AlcoholAction Ireland
www.alcoholireland.ie

The national charity for alcohol-related issues

Coleraine House
Coleraine Street
Dublin 7
D07 E8XF
admin@alcoholactionireland.ie
Tel +353 1 8780610

Alan Guidon
Clerk to the Oireachtas Committee on Justice
Leinster House
Kildare Street
Dublin
D02 XR20

Email justice@oireachtas.ie

1 Dec 2022

Re: General Scheme of Sale of Alcohol Bill

Dear Mr Guidon

Thank you for the invitation to submit written evidence to the Oireachtas Committee on Justice in relation to the General Scheme of the Sale of Alcohol Bill. Please find attached our submission.

Our submission is also supported by a number of health advocates including The Irish Association for Emergency Medicine and Mental Health Reform.

We have access to considerable international expertise on alcohol licensing policy and would very much appreciate an opportunity to present evidence in person to the Committee on Justice on these matters.

Yours sincerely

Dr Sheila Gilheany
CEO Alcohol Action Ireland

1 Dec 2022
Alcohol Action Ireland (AAI) is the national independent advocate working to reduce harm from alcohol.

We campaign for the burden of alcohol harm to be lifted from the individual, community and State, and have a strong track record in effective advocacy, campaigning and policy research.

Our work involves providing information on alcohol-related issues, creating awareness of alcohol-related harm and offering public policy solutions with the potential to reduce that harm, with an emphasis on the implementation of the Public Health (Alcohol) Act.

AAI support the work of the HSE Alcohol Programme, informing strategic alcohol initiatives as an instrument of public health planning.

AAI is a member of the Public Health Alcohol Research Group established by the Minister for Health in Ireland to advise on evaluation research.

We act as the secretariat to the Alcohol Health Alliance Ireland, as its co-founding member, and serve on the Board of Eurocare – European Alcohol Policy Alliance, Brussels.

Alcohol Action Ireland very much appreciates the opportunity to bring evidence to the Oireachtas Committee on Justice in relation to its pre-legislative scrutiny on the General Scheme of the Sale of Alcohol Bill which was published on 25 October 2022.

Alcohol Action Ireland

CEO Dr Sheila Gilheany

Coleraine House, Coleraine Street, Dublin 7, D07 E8XF

T: +353 1 878 0610

E: admin@ alcoholactionireland.ie

W: Alcoholireland.ie

Alcohol Action Ireland Submission to Oireachtas Committee on Justice on the General Scheme of Sale of Alcohol Bill

Contents

Summary

Alcohol Action Ireland supports the modernisation and streamlining of the alcohol licensing process. We also welcome opportunities to enhance night-life in Ireland.

However, there is an underlying assumption in the Bill that in order to have a vibrant nightlife, there must be additional provision for alcohol sales. There is very little consideration given to the harms associated with the increased availability of alcohol and to public health matters.

Ireland has a profoundly unhealthy relationship with alcohol, which is a psychoactive substance that has huge human and financial implications across society in Ireland. In Ireland, alcohol licensing cannot be viewed simply as an administrative process that will allow businesses to garner more trade. Alcohol is 'no ordinary commodity – 'it causes cancer, is neurotoxic, a teratogen and addictive. Sale of alcohol is unique and is therefore unlike the sale of any other product. The wellbeing of citizens and public health considerations must be given primacy in relation to this Bill.

Alcohol Action Ireland considers that there is a need to include a number of elements in the Bill.

1. The health of the public should be a core element of licensing. This should be stated in the legislation as a primary purpose of the Bill.
2. A Health Impact Assessment of the Bill should be carried out in a structured way to examine health considerations.
3. A statutory system to monitor the impact of alcohol sales in specific areas and in individual premises is essential. The Bill makes provision for the HSE/Gardai/community groups to make objections to grant or renew a license. However, unless these groups have access to the key information, they will be unable to do so effectively. Licensee holders must be required to give details of their alcohol sales as a condition of license renewal. This must be built into the licensing grant and renewal system.
4. There should be a statutory maximum limit on the density of alcohol outlets and detailed monitoring of the density of alcohol outlets
5. Consideration should be given to other data monitoring systems such as the Cardiff Model[1] which has been shown to reduce violence related hospital admissions by 35% and serious violence recorded by the police by 42%.
6. We propose a levy system which would enable licensing authorities to raise a contribution from alcohol suppliers towards the costs of alcohol harm to the State.
7. Give consideration as to how this Bill relates to other legislation including the Public Health (Alcohol) Act 2018 and the recently proposed Gambling Regulation Bill.
8. Provide clarity on some of the provisions in relation to harms of alcohol to children.
9. Provide clarity on the role of the Health Service Executive.

There are also significant concerns about a number of aspects of the Bill as proposed which are likely to lead to increased alcohol use and consequent increased alcohol harms. These concerns reflect the robust evidence-base which demonstrates that alcohol sales and harms are increased in proportion to the duration of time that alcohol is on sale. These include:

10. The general extension of licensing hours of all bars/restaurants from 11.30pm to 12.30am
11. The facilitating of late-night opening of bars to 2.30am
12. The extension of nightclub hours to 6am
13. The introduction of cultural amenity licenses to venues not usually having a license – eg museums, galleries, theatres etc.
14. The revoking of the requirement to extinguish a license before opening a new premises. This will likely increase the number and density of alcohol outlets.

Ireland's public health policy in relation to alcohol is set out in the strategy document, Reducing Harm, Supporting Recovery - A health-led response to drug and alcohol use in Ireland 2017-2025. A key part of that strategy is the implementation of the Public Health (Alcohol) Act 2018. While some progress has been made in this area, there are significant measures within the Act which have not yet been implemented which is delaying progress towards achieving its goal of a 20% reduction in alcohol use.

The measures proposed under the Sale of Alcohol Bill will further undermine progress in reducing the harms from alcohol in Ireland.

Section 1: Alcohol use in Ireland

Over the last 50 years, alcohol use in Ireland[2] trebled. In 2019 Ireland had one of the highest rates of annual alcohol consumption in the world at 10.8 litres per capita, and failed to reduce alcohol consumption to the Government target of 9.1l per capita.

Alcohol consumption in Ireland is 80% above the global average and 19% above the Department of Health target of 9.1 litres per capita. During the pandemic there was a reduction in alcohol consumption to 9.5 litres per capita, likely due to public health measures such as prolonged pub closures, and indications are that in 2022 consumption has rebounded to near pre-pandemic levels.

This equates to annual alcohol use of 223 cans of beer PLUS 11 bottles of gin/vodka PLUS 39 bottles of wine PLUS 35 cans of cider per drinker.[3]

A Health Research Board study[4] demonstrated that a high level of alcohol consumption and related harms arises from heavy episodic drinking (HED)- ie, binge drinking. Ireland has a particularly high level of HED, ranking eighth in the world[4]. The HRB recommends that population-based approaches to reducing alcohol-related harm are most appropriate in the Irish context.

There is a popular myth that only people with a dependency on alcohol have an alcohol problem, or cause problems in society or the family. This has been long debunked. Such a narrative is a powerful impediment to political understanding of the necessity of legislative measures to reduce alcohol use.

Section 2: Alcohol harms in Ireland

Alcohol is a major cause of death, illness and disease, hospitalisations, self-harm, and violence in Ireland and has serious impacts on public health and health service delivery.

Four people die every day[5] from alcohol in Ireland – 1460 annually. One third of these deaths are from incident and injury eg falls, assaults, traffic collisions, self-harm.

- One in two people in Ireland drink at hazardous or harmful levels equating to an estimated 1.5 million people[6], and an estimated one in seven people in Ireland, or 578,000 people, have an alcohol use disorder, with 40% engaging in heavy episodic drinking (i.e., binge drinking) at least once a month.
- 37% of drinkers aged 15-24 years old have an alcohol use disorder
- Increasing the duration and locations at which alcohol is available results in increased alcohol-related harms including assaults, injuries, and road traffic collisions.

The estimated **economic cost**[7] to Irish society of problem alcohol use annually is €3.7 billion, including a cost of €1.2 billion to the healthcare system for alcohol-related illnesses and a cost of €1.19 billion to the justice system due to alcohol-related crime.

For example:

- A study[8] in 29 emergency departments in Ireland found that alcohol-related presentations accounted for 6% of all presentations, with 57% arriving by ambulance. In the early hours of Sunday morning, alcohol-related presentations accounted for 29% of all presentations.
- The average length of stay in hospital for alcohol-related conditions increased from 6.0 days in 1995 to 10.3 days in 2018.[2]
- Alcohol is involved in an estimated 50% of suicides[9] in Ireland.
- Hospital admissions for alcohol related liver disease (ALD) has risen 262% from 1995 to 2017, reaching the highest it has ever been since recording began at 102.3 discharges per 100,000 persons.[2]
- The hospital mortality rate for ALD patients in Ireland is 8.4%, more than double that reported for common conditions such as heart disease, stroke or cancer.

Alcohol not only harms the health of individuals, but causes significant **harm to others** and our communities, including many 'hidden harms':

- Ireland has the third highest rate[10] of Foetal Alcohol Spectrum Disorders (FASD) among children and youth in the world, at 47.5 per 1000 population. FASD is associated with physical, mental, educational, social, and behavioral difficulties.
- At least one in 6 children experience harm from parental problem alcohol use.[7]
- One in two people in Ireland report experiencing harm due to strangers' drinking.[7]
- Alcohol plays a prominent role in domestic, sexual and gender-based violence. Research in Ireland found that alcohol was involved in 34% of domestic abuse cases and almost half of adult sexual assault cases.[11]
- The Probation Services found that alcohol was linked to the current offence of 53% of clients[12] .
- Typical alcohol-related crimes include drink driving, public disorder, assault, criminal damage, sexual and domestic violence. The President of the District Court, Judge Peter Kelly commented, "*If alcohol disappeared overnight, the courts could close down*."[13]

Section 3: Evidence in relation to licensing hours

Availability and accessibility of alcohol[14] are the main determinants of alcohol use and alcohol-related harm in the population, as outlined in the World Health Organisation's (WHO) SAFER initiative.

The WHO has consistently identified restrictions on alcohol availability as a highly effective and cost-effective 'best-buy 'for the prevention and reduction of alcohol harm.

International evidence[15] is overwhelmingly clear that any changes in the number and density of licensed premises, as well as permitted trading hours, are associated with changes in the patterns of alcohol-related harms and evidence is growing for its impact on increasing chronic health harms.

It is commonly believed in Ireland that because European cities have liberal laws around licensed premises, they don't have problems with alcohol. This is not the case.

In Germany, where laws around alcohol are lauded by those citing its buoyant nighttime economy, the country is '*one of the most-addicted societies in the world*, 'according to a study[16] by the German Central Office for Addiction Issues. Alcohol-related costs in Germany are estimated at €40 billion annually.

In France a 2021 report identified that 30% of the population has an alcohol problem. Alcohol is the leading cause of hospitalisation in the country and accounts for 41,000 deaths annually. [17]

Other examples demonstrating relaxed alcohol laws and increased harms include:

- The Licensing Act 2003 in England enabled staggered closing times and one of the stated aims of the Act was to reduce violence and disorder at fixed, peak closing times. Research[18] demonstrated that there was no change in overall levels of violence, that violence was shifted later into the night and for most hospitals, admissions relating to alcohol increased.
- Research[19] from Norway in 2012 suggested that each additional 1-hour extension to the opening times of premises selling alcohol was associated with a 16% increase in violent crime.

In Ireland, An Gardai Siochana have highlighted[20] an increase in alcohol-related offences, which they attribute to a buoyant night-time economy. In 2017, Gardai reported that public drunkenness offences in Dublin were 40 per cent higher than in 2016, and that public-order crime had increased 14 per cent. In 2019, Deputy Commissioner Twomey, said that the number of crimes against the person, including assaults and increases in the summer months, which he believed was related to the consumption of alcohol.

Conversely, studies in Switzerland[21], Australia and New Zealand have demonstrated that reducing late-night opening hours substantially reduces rates of violence.

Section 4: Evidence in relation to density of alcohol outlets

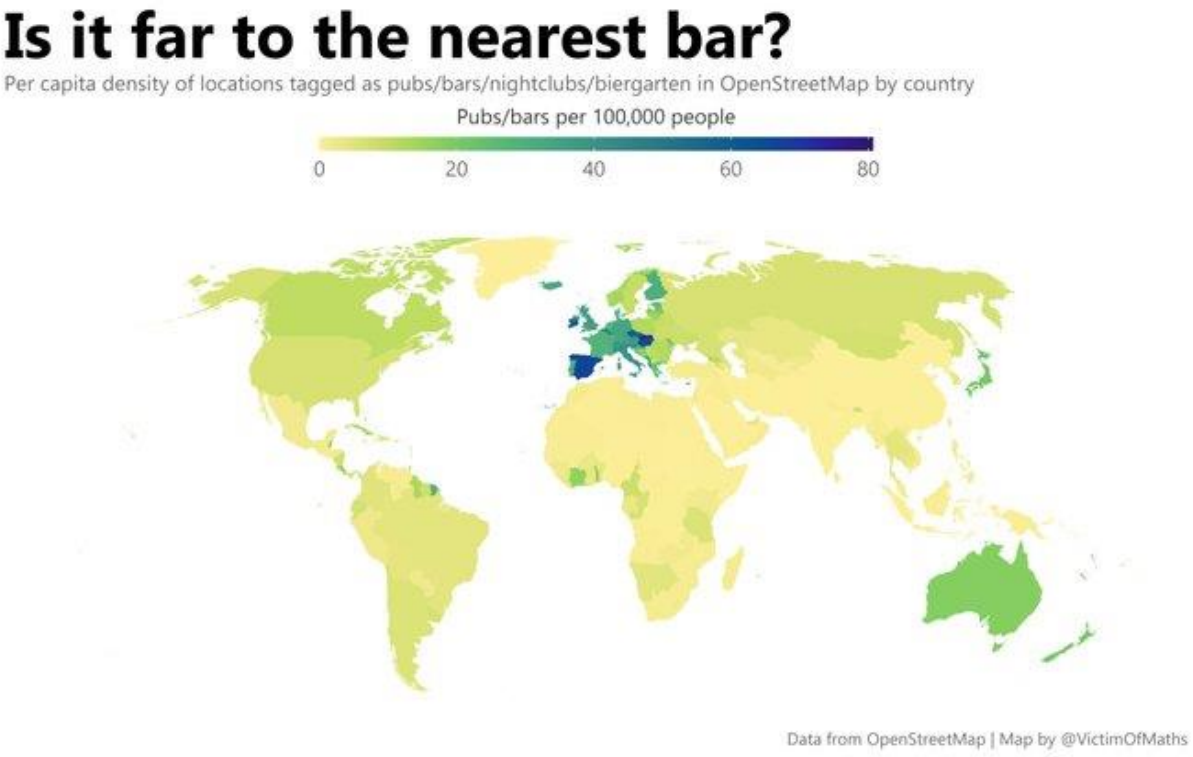
In November 2022, the World Health Organisation released a comprehensive report[22] reinforcing the public health considerations in relation to the sale of alcohol.

The report notes that the density of and proximity to alcohol establishments have long been associated with pedestrian injuries, suicide, and long-term chronic harm, such as cancer and death. The evidence is particularly robust for suicide, alcohol-related deaths, sexually transmitted diseases, and child maltreatment. In particular, emerging evidence associates higher densities of alcohol outlets with pedestrian injuries and cancers.

Areas with higher densities of on-premise establishments tend to be more associated with acute alcohol harm. Areas with higher off-premise outlet density tend to have higher consumption rates, particularly establishments such as grocery stores, where customers can "bundle" alcohol with other purchases.

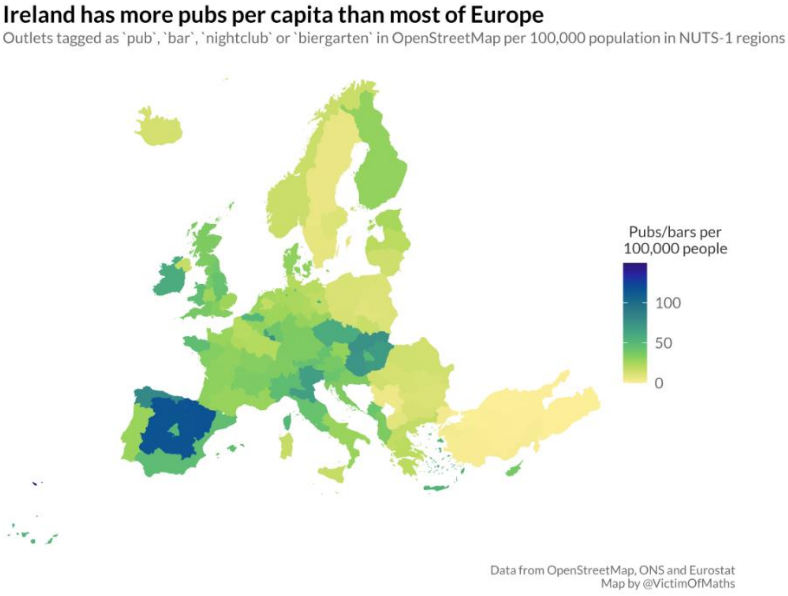
A study[23] from New Zealand demonstrated that greater geographic access to alcohol outlets was associated with increased levels of serious violent offending.

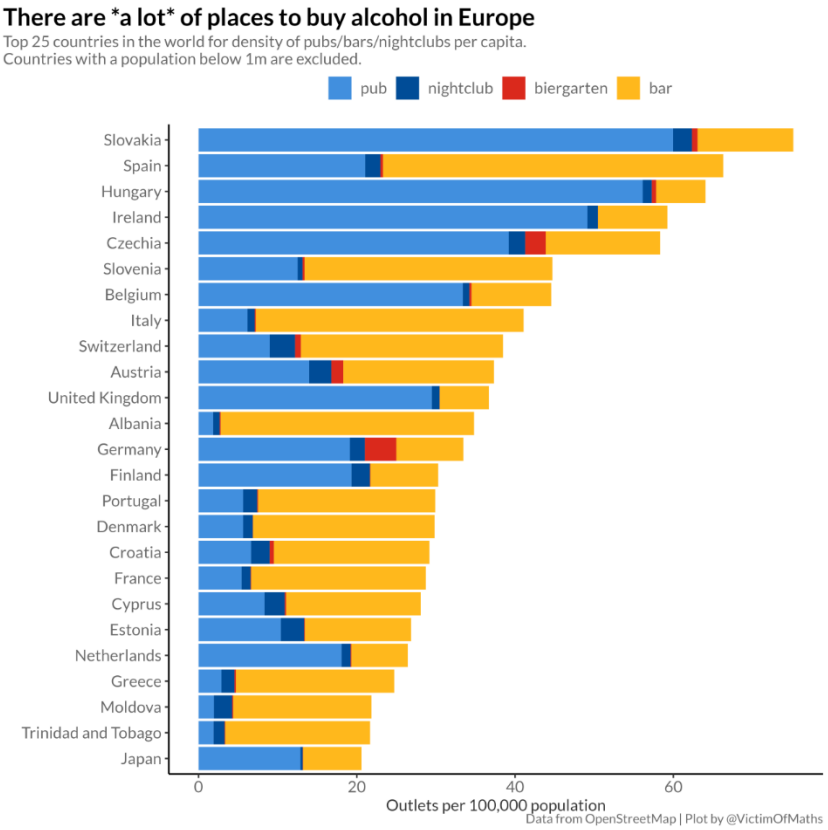
Increased density of alcohol outlets[24] is associated with increased levels of alcohol harm and in particular studies have shown increased levels of domestic violence. For example, a report published in November 2022[25] found a very clear relationship between the level of alcohol use and child abuse in neighbourhoods. With a 1% higher per capita volume of alcohol consumed, there were 3.2% more children entering foster care due to alcohol-related concerns. The same study noted having one more off-premise alcohol outlet, on average, was related to a 13.5% increase in substantiated instances of child abuse and neglect and a 10.5% increase in total foster care entries.



In Ireland alcohol has become significantly more widely available and the map above indicates Ireland's per capita density of bars is one of the highest in the world, even higher than that of N. Ireland and the UK.

Using Open Street May data, Dr Colin Angus of Sheffield University has estimated that Ireland has the 4th highest number of pubs/bars/clubs per capita of any country in the world (excluding countries with populations below 1 million).





In the 1970s, Special Exemption Orders became more widely available and the number issued increased four-fold. Loosening of restrictions on securing an off-trade licence in the 1990s and beyond has seen retail off-licences numbers increase from under 1,000 to over 5,000 in 2013.[26] A 2019 study by Dublin 12 and Canal Communities Local Drug and Alcohol Task Forces demonstrated that the number of licensed outlets in these communities increased from 49 to 125 outlets over the previous 20 years, and that most people are now living within 300 metres (approx. 2-3 minute walk) of an outlet licensed to sell alcohol.[27] The same report highlights the alcohol harms in the area and notes the normalization of alcohol provision.

The WHO report also highlights – among many other salient points, that limiting alcohol establishment density is an effective, evidence-based means of reducing the harm associated with alcohol consumption and has the potential to advance equity and public health agendas. The WHO provides a number of tools for measuring the density of alcohol outlets and highly recommends that communities are involved in decision making around licensing.

Section 5: Addressing alcohol availability as a public health context

Given the evidence cited above relating to the harmful effects of increased alcohol availability, there is a clear need to address alcohol use in Ireland. Public health and public safety should be core elements of the licensing of alcohol sales. This should be stated in the legislation as the primary purpose of the Bill. However, the Bill as it stands has no stated health objective, which seems an astonishing oversight, and is at variance with the primacy of health as an issue in the Public Health Alcohol Bill.

We propose that there should be a Health Impact Assessment (HIA) prior to any changes in the legislation regarding sale of alcohol. This is a structured process which can determine the potential positive and negative heath impacts of the Draft Sale of Alcohol Bill and identify if certain groups within the population are more likely to be negatively affected by the new legislation than others.

We propose that the Sale of Alcohol Bill:

- **SHOULD** NOT increase the temporal or physical availability of alcohol, as this is likely to increase consumption and subsequent harms.

- **SHOULD** NOT further normalise alcohol use by creating new drinking occasions through diversification of licensing (cinemas, public transport, sports clubs etc.) and through the proposed new category of cultural amenity licence.

- **SHOULD ALIGN** with existing health policy and legislation in relation to alcohol.

Section 6: Public Health (Alcohol) Act 2018

Public health alcohol policy as set out in the Public Health (Alcohol) Act 2018 (PHAA) aims for a 20% reduction in alcohol use across the whole of population. The target was 9.1 litres per capita over the age of 15 years to be reached by 2020. This was not achieved – alcohol use is 18% above this level. The quite modest measures within the PHAA are based on the World Health Organisation's evidence-based' best buys 'around reducing alcohol harm – ie controls on price, promotion and availability.

Given that the proposals in the Sale of Alcohol Bill as published will increase the availability of alcohol, it is diametrically at odds with the objectives of existing government policy and indeed existing legislation regarding alcohol. This is compounded by the significant delay in implementing the measures within the PHAA, with no indication as to when key measures on restrictions on advertising content and the broadcast watershed for advertising will be introduced.

Section 7: Licensing hours and locations

The Sale of Alcohol Bill provides for a considerable extension of licensing hours and locations. In brief these are:

1. The general extension of licensing hours of all bars/restaurants from 11.30pm to 12.30am
2. Off-licence hours change to 10.30am to 10.00pm every day
3. The facilitating of late-night opening of bars to 2.30am
4. The extension of nightclub hours to 6am
5. The introduction of cultural amenity licenses to venues not usually having a license – eg museums, galleries, theatres etc.

In view of the evidence provided above, there is deep concern among public health advocates and the wider public in general about these proposals. As well as the inevitable additional harm which will arise from such extensions, there are also the concerns of those who do not drink at all (25% of the population), those who prefer not to drink on particular occasions and those who are in recovery from an alcohol problem.

The Bill very much facilitates an idea that all occasions should be drinking occasions and that this is an essential component of enhancing the night-time economy.

Paradoxically, a significant obstacle to our citizens, or visitors, enjoying a vibrant night-time economy is a fear of public drunkenness and related anti-social behaviour. The 2018 HSE/TCD study, 'The Untold Story', reaffirms that view, 27% of people surveyed confirmed being bothered by the drinking of strangers; 23% highlighting that they had been harassed on the street; and one in five feeling unsafe in public places.[7] Such concern is confirmed by polling data which indicates that 47% do not support the proposal to allow nightclubs to remain open until 6am.[28]

Concern has also been expressed by addiction specialists that the extension of opening hours to 6am could lead to an increase in the level of use of illegal drugs in particular, cocaine.

Section 8: Extinguishing of licenses

AAI has particular concerns about the revoking of the requirement to extinguish a license before opening a new premises (on-sales only). This will likely increase the number and density of alcohol outlets.

We recommend there is a cap on the total number of licences granted within on- and off-licence sectors respectively.

We are concerned that the extinguishment of a licence for a small rural pub can be replaced by a licence for a large off-licence for example. The current mechanism should be revised so that 'like for like' licences are granted. For example, any new on-licence granted should not result in additional alcohol sales, consumption or harms. Consideration should therefore be given to the setting (rural/urban) and population size in which the new license is being granted to ensure it is proportionate to the license being extinguished.

Section 9: Monitoring of density of alcohol outlets

A limit on the density of alcohol outlets in local areas should be established. This should be done in consultation with local communities using tools provided by the WHO. This could form part of a Health Impact Assessment of the Sale of Alcohol Bill. Monitoring of the density of outlets is also a key part of any data collection and basic details such as the Eircode of premises should be readily available. At present this has proved difficult for researchers to obtain.

Section 10: Monitoring of alcohol sales and impact

We propose that **t**here is a need for a statutory system of monitoring alcohol sales and the impact of alcohol sales in specific areas and in individual premises.

While the Bill makes provision for the HSE/Gardai/community groups to make objections to license grant or renewal, if these groups do not have the key information, it will be difficult to comment in a meaningful way on particular licensing applications. License holders should be required to give details of their alcohol sales as a condition of license renewal. This needs to be built into the licensing grant and renewal system. Such information already exists within Revenue as part of licensee holders returns but is not made publicly available.

Data needs to be gathered in a systematic way around specific harms such as:

- Alcohol-related ambulance call outs
- Alcohol-related attendances and admissions to hospital
- Public order offences
- Alcohol-related assaults
- Alcohol-related domestic violence
- Alcohol-related sexual- and gender-based violence

Such data along with localised information on alcohol sales would give a clear picture of the impact of alcohol licensing on specific area and allow for informed decision-making regarding granting or refusing a license.

Much of this data is relatively easily collated but without a statutory obligation to do so and resources provided, it will not happen.

Regular surveys of the public's experience and views on night-life should be commissioned to provide insights into the outcomes of licensing.

Section 11: Cardiff Model

Alongside the need for statutory monitoring data as outlined above, consideration should also be given to a statutory anonymised system of data sharing known as the Cardiff Model[i].

Alcohol-related presentations are a significant burden on hospital Emergency Departments and ambulance services, especially in the early hours of Sunday mornings. A data collection system, based on centrally collecting and sharing data from hospital emergency departments and police to inform policy development and improve strategies to reduce alcohol-related harm – should be developed in Ireland. Such a system would provide baseline data around night-time alcohol-related harm and violence, and would be an invaluable tool to measure the effect of any changes to licensing laws.

Background

Research in Cardiff found that one half to two thirds of violence which results in hospital treatment is not known to the police. Subsequent research found that police knowledge of violence depends on people reporting these offences, but that many of the injured do not report because they are afraid of reprisals, don't want their own conduct scrutinised, or because they don't think the police could take effective action if they do report.

Three components

The Cardiff Model has three key components:

1. Continuous data collection in hospital emergency departments (EDs) on precise violence location, time, weapon and numbers of assailants
2. Information anonymised and shared regularly by hospitals with crime analysts who combine and summarise police and ED data to identify areas and times of violence concentrations

3. Combined information translated into violence prevention by a Violence Prevention Board.

Outcomes

- Reduced violence related hospital admissions by 35%
- Reduced serious violence recorded by the police by 42%
- Substantially reduced the costs of violence to health services relative to the costs of the Model
- Substantially reduced the costs of violence to the criminal justice system
- Reduced violence in premises licensed to serve alcohol.

Implementation in the UK

- Early adopters included public health and police partners on Merseyside, and in Cambridge and the Southeast health region of England.
- Welsh Government, through its Community Safety Directorate, instituted training workshops for key professionals: ED receptionists who record the necessary data electronically, data analysts, police managers, local government officials, ED doctors and community safety partnership personnel.
- In the mid-2000s the Violence Reduction Unit in Scotland introduced this approach.
- In 2008, the UK government adopted this approach in its alcohol strategy Safe Sensible Social.
- In 2010, the new UK administration made this approach part of its programme for government.
- In 2016, government commitment to this approach was reiterated in its Modern Crime Prevention strategy.
- The Cardiff Model dataset was codified (ISB 1594), published by NHS Digital and incorporated into the new Emergency Care Data Set which software suppliers are required to include in their products.
- Cardiff Model data collection in EDs became mandatory under the terms of the standard National Health Service contract.

Section 12 Role of Health Service Executive clarified

In addition to the concerns in relation to the intent of the PHAA as outlined in Section 6 of this document, there is also clarity needed in relation to the role of the Health Service Executive.

Section 4 of the PHAA was commenced in November 2021 and due to come into operation in November 2022. This requires that the applicant for an alcohol licence (grant or renewal) must give one month's notice in writing to the Health Service Executive. However, the Sale of Alcohol Bill makes no mention of this requirement.

Section 13 Gambling Regulation Bill

In November 2022 the government approved a Gambling Regulation Bill. This provides for restrictions on gambling advertising, a Social Impact Fund for research and treatment in this area and a Gambling Regulator Authority to enforce the advertising and sponsorship rules across all media and to examine the licensing laws.

There are many similarities between alcohol and gambling and indeed there is research which indicates a significant overlap in issues in both. For example, there is a marked correlation between problem gambling and substance use (drug use, alcohol use disorder and/or smoking), with 13% of those with an alcohol use disorder classified as an at-risk or problem gambler compared with 2% of low-risk drinkers.[29]

With this in mind there is a need to ensure that measures in the Sale of Alcohol Bill align with measures in the Gambling Regulation Bill.

Section 14 Levy on industry

Alcohol harm currently costs the State at least €3.7 billion annually, while excise duties only raise €1.2 billion annually. There is a clear need for a "polluter pays principle" to be adopted in relation to alcohol harm. The Gambling Regulation Bill gives a good model for a Social Impact Fund and a similar approach should be adopted in relation to the licensing of alcohol sales.

Conclusion

Alcohol is a psychoactive substance that has huge negative human and financial implications across society.

In this landscape, alcohol licensing cannot be viewed simply as an administrative process that will allow businesses to garner more trade. Alcohol is 'no ordinary commodity – 'it is a carcinogen, neurotoxic, a teratogen and addictive, and its sale is therefore unlike the sale of any other product.

Clearly, public health objectives and alcohol harms are already seriously out of balance with one another. Measures proposed under the Sale of Alcohol Bill will only further tip that balance, causing the costs – both human and financial – to increase substantially over time and reduce progress being made since the passage of the Public Health Alcohol Act.

In order to comprehensively address alcohol harms in Ireland, there is a need to establish a statutory Office for Alcohol Harm Reduction, which will take the lead on co-ordinating all aspects of alcohol regulation in Ireland including licensing, marketing and promotion, strategic development of treatment services, education/prevention programming, commissioning of relevant data, plus monitoring and evaluation of policy in this area. In this regard, there is much to learn from the approach of the Gambling Regulation Bill.

References

[1] https://www.cardiff.ac.uk/security-crime-intelligence-innovation-institute/publications/research-briefings/the-cardiff-model
[2] O'Dwyer C, Mongan D, Doyle A and Galvin B (2021) Alcohol consumption, alcohol-related harm and alcohol policy in Ireland. HRB Overview Series 11. Dublin: Health Research Board. https://www.drugsandalcohol.ie/33909

[3] Alcohol Action Ireland 2021 Market Review. https://alcoholireland.ie/wp-content/uploads/filebase/reports/21999-AAI-Market-Review-2022_v4screen.pdf

[4] O'Dwyer, Claire and Mongan, Deirdre and Millar, Sean and Rackard, Marion and Galvin, Brian and Long, Jean and Barry, Joe (2019) Drinking patterns and the distribution of alcohol-related harms in Ireland: evidence for the prevention paradox. BMC Public Health, 19, p. 1323. doi: 10.1186/s12889-019-7666-4.

[5] Kabir Z, Gilheany S, McKinney E. Kitt K. Global burden of disease: Estimates of alcohol use and attributable burden in Ireland. Alcohol Action Ireland. https://alcoholireland.ie/wp-content/uploads/filebase/reports/21883_AAI_ICC_GBD_Policy_Paper_v4_online.pdf

[6] Mongan D, Millar SR, and Galvin B (2021) The 2019–20 Irish National Drug and Alcohol Survey: Main findings. Dublin: Health Research Board. https://www.drugsandalcohol.ie/34287

[7] Hope A, Barry J & Byrne S. (2018). The untold story: Harms experienced in the Irish population due to others' drinking. Dublin: Health Service Executive.

[8] McNicholl B, Goggin D, O'Donovan D. Alcohol-related presentations to emergency departments in Ireland: a descriptive prevalence study. *BMJ Open* 2018;8:e021932. doi:10.1136/bmjopen-2018-021932

[9] Suicide among Young People and Adults in Ireland: Method Characteristics, Toxicological Analysis and Substance Abuse Histories Compared

Ella Arensman , Marco Bennardi , Celine Larkin, Amanda Wall, Carmel McAuliffe, Jacklyn McCarthy, Eileen Williamson, Ivan J. Perry Published: November 29, 2016**https://doi.org/10.1371/journal.pone.0166881**

[10] Estimation of national, regional, and global prevalence of alcohol use during pregnancy and fetal alcohol syndrome: a systematic review and meta-analysis

Svetlana Popova, PhD Shannon Lange, MPH Charlotte Probst, MSc Gerrit Gmel, MSc Prof Jürgen Rehm, PhD Lancet Global Health Open Access Published: January 12, 2017 DOI:**https://doi.org/10.1016/S2214-109X(17)30021-9**

[11] Dorothy Watson, Sara Parsons, 2005.ESRI and National Crime Council of Ireland. Domestic Abuse of Women and Men in Ireland: Report on the National Study of Domestic Abuse

[12] Rooney L. 2021. Probation Service Research Report 8. Informing & Supporting Change: Drug and Alcohol Misuse among People on Probation Supervision in Ireland

[13] https://www.irishtimes.com/news/crime-and-law/courts/district-court/inside-ireland-s-district-courts-if-alcohol-disappeared-overnight-the-courts-could-close-1.4781655?

[14] https://www.who.int/initiatives/SAFER

[15] Burton R, Henn C, Lavoie D, O'Connor R, Perkins C, Sweeney K, Greaves F, Ferguson B, Beynon C, Belloni A, Musto V, Marsden J, Sheron N. A rapid evidence review of the effectiveness and cost-effectiveness of alcohol control policies: an English perspective. Lancet. 2017 Apr 15;389(10078):1558-1580. doi: 10.1016/S0140-6736(16)32420-5. Epub 2016 Dec 2. PMID: 27919442.

[16] https://movendi.ngo/news/2019/04/18/study-germany-has-an-alcohol-problem/

[17] National Institute of Health and Medical Research (Inserm) "Reduction of damage associated with the consumption of alcohol". 2021

[18] Burton R, Henn C, Lavoie D, O'Connor R, Perkins C, Sweeney K, Greaves F, Ferguson B, Beynon C, Belloni A, Musto V, Marsden J, Sheron N. A rapid evidence review of the effectiveness and cost-effectiveness of alcohol control policies: an English perspective. Lancet. 2017 Apr 15;389(10078):1558-1580. doi: 10.1016/S0140-6736(16)32420-5. Epub 2016 Dec 2. PMID: 27919442.

[19] Rossow I, Norström T. The impact of small changes in bar closing hours on violence. The Norwegian experience from 18 cities. Addiction. 2012 Mar;107(3):530-7. doi: 10.1111/j.1360-0443.2011.03643.x. Epub 2011 Nov 29. PMID: 21906198; PMCID: PMC3380552.

[20] https://www.irishtimes.com/news/crime-and-law/alcohol-related-crime-booms-in-dublin-as-nightlife-picks-up-1.3291974

[21] Wicki M, Bertholet N, Gmel G. Estimated changes in hospital admissions for alcohol intoxication after partial bans on off-premises sales of alcoholic beverages in the canton of Vaud, Switzerland: an interrupted time-series analysis. Addiction. 2020 Aug;115(8):1459-1469. doi: 10.1111/add.14967. Epub 2020 Feb 5. PMID: 31925836.

[22] A public health perspective on alcohol establishments: licensing, density and locations. Brief 8, November 2022. Geneva: World Health Organization; 2022. Snapshot shttps://apps.who.int/iris/rest/bitstreams/1476533/retrieve

[23] Day, P., Breetzke, G., Kingham, S. and Campbell, M. (2012), Close proximity to alcohol outlets is associated with increased serious violent crime in New Zealand. Australian and New Zealand Journal of Public Health, 36: 48-54. https://doi.org/10.1111/j.1753-6405.2012.00827.x

[24] Centers for Disease Control and Prevention. *Guide for Measuring Alcohol Outlet Density*. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2017.

[25] Freisthler, B., Kranich, C., Price Wolf, J., Boyd, R. & Gruenewald, P.J. (2022) Neighborhood market potentials for alcohol use and rates of child abuse and neglect. *Alcoholism: Clinical and Experimental Research*, 00, 1– 12. Available from: https://doi.org/10.1111/acer.14975

[26] Mongan, D & Long J. (2016). Alcohol in Ireland: consumption, harm, cost and policy response. HRB Overview Series 10. Dublin: Health Research Board

[27] Dowling, A. (2019). Dublin 12 and Canal Communities Local Drugs Task Force: evidence baseline report. Canal Communities Local Drugs Task Force and D12 Local Drug and Alcohol Task Force.

[28] https://www.thejournal.ie/red-c-opinion-poll-nightclub-pub-opening-hours-5916298-Nov2022/

[29] Mongan D, Millar SR, Doyle A, Chakraborty S, and Galvin B (2022) Gambling in the Republic of Ireland: Results from the 2019–20 National Drug and Alcohol Survey. Dublin: Health Research Board. https://www.drugsandalcohol.ie/35305