no change in use among males aged 65 years and older (Figure 37).

Figure 37 Trends in recent use of opioid pain relievers, sex by age group)



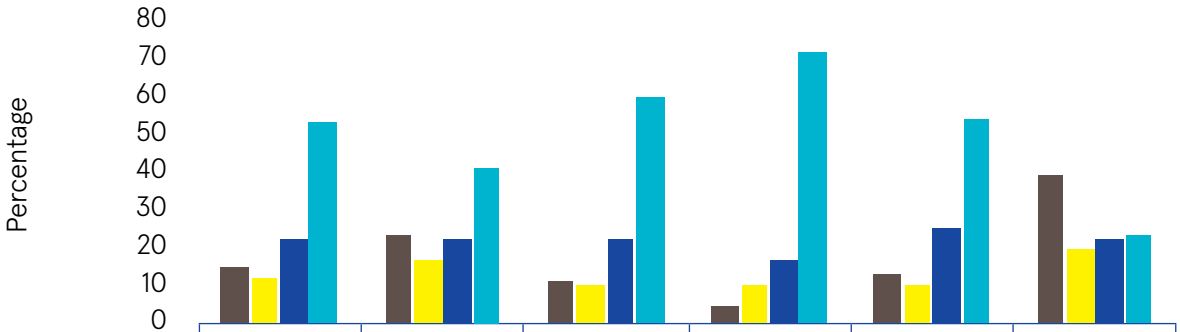
	15-34	35-64 Males	65+	15-34	35-64 Females	65+
2010-11	23.1	24.8		33.4	30.3	
2014-15	41.6	39.6	24.1	55.4	47.7	34.3
2019-20	24.0	30.4	24.1	38.0	39.3	28.6

In the 2010–11 survey, those aged 65 years and older were not included

7.3.2 Frequency of opioid pain reliever use

One in seven (14.5%) current users used opioid pain relievers on 20 days or more in the previous month, which is considered to be daily or almost daily use. This was more common among those aged 65 years or older (38.3%) compared with 15–34-year-olds (3.7%) and 35–64-year-olds (12.2%). Although females were more likely to use opioid pain relievers, males were more likely than females to report daily or almost daily use (22.1% versus 10.7%) (Figure 38).

Figure 38 Frequency of opioid pain reliever use in the last month among current users, by sex and age group



	All adults	Males	Females	15-34	35-64	65+
20 days	14.5	22.1	10.7	3.7	12.2	38.3
10-19 days	11.3	15.7	9.1	9.8	9.6	18.5
4-9 days	21.5	21.9	21.4	15.9	24.7	21.2
1-3 days	52.7	40.4	58.8	70.6	53.5	22.1

7.3.3 Type of opioid pain relievers used

The most common type of opioid pain reliever used by current users in the last 30 days were over-the-counter (OTC) codeine products (80.2%) (Table 32). On the most recent occasion that current users took opioid pain relievers, 62.9% obtained them from a pharmacy in Ireland without a prescription, 25.6% got them using a prescription written for them, and 7.2% got them from a friend, spouse, or relative.

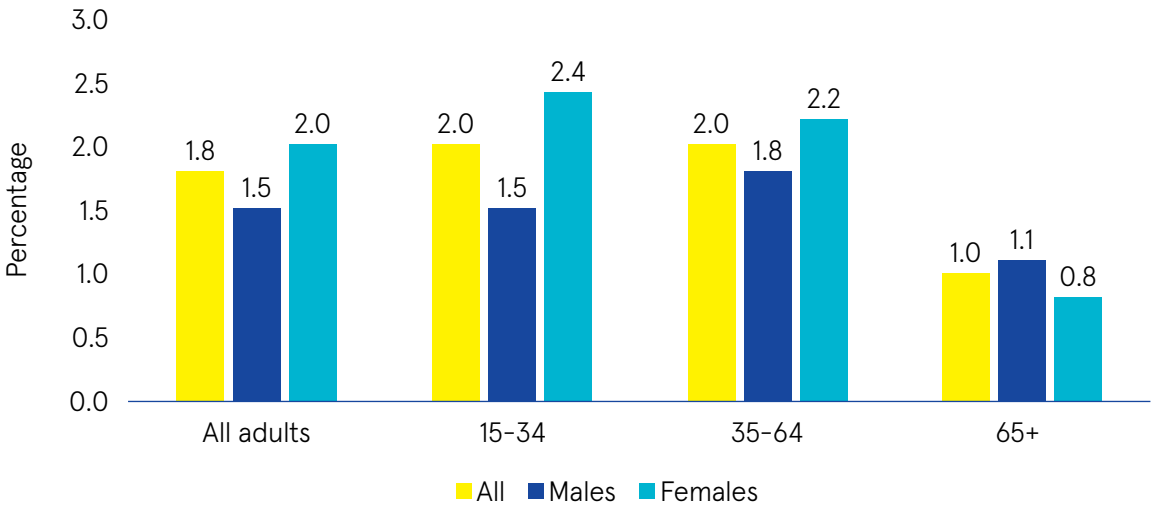
Table 32 Type of opioid pain reliever used by current users in the last 30 days

Type of opioid pain reliever (N=751)	%
OTC codeine products	80.2
Prescription codeine (e.g. Panadeine Forte)	14.4
Tramadol	4.0
Pregabalin	1.2
Morphine, hydromorphone	1.0
Oxycodone	0.8
Fentanyl	0.2
Other	3.7

7.3.4 Non-medical use of opioid pain relievers

The proportion of people reporting non-medical use of opioid pain relievers in the last year was 1.8%. Those most likely to use opioid pain relievers in this way were females aged 15–34 years (Figure 39).

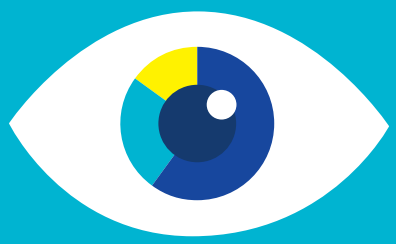
Figure 39 Recent non-medical use of opioid pain relievers 2019–20, by sex and age group



Among those who used opioid pain relievers in a non-medical way in the last year, 14.1% used them in this manner at least four times per week, 13.3% used them two to three times per week, 14.1% used them two to three times per month, and 58.5% used them once per month or less.

08

Perceptions and attitudes



This section presents the main findings on the perceptions and attitudes of people in Ireland towards drug use, including tobacco and alcohol.

8.1 Attitudes towards permitting cannabis use

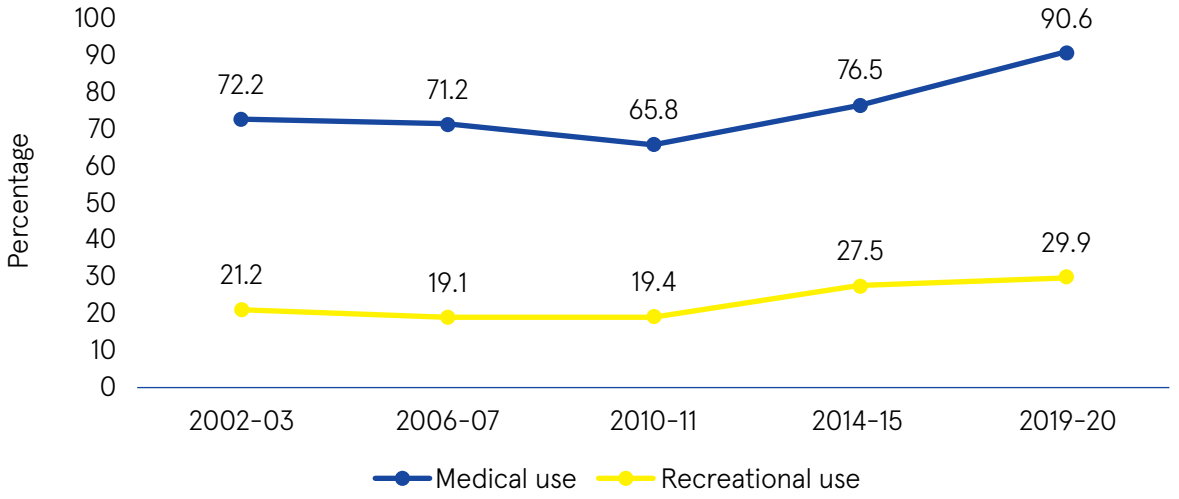
Respondents were asked if they agreed with permitting cannabis for medical and recreational use. There was a high level of agreement (88.8%) for permitting cannabis for medical use, with the highest level of support reported by lifetime users of cannabis (98.6%). There was less support (26.2%) for permitting cannabis for recreational use. Support for recreational use was higher among 15–34-year-olds (34.8%) compared with those aged 65 years and older (9.1%). Males were also more likely than females to support recreational cannabis use (31.1% versus 21.4%). Two-thirds of lifetime cannabis users (65.6%) agreed with permitting cannabis for recreational use (Table 33).

Table 33 Support for permitting cannabis for medical and recreational use (%)

	All adults	Males	Females	15–34	35–64	65+	Lifetime use
Medical use of cannabis							
Fully agree	65.3	66.0	64.7	66.3	67.6	57.8	84.4
Somewhat agree	23.5	22.2	24.7	24.2	23.1	23.1	14.2
Neither	2.3	2.4	2.3	1.5	2.5	3.5	0.3
Somewhat disagree	2.4	2.7	2.2	2.8	1.6	4.0	0.2
Fully disagree	3.2	3.6	2.8	2.0	2.8	6.2	0.6
Don't know	3.2	3.2	3.3	3.2	2.4	5.4	0.4
Recreational use of cannabis							
Fully agree	9.3	12.6	6.0	14.3	8.6	2.2	30.6
Somewhat agree	16.9	18.5	15.4	20.5	18.2	6.9	35.0
Neither	9.3	9.4	9.2	11.5	9.0	6.3	6.3
Somewhat disagree	15.5	13.8	17.1	14.5	15.7	16.4	11.2
Fully disagree	44.7	41.0	48.3	34.3	44.1	64.8	13.2
Don't know	4.3	4.7	4.0	4.9	4.3	3.3	3.6

Figure 40 presents the trends in attitudes of 15–64-year-olds towards permitting cannabis use since 2002–03. There has been an increase in support of both medical (18.4 percentage points) and recreational (8.7 percentage points) cannabis use.

Figure 40 Trends in support for permitting medical and recreational use of cannabis (15–64-year-olds)



8.2 Disapproval of drug use

Respondents were asked about the extent of their approval/disapproval regarding trying ecstasy once or twice, trying heroin once or twice, smoking 10 cigarettes per day, and smoking cannabis occasionally. The proportion of respondents who reported that they either disapproved or strongly disapproved of each of these behaviours is presented in Table 34. For each of the behaviours listed in Table 34, the majority of respondents reported disapproval or strong disapproval, ranging from 70.9% for smoking cannabis occasionally to 95.7% for trying heroin once or twice. Disapproval was more common among females than males and, with the exception of smoking 10 cigarettes per day, increased with increasing age. Those who had ever engaged in the listed behaviours were less likely to report disapproval of the behaviours in question. One-third (33.1%) of those who had ever used cannabis reported disapproval for smoking cannabis occasionally, with a similar proportion of lifetime ecstasy users (35.7%) reporting disapproval for trying ecstasy once or twice. In comparison, two-thirds of lifetime tobacco users (66.1%) reported disapproval for smoking 10 cigarettes per day.

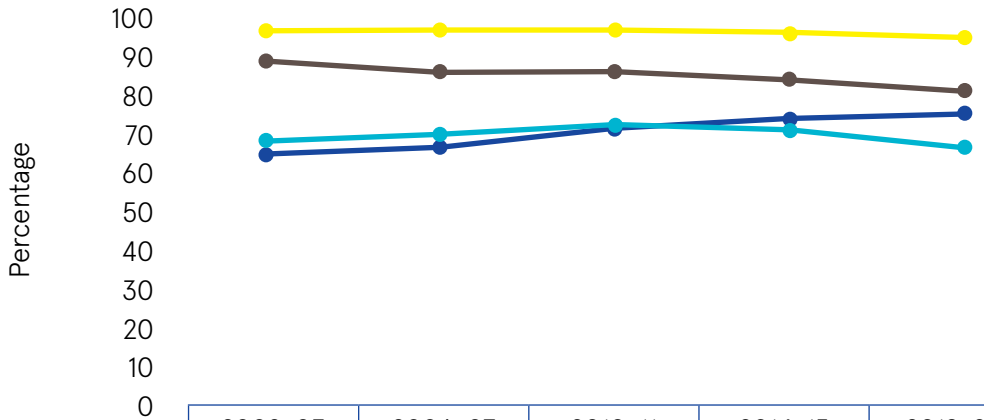
Table 34 Disapproval of drug use, by sex, age, and lifetime use, 2019–20 (%)

	All adults	Males	Females	15–34	35–64	65+	Lifetime use*
Trying ecstasy once or twice	83.9	80.0	87.7	73.6	86.9	93.5	35.7
Trying heroin once or twice	95.7	95.0	96.4	94.8	95.9	96.7	–
Smoking 10 cigarettes per day	76.9	74.0	79.6	76.2	75.7	81.4	66.1
Smoking cannabis occasionally	70.9	67.5	74.2	60.2	71.5	87.8	33.1

*Due to the low number of respondents who reported lifetime heroin use, disapproval among lifetime heroin users is not reported for 'trying heroin once or twice'.

Since 2002–03, there has been little change in the percentage of 15–64-year-olds reporting disapproval for trying heroin once or twice and for smoking cannabis occasionally. Disapproval for trying ecstasy once or twice decreased slightly in each survey, from 89.3% in 2002–03 to 81.8% in 2019–20. Conversely, disapproval for smoking 10 cigarettes per day has increased with each survey, from 65.6% in 2002–03 to 75.9% in 2019–20 (Figure 41).

Figure 41 Trends in disapproval of drug use (15–64-year-olds)



	2002-03	2006-07	2010-11	2014-15	2019-20
Trying ecstasy once or twice	89.3	86.9	86.6	84.7	81.8
Trying heroin once or twice	97.1	97.5	97.4	96.6	95.5
Smoking 10 cigarettes per day	65.6	67.4	71.9	74.3	75.9
Smoking cannabis occasionally	68.8	70.5	73.0	71.6	67.2

8.3 Perception of risk

Respondents were asked how much they thought people risk harming themselves physically or in other ways when they do the following: smoke one or more packs of cigarettes per day, binge drink, smoke cannabis regularly, try ecstasy once or twice, try cocaine once or twice, or try crack once or twice. The proportion of respondents who perceived great risk to be associated with each of these behaviours is presented in Table 35. The majority of respondents perceived great risk to be associated with each of the behaviours in question, ranging from 57.0% for smoking cannabis regularly to 82.1% for trying crack once or twice. Females and older respondents were more likely than males and younger respondents to perceive great risk for each behaviour. This was particularly evident for smoking cannabis regularly – just 40.9% of 15–34-year-olds perceived this to be associated with great risk, compared with 59.3% of 35–64-year-olds and 78.6% of those aged 65 years and older. A comparatively high proportion of lifetime tobacco and alcohol users reported great risk for using these substances compared with lifetime users of illegal drugs. Of those who had ever used tobacco, 59.7% perceived smoking one or more packs of cigarettes per day to be of great risk; in comparison, just 30.1% of lifetime cannabis users associated smoking cannabis regularly with great risk.

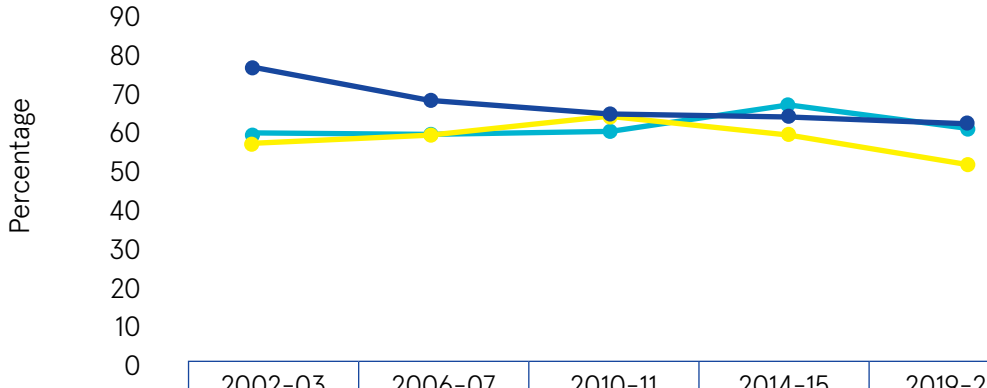
Table 35 Perception of great risk associated with tobacco, alcohol, and drug use, by sex, age, and lifetime use, 2019–20 (%)

	All adults	Males	Females	15–34	35–64	65+	Lifetime use
Smoke one or more packs of cigarettes per day	62.6	58.8	66.4	56.6	64.1	68.9	59.7
Binge drink	58.8	53.7	63.8	48.7	60.5	71.8	57.5
Smoke cannabis regularly	57.0	51.2	62.7	40.9	59.3	78.6	30.1
Try ecstasy once or twice	65.6	60.0	71.0	52.8	68.7	79.0	21.5
Try cocaine once or twice	70.0	64.7	75.1	58.2	72.3	84.0	26.3
Try crack once or twice*	82.1	79.7	84.5	75.3	84.4	87.4	

* Due to the low number of respondents who reported lifetime crack use, great risk among lifetime crack users is not reported for 'trying crack once or twice'.

Respondents in the 2019–20 survey were less likely to perceive great risk from smoking cannabis regularly or trying ecstasy once or twice, but were more likely to perceive great risk from smoking at least one pack of cigarettes per day (Figure 42). Due to changes in question wording, trends are not presented for binge drink, try cocaine once or twice, or try crack once or twice.

Figure 42 Trends in perception of great risk associated with tobacco, alcohol, and drug use (15–64-year-olds)



	2002-03	2006-07	2010-11	2014-15	2019-20
Smoke 1+ packs of cigarettes per day	59.6	59.8	60.4	67.3	61.2
Smoking cannabis regularly	57.2	59.6	64.0	59.9	52.3
Try ecstasy once or twice	77.1	68.7	65.0	64.5	62.6

8.4 Perception of people addicted to drugs

Respondents were asked if they perceived a person who is addicted to drugs more as a criminal or more as a patient. The most common perception was 'more as a patient' (46.6%), followed by 'both a criminal and a patient' (24.1%), 'neither a criminal nor a patient' (12.5%), and 'more as a criminal' (8.8%), while 8.0% did not know or could not decide. Those who had ever used illegal drugs were least likely to perceive a drug addict 'more as a criminal' (3.6%) (Table 36).

Table 36 Perception of people addicted to drugs, by sex, age, and lifetime illegal drug use (%)

	All	Males	Females	15–34	35–64	65+	Ever used illegal drugs
More as a criminal	8.8	9.5	8.1	8.1	8.7	10.2	3.6
More as a patient	46.6	45.2	48.0	43.3	47.0	51.5	54.0
Neither a criminal nor a patient	12.5	14.0	11.2	14.5	12.8	8.4	20.3
Both a criminal and a patient	24.1	23.4	24.7	24.1	24.8	22.0	16.0
Don't know/cannot decide	8.0	7.9	8.0	9.9	6.8	7.9	6.2

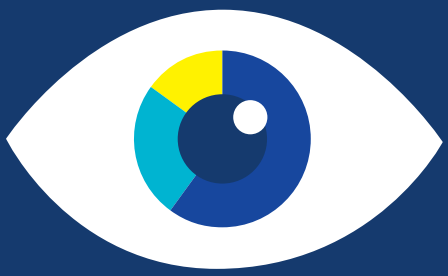
There has been a reduction in the proportion of 15–64-year-olds who perceive a a person who is addicted to drugs more as a criminal since 2002–03 (from 16.5% to 8.5%). At the same time, there have been increases in the proportion of respondents who perceive a person who is addicted to drugs as neither a criminal nor a patient and as both a criminal and a patient (Table 37).

Table 37 Trends in perception of people addicted to drugs (among 15–64-year-olds) (%)

	2002–03	2006–07	2010–11	2014–15	2019–20
More as a criminal	16.5	17.5	19.7	12.2	8.5
More as a patient	55.6	50.6	47.5	43.9	45.6
Neither a criminal nor a patient	7.7	9.3	10.8	14.3	13.4
Both a criminal and a patient	17.3	20.2	19.4	25.4	24.5
Don't know/cannot decide	2.9	2.4	2.6	4.2	8.0

09

Impact of drug use on communities



Questions on the impact of drug use on local communities were included in the 2019–20 NDAS for the first time. Specific questions on drug-related intimidation were also included, as the Regional Drug and Alcohol Task Forces have identified drug-related intimidation as being a pressing issue for many communities in Ireland.

9.1 Problems associated with people using or dealing drugs

More than one-third (37.0%) of respondents stated that there was a problem with people using or dealing drugs in their local area, 40.2% said that there was no problem, and 22.7% did not know. Of those who stated that there was a problem in their local area, 35.6% said it was a very big problem, 46.8% said it was a fairly big problem, 13.4% said it was not a very big problem, and 4.3% did not know. Respondents who stated that people using or dealing drugs was a very big or fairly big problem (30.5% of all respondents) were asked to select from the options provided in Table 38 what specific drug-related problems were present in their local area. The problems most commonly reported by these respondents were drugs being too easily available (84.4%), people dealing drugs (64.6%), and children and teenagers taking drugs (53.7%).

Table 38 Problems associated with people using or dealing drugs

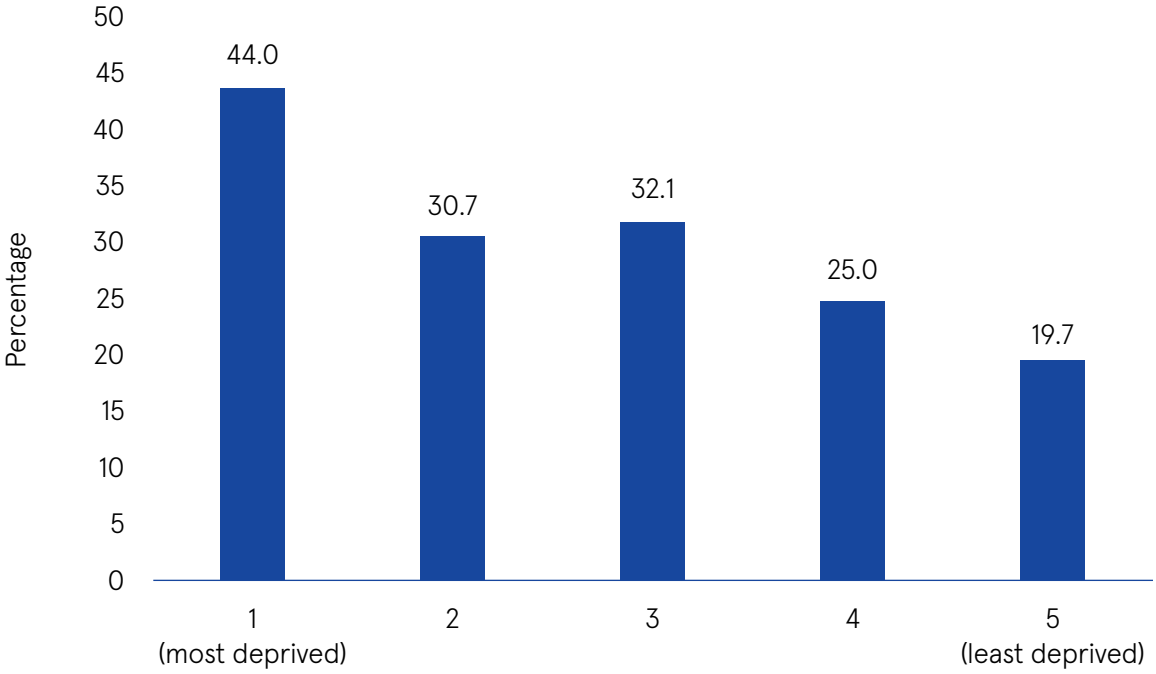
Weighted responses=1,756	%
Drugs being too easily available	84.4
People dealing drugs	64.6
Children and teenagers taking drugs	53.7
People taking hard drugs	41.0
People smoking cannabis in public places	39.1
Stealing, theft, or burglary related to drug use	36.8
General violent crime related to drug use or dealing	24.5
Violence between drug gangs	20.2
Begging related to drug use	19.2
Used needles (e.g. on the streets, in stair wells, in car parks)	13.2
Crack houses	9.4

Respondents could select more than one option.

Three in ten (30.5%) of respondents reported that there was a very big or fairly big problem with people using or dealing drugs in their local area. Those who lived in deprived areas were more likely to report that there was a very big or fairly big problem with people using or

dealing drugs in their local area (Figure 43), with 44.0% of respondents in the most deprived quintile reporting such problems compared with 19.7% in the least deprived quintile.

Figure 43 Proportion of respondents reporting that people using or dealing drugs was a very big or fairly big problem in their local area, by area deprivation level



9.2 Drug-related intimidation

One in 10 respondents (9.9%), corresponding to 387,000 of the general population aged 15 years and older, had either personal experience of drug-related intimidation or knew somebody who had been intimidated; 1.5% had personal experience of drug-related intimidation while 2.0% had a family member who had been intimidated because of a debt to a drug dealer (Table 39).

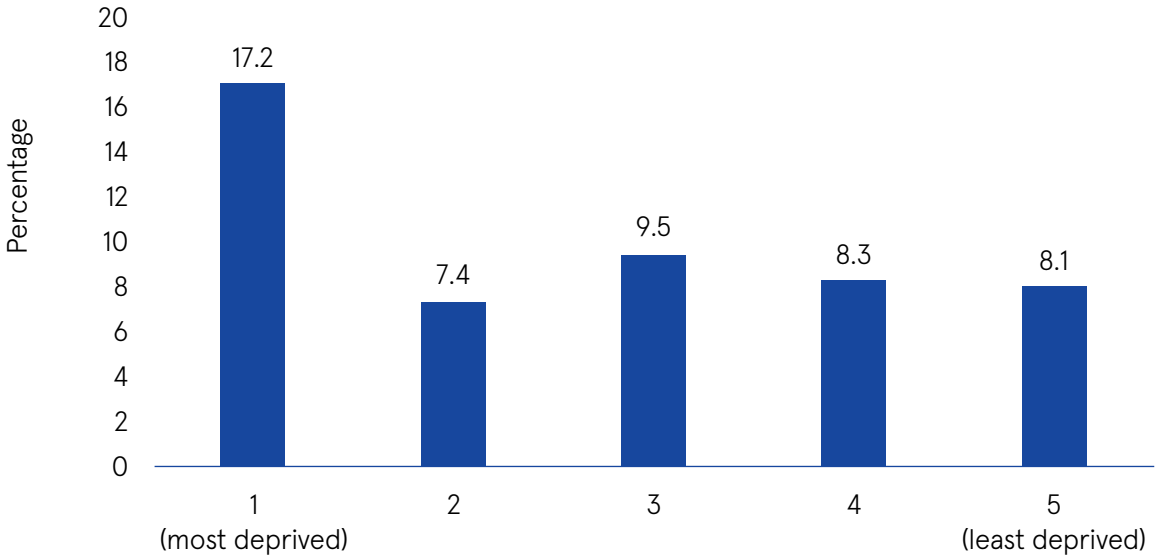
Table 39 Proportion of respondents reporting experience of drug-related intimidation

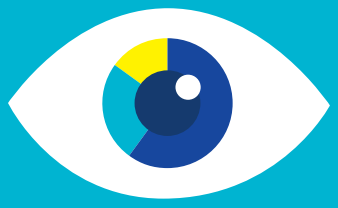
Experience of drug-related intimidation	%
Personal experience of drug-related intimidation	1.5
I have been intimidated because of a debt to a drug dealer	*1.1*
I have been intimidated by drug dealers/users	*0.4*
A family member has been intimidated because of a debt to a drug dealer	2.0
I know people in my local area who have been intimidated because of a debt to a drug dealer	6.8
Someone I know has been intimidated by drug dealers/users	0.2
Other	0.1

Respondents could select more than one option.

Those who had experience of drug-related intimidation were twice as likely to live in the most deprived quintile (17.2%) compared with any of the less deprived quintiles (7.4–9.5%) (Figure 44). Respondents living in Dublin were most likely to have experience of drug-related intimidation (15.6%), followed by those living in the rest of Leinster (9.8%), Connaught/Ulster (6.3%), and Munster (6.1%).

Figure 44 Experience of drug-related intimidation, by area deprivation level






10

Conclusion and policy implications




The NDAS collects information on tobacco, alcohol, and drug use among the general population. This is the fifth such survey undertaken in the Republic of Ireland, providing an opportunity to observe trends over time.

The prevalence of tobacco use among survey respondents aged 15 years and older was found to be 17.4%, which is similar to the smoking rate (17.0%) reported in the 2019 Healthy Ireland Survey.[11] There has been a decline in the use of tobacco in each of the five waves of the NDAS. A range of tobacco control policies have been implemented since the first wave of the NDAS in 2002–03, which may have impacted on smoking rates. These include excise increases, the workplace smoking ban, graphic warnings on packaging, and standardised (plain) packaging of tobacco.[12] Our results also show that tobacco use is associated with deprivation; those living in the most deprived quintile were much more likely than those in the less deprived quintiles to report current smoking, daily smoking, and smoking at least 20 cigarettes per day.

With respect to alcohol use, there has been little change since the 2014–15 survey, although the proportion of non-drinkers has increased since 2002–03, particularly among those aged 15–34 years. Nevertheless, while one in four survey respondents indicated not using alcohol, more than one-half of drinkers consumed alcohol in a hazardous way, and one in five drinkers met the criteria for alcohol use disorder (AUD). The 2019–20 NDAS findings suggest that young male users of alcohol are at particular risk from their drinking patterns, with 37% of 15–34-year-old male drinkers meeting the criteria for AUD. These results demonstrate a need to fully implement the measures contained in the Public Health (Alcohol) Act 2018, including minimum unit pricing.

There has been no change in the prevalence of recent illegal drug use since 2014–15; however, there have been changes regarding the types of drugs used. While there has been a small decrease in the prevalence of cannabis use, the use of stimulant-type drugs (including cocaine, ecstasy, and amphetamines) has increased, and there has also been an increase in the use of LSD and poppers. Similar trends have been observed in Irish treatment data, where there has been a small decrease in treated cannabis use, but a considerable increase in treated cocaine use.[13] The prevalence of recent NPS use remains very low, at 0.8% among 15–64-year-olds (compared with 3.5% in 2010–11), perhaps highlighting the continued impact of the Criminal Justice (Psychoactive Substances) Act 2010, which made the sale, import, export, or advertisement of unregulated psychoactive substances for human consumption illegal. The Act also gave appropriate powers to An Garda Síochána and the Courts to intervene quickly to prevent trade in a non-criminal procedure via the use of prohibition and closure orders.

Compared with previous surveys, those who reported illegal drug use were more likely to report the recent use of two or more illegal substances. In the current survey, 25.0% reported having used at least three illegal drugs in the last year compared to 15.4% in 2014–15. The 2019–20 NDAS also asked about the use of two or more substances (including alcohol) on the same occasion. Alcohol was the drug most commonly used with cannabis, cocaine, and ecstasy. This was particularly apparent among recent cocaine users (93.4%). In addition, among those who had ever used cocaine, 84.9% reported that they had also used alcohol on the occasion of their first cocaine use. Given the increased risk of both physical and psychological harm associated with polydrug use, it will be important to monitor these trends going forward and to develop harm reduction initiatives in order to reduce polydrug use and avert harm.

Males were more than twice as likely as females to report recent use of an illegal drug, except in the youngest age group (15–24 years), in which there was little difference between illegal drug use among males and females. Participants in the 15–24-year-old age group were also

those who reported the highest prevalence of use for each illegal drug, except for cocaine and NPS. The cohort that reported the highest level of recent drug use was males aged 25–34 years, of whom one in four had used an illegal drug in the last year. The median age at first use of the most commonly used illegal drugs was found to have increased slightly compared with the 2002–03 survey.

While recent cannabis use among males decreased overall between 2014–15 and 2019–20, cannabis prevails as the most popular illegal drug in the population, while its use among males aged 25–34 years has continued to increase. Of survey respondents who had used cannabis in the last year, nearly one in five were found to meet the criteria for cannabis use disorder (CUD), although there has been a noticeable decrease in CUD among males and 15–34-year-olds since the last survey. Ecstasy was the second most commonly used illegal drug in the year prior to the survey; the largest increase in ecstasy use was seen among males aged 25–34 years, with almost 1 in 10 males in this age group having used ecstasy in the last year. A similar proportion of this cohort had used cocaine in the last year, with males being more likely to report recent cocaine use than females. Noticeable increases in cocaine use were also observed among females aged 15–24 years. Overall, recent cocaine use was found to have increased significantly among 15–64-year-olds since 2014–15.

There has been much debate in Ireland around the liberalisation of cannabis laws, and legislation was passed in 2019 to allow for the Medical Cannabis Access Programme to come into operation in Ireland on a pilot basis for 5 years. There was strong agreement among survey respondents for permitting cannabis for medical use (88.8%), but far less support for permitting cannabis for recreational use (26.2%). The majority of respondents reported disapproval or strong disapproval for smoking cannabis regularly (70.9%), with more than one-half (57.0%) perceiving great risk to be associated with smoking cannabis regularly.

Regarding prescribable drugs, there were significant decreases in recent use of both sedatives/tranquillisers and opioid pain relievers. The prevalence of sedative/tranquilliser use is currently at 2006–07 levels. In 2018, the Health Service Executive Medicines Management Programme published the document *Guidance on appropriate prescribing of benzodiazepines and z-drugs (BZRA) in the treatment of anxiety and insomnia*.[14] In terms of legislative requirements, the Misuse of Drugs Regulations 2017 update had implications for benzodiazepines and z-drugs. It is possible that these changes in practice and legislation have impacted on the prevalence of sedative/tranquilliser use. However, it is less clear why we have seen a significant decrease in opioid pain reliever use.

Questions on the impact of drug use on local communities were included in the 2019–20 NDAS for the first time. More than one-third of respondents stated that there was a problem with people using or dealing drugs in their local area. Those who lived in deprived areas were more likely to report that there was a very big or fairly big problem with people using or dealing drugs in their local area, with 44.0% of respondents in the most deprived quintile reporting such problems compared with 19.1% in the least deprived quintile. One in 10 respondents had either personal experience of drug-related intimidation or knew somebody who had been intimidated. Those who lived in the most deprived quintile were twice as likely to experience drug-related intimidated when compared with those in the least deprived quintile. While people living in deprived areas are no more likely than those living in less deprived areas to use illegal drugs, our results indicate that people living in the most deprived areas are disproportionately negatively impacted by drug use activities.

When interpreting the results presented in this report, it is important to consider them in the context of the survey's strengths and limitations. The NDAS is a large national survey that is representative of the Irish population; it has been undertaken five times using the

same methodology and model questionnaire developed by the EMCDDA. In addition, data collection was conducted by a large and experienced survey-based marketing research company and all researchers were thoroughly trained with reference to a standard operating procedures manual. We can therefore be confident that our results are valid and provide reliable prevalence estimates for comparison with the previous waves of the NDAS conducted in Ireland. In addition, the 63.9% response rate is high by international standards. However, there are several limitations which should also be noted. The sampling frame utilised by the NDAS only includes private households and consequently does not allow for people in prison or other institutionalised individuals, homeless individuals, or Travellers to be included, potentially excluding adults who may be more likely than the general population to use drugs. As the survey did not make a specific provision for interviews to be conducted in languages other than English this may have impacted on the participation of non-Irish respondents. Although the NDAS includes questions on the prevalence of heroin and crack cocaine use, the numbers included in the sample are too small for reliable prevalence estimates. Therefore, it will be necessary to complement this survey by using other methods, such as the capture-recapture method or the multiplier method, to estimate the prevalence of high-risk drug users. The NDAS may also be subject to non-response bias, however, it is not possible to ascertain any demographic (except for region of residence) or socioeconomic information on those who did not participate. Drug prevalence questions are considered to be sensitive and therefore people may refuse to participate or under-report their drug use. NDAS results were based on self-reports that may be influenced by reporting or recall bias. Due to restrictions arising from Covid-19, fieldwork was curtailed before the target sample was achieved. The proportion of achieved interviews (5,762) was 87.8% of the initial target (6,560). The target number of completed interviews was only achieved in two of the RDATF areas and the response rate was particularly low in the North Dublin area (41.0%).

Ireland's national drug strategy adopts a health-led approach and is based on sound epidemiological data and an understanding of the extent, patterns, and consequences of psychoactive substance use from a public health perspective. This information is made available through an extensive monitoring system that provides data and analysis on prevalence, treatment demand, and other epidemiological indicators, such as estimates of hidden drug use. In recent years researchers have used innovative tools for estimating drug use and observing patterns of drug use behaviours, such as wastewater analysis and online surveys, to complement the traditional epidemiological tools.

The effective implementation of drug policy depends on accurate estimates of the level of drug use within the population that this policy is designed to benefit. Population surveys based on continuing developments in epidemiological research provide reliable data on drug prevalence, the nature of drug use and its distribution across age groups and sexes. When repeated, these surveys enable policymakers to observe trends over time, an essential insight when measuring the effectiveness of interventions and predicting what phenomena will need attention in the future. Ireland's NDAS includes estimates of problematic use of alcohol and cannabis, information that will be useful to service planners' decisions on future treatment needs. It also presents detailed information on public attitudes and perceptions regarding drugs and the impact of the illicit drug markets on communities. This provides a perspective on Irish society's thinking on drug issues, and on how the drug situation affects people's lives indirectly.

The findings in this report will add to policy-makers', service providers' and the general public's understanding of the drug phenomenon. It will be a key support in the ongoing development of an evidence-informed response to this continually changing feature of contemporary life.

Appendices

Appendix I Tables: Prevalence of drug, alcohol, and tobacco use

Table 40 Prevalence of drug, alcohol, and tobacco use among all adults aged 15 years and older, by drug type

N=5,762	Lifetime % (95% CI)	Last year % (95% CI)	Last month % (95% CI)
Any illegal drug	23.0 (21.6–24.3)	7.4 (6.6–8.2)	4.1 (3.5–4.8)
Cannabis	20.7 (19.4–22.0)	5.9 (5.1–6.7)	2.9 (2.4–3.5)
Ecstasy	8.5 (7.6–9.4)	2.2 (1.8–2.8)	1.0 (0.8–1.4)
Cocaine (including crack)	6.9 (6.0–7.7)	1.9 (1.5–2.4)	0.6 (0.4–0.9)
Cocaine powder	6.6 (5.8–7.4)	1.9 (1.5–2.3)	0.6 (0.4–0.9)
LSD	4.8 (4.2–5.5)	0.9 (0.6–1.2)	0.4 (0.3–0.7)
Magic mushrooms	4.7 (4.1–5.4)	0.4 (0.3–0.7)	0.1 (0.0–0.2)
Amphetamines	4.0 (3.4–4.7)	0.8 (0.6–1.2)	0.2 (0.1–0.4)
Poppers	3.9 (3.3–4.5)	1.4 (1.1–1.8)	0.9 (0.6–1.2)
NPS	2.0 (1.6–2.5)	0.6 (0.4–0.9)	0.2 (0.1–0.4)
Solvents	1.7 (1.3–2.1)	0.0 (0.0–0.1)	0.0 (0.0–0.0)
Crack	0.6 (0.4–0.9)	0.2 (0.1–0.4)	0.0 (0.0–0.1)
Heroin	0.3 (0.1–0.5)	0.0 (0.0–0.1)	0.0 (0.0–0.0)
Opioid pain relievers	53.1 (51.5–54.7)	32.2 (30.7–33.6)	13.1 (12.0–14.2)
Sedatives and tranquillisers	12.7 (11.7–13.8)	5.5 (4.7–6.2)	3.2 (2.7–3.8)
Anabolic steroids	0.3 (0.2–0.6)	0.1 (0.0–0.3)	0.0 (0.0–0.2)
Methadone	0.1 (0.1–0.3)	0.0 (0.0–0.2)	0.0 (0.0–0.1)
Alcohol	80.4 (79.1–81.6)	74.2 (72.8–75.6)	61.8 (60.2–63.3)
Tobacco	42.9 (41.4–44.5)	20.2 (18.9–21.5)	17.8 (16.5–19.0)

All figures are based on weighted data, are rounded to the nearest decimal place, and are based on valid responses.

CI = confidence interval

When the figure 0.0% is reported, it can mean that either no respondents reported use of the drug or that a very low number reported use and that due to rounding it is presented as 0.0%. Confidence intervals are only provided after 0.0% if there are observations in the category. Where there are no confidence intervals, this means that there were no observations.

Table 41 Prevalence of drug, alcohol, and tobacco use among 15–64-year-olds, by drug type

N=4,719	Lifetime % (95% CI)	Last year % (95% CI)	Last month % (95% CI)
Any illegal drug	27.1 (25.5–28.8)	9.0 (7.9–10.0)	4.9 (4.2–5.8)
Cannabis	24.4 (22.8–26.0)	7.1 (6.2–8.1)	3.4 (2.8–4.2)
Ecstasy	10.3 (9.2–11.5)	2.7 (2.2–3.4)	1.3 (0.9–1.8)
Cocaine (including crack)	8.3 (7.3–9.3)	2.3 (1.8–3.0)	0.7 (0.5–1.1)
Cocaine powder	8.1 (7.1–9.1)	2.3 (1.8–2.9)	0.7 (0.5–1.1)
LSD	5.7 (4.9–6.6)	1.1 (0.7–1.5)	0.5 (0.3–0.8)
Magic mushrooms	5.7 (4.8–6.5)	0.5 (0.3–0.9)	0.1 (0.0–0.3)
Amphetamines	4.8 (4.0–5.6)	1.0 (0.7–1.5)	0.3 (0.1–0.5)
Poppers	4.7 (4.0–5.6)	1.7 (1.3–2.3)	1.1 (0.7–1.5)
NPS	2.5 (1.9–3.1)	0.8 (0.5–1.2)	0.3 (0.1–0.5)
Solvents	2.0 (1.6–2.6)	0.0 (0.0–0.2)	0.0 (0.0–0.0)
Crack	0.7 (0.5–1.1)	0.2 (0.1–0.4)	0.0 (0.0–0.2)
Heroin	0.3 (0.2–0.6)	0.0 (0.0–0.2)	0.0 (0.0–0.0)
Opioid pain relievers	54.7 (52.8–56.5)	33.4 (31.6–35.2)	13.1 (11.8–14.3)
Sedatives and tranquillisers	11.8 (10.6–13.0)	4.9 (4.2–5.8)	2.4 (1.9–3.1)
Anabolic steroids	0.4 (0.2–0.7)	0.1 (0.0–0.3)	0.0 (0.0–0.2)
Methadone	0.2 (0.1–0.4)	0.1 (0.0–0.2)	0.0 (0.0–0.2)
Alcohol	83.0 (81.6–84.4)	77.7 (76.1–79.2)	65.3 (63.6–67.1)
Tobacco	42.4 (40.6–44.3)	22.3 (20.8–23.9)	19.5 (18.0–21.0)

All figures are based on weighted data, are rounded to the nearest decimal place, and are based on valid responses.

Table 42 Prevalence of drug, alcohol, and tobacco use among 15–34-year-olds, by drug type

N=1,813	Lifetime % (95% CI)	Last year % (95% CI)	Last month % (95% CI)
Any illegal drug	31.8 (28.6–35.0)	17.7 (15.1–20.4)	9.8 (7.8–11.9)
Cannabis	27.3 (24.2–30.4)	13.8 (11.4–16.2)	6.5 (4.8–8.2)
Ecstasy	13.7 (11.3–16.1)	6.5 (4.8–8.2)	3.1 (2.1–4.6)
Cocaine (including crack)	10.6 (8.5–12.7)	4.8 (3.6–6.6)	1.5 (0.9–2.6)
Cocaine powder	10.5 (8.4–12.6)	4.7 (3.4–6.4)	1.4 (0.8–2.5)
LSD	6.6 (4.9–8.4)	2.4 (1.5–3.7)	1.3 (0.7–2.4)
Magic mushrooms	4.9 (3.6–6.6)	1.0 (0.5–2.0)	0.3 (0.1–0.9)
Amphetamines	5.6 (4.0–7.2)	2.3 (1.5–3.6)	0.7 (0.3–1.5)
Poppers	7.8 (5.9–9.6)	4.1 (2.9–5.7)	2.4 (1.5–3.7)
NPS	4.2 (3.1–5.9)	1.9 (1.2–3.1)	0.7 (0.3–1.5)
Solvents	2.4 (1.6–3.8)	0.0 (0.0–0.0)	0.0 (0.0–0.0)
Crack	0.9 (0.5–1.9)	0.4 (0.1–1.1)	0.1 (0.0–0.6)
Heroin	0.4 (0.1–1.1)	0.0 (0.0–0.0)	0.0 (0.0–0.0)
Opioid pain relievers	50.2 (46.7–53.6)	31.0 (27.8–34.2)	12.3 (10.1–14.6)
Sedatives and tranquillisers	7.8 (5.9–9.6)	4.0 (2.8–5.6)	1.8 (1.1–2.9)
Anabolic steroids	0.7 (0.3–1.6)	0.1 (0.0–0.7)	0.0
Methadone	0.2 (0.1–0.8)	0.1 (0.0–0.7)	0.1 (0.0–0.6)
Alcohol	80.3 (77.5–83.0)	76.5 (73.6–79.5)	63.2 (59.9–66.6)
Tobacco	32.7 (29.5–35.9)	25.6 (22.5–28.6)	21.0 (18.2–23.8)

All figures are based on weighted data, are rounded to the nearest decimal place, and are based on valid responses.

Table 43 Prevalence of drug, alcohol, and tobacco use among 35–64-year-olds, by drug type

N=2,906	Lifetime % (95% CI)	Last year % (95% CI)	Last month % (95% CI)
Any illegal drug	24.2 (22.4–26.0)	3.5 (2.8–4.3)	1.9 (1.4–2.6)
Cannabis	22.6 (20.8–24.3)	2.9 (2.3–3.8)	1.5 (1.1–2.1)
Ecstasy	8.3 (7.1–9.4)	0.4 (0.2–0.7)	0.1 (0.0–0.4)
Cocaine (including crack)	6.9 (5.8–8.0)	0.8 (0.5–1.3)	0.3 (0.1–0.6)
Cocaine powder	6.6 (5.5–7.6)	0.7 (0.5–1.2)	0.3 (0.1–0.6)
LSD	5.1 (4.2–6.1)	0.2 (0.1–0.5)	0.0 (0.0–0.0)
Magic mushrooms	6.1 (5.1–7.1)	0.3 (0.1–0.6)	0.0 (0.0–0.0)
Amphetamines	4.2 (3.5–5.2)	0.2 (0.1–0.5)	0.0 (0.0–0.0)
Poppers	2.8 (2.2–3.6)	0.3 (0.1–0.6)	0.2 (0.1–0.6)
NPS	1.3 (0.9–1.9)	0.1 (0.0–0.3)	0.0 (0.0–0.0)
Solvents	1.8 (1.3–2.4)	0.0 (0.0–0.2)	0.0 (0.0–0.0)
Crack	0.6 (0.3–1.0)	0.1 (0.0–0.3)	0.0 (0.0–0.0)
Heroin	0.3 (0.1–0.6)	0.0 (0.0–0.3)	0.0 (0.0–0.0)
Opioid pain relievers	57.5 (55.4–59.6)	34.9 (32.9–36.9)	13.5 (12.1–15.0)
Sedatives and tranquillisers	14.3 (12.8–15.8)	5.5 (4.5–6.4)	2.8 (2.2–3.6)
Anabolic steroids	0.1 (0.1–0.4)	0.1 (0.0–0.3)	0.0 (0.0–0.2)
Methadone	0.2 (0.1–0.4)	0.0 (0.0–0.2)	0.0 (0.0–0.0)
Alcohol	84.8 (83.2–86.3)	78.4 (76.7–80.2)	66.7 (64.6–68.7)
Tobacco	48.5 (46.4–50.6)	20.3 (18.6–22.0)	18.6 (16.9–20.2)

All figures are based on weighted data, are rounded to the nearest decimal place, and are based on valid responses.

Table 44 Prevalence of drug, alcohol, and tobacco use among males aged 15–64 years, by drug type

N=2,339	Lifetime % (95% CI)	Last year % (95% CI)	Last month % (95% CI)
Any illegal drug	32.8 (30.3–35.3)	12.3 (10.6–14.0)	7.0 (5.7–8.4)
Cannabis	29.5 (27.1–32.0)	9.9 (8.3–11.5)	5.0 (3.9–6.2)
Ecstasy	14.8 (12.9–16.7)	3.9 (3.0–5.0)	1.9 (1.3–2.8)
Cocaine (including crack)	11.6 (9.9–13.3)	3.5 (2.7–4.7)	1.3 (0.8–2.0)
Cocaine powder	11.2 (9.5–12.8)	3.4 (2.6–4.5)	1.2 (0.8–2.0)
LSD	8.7 (7.2–10.2)	1.8 (1.2–2.6)	0.9 (0.5–1.5)
Magic mushrooms	8.6 (7.1–10.1)	0.9 (0.5–1.5)	0.2 (0.1–0.6)
Amphetamines	7.3 (5.9–8.7)	1.5 (1.0–2.3)	0.4 (0.2–0.9)
Poppers	7.4 (6.0–8.8)	3.0 (2.2–4.0)	1.8 (1.2–2.6)
NPS	3.7 (2.8–4.9)	1.2 (0.7–1.9)	0.4 (0.2–0.9)
Solvents	3.1 (2.3–4.2)	0.0 (0.0–0.3)	0.0 (0.0–0.0)
Crack	1.1 (0.7–1.8)	0.3 (0.1–0.7)	0.1 (0.0–0.4)
Heroin	0.6 (0.3–1.1)	0.0 (0.0–0.4)	0.0 (0.0–0.0)
Opioid pain relievers	50.3 (47.6–53.0)	27.9 (25.5–30.3)	8.4 (6.9–9.9)
Sedatives and tranquillisers	10.9 (9.2–12.5)	5.0 (3.9–6.2)	2.2 (1.5–3.1)
Anabolic steroids	0.5 (0.3–1.1)	0.2 (0.1–0.6)	0.0 (0.0–0.3)
Methadone	0.3 (0.1–0.8)	0.1 (0.0–0.5)	0.0 (0.0–0.4)
Alcohol	84.5 (82.6–86.4)	79.8 (77.7–82.0)	68.6 (66.2–71.1)
Tobacco	46.2 (43.5–48.8)	26.0 (23.7–28.4)	23.5 (21.3–25.8)

All figures are based on weighted data, are rounded to the nearest decimal place, and are based on valid responses.

Table 45 Prevalence of drug, alcohol, and tobacco use among females aged 15–64 years, by drug type

N=2,380	Lifetime % (95% CI)	Last year % (95% CI)	Last month % (95% CI)
Any illegal drug	21.6 (19.4–23.7)	5.7 (4.4–6.9)	2.9 (2.1–3.9)
Cannabis	19.3 (17.2–21.4)	4.4 (3.4–5.6)	2.0 (1.3–2.8)
Ecstasy	6.0 (4.7–7.2)	1.6 (1.1–2.4)	0.6 (0.3–1.2)
Cocaine (including crack)	5.1 (3.9–6.2)	1.2 (0.7–1.9)	0.4 (0.2–0.9)
Cocaine powder	5.0 (3.9–6.2)	1.1 (0.7–1.8)	0.2 (0.1–0.6)
LSD	2.8 (2.0–3.8)	0.3 (0.1–0.8)	0.2 (0.1–0.6)
Magic mushrooms	2.8 (2.0–3.8)	0.2 (0.1–0.6)	0.1 (0.0–0.5)
Amphetamines	2.2 (1.6–3.2)	0.5 (0.3–1.1)	0.1 (0.0–0.4)
Poppers	2.1 (1.4–2.9)	0.5 (0.2–1.0)	0.1 (0.0–0.4)
NPS	1.2 (0.8–1.9)	0.4 (0.2–0.8)	0.0 (0.0–0.0)
Solvents	0.9 (0.6–1.6)	0.0 (0.0–0.0)	0.0 (0.0–0.0)
Crack	0.3 (0.1–0.8)	0.1 (0.0–0.5)	0.1 (0.0–0.5)
Heroin	0.1 (0.0–0.4)	0.0 (0.0–0.0)	0.0 (0.0–0.0)
Opioid pain relievers	59.0 (56.4–61.6)	38.8 (36.2–41.3)	17.6 (15.6–19.6)
Sedatives and tranquillisers	12.7 (11.0–14.5)	4.8 (3.8–6.1)	2.7 (1.9–3.6)
Anabolic steroids	0.2 (0.1–0.6)	0.1 (0.0–0.4)	0.0
Methadone	0.1 (0.0–0.4)	0.0	0.0
Alcohol	81.6 (79.6–83.6)	75.6 (73.3–77.8)	62.1 (59.6–64.6)
Tobacco	38.7 (36.2–41.3)	18.7 (16.6–20.7)	15.5 (13.6–17.4)

All figures are based on weighted data, are rounded to the nearest decimal place, and are based on valid responses.

Table 46 Prevalence of drug, alcohol, and tobacco use, by age group (%)

	Lifetime					Last year					Last month				
	15–24	25–34	35–44	45–54	55–64	15–24	25–34	35–44	45–54	55–64	15–24	25–34	35–44	45–54	55–64
Weighted responses	*911*	*902*	*1136*	*975*	*795*	*911*	*902*	*1136*	*975*	*795*	*911*	*902*	*1136*	*975*	*795*
Any illegal drug	26.7	36.9	33.5	22.9	12.7	18.5	17.0	6.4	2.1	1.0	10.5	9.2	3.4	1.3	0.5
Cannabis	22.7	31.9	30.7	21.4	12.2	14.5	13.1	5.2	2.1	0.7	6.8	6.2	2.6	1.2	0.3
Ecstasy	10.2	17.3	15.2	6.5	0.4	7.2	5.8	0.9	0.0	0.0	4.4	1.9	0.3	0.0	0.0
Cocaine (including crack)	7.0	14.2	10.7	6.6	1.7	4.6	5.1	1.7	0.3	0.1	1.3	1.7	0.5	0.2	0.0
Cocaine powder	6.8	14.2	10.3	6.3	1.7	4.4	5.0	1.6	0.3	0.1	1.1	1.7	0.5	0.2	0.0
LSD	3.9	9.4	8.1	4.7	1.4	2.4	2.3	0.6	0.0	0.0	1.7	0.9	0.0	0.0	0.0
Poppers	7.0	8.6	4.9	1.7	1.0	4.6	3.5	0.5	0.0	0.2	2.9	1.9	0.5	0.0	0.1
Magic mushrooms	2.5	7.3	9.9	5.3	1.7	0.6	1.4	0.5	0.1	0.1	0.3	0.3	0.0	0.0	0.0
Amphetamines	2.8	8.5	7.4	3.3	1.0	2.4	2.2	0.6	0.0	0.0	0.9	0.5	0.0	0.0	0.0
NPS	2.7	5.8	2.7	0.7	0.1	1.7	2.2	0.1	0.0	0.1	1.0	0.3	0.0	0.0	0.0
Solvents	1.2	3.7	2.3	2.3	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Crack	0.7	1.2	0.9	0.6	0.1	0.6	0.3	0.2	0.0	0.0	0.1	0.0	0.0	0.0	0.0
Heroin	0.0	0.7	0.4	0.3	0.2	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Opioid pain relievers	47.1	53.3	61.8	56.8	52.2	31.9	30.1	37.6	35.5	30.3	14.9	9.8	14.1	12.7	13.8
Sedatives and tranquillisers	3.8	11.8	13.7	14.1	15.6	2.6	5.4	5.6	4.0	7.1	1.3	2.3	1.9	2.6	4.3
Anabolic steroids	0.3	1.1	0.2	0.2	0.0	0.0	0.3	0.1	0.2	0.0	0.0	0.1	0.1	0.0	0.0
Methadone	0.0	0.4	0.2	0.2	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0
Alcohol	73.6	87.0	89.2	83.2	80.4	71.8	81.3	84.3	76.7	72.1	60.2	66.2	70.4	66.5	61.4
Tobacco	21.8	43.7	45.8	52.6	47.4	19.1	32.0	21.7	21.6	16.6	13.1	28.9	19.1	20.6	15.2

All figures are based on weighted data, are rounded to the nearest decimal place, and are based on valid responses.

Table 47 Prevalence of drug, alcohol, and tobacco use among males, by age group (%)

	Lifetime					Last year					Last month				
	15–24	25–34	35–44	45–54	55–64	15–24	25–34	35–44	45–54	55–64	15–24	25–34	35–44	45–54	55–64
Weighted responses	*462*	*445*	*554*	*485*	*393*	*462*	*445*	*554*	*485*	*393*	*462*	*445*	*554*	*485*	*393*
Any illegal drug	29.3	45.0	43.0	28.6	14.0	20.6	25.8	10.2	3.2	1.4	12.3	14.5	5.8	1.6	0.8
Cannabis	25.3	39.9	38.6	26.8	13.6	16.3	20.6	8.3	3.2	1.0	8.2	9.8	4.6	1.5	0.5
Ecstasy	12.4	23.9	23.1	10.7	0.8	8.9	9.7	1.0	0.1	0.0	5.9	3.3	0.6	0.0	0.0
Cocaine (including crack)	7.6	20.8	15.9	9.8	2.1	4.6	9.7	2.6	0.6	0.3	2.2	3.0	0.8	0.5	0.0
Cocaine powder	7.2	20.7	15.2	9.1	2.0	4.2	9.4	2.6	0.6	0.3	1.9	3.0	0.8	0.5	0.0
LSD	5.5	13.2	12.7	8.1	2.6	3.8	4.4	0.8	0.0	0.0	2.9	1.5	0.0	0.0	0.0
Poppers	10.1	14.8	7.2	2.7	1.9	7.3	6.8	0.8	0.0	0.4	4.1	3.8	0.8	0.0	0.3
Magic mushrooms	3.8	9.6	15.6	9.0	2.6	0.5	2.4	1.1	0.2	0.1	0.5	0.6	0.0	0.0	0.0
Amphetamines	3.3	12.7	11.8	5.9	1.6	2.9	4.1	0.8	0.0	0.0	1.2	1.0	0.0	0.0	0.0
NPS	4.1	8.5	4.5	1.0	0.1	2.3	3.6	0.2	0.0	0.0	1.5	0.6	0.0	0.0	0.0
Solvents	0.8	5.4	4.0	4.3	0.5	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0
Crack	0.9	2.1	1.4	1.0	0.2	0.7	0.5	0.2	0.0	0.0	0.3	0.0	0.0	0.0	0.0
Heroin	0.0	1.4	0.8	0.3	0.2	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Opioid pain relievers	40.3	50.6	59.4	52.4	46.3	22.3	25.7	36.5	26.2	27.0	5.7	6.2	10.8	7.6	11.7
Sedatives and tranquillisers	4.1	11.0	14.8	10.5	13.5	3.1	5.1	7.5	2.4	6.4	1.3	1.8	2.6	1.9	3.4
Anabolic steroids	0.4	1.8	0.2	0.3	0.0	0.0	0.6	0.0	0.3	0.0	0.0	0.2	0.0	0.0	0.0
Methadone	0.0	0.7	0.5	0.2	0.0	0.0	0.5	0.1	0.0	0.0	0.0	0.2	0.0	0.0	0.0
Alcohol	76.7	90.7	89.9	81.8	82.3	75.0	87.0	84.3	76.8	74.9	62.5	73.9	74.5	66.2	64.7
Tobacco	25.8	51.7	48.3	55.2	49.9	22.2	42.2	22.1	27.2	16.3	17.4	39.6	19.3	26.0	15.3

All figures are based on weighted data, are rounded to the nearest decimal place, and are based on valid responses.

Table 48 Prevalence of drug, alcohol, and tobacco use among females, by age group (%)

	Lifetime					Last year					Last month				
	15–24	25–34	35–44	45–54	55–64	15–24	25–34	35–44	45–54	55–64	15–24	25–34	35–44	45–54	55–64
Weighted responses	*449*	*458*	*582*	*490*	*402*	*449*	*458*	*582*	*490*	*402*	*449*	*458*	*582*	*490*	*402*
Any illegal drug	24.1	29.1	24.4	17.2	11.3	16.3	8.4	2.7	1.0	0.6	8.6	4.0	1.1	1.0	0.2
Cannabis	20.1	24.3	23.3	16.2	10.9	12.8	5.7	2.4	1.0	0.4	5.5	2.8	0.7	1.0	0.2
Ecstasy	7.8	10.9	7.8	2.3	0.1	5.4	1.9	0.9	0.0	0.0	2.8	0.5	0.0	0.0	0.0
Cocaine (including crack)	6.5	7.8	5.8	3.4	1.4	4.5	0.7	0.7	0.0	0.0	0.3	0.5	0.1	0.0	0.0
Cocaine powder	6.5	7.8	5.5	3.4	1.4	4.5	0.7	0.6	0.0	0.0	0.3	0.5	0.1	0.0	0.0
LSD	2.2	5.8	3.8	1.4	0.2	1.1	0.3	0.3	0.0	0.0	0.5	0.3	0.0	0.0	0.0
Poppers	3.8	2.6	2.8	0.7	0.1	1.9	0.2	0.3	0.0	0.0	1.6	0.0	0.3	0.0	0.0
Magic mushrooms	1.2	5.1	4.5	1.7	0.8	0.6	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Amphetamines	2.3	4.4	3.2	0.7	0.3	1.9	0.3	0.4	0.0	0.0	0.5	0.0	0.0	0.0	0.0
NPS	1.3	3.1	1.0	0.5	0.2	1.1	0.7	0.0	0.0	0.2	0.5	0.0	0.0	0.0	0.0
Solvents	1.6	2.0	0.7	0.3	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Crack	0.4	0.4	0.4	0.2	0.1	0.4	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Heroin	0.0	0.1	0.0	0.2	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Opioid pain relievers	54.2	55.8	64.1	61.1	58.0	41.8	34.3	38.7	44.7	33.6	24.2	13.2	17.2	17.7	15.9
Sedatives and tranquillisers	3.5	12.5	12.6	17.6	17.6	2.1	5.6	3.7	5.6	7.7	1.2	2.8	1.3	3.3	5.2
Anabolic steroids	0.2	0.5	0.1	0.2	0.0	0.0	0.0	0.1	0.1	0.0	0.0	0.0	0.1	0.0	0.0
Methadone	0.0	0.1	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Alcohol	70.4	83.3	88.5	84.6	78.5	68.5	75.8	84.3	76.6	69.3	57.9	58.8	66.6	66.8	58.2
Tobacco	17.8	35.9	43.4	50.0	44.9	16.0	22.1	21.3	16.1	16.9	8.7	18.5	18.9	15.3	15.1

All figures are based on weighted data, are rounded to the nearest decimal place, and are based on valid responses.

Appendix II Tables: Trends in lifetime, last year, and last month prevalence of drug, alcohol, and tobacco use

This appendix presents trends in the prevalence of drug, alcohol, and tobacco use for the five waves of the National Drug and Alcohol Survey (NDAS) which have been undertaken to date. As the first three surveys collected data on 15–64-year-olds only, trends for the five time points are presented for this age group.

There have been some changes in question wording and in the information provided on the showcards, which may impact on the comparability of some measures between surveys. These changes are as follows:

- Opioid pain relievers: In the 2002–03 and 2006–07 surveys, the showcard for opioid pain relievers simply contained the word 'codeine' without providing any description or examples. Since 2010–11, the showcard for opioid pain relievers contains a comprehensive list of the codeine products used in Ireland. Consequently, tests of statistical significance for differences between the first three surveys are not reported for opioid pain relievers.

- Tobacco and alcohol: Minor changes in question wording and the calculation for last month use of both tobacco and alcohol were introduced in the 2014–15 survey.

- Sedatives and tranquillisers: No prevalence figures are presented for sedatives and tranquillisers for 2002–03, as that survey asked about the use of either sedatives, tranquillisers, or antidepressants; subsequent surveys have asked about the use of sedatives/tranquillisers separately from the use of antidepressants.

'Any illegal drug' refers to cannabis, ecstasy, cocaine powder, magic mushrooms, amphetamines, poppers, LSD, new psychoactive substances (NPS), solvents, crack, and heroin. In the 2010–11 survey, questions on NPS were included for the first time but were not included in the 'any illegal drug' grouping as NPS only became illegal following the Criminal Justice (Psychoactive Substances) Act 2010. In order to ensure comparability with the 2014–15 and 2019–20 surveys in our trends analysis, we have reclassified NPS as an illegal drug for the 2010–11 survey. This means that there may be discrepancies between the results published here and those published in previous NDAS reports.

Changes that are found to be statistically significant are reported. When considering the results, it should be borne in mind that statistical significance does not imply that the change is of practical importance. The tests of statistical significance are used to establish the degree of confidence with which we can infer that the observed changes in drug prevalence between surveys are not due to sampling error. A significance level of 5% has been specified, which means that the likelihood that sampling error accounts for the observed change is less than 5%.

Table 49 Trends in drug, alcohol, and tobacco use among 15–64-year-olds, by drug type (%)

	Lifetime					Last year					Last month				
	2002–03	2006–07	2010–11	2014–15	2019–20	2002–03	2006–07	2010–11	2014–15	2019–20	2002–03	2006–07	2010–11	2014–15	2019–20
Any illegal drug	18.5	24.0*	27.2*	30.7*	27.1*	5.6	7.2*	8.0	8.9*	9.0	3.0	2.9	3.2	4.7*	4.9
Cannabis	17.3	21.9*	25.3	27.9*	24.4*	5.1	6.3*	6.0	7.7*	7.1	2.6	2.6	2.8	4.4*	3.4*
Ecstasy	3.7	5.5*	6.9	9.2*	10.3	1.1	1.2	0.5*	2.1*	2.7	0.3	0.3	0.1*	1.0*	1.3
Cocaine (including crack)	3.0	5.3*	6.8	7.8	8.3	1.1	1.7*	1.5	1.5	2.3*	0.4	0.5	0.5	0.4	0.7
Cocaine powder	2.9	5.1	6.7	7.6	8.1	1.1	1.6*	1.5	1.4	2.3*	0.4	0.5	0.5	0.4	0.7
LSD	2.9	2.9	4.4	3.8	5.7*	0.1	0.1	0.3	0.3	1.1*	0.0	0.0	0.0	0.1	0.5*
Poppers	2.6	3.3	3.9	4.1	4.7	0.4	0.5	0.2*	0.6*	1.7*	0.1	0.1	0.0	0.1	1.1*
Magic mushrooms	3.8	5.9*	6.5	6.1	5.7	0.4	0.6	0.5	0.6	0.5	0.0	0.0	0.0	0.1	0.1
Amphetamines	2.9	3.5	4.5*	4.1	4.8	0.4	0.4	0.4	0.3	1.0*	0.2	0.1	0.1	0.0	0.3*
NPS	~	~	~	3.5	2.5*	~	~	3.5	0.8*	0.8	~	~	~	0.1	0.3*
Solvents	1.7	1.9	2.6	3.2	2.0*	0.1	0.0	0.1*	0.2	0.0*	0.0	0.0	0.1	0.1	0.0
Crack	0.3	0.6	0.6	1.1*	0.7	0.1	0.1	0.1	0.2	0.2	0.0	0.0	0.0	0.1	0.0
Heroin	0.5	0.4	0.8*	0.9	0.3*	0.1	0.1	0.1	0.2	0.0*	0.1	0.0	0.1	0.0	0.0
Opioid pain relievers+	3.0	6.2	38.8	63.8*	54.7*	0.5	2.2	27.9	45.8*	33.4*	0.2	0.9	14.2	21.0*	13.1*
Sedatives and tranquillisers	~	10.6	13.9*	13.1	11.8	~	4.7	6.5*	6.1	4.9*	~	3.0	2.8	3.3	2.4
Anabolic steroids	0.0	0.6*	1.3*	1.2	0.4*	0.0	0.3*	0.5	0.3	0.1	0.0	0.1*	0.3	0.2	0.0
Methadone	0.3	0.4	0.5	0.7	0.2*	0.2	0.2	0.2	0.3	0.1*	0.1	0.1	0.2	0.2	0.0
Alcohol	90.1	90.2	90.3	85.3*	83.0*	83.8	84.2	85.3	79.9*	77.7	73.9	73.2	70.6*	65.0*	65.3
Tobacco	60.0	57.9	56.7	50.8*	42.4*	38.0	36.3	32.5*	31.3	22.3*	33.2	32.6	28.3*	27.4	19.5*

* Significant change ($p<0.05$) in prevalence of a drug when compared with prevalence reported in the previous survey.
~ Prevalence not asked.
+ Data from 2002–03 and 2006–07 are not comparable with later surveys.

Table 50 Trends in drug, alcohol, and tobacco use among males aged 15–64 years, by drug type (%)

	Lifetime					Last year					Last month				
	2002–03	2006–07	2010–11	2014–15	2019–20	2002–03	2006–07	2010–11	2014–15	2019–20	2002–03	2006–07	2010–11	2014–15	2019–20
Any illegal drug	23.8	29.5*	35.5*	38.8	32.8*	7.8	9.6	11.8	12.9*	12.3	4.1	4.5	5.3	7.1*	7.0
Cannabis	22.2	27.2*	33.2*	35.8	29.5	7.2	8.6	9.1	11.2	9.9	3.4	4.1	4.7	6.6	5.0
Ecstasy	4.9	7.4*	10.1	12.9*	14.8	1.5	1.8	0.6*	3.1*	3.9	0.6	0.5	0.1*	1.1*	1.9
Cocaine (including crack)	4.3	7.1*	9.9*	11.1	11.6	1.7	2.3	2.3	2.6	3.5	0.7	0.8	0.8	0.9	1.3
Cocaine powder	4.1	6.9*	9.7*	10.6	11.2	1.7	2.2	2.3	2.4	3.4	0.7	0.8	0.8	0.7	1.2
LSD	4.3	4.1	6.7	5.8	8.7*	0.2	0.2	0.5	0.4	1.8*	0.0	0.1	0.1	0.2	0.9*
Poppers	3.8	4.3	6.0	6.0	7.4	0.4	0.6	0.3	0.9*	3.0*	0.1	0.1	0.1	0.2	1.8*
Magic mushrooms	5.6	8.0*	9.5	8.6	8.6	0.6	0.9	0.8	0.8	0.9	0.1	0.0	0.1	0.2	0.2
Amphetamines	4.0	4.6	6.6*	5.8	7.3	0.6	0.5	0.4	0.5	1.5*	0.2	0.1	0.1	0.1	0.4*
NPS	~	~	~	4.7	3.7	~	~	5.4	1.2*	1.2	~	~	~	0.1	0.4
Solvents	2.2	2.3	3.8*	4.4	3.1	0.0	0.0	0.2	0.4	0.0*	0.0	0.0	0.1	0.1	0.0
Crack	0.5	0.8	1.0	1.9*	1.1	0.1	0.1	0.2	0.5	0.3	0.0	0.0	0.0	0.2	0.1
Heroin	0.7	0.5	1.2*	1.2	0.6	0.1	0.1	0.2	0.2	0.0	0.1	0.0	0.1	0.1	0.0
Opioid pain relievers+	2.0	4.8	35.2	59.4*	50.3*	0.4	1.5	24.0	40.5*	27.9*	0.2	0.9	11.1	16.3*	8.4*
Sedatives and tranquillisers	~	8.1	12.4*	10.8	10.9	~	3.7	5.7*	4.4	5.0	~	2.4	2.3	2.4	2.2
Anabolic steroids	0.0	0.7*	1.4*	1.9	0.5*	0.0	0.3*	0.6	0.4	0.2	0.0	0.1	0.3	0.3	0.0
Methadone	0.4	0.4	0.7	1.0	0.3*	0.2	0.1	0.4	0.3	0.1	0.1	0.1	0.3	0.2	0.0
Alcohol	92.5	91.8	92.5	87.4*	84.5*	86.0	86.4	87.5	82.5*	79.8	78.3	78.1	76.3	70.3*	68.6
Tobacco	61.6	59.1	60.6	54.9*	46.2*	38.2	36.8	35.7	34.4	26.0*	33.4	33.6	31.3	30.7	23.5*

* Significant change ($p<0.05$) in prevalence of a drug when compared with prevalence reported in the previous survey.
~ Prevalence not asked.
+ Data from 2002–03 and 2006–07 are not comparable with later surveys.

Table 51 Trends in drug, alcohol, and tobacco use among females aged 15–64 years, by drug type (%)

	Lifetime					Last year					Last month				
	2002–03	2006–07	2010–11	2014–15	2019–20	2002–03	2006–07	2010–11	2014–15	2019–20	2002–03	2006–07	2010–11	2014–15	2019–20
Any illegal drug	13.1	18.6	19.0	22.6	21.6	3.4	4.7	4.3	4.9	5.7	1.8	1.4	1.1	2.2*	2.9
Cannabis	12.3	16.8	17.5	20.0	19.3	2.9	3.9	2.9	4.3	4.4	1.7	1.2	0.9	2.1*	2.0
Ecstasy	2.6	3.6	3.7	5.6	6.0	0.6	0.6	0.3	1.1	1.6	0.0	0.2	0.0	0.8*	0.6
Cocaine (including crack)	1.6	3.5	3.8	4.6	5.1	0.5	1.0	0.7	0.5	1.2*	0.0	0.2*	0.3	0.2	0.2
Cocaine powder	1.6	3.4	3.8	4.5	5.0	0.5	1.0	0.7	0.5	1.1*	0.0	0.2*	0.3	0.2	0.2
LSD	1.4	1.7	2.2	1.9	2.8	0.0	0.1	0.1	0.2	0.3	0.0	0.0	0.0	0.0	0.1
Poppers	1.3	2.4	1.9	2.3	2.1	0.4	0.3	0.1	0.3	0.5	0.1	0.1	0.0	0.1	0.4
Magic mushrooms	2.0	3.8	3.6	3.5	2.8	0.1	0.4	0.2	0.3	0.2	0.0	0.0	0.0	0.0	0.0
Amphetamines	1.9	2.4	2.5	2.4	2.2	0.2	0.3	0.4	0.1	0.5*	0.1	0.1	0.0	0.0	0.1
NPS	~	~	~	2.3	1.2*	~	~	1.6	0.5	0.4	~	~	~	0.1	0.1
Solvents	1.1	1.4	1.3	2.0	0.9*	0.1	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.1	0.0
Crack	0.1	0.3	0.2	0.2	0.3	0.1	0.1	0.1	0.0	0.1*	0.0	0.0	0.0	0.0	0.0
Heroin	0.3	0.4	0.3	0.5	0.1*	0.1	0.1	0.1	0.1	0.0	0.1	0.1	0.0	0.0	0.0
Opioid pain relievers+	3.0	6.2	42.4	68.2*	59.0*	0.5	2.2	31.7	51.1*	38.8*	0.2	0.9	17.1	25.6*	17.6*
Sedatives and tranquillisers	~	13.2	15.5*	15.3	12.7*	~	5.7	7.3	7.7	4.8*	~	3.6	3.3	4.1	2.7
Anabolic steroids	0.0	0.6*	1.1*	0.5*	0.2	0.0	0.3*	0.5	0.2*	0.1	0.0	0.1	0.3	0.1	0.0
Methadone	0.3	0.3	0.2	0.4	0.1	0.2	0.3	0.1	0.2	0.0*	0.2	0.2	0.1	0.2	0.0*
Alcohol	90.1	90.2	90.3	85.3*	81.6	83.3	84.0	85.3	77.3*	75.6	73.9	73.2	70.6	65.0*	62.1
Tobacco	58.4	56.8	52.7*	46.7*	38.7*	37.8	35.8	29.4*	28.2	18.7*	33.0	31.6	25.2*	24.1	15.5*

* Significant change ($p<0.05$) in prevalence of a drug when compared with prevalence reported in the previous survey.
~ Prevalence not asked.
+ Data from 2002–03 and 2006–07 are not comparable with later surveys.

Table 52 Trends in drug, alcohol, and tobacco use among 15–34-year-olds, by drug type (%)

	Lifetime					Last year					Last month				
	2002–03	2006–07	2010–11	2014–15	2019–20	2002–03	2006–07	2010–11	2014–15	2019–20	2002–03	2006–07	2010–11	2014–15	2019–20
Any illegal drug	25.9	31.4*	35.7*	37.2	31.8	9.8	12.2*	12.3	15.7*	17.7	5.2	5.0	5.3	8.5*	9.8
Cannabis	23.8	28.6*	33.4*	33.5	27.3*	8.7	10.6	10.3	13.8*	13.8	4.3	4.3	4.5	8.1*	6.5
Ecstasy	7.1	9.1*	10.9	14.0	13.7	2.3	2.4	0.9*	4.4*	6.5*	0.6	0.6	0.1	2.1*	3.1
Cocaine (including crack)	4.7	8.2*	9.4	10.7	10.6	2.0	3.1*	2.8	2.9	4.8*	0.7	1.1	1.0	0.9	1.5
Cocaine powder	4.5	7.9*	9.3	10.3	10.5	2.0	2.9	2.7	2.7	4.7*	0.7	1.0	1.0	0.8	1.4
LSD	4.5	3.7	5.4	3.0*	6.6*	0.2	0.3	0.6	0.6	2.4*	0.0	0.1	0.1	0.2	1.3*
Poppers	4.7	5.5	6.2	5.9	7.8	0.8	0.9	0.2	1.4*	4.1*	0.2	0.1	0.0	0.3*	2.4*
Magic mushrooms	5.9	8.6*	8.2	7.0	4.9	0.7	1.2	0.8	1.2	1.0	0.1	0.0	0.0	0.3*	0.3
Amphetamines	4.8	5.1	6.4	4.8	5.6	0.8	0.8	0.8	0.6	2.3*	0.3	0.2	0.0	0.1	0.7
NPS	~	~	~	6.0	4.2	~	~	6.7	1.6	1.9	~	~	~	0.1	0.7
Solvents	3.3	3.2	3.8	4.1	2.4*	0.1	0.0	0.2	0.3	0.0*	0.0	0.0	0.1	0.1	0.0
Crack	0.5	1.0	0.7	1.5*	0.9	0.2	0.2	0.2	0.4	0.4	0.0	0.1	0.0	0.1	0.1
Heroin	0.7	0.5	0.7	0.8	0.4	0.2	0.1	0.2	0.4	0.0*	0.1	0.0	0.0	0.1	0.0
Opioid pain relievers+	2.9	4.6	37.0	62.6*	50.2*	0.6	1.7	28.3	48.6*	31.0*	0.1	0.8	14.2	22.4*	12.3*
Sedatives and tranquillisers	~	5.9	10.1*	8.9	7.8	~	2.6	4.8*	4.1	4.0	~	1.3	1.0	1.6	1.8
Anabolic steroids	0.0	0.4*	1.5*	1.5	0.7	0.0	0.3*	0.6	0.3	0.1	0.0	0.1	0.3	0.2	0.0
Methadone	0.6	0.5	0.4	0.8	0.2*	0.4	0.2	0.3	0.5	0.1	0.2	0.1	0.1	0.3	0.1
Alcohol	92.0	90.4	89.4	83.4*	80.3	86.5	86.3	86.3	79.9*	76.5	74.6	73.7	70.9	64.6*	63.2
Tobacco	57.4	56.3	53.0	47.0*	32.7*	43.1	40.8	37.3	38.3	25.6*	36.9	36.0	31.3*	32.8	21.0*

* Significant change ($p<0.05$) in prevalence of a drug when compared with prevalence reported in the previous survey.
~ Prevalence not asked.
+ Data from 2002–03 and 2006–07 are not comparable with later surveys.

Table 53 Trends in drug, alcohol, and tobacco use among 35–64-year-olds, by drug type (%)

	Lifetime					Last year					Last month				
	2002–03	2006–07	2010–11	2014–15	2019–20	2002–03	2006–07	2010–11	2014–15	2019–20	2002–03	2006–07	2010–11	2014–15	2019–20
Any illegal drug	11.8	17.6*	20.6*	25.6*	24.2	1.9	2.9*	2.9	3.6	3.5	0.9	1.2	1.6	1.7	1.9
Cannabis	11.4	16.2*	19.0*	23.5*	22.6	1.8	2.7*	2.6	3.0	2.9	0.9	1.2	1.4	1.5	1.5
Ecstasy	0.7	2.3*	3.7*	5.6*	8.3*	0.0	0.2*	0.2	0.4	0.4	0.0	0.1	0.0	0.1	0.1
Cocaine (including crack)	1.4	2.8*	4.8*	5.6	5.9	0.3	0.5	0.5	0.5	0.8	0.0	0.1	0.1	0.2	0.3
Cocaine powder	1.4	2.7*	4.7*	5.4	6.6	0.3	0.5	0.5	0.4	0.7	0.0	0.1	0.1	0.2	0.3
LSD	2.0	2.2*	3.7*	4.5	5.1	0.0	0.0	0.1	0.0	0.2	0.0	0.0	0.0	0.0	0.0
Poppers	0.7	1.4*	2.2	2.8	2.8	0.0	0.1	0.2	0.0*	0.3*	0.0	0.0	0.1	0.0	0.2
Magic mushrooms	2.0	3.5*	5.2*	5.4	6.1	0.1	0.2	0.2	0.1	0.3	0.0	0.0	0.1	0.0	0.0
Amphetamines	1.3	2.2*	3.0	3.5	4.2	0.1	0.1	0.1	0.1	0.2	0.0	0.0	0.1	0.0	0.0
NPS	~	~	~	1.5	1.3	~	~	1.0	0.2*	0.1	~	~	~	0.0	0.0
Solvents	0.2	0.8	1.5*	2.5*	1.8	0.0	0.0	0.1	0.2	0.0*	0.0	0.0	0.1	0.1	0.0
Crack	0.2	0.2	0.5	0.8	0.6	0.0	0.0	0.1	0.1	0.1	0.0	0.0	0.0	0.0	0.0
Heroin	0.3	0.4	0.8	0.9	0.3*	0.0	0.1	0.1	0.0	0.0	0.0	0.1	0.1	0.0	0.0
Opioid pain relievers+	3.0	7.6	40.2	64.6*	57.5*	0.4	2.5	27.6*	43.6*	34.9*	0.2	1.1	14.1*	19.9*	13.5*
Sedatives and tranquillisers	~	14.7	16.9*	16.3	14.3	~	6.5	7.8	7.7	5.5*	~	4.5	4.1	4.6	2.8*
Anabolic steroids	0.0	0.8*	1.1	1.0	0.1*	0.0	0.3*	0.4	0.3	0.1	0.0	0.1	0.2	0.1	0.0
Methadone	0.1	0.2	0.5	0.6	0.2*	0.1	0.1	0.2	0.1	0.0	0.1	0.1	0.2	0.1	0.0
Alcohol	88.3	90.1	91.0	86.7*	84.8	81.3	82.0	84.5*	79.9*	78.4	73.3	72.7	70.4	65.2*	66.7
Tobacco	62.3	59.4	59.5	53.7*	48.5*	33.4	32.3	28.8*	25.9*	20.3*	29.8	29.7	25.9*	23.2*	18.6*

* Significant change ($p<0.05$) in prevalence of a drug when compared with prevalence reported in the previous survey.
~ Prevalence not asked.
+ Data from 2002–03 and 2006–07 are not comparable with later surveys.

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