



RCPI Policy Group on Alcohol
Reducing Alcohol Health Harm

April 2013

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Reducing Alcohol Health Harm

1 Executive Summary

- 1.1 As part of the Royal College of Physicians of Ireland's (RCPI) aim to play a proactive role in the development of healthcare policy in Ireland, it has convened a number of issue-focused policy groups that allow medical and other experts to meet and to discuss healthcare matters of concern to healthcare providers and the general public. In response to the increasing levels of alcohol-related harm observed in recent years in Ireland, RCPI established a Policy Group on Alcohol in 2012. This policy group is cross-speciality and is focused on highlighting alcohol harm, proposing solutions to reduce this harm, and influencing decision makers to take action to address the damage caused by alcohol misuse.
- 1.2 High levels of alcohol consumption and a high prevalence of binge drinking, especially among young people, have serious health implications. These health implications range from alcoholic liver disease to increased risk of various forms of cancer. Alcohol misuse is also associated with family and social harms, and costs the state vast amounts of money and resources.
- 1.3 Despite the high societal and economic cost of problem alcohol use in Ireland, actions to reduce alcohol consumption and to address harmful drinking patterns have, to date, been limited. The Royal College of Physicians of Ireland believes that there are proven solutions to this problem which should be implemented immediately for the benefit of the individual and for society in general.
- 1.4 Many of these solutions have already been outlined in the Department of Health 2012 Steering Group Report on a National Substance Misuse Strategyⁱ (NSMS), and the RCPI Policy Group on Alcohol urges the Government to take action to implement these recommendations.
- 1.5 In addition, the group proposes a number of actions within the health system aimed at reducing damage to health caused by alcohol misuse.

ⁱReferred to throughout this document as NSMS report

1.6 Overall recommendationⁱⁱ:

Summary of Key Recommendations	
<p>Societal/Public Health Solutions:</p> <p>Minimum Pricing</p>	<p>We support the introduction of minimum pricing to prevent the sale of cheap alcohol.</p> <ul style="list-style-type: none"> • We support this recommendation of the Steering Group on a National Substance Misuse Strategy. • Minimum pricing will not affect the price of pint in the pub. Rather it will target off-trade sales where the cheapest alcohol is sold.
<p>Alcohol Availability</p>	<p>We support measures to reduce the availability of alcohol</p> <ul style="list-style-type: none"> • Number of alcohol outlets should be reduced. • Alcohol sales in off-trade outlets should be managed better and low cost sales promotions and discounts should be strictly controlled. • Alcohol should be sold in zoned areas in mixed retail outlets. • Sale and supply to minors should not be tolerated and there should be punitive fines with rigorous implementation and oversight.
<p>Changing the Culture of Alcohol Consumption</p>	<p>We support measures to change the culture of excessive alcohol consumption.</p> <ul style="list-style-type: none"> • Alcohol advertising/marketing encourages people, particularly younger people, to consume alcohol and contributes to a culture of acceptability in relation to excessive alcohol consumption. • Alcohol sponsorship of sports events and organisations should be phased out. • Stricter controls should be introduced on where and when alcohol advertising is placed, with a view to limiting exposure of minors to alcohol marketing.
<p>Guidelines on Alcohol Consumption</p>	<p>We support dissemination of guidelines on low risk levels of alcohol consumption.</p> <ul style="list-style-type: none"> • Weekly low-risk consumption guidelines as outlined in NSMS should be adopted. • RCPI will also play its part in developing and implementing more detailed clinical guidelines and

ⁱⁱ See appendix- *Factsheet on Alcohol Health Harm* for summary of evidence and recommendations.

<p>Medical/ Health System Supports:</p>	<p>clinical information to provide extra information for the population in interpreting these guidelines</p> <ul style="list-style-type: none"> Labeling on alcohol products sold in Ireland should show units of alcohol, grams of alcohol per container, calorific content and health warnings.
<p>Alcohol Screening and Brief Interventions</p>	<p>We propose that Alcohol Screening and Brief Interventions be embedded in clinical practice.</p> <ul style="list-style-type: none"> Currently no formal guidelines for screening and BIs in acute hospitals. Screening for hazardous, harmful and dependent drinking should be embedded into clinical care. Screening should be linked to the provision of brief interventions by trained health care workers. There should be adequate access to tier two, three and four alcohol services for patients not responding to brief intervention.
<p>Model of Care for Alcohol-related Health Problems</p>	<p>We recommend that an integrated model of care be developed for treatment of alcohol-related health problems.</p> <ul style="list-style-type: none"> Clinical guidelines for treatment of alcohol-related health problems should be developed for healthcare professionals across all relevant sectors of the health and social care system. Links between alcohol treatment services in hospitals and the community should be strengthened. Aftercare in the community should be supported particularly with respect to relapse prevention. The referral relationship between primary and secondary care needs to be improved. Outpatient detoxification services to be established. Alcohol-related mental illness should be included within the model of care. Acute hospitals should have an alcohol team led by a consultant or senior nurse, and incorporating at least one alcohol nurse specialist.
<p>Funding for Research</p>	<p>We recommend that the Government allocate specific funding for research into alcohol-related harms, especially alcoholic liver disease.</p> <ul style="list-style-type: none"> There is very little funding available for research into alcohol-related harm, especially alcoholic liver disease. Levies on the alcohol industry should be used to support this research.

2 RCPI Policy Group on Alcohol

- 2.1 As part of the Royal College of Physicians of Ireland's (RCPI) aim to play a proactive role in the development of healthcare policy in Ireland, it has convened a number of issue-focused policy groups that allow medical and other experts to meet and to discuss healthcare matters of concern to healthcare providers and the general public. These policy groups provide evidence-based position papers that outline the issue(s) and propose steps to address the issue(s).
- 2.2 In keeping with this aim, RCPI established a **Policy Group on Alcohol** in 2012 to reduce the damage to health caused by problem alcohol use. One of the main drivers for establishment of this policy group is the dramatic increase observed by physicians in recent years in alcohol-related morbidity and mortality, especially in younger people.
- 2.3 The remit of the policy group is to: highlight the rising levels of alcohol health harm in Ireland; propose evidence-based solutions to reducing this harm; influence decision-makers to take positive action to address the damage caused by problem alcohol use.
- 2.4 The policy group's remit will be accomplished by producing evidence-based policy statements which provide an expert view on the *clinical priorities* relating to alcohol and alcohol-related harm in Ireland by outlining the issues, the challenges and providing solutions.
- 2.5 In addition, the policy group plans on raising awareness of alcohol health harm through media campaigns and public meetings, and considering how outcomes of the evidence-base can be translated into postgraduate medical training and education.
- 2.6 The policy statements and awareness of alcohol health harm will add to the national debate on the issue and, importantly, will recommend tangible actions to reduce damage to health caused by alcohol misuse.

3 The Problem

3.1 Alcohol Consumption and Irish Society

3.1.1 As a nation, the Irish are heavy alcohol consumers. This should come as no surprise, as the image of the Irish as a nation of drinkers is propagated directly and indirectly worldwide. For example, Guinness and ‘Irishness’ have become intrinsically linked; the visit of a foreign dignitary is frequently not complete without a photo of them drinking a pint of ‘the black stuff’; and the Guinness Storehouse was the most popular fee-charging tourist attraction in the country in 2011.¹ Part of the very appeal of Ireland as a tourist destination lies in the notion of ‘craic’, often to be found in a cosy pub, traditional music playing, a turf fire blazing, as the visitor is enveloped in a truly Irish welcome.

3.1.2 The place of the pub as a centre for Irish social life is indisputable. There is scarcely a small village or parish in the country that does not have a ‘local’. Irish people go to the pub for various reasons: to celebrate; to commiserate; to welcome visitors; to pass the time; to meet friends; and to befriend strangers.

3.2 Drinking Trends

3.2.1 While the pub continues to play a central role in community and social life, recent years have seen a shift from alcohol sales in pubs to sales in the off-trade sectorⁱⁱⁱ. Between 1998 and 2010 there was a 161 per cent increase in the number of full off-licences, while pub licences decreased by 19 per cent over the same period.² Supermarkets, convenience stores and even petrol stations sell alcohol, often at discounted prices. The abolition of the Restrictive Practices (Groceries) Order in 2006 allowed for a variety of goods to be sold below cost price, including alcohol.

3.2.2 Ireland is not the highest consumer of alcohol in the EU. At 11.9 litres (2010 figures) per capita, Ireland ranks 6th in terms of pure alcohol consumption

ⁱⁱⁱ Off-trade refers to off-licences and mixed retail outlets; on-trade refers to bars, restaurants etc.

per capita (>15 years), after Latvia^{iv}, Romania, Austria, Lithuania and France.³ This amount is still substantially higher than the European average of 10.7 litres and 16 per cent higher than our UK neighbours.⁴ It is also substantially in excess of the reduced alcohol consumption target of 9.2 litres per capita as specified in the 'Healthy Ireland' framework, recently launched by the Department of Health.⁵ It should be noted that adjustments to exclude all those under the age of 18 would give a recommended per capita (≥ 18) consumption of 6.91 litres.

- 3.2.3 There are a relatively high number of abstainers in Ireland. A European survey on attitudes to alcohol revealed a rate of abstention (in the 12 month period preceding the survey) of 24 per cent. This compares with abstention rates of 19 per cent and 17 per cent in the UK and France respectively.⁶ Given this high rate of abstainers, actual alcohol consumption per drinker is greater than the 11.9 litres referred to above, and targets for reduced consumption should take this into account.
- 3.2.4 Looking beyond overall levels of consumption to drinking patterns, according to a European survey conducted in 2009, Ireland has a higher prevalence of binge drinking than any other EU country with 44 per cent of drinkers stating that they binge drink^v on a regular basis.⁷ It is worth noting that this represents a decrease from previous years; for example WHO data from 2002 indicated binge drinking levels then were extremely high at 55.6 per cent of male drinkers and 20.2 per cent of female drinkers.⁸ Overall consumption has also declined in recent years since a peak of 14.2 litres per capita in 2002.⁹ These statistics on declining rates of alcohol consumption are sometimes cited as indicators that the attitude to alcohol as a nation is changing and improving. However, it is more likely that this change is related to reduction in income rather than changes in attitude. Notably, from 1980 to 2010, average alcohol consumption decreased in Europe by an average of 15 per cent, while consumption in Ireland over that period increased by 24 per cent.¹⁰ In fact, since 1963, alcohol consumption per adult in Ireland has almost doubled.¹¹ Arguments against more stringent

^{iv} Luxembourg has highest recorded per capita consumption but is disregarded here because of the high volume of purchases by non-residents in this country.

^v 5 or more drinks per drinking occasion

alcohol policies which cite the Irish 'drinking culture' as an integral part of historical Irish identity often do not acknowledge this relatively recent increase in consumption.

- 3.2.5 In terms of total consumption, and frequency of binge drinking, Irish men drink more, and engage in binge drinking more often than women.¹² However a higher proportion of Irish women (77 per cent) drink alcohol when compared with other European countries (68 per cent).¹³
- 3.2.6 The relatively high proportion of abstainers, combined with high levels of binge drinking indicates an inability to adopt a moderate consumption pattern. The highest proportion of binge drinkers is in the 18-29 age group, and although instances of binge drinking were decreasing among other age groups, among 18-23 year olds, binge drinking was still increasing in 2007. Young people were also more likely to exceed the weekly recommended limit.¹⁴
- 3.2.7 Because of the relatively high per capita consumption of alcohol in Ireland, the even higher consumption per drinker given our high rate of abstainers and the high prevalence of binge drinking, the effects of alcohol on the health and social fabric in Ireland are considerable.

Economic Contribution of the Alcohol Industry

- 3.2.8 Alcohol has a prominent place in the Irish economy. The hospitality industry provides an estimated 50,000 full time equivalent jobs, the majority of which are in the on-trade sector. The turnover of the industry in 2008 was approximately €2.95bn, representing 2.4 per cent of total manufacturing turnover.¹⁵ In addition, alcohol manufacturing and retail generated €2bn in VAT and excise revenues in 2008.¹⁶
- 3.2.9 Surveys show that the average Irish adult spends between €1300¹⁷ and almost €2000 a year on alcohol.¹⁸ This upper figure represents almost 5 per cent of total household expenditure, and is greater than average household expenditure on fuel and light or clothing and footwear.¹⁹
- 3.2.10 It is worth noting that many arguments against increased controls on the alcohol industry point to the significant loss to Government revenue and economic output that would result if alcohol consumption decreased. This argument however, does not take into account that consumers would spend money on other services and goods even if they reduce spending on alcohol.

In addition, there is a substantial economic cost associated with alcohol-related harm which should also be taken into account (see section 3.5).

3.2.11 Notwithstanding the significant economic contribution of the drinks industry, and the social and societal function of alcohol in Ireland, alcohol is not an ordinary commodity, and should not be treated as such. Failure to recognise the multiple harms associated with alcohol consumption causes severe harm on an individual, family and societal level.

3.3 Alcohol Consumption and Health Harm

*“Alcoholic beverages are items of consumption with many customary uses and are commodities important to many people’s livelihood. But social customs and economic interests should not blind us to the fact that alcohol is a toxic substance. It has the potential to affect adversely nearly every organ and system of the body. No other commodity sold for ingestion, not even tobacco, has such wide ranging adverse physical effects”.*²⁰

Mortality

3.3.1 Alcohol is a psychoactive substance that has health impacts on the individual, which vary depending on levels and patterns of consumption. In large amounts, alcohol has a toxic effect and can be fatal. Long term heavy consumption of alcohol is associated with mortality from wholly alcohol attributable diseases such as alcoholic liver disease, the majority of these deaths being from alcoholic liver cirrhosis.²¹

3.3.2 For the vast majority of people, consumption of alcohol above the low risk guidelines has a negative health impact. Contrary to the popular belief that a glass of wine a day is good for your health, any health benefit from alcohol consumption is limited to a very small segment of the population. A recent study examining alcohol attributable mortality in Ireland showed that net benefit from alcohol consumption was limited to people over 75 years of age.²²

3.3.3 According to the World Health Organisation (WHO), almost 4 per cent of all deaths worldwide are attributed to alcohol. This is greater than deaths

caused by HIV/AIDS, violence or tuberculosis.²³ A European report on Alcohol and Public health estimated that 1 in 4 deaths in young European males were due to alcohol.²⁴

- 3.3.4 In Ireland, between 2000 and 2004, it was estimated that 4.4 per cent of deaths were caused by alcohol. This figure includes deaths from chronic alcohol-related conditions such as alcoholic liver disease and liver cancer, and accidental and non-accidental deaths while under the influence of alcohol.²⁵ A report by the National Drug Related Deaths Index which focuses on deaths in alcohol dependent people found that in 2008, there were 88 deaths every month which were directly attributable to alcohol.²⁶ The same report also showed that between 2004 and 2008, alcohol caused nearly twice as many deaths as all other drugs combined.²⁷
- 3.3.5 Alcohol is strongly linked to suicide, particularly suicides in young men.²⁸ A 2006 study showed that more than half of all people who died from suicide had alcohol in their blood.²⁹ From 2000 to 2004, alcohol was estimated to be the major contributing factor in 823 suicides.³⁰ There is a complex link between alcohol misuse, unemployment and suicide. A WHO report from 2011 focusing on mental health and the economic crisis predicted that the economic crisis may lead to increased suicide and alcohol-related death rates.³¹

Morbidity

*“The WHO has attributed 60% of the disease burden in Europe to seven leading risk factors: hypertension, tobacco use, alcohol misuse, high cholesterol, being overweight, low fruit and vegetable intake and physical inactivity”.*³²

- 3.3.6 Alcohol is fully (100 per cent) attributable as a cause in 9 disease categories including alcoholic liver disease.³³ Alcoholic liver cirrhosis is the form of liver disease most often associated with alcohol misuse and cirrhosis mortality has traditionally been used as an indicator for tracing the health consequences of alcohol misuse in Europe.³⁴
- 3.3.7 Members of the RCPI Policy Group on Alcohol have observed a dramatic increase in (alcohol-related) severe morbidity and mortality in younger people. Death from alcohol cirrhosis is no longer limited to older men as was once the case. It is now commonplace for physicians to see young men and women in their 20s and 30s dying in acute hospitals from liver disease

secondary to alcohol. Analysis of data from Ireland's Hospital In-Patient Enquiry (HIPE) system confirms that chronic alcohol-related conditions are becoming increasingly common among young age groups. In Ireland between 1995 and 2007, the rate of discharges for Alcoholic Liver Disease increased by 247 per cent for 15-34 year olds, and by 224 per cent for 35-49 year olds.³⁵

- 3.3.8 Mortality related to cirrhosis, the commonest cause of which is alcohol, doubled from 1994 to 2008 and hospital admissions in Ireland for alcoholic liver disease almost doubled between 1995 and 2007.³⁶ This increase appears to be directly related to increased alcohol consumption and changes in drinking patterns, especially in relation to binge drinking. In the same period, 72 per cent of deaths from alcoholic liver disease were in patients younger than 65 years of age indicating that this is a significant cause of premature mortality.³⁷ Similarly to Ireland, the UK has also registered an increased incidence of alcoholic liver disease³⁸ in recent decades, but in most other European countries the prevalence of alcoholic liver disease and associated mortality is falling.³⁹
- 3.3.9 Patients with liver disease with or without alcoholic hepatitis impose significant demands on hospital resources and frequently require a multidisciplinary approach in an intensive care setting.
- 3.3.10 Alcohol-related disorders accounted for 1 in 10 first admissions to Irish psychiatric hospitals in 2011.⁴⁰
- 3.3.11 Even at relatively low levels of consumption, alcohol increases the risk of many medical conditions. Alcohol is classified as a group 1 carcinogen and it is one of the most important causes of cancer in Ireland being a risk factor in 7 types of cancer. The link between alcohol and cancer of the larynx, pharynx and oesophagus is the greatest, as there is more than 100 per cent increase in risk from an average consumption of 50g of pure alcohol per day.⁴¹ For female breast cancer there is a slight increased risk with consumption of any amount of alcohol but for those women consuming >45g of pure alcohol per day, each additional 10g of alcohol per day is associated with a 7 per cent increased risk.⁴² For colorectal cancer, consumption of 50g of pure alcohol per day increases the risk by 10-20 per cent.⁴³ The National Cancer Control Programme (NCCP) conducted research in 2012 to calculate Ireland's overall and organ-specific, cancer incidence and

mortality attributable to alcohol consumption and found that approximately 5 per cent of newly diagnosed cancers and cancer deaths are attributable to alcohol i.e. around 900 cases and 500 deaths each year. The greatest impact was on organs of the upper aero-digestive tract. Cancer risk due to alcohol is deemed to be same, regardless of the type of alcohol consumed, and even drinking within the recommended limits carries an increased risk.⁴⁴

3.3.12 Drinking alcohol while pregnant can cause a range of birth defects, known as Foetal Alcohol Spectrum Disorders (FASD). Signs of FASD include:⁴⁵

- Distinctive facial features
- Deformities of joints, limbs and fingers
- Slow physical growth before and after birth⁴⁶
- Vision difficulties or hearing problems
- Small head circumference and brain size (microcephaly)
- Poor coordination
- Mental retardation and delayed development
- Learning disorders
- Abnormal behaviour, such as a short attention span, hyperactivity, poor impulse control, extreme nervousness and anxiety
- Heart defects

3.3.13 There is also evidence to link alcohol consumption in pregnancy to miscarriage.⁴⁷ Despite this, a recent Irish study revealed that among a sample of women who had a positive pregnancy test, more than half drank alcohol subsequently, some to excess (>50g pure alcohol per week).⁴⁸ More than a third of pregnancies among women in Ireland are unplanned, resulting in unintended excess alcohol intake in the periconceptual period.⁴⁹ In addition binge drinking is highly prevalent among women of reproductive age and is associated with unplanned intercourse, sexually transmitted infections and unplanned pregnancy.

3.3.14 It is worth noting that whilst there is conflicting evidence on the extent of harm caused to the foetus by alcohol during pregnancy, advice from the

Department of Health and other national health departments is that alcohol in pregnancy should be avoided.^{50 51}

3.3.15 Because the brain is still developing, drinking in adolescence has the potential to cause detrimental effects, including neurocognitive impairment.⁵² Evidence also suggests that adolescents who misuse alcohol are more likely to suffer side effects such as appetite changes, weight loss, eczema, headaches and sleep disturbance. Younger people are also affected by the same chronic diseases and conditions associated with excess alcohol consumption in adults, and deaths from liver disease are now occurring at younger ages.⁵³

3.4 Personal, Family and Social Harms

3.4.1 These health harms are only part of the problem related to alcohol. There are wider personal and family impacts which have a negative effect on both the individual and on society.

3.4.2 Excessive alcohol use frequently leads to unsafe sex resulting in unplanned pregnancies and sexually transmitted diseases. A recent report from the UK highlighted that 82 per cent of 16-30-year-olds reported drinking alcohol before sexual activity and that young people who were drunk the first time they had sex, were less likely to use condoms.⁵⁴ The study also showed that people aged 16-24 are among the highest consumers of alcohol (in the UK) and have the highest rate of sexually transmitted infections. A number of other studies show associations between alcohol consumption and Sexually Transmitted Infections (STIs).⁵⁵ In an Irish study 45 per cent of men and 26 per cent of women stated that alcohol consumption contributed to having sex without using contraception.⁵⁶

3.4.3 Domestic abuse and child abuse is often linked to harmful alcohol use. It is estimated that 16 per cent of child abuse and neglect cases are associated with adult alcohol problems⁵⁷ and that 1 in 11 Irish children are negatively impacted by a parent's drinking.⁵⁸ Alcohol misuse is often a factor in marital disharmony and break-up and in cases of domestic violence.⁵⁹

3.4.4 Links between alcohol and crime are well established. Intoxication of both perpetrator and victims has been noted in a high percentage of instances of homicide and sexual assault. Public disorder offences which are alcohol-related are common, as are drink driving offences.⁶⁰

- 3.4.5 A Rape and Justice in Ireland briefing paper by the Rape Crisis Network outlined research which indicates that decisions on the consumption of alcohol made by both men and women can have the effect of facilitating the incidence of rape and make the detection and prosecution of rape more difficult. Alcohol consumption also affects decisions on whether to report alleged rapes.⁶¹
- 3.4.6 Any level of blood alcohol concentration is associated with a higher risk of road traffic accidents. From 2003 to 2005, over half of all drivers fatally injured in RTAs in Ireland had alcohol in their blood, with younger drivers (20-24 years) more likely to be over the legal limit. Random alcohol testing introduced in 2006 has been successful in reducing road deaths.⁶²
- 3.4.7 Similarly, alcohol consumption increases the risk of other types of accidents. In 2002, 1 in 4 injuries presenting to accident and emergency departments was related to alcohol and over half of these injuries occurred in people younger than 30 years of age.⁶³
- 3.4.8 Excessive alcohol consumption by young people is particularly worrying, as early onset alcohol use increases the risk of problem alcohol and drug use later in life.⁶⁴ Irish adolescents with serious drug and alcohol problems had commenced alcohol use at a much earlier age than their counterparts without significant drug or alcohol problems.⁶⁵ There is also evidence to suggest that alcohol consumption has a negative effect on educational performance.⁶⁶

3.5 Economic Costs of Alcohol

- 3.5.1 The information in the preceding section shows that alcohol consumption has a health and wellbeing cost to the individual, and that alcohol causes behaviour which can be harmful to both the person consuming the alcohol and others they come into contact with. Interventions which reduce alcohol consumption and/or risky patterns of consumption would therefore have a positive impact on the wellbeing of Irish society.
- 3.5.2 Given the economic and employment role of the alcohol industry, the taxation revenue generated by alcohol sales, and the probability that interventions to reduce alcohol consumption will require a financial investment, it is important to understand the financial cost of alcohol to the State at present.

- 3.5.3 Alcohol costs the State vast amounts of money and resources. There are direct costs to the health care system associated with treating alcohol dependency and effects of harmful alcohol consumption. Alcohol is also recognised as a causal and contributory factor in various incidences of crime, which carry a financial cost to the State. Other costs relate to road accidents, suicide and alcohol-related premature mortality.
- 3.5.4 There are also substantial business costs associated with direct health-related consequences of alcohol misuse. Alcohol consumption can impact work performance and is frequently the cause of absenteeism and physical injuries in the workplace.⁶⁷
- 3.5.5 A study commissioned by the HSE examined costs of harmful alcohol use in Ireland in 2007. It estimated that the overall cost in 2007 was €3.7bn or 1.9 per cent of total GNP.⁶⁸ This figure is 1.8 times the amount made by the Government in alcohol-related excise and VAT revenues in 2008. Some of these costs are broken down below.
- Costs to the health system were €1.2bn
 - Alcohol-related crime costs €1.19bn
 - Alcohol-related road accidents cost €526m
 - Loss of economic output due to absenteeism cost €330m

Alcohol is associated with approximately 2000 beds being occupied every night in Irish acute hospitals.⁶⁹ As mentioned previously, a quarter of all injuries presenting to accident and emergency were alcohol-related, and alcohol-related admissions to acute hospitals doubled between 1995 and 2008.⁷⁰

Despite the high societal and economic cost of alcohol misuse in Ireland, actions to reduce alcohol consumption and to address harmful drinking patterns have to date been limited. The RCPI Policy Group on Alcohol believes that there are proven solutions to this problem which should be implemented immediately for the benefit of individual consumers and for society in general.

4 Current Government Policy

- 4.1 Current Government policy in relation to alcohol is ambiguous. While there is legislation from the Department of Justice relating to licensing and public order, there is no legislation on the statute books from the Department of Health in relation to alcohol.
- 4.2 The Department of Health published the report of the Steering Group of the National Substance Misuse Strategy in January 2012. This report has 45 recommendations; 15 of these are in relation to supply control, 7 are in relation to prevention, 20 are in relation to treatment and rehabilitation and 3 are in relation to research. A range of agencies has been assigned primary responsibility for the different recommendations. It had been stated that a Memorandum for Government in relation to a number of these recommendations would be presented in June 2012. This did not happen and the report has been referred to the Oireachtas Committee on Health. This same Oireachtas Committee produced a report in December 2011 outlining a broad public health approach to alcohol policy.⁷¹ Both reports recommended bringing forward legislation, but this has yet to be done by the Houses of the Oireachtas.
- 4.3 Within Government there appear to be differing views on the Steering Group report. It is deeply concerning that there appears to be ambiguity at Government level on the implementation of the recommendations of this report.
- 4.4 In March 2013, the Minister for Health stated that specific proposals based on the recommendations for the Steering Group report would soon be brought forward for consideration by Government. The minister also indicated his support for minimum pricing, one of the key recommendations of the report.
- 4.5 The 'Healthy Ireland' framework launched in March 2013 refers to the National Substance Misuse Strategy report and reaffirms Government commitment to reducing alcohol consumption.
- 4.6 The policy group welcomes the recommendations of the Steering Group Report. The following section summarises what the RCPI Policy Group on

Alcohol believes are the important actions which should be enacted or put into practice, with reference to recommendations from that report.

- 4.7 The actions/solutions proposed by the RCPI Policy Group on Alcohol fall into two separate categories. The first are solutions to be taken at the societal or public health level. The second category refers to actions which should be taken within the health system to address alcohol-related harm.

5 The Solutions - Societal/Public Health

The RCPI Policy Group on Alcohol strongly believes that from a societal/public health perspective, there are four areas where concrete, immediate actions could be put in place to limit alcohol consumption, thereby reducing alcohol-related harm.

5.1 Minimum Pricing

We support the introduction of minimum pricing to prevent the sale of cheap alcohol.

- 5.1.1 We support the recommendation of the NSMS Steering Group report that alcohol should be made less affordable and less available. The report recommended that this should be done through excise duties and minimum pricing. In December 2012 the Government increased excise duty on a pint of beer or cider and a standard measure of spirits by 10 cents, and the duty on a 75 cl. bottle of wine by €1.
- 5.1.2 These measures do not sufficiently address the issue of reducing the proliferation of cheap alcohol. Alcohol has become much more affordable in recent years. Between 2002 and 2007 there was a 44 per cent increase in the quantity of lager which could be purchased with one week's disposable income.⁷² Alcohol Action Ireland highlights that it is now possible at current prices, for a women to reach her weekly recommended low risk limit for €6.30, while a man can reach his low risk limit for less than €10.⁷³
- 5.1.3 Research shows that alcohol, like other commodities, concurs with a fundamental law of economics which maintains that demand for a product falls as its price rises.⁷⁴ Experience in Ireland also supports this; excise increases in 2003 and 2002 on spirits and cider respectively, showed a

corresponding decrease in consumption.⁷⁵ Furthermore, alcohol price increases have been shown to reduce harm related to alcohol.⁷⁶

- 5.1.4 Studies indicate that harmful drinkers are more likely to drink cheap alcohol than moderate consumers of alcohol. There is also evidence to suggest that risky alcohol consumption among young people is strongly related to disposable income.⁷⁷ Thus, it is likely that increases in price would reduce alcohol consumption in both young people, and in heavier drinkers.
- 5.1.5 Minimum pricing is considered by the WHO to be one of the most cost-effective actions to reduce alcohol consumption in populations with moderate or high levels of drinking. This is based on analysis and costing of a range of interventions, including education, advertising and drink driving legislation.⁷⁸
- 5.1.6 In the UK, extensive research has been done by the Sheffield Alcohol Policy group on minimum pricing, including studies commissioned by the English and Scottish Governments on the implementation of minimum pricing policies in their jurisdictions. Despite the fact that the process has stalled in both England and Scotland at the time of writing this policy statement, there is a wealth of research which supports both the principle of minimum pricing and offers insights on implementation of such a model. In Ireland, a health impact assessment was being commissioned at the time of writing to study the impact of different minimum prices on a range of areas such as health, crime and likely economic impact, in conjunction with Northern Ireland.
- 5.1.7 Recent evidence from British Columbia, Canada showed that between 2002 and 2009, introduction of minimum pricing reduced the percentage of alcohol-related deaths, with a reduction already seen only 1 year after the minimum price increases came into effect.⁷⁹ Introduction of minimum pricing in Saskatchewan province in Canada also reduced alcohol consumption, with a 10 per cent increase in minimum price associated with an 8.4 per cent reduction in total consumption.⁸⁰
- 5.1.8 In Ireland, there is public support for minimum pricing. In a recent Health Research Board (HRB) survey, almost 58 per cent of respondents agreed that there should be a minimum price below which alcohol cannot be sold and

over 35 per cent of respondents said they would decrease the amount they purchase in response to a ten per cent price increase.⁸¹

5.1.9 Critics of the minimum pricing model argue that a minimum price for alcohol would affect those on low incomes disproportionately. However, it should be remembered that people on low incomes often suffer from a range of health inequalities that can be made worse by alcohol use.

5.1.10 It is the opinion of the RCPI policy group on alcohol that minimum pricing should not affect the price of drinks in the on-trade sector. The sale of alcohol in the controlled environment of bars and restaurants is less of a concern than the cheap alcohol sales from the off-trade. Instead, minimum pricing will target off-trade sales where the cheapest alcohol is sold.

5.2 Reduced Availability

We support measures to reduce the availability of alcohol.

5.2.1 It is the opinion of the RCPI Policy Group on Alcohol that alcohol should be made less available, through both the introduction of new legislation and controls and through stricter enforcement of existing controls. We propose that there should be a reduction in the number of outlets where alcohol can be purchased. There should also be stricter controls on alcohol promotions and the placement of alcohol in mixed retail outlets.

5.2.2 Studies from both Finland and Sweden showed linkages between alcohol-related harm and the number of outlets selling alcohol.⁸² In Ireland, the increase in recent years in the number of off-licences is of particular concern. We support the recommendation of the NSMS report that the HSE should be allowed to object to the granting of new licences/ renewal of licences. To date these matters have been dealt with from a criminal justice perspective but this recommendation emphasises that alcohol and the harm it causes is a health issue as well.

5.2.3 There is a need for off-trade outlets to manage alcohol sales more responsibly. The proliferation of alcohol promotions encourages increased consumption⁸³ and thus sales promotions and discounts should be more strictly controlled. We support the NSMS report recommendation that a

statutory code of practice on the sale of alcohol in the off-trade sector be introduced.

- 5.2.4 The placement of alcohol in mixed retail outlets alongside groceries gives the impression that alcohol is an ordinary commodity, and normalises alcohol as part of a weekly shopping list. In the long term, we are in favour of alcohol only being sold in specialist off-licences. In the short term, we support of the idea that in mixed retail outlets alcohol should only be sold in zoned areas. We recommend commencement of Section 9 of the Intoxicating Liquor Act 2008 which provides for structural separation of alcohol products from other beverages and food products in premises which are engaged in mixed trading, such as supermarkets, convenience stores and petrol stations. A voluntary code of practice which includes reference to structural separation has meant that some outlets have implemented structural separation, but this is not widespread.
- 5.2.5 Because of the health impact on alcohol and young people, sale and supply to minors should not be tolerated. There should be punitive fines with rigorous implementation and oversight for sale and supply to minors.
- 5.2.6 There are a range of measures to further counter drink-driving outlines in the NSMS report. The Irish Government's approach to drink driving, both in the previous and in the current Government, is exemplary and has resulted in a reduction in the loss of life on our roads to a substantial degree. The RCPI Policy Group on Alcohol commends the Department of Transport on its initiatives over the years in relation to drink driving. The diligent action in this sphere shows that culture can change with leadership.

5.3 Changing Culture

We support measures to change the culture of excessive alcohol consumption.

- 5.3.1 The RCPI Policy Group on Alcohol is of the view that the cultural acceptance of excessive alcohol consumption in Ireland is an issue which needs to be addressed urgently. Though awareness campaigns and education on alcohol are not the most cost-effective methods of reducing alcohol consumption, they have a role to play in challenging the culture of alcohol in Irish society.

Of more concern however, are the advertising and marketing campaigns which especially influence young people.

- 5.3.2 Advertising and marketing of alcohol encourage people to consume alcohol and contribute to a culture of acceptability in relation to excessive alcohol consumption. There is evidence to suggest that alcohol marketing is linked to youth drinking initiation and continued drinking.⁸⁴ Recent analysis showed that younger people (10-15 years) in the UK are much more exposed to alcohol marketing than adults, and we believe the same is true for younger people in Ireland.⁸⁵ Taking this into account, stricter controls should be introduced on where and when alcohol advertising is placed, with a view to limiting exposure of minors to alcohol marketing. This applies to outdoor advertising, traditional media advertising, and new media advertising. We support the recommendations of the NSMS report in relation to a statutory framework with provisions on alcohol advertising to address this issue.
- 5.3.3 We believe that in particular, alcohol sponsorship in sport should no longer be the norm. Alcohol is a drug, and as such can no longer be perceived as a normal component of sporting activity. The RCPI Policy Group on Alcohol is of the view that alcohol sponsorship of sports events and organisations should be phased out. This phasing out in the first instance should provide for a ban on all new sponsorship arrangements being put in place. The existing arrangements need a stepped approach towards eventual cessation.
- 5.3.4 These are the recommendations of the National Substance Misuse Steering Group that have been the most controversial. The alcohol industry has a very powerful voice in Ireland and the contribution of this industry to sporting and cultural events is substantial. Many arguments for continued alcohol sponsorship point to the potential financial gap which sporting organisations would suffer if alcohol sponsorship was no longer allowed. This argument does not allow for the fact that there may be other (non alcohol-related) sponsors who would be interested in the marketing opportunity that this gap would create.
- 5.3.5 Although drinks companies who sponsor sporting events deny that alcohol sponsorship serves to increase alcohol consumption, the evidence is that it does. An analysis of 13 longitudinal studies involving 38000 young people led the authors to conclude that alcohol advertising and promotion increases

the likelihood that adolescents will start to use alcohol, and to drink more if they are already using alcohol.⁸⁶ Also, from Australia there is evidence that sportspeople exposed to alcohol sport sponsorship had higher drinking scores.⁸⁷

- 5.3.6 Other commercial sponsors of sport in Ireland should be actively pursued and the Government needs to examine the degree to which the State will accept responsibility for the funding of sport and culture in Ireland.
- 5.3.7 Although this is a controversial issue, there is indication that there is sizeable public support for the ending of alcohol sponsorship of sports; 42 per cent support this, according to the HRB survey previously mentioned.⁸⁸

5.4 Alcohol Consumption Guidelines

We support dissemination of guidelines on low-risk levels of alcohol consumption.

- 5.4.1 The HRB report on attitudes to alcohol indicates that knowledge of standard drink measures and weekly low-risk consumption amounts is weak. Less than one in ten respondents were clear on the number of standard drinks in four different alcoholic drinks of various measures or the recommended weekly number of standard drinks for men and for women.⁸⁹ There is an important public health information campaign required to increase public knowledge as a prelude to behaviour change. Education campaigns, which are mentioned in the NSMS recommendations, together with more appropriate labeling, can help individuals to make more informed choices.
- 5.4.2 There is some personal responsibility in relation to alcohol consumption and while Government can regulate and make the environment less conducive to alcohol-related harm than it currently is, there is an onus on individuals to change. Better information from health sources will help individuals make more informed choices as will a restriction on information from commercial sources.
- 5.4.3 The Royal College of Physicians of Ireland supports the stated weekly low-risk guidelines of 11 standard drinks per week (112 grams of pure alcohol) for women and 17 standard drinks per week (168 grams of pure alcohol) for men, as outlined in the NSMS report. The RCPI also supports the recent advice from the Department of Health that people should not consume

alcohol at levels greater than these weekly low-risk guidelines; that they should spread their drinks out over the week; that they should not consume more than 5 standard drinks in any one sitting; and that they should have at least 3 alcohol-free days during the week.

5.4.4 RCPI will also play its part in developing and implementing more detailed clinical guidelines and clinical information to provide extra information for the population in interpreting these guidelines.

5.4.5 We also support the NSMS recommendation that labels on alcohol products sold in Ireland should include the number of both units of alcohol and grams of alcohol per container, calorific content and health warnings, particularly in relation to consuming alcohol in pregnancy.

6 The Solutions - Medical Supports

There are a number of areas within our Health System where targeted actions can support alcohol harm reduction.

The RCPI policy group on Alcohol believes that investment in alcohol services within the Health System will reap financial savings in the long term. Although some of the solutions will be costly, the costs of implementing any of these changes need to be balanced against the cost of alcohol treatment, and the societal costs of alcohol.

6.1 Alcohol Screening and Brief Interventions

We propose that Alcohol Screening and Brief Interventions be embedded in clinical practice.

6.1.1 Much of the treatment for alcohol-related problems has focused on individuals who are alcohol dependent. Alcohol-related harm however is not limited to this group, and there is a need to broaden the focus of alcohol services to include drinkers who may not be alcohol dependent, but who consume alcohol in a harmful/hazardous manner.

6.1.2 Early detection of harmful and hazardous drinkers can be facilitated by seeking detailed alcohol history from patients who present with conditions

or injuries associated with alcohol misuse. This early detection could lead to a reduction in the number of patients progressing to severe alcohol-related harms.

- 6.1.3 Brief Interventions^{vi} are interventions for hazardous drinkers who consume alcohol at levels at which they risk experiencing associated problems. Generally, Brief Interventions are aimed at those hazardous drinkers who may not have symptoms of alcohol dependence. They are short and cheaper to implement than conventional specialist alcohol treatments. A Brief Intervention usually comprises assessment of alcohol consumption and provisions of information on harmful drinking to the individual, including booklets and information on local services.⁹⁰
- 6.1.4 Screening involves identifying people who do not specifically present to health services for alcohol-related problems, but who may be consuming alcohol at harmful/hazardous levels. Various screening methodologies have proven to be useful including the WHO Alcohol Use Disorders Identification Test (AUDIT). This test is administered by means of a questionnaire containing 10 questions on frequency and intensity of drinking. Based on responses, an individual's risk can be categorised from low risk through to possible dependence.⁹¹
- 6.1.5 Screening can be conducted by various methods, but the AUDIT questionnaire is considered to be one of the most suitable for use in the general hospital. One advantage is that it can be easily incorporated into a lifestyle questionnaire which shifts the focus towards public health and management of the whole patient.⁹² Other tests include the Paddington Alcohol Test, and the Fast Alcohol Screening Tests (FAST).
- 6.1.6 Indications are that the general public would welcome such screening. According to the HRB report on alcohol attitudes "there is near complete support (95 per cent or over) for healthcare professionals asking about alcohol consumption where it is linked to the patient's condition or treatment".⁹³
- 6.1.7 Although screening and BIs are an effective way of dealing with harmful drinkers, there are currently no formal guidelines for screening and BIs in

^{vi} Sometimes referred to as brief advice

acute hospitals in Ireland. RCPI supports the recommendation of the NSMS report that clear guidelines should be developed and implemented across all acute hospitals and other relevant sectors of the health system.

- 6.1.8 The RCPI Policy Group on Alcohol recommends that screening for hazardous, harmful and dependent drinking should be embedded into clinical care to allow for early identification of hazardous/harmful and dependent drinkers. It should be linked to the provision of brief intervention by trained health care workers in a primary care setting. Follow up and extended brief advice should be offered to those patients not responding to brief interventions. Those people with continuing problems or with dependence should be referred to specialist treatment centres.
- 6.1.9 There should also be adequate access to tier two, three and four alcohol services for those patients not responding to brief intervention. In particular, tier three services are required where medically assisted withdrawal from alcohol can be provided on an out-patient basis.
- 6.1.10 RCPI supports the recommendations of the NSMS report with respect to inclusion of a specific module on screening and brief interventions for different health service providers.

6.2 Integrated Model of Care

We recommend that an integrated model of care be developed for treatment of alcohol-related health problems.

- 6.2.1 There is an urgent need to develop clinical guidelines/standards/protocols for healthcare professionals across all relevant sectors of the health and social care system for treatment of alcohol-related health problems.
- 6.2.2 Most alcohol treatment programmes are now community rather than hospital based. Unfortunately, the links between the hospital and the community based programmes are almost non-existent. Typically, a patient leaving hospital will be given a list of community programmes in their locality or asked to contact their general practitioner to arrange referral. There is no structure in place for the alcohol treatment programme to receive information relating to the in-patient care. Similarly, hospital-based consultants never receive reports or updates on mutual patients from the alcohol services. Some hospitals employ alcohol or addiction nurses one

of whose duties is to improve communication between the service providers. In other institutions social workers perform that role. Many patients commit to abstinence in hospital and it is a pity if that momentum is lost following discharge. Efforts are thus needed to strengthen links between the hospital and the community.

- 6.2.3 Many alcohol dependent patients who are admitted for treatment to hospital and or diagnosed with alcoholic liver disease are in need of post discharge supervision and support. Without this supervision and support, many patients return to former drinking patterns, default on follow up and re-present as emergencies with liver failure.
- 6.2.4 Recognising the vital role that community services play in alcohol treatment, RCPI recommends that services providing after care in the community should be supported and improved, particularly with respect to relapse prevention.
- 6.2.5 At present the referral relationship between primary and secondary care needs to be improved.
- 6.2.6 There is a need for outpatient detoxification services to be established under the auspices of addiction services.
- 6.2.7 Alcohol-related mental illness should be included within the model of care. RCPI recommends implementation of the recommendations in *A Vision for Change*⁹⁴ in relation to establishing clear linkages between the addiction services, primary care services, community mental health teams and specialist mental health teams.
- 6.2.8 All acute hospitals should have an alcohol team led by a consultant or senior nurse, and incorporating at least one alcohol nurse specialist. This will lead to improvements in screening and Brief Intervention, improved management of acute alcohol withdrawal and will provide for better follow up and links between acute hospitals and the community.
- 6.2.9 Treatment of alcohol liver disease should be centralised to improve prognosis. There is a large literature showing that in many surgical and medical conditions outcomes depend on hospital volume. Based on this evidence, it is the opinion of the RCPI policy group on alcohol that patients with advanced stage alcoholic liver disease would benefit from centralised treatment.

6.3 Research Funding

We recommend that the Government allocate specific funding for research into alcohol-related harms, especially alcoholic liver disease.

- 6.3.1 There is very little funding available for research into alcohol-related harm, especially alcoholic liver disease. Despite the high associated mortality for alcoholic liver disease, it is an unpopular subject with funding bodies, and as a result, there have been no advances in treatment and no new drugs have been developed.
- 6.3.2 We therefore call on the Government to allocate specific funding for research into alcohol-related harms. Based on the polluter pays principle, the Government should use social responsibility levies on the alcohol industry to support this research. It is important to emphasise however, that any research conducted should be independent of the alcohol industry, and the funds should be spent on front-line research; both clinical and epidemiological.

7 Members of the RCPI Policy Group on Alcohol

The membership of the RCPI Policy Group on Alcohol is as follows:

Members	Institution
<u>CHAIR</u>	
Prof Frank Murray	Beaumont Hospital Dublin & Royal College of Physicians of Ireland (RCPI)
<u>MEMBERS</u>	
Prof Joe Barry	Faculty of Public Health Medicine, RCPI
Dr Turlough Bolger	Faculty of Paediatrics, RCPI
Dr Thomas Breslin	Irish Association for Emergency Medicine
Dr William Flannery	The College of Psychiatry of Ireland
Dr Blanaid Hayes	Faculty of Occupational Medicine, RCPI
Dr Fenton Howell	Clinical Lead, Chronic Disease Prevention Programme
Dr Marie Laffoy	National Cancer Control Programme
Prof Aiden McCormick	Irish Society of Gastroenterology
Prof Deirdre Murphy	Institute of Obstetricians and Gynaecologists, RCPI
Dr Brian Norton	Irish College of General Practitioners
Dr Kieran O'Shea	Institute of Orthopaedic Surgery
Dr Eimear Smith	Irish Association for Rehabilitation Medicine
Dr Steven Stewart	Centre for Liver Disease Mater Misericordiae Hospital
Prof William Tormey	Faculty of Pathology, RCPI
Prof Michael Walsh	Irish Cardiac Society

Further information relating to this position paper, and the members of the policy group, please contact the Royal College of Physicians of Ireland at www.rcpi.ie or at +353 1 8639700.

8 Appendix- Factsheet on Alcohol Health Harm

What is the Problem?

“We are seeing different health problems emerging; frequently the cause is our modern lifestyle. This trend is worrying and unless we make some significant changes, we are facing an unhealthy and costly future”. (An Taoiseach Enda Kenny, Healthy Ireland Framework 2013-2015)

Excessive alcohol consumption is embedded in Irish society.

- Drinking alcohol in the pub is an important aspect of Irish community and social life. The same does not apply for alcohol from off-licences.
- Alcohol consumption per capita at 11.9L is higher than the European Average of 10.7L, and 6th highest in the EU. This is much higher than consumption target of the Healthy Ireland Framework of 9.2L.
- Ireland has a higher prevalence of binge drinking than any other European country, with the highest percentage of binge drinkers in the 18-29 age groups.
- Binge drinking is increasing among 18-23 yr olds.
- Since 2001 when consumption peaked at 14.2L, alcohol consumption has been decreasing but alcohol consumption per capita has almost doubled since 1963.
- Alcohol consumption in Ireland per capita increased by 24% between 1980 and 2010 while during this period, the European average decreased by 15%.
- A relatively high number of abstainers and a high prevalence of binge drinking indicate an inability to adopt a moderate consumption pattern.
- Higher proportion of Irish women drink compared with women in other European countries (77% compared to 68%).
- The average Irish person spends approximately €2000 per year on alcohol.

Excessive alcohol consumption is directly related to health harm.

- 88 deaths every month in Ireland are directly attributable to alcohol.
- Between 2004 and 2008, alcohol caused nearly twice as many deaths as all other drugs combined.
- Alcohol is a major contributing factor in suicide in Ireland - study shows that more than half of people who died from suicide had alcohol in their blood.
- Disease and health service utilisation:
 - Even at relatively low levels of consumption, alcohol increases the risk of many types of cancer.
 - Mortality related to cirrhosis, the commonest cause of which is alcohol, doubled from 1994 to 2008.

- Between 1995 and 2007, hospital admissions for liver disease increased by 191%.
- 72 % of deaths from alcoholic liver disease were in patients <65yrs old.
- Alcoholic liver disease becoming more common in younger people.
- Alcohol-related disorders accounted for 1 in 10 first admissions to Irish psychiatric hospitals in 2011.
- 1 in 4 injuries presenting to A&E departments are related to alcohol.
- Drinking alcohol while pregnant can cause a range of birth defects and intellectual impairments in the unborn child (Foetal Alcohol Spectrum Disorders).
- Because the brain is still developing, drinking in adolescence has the potential to cause detrimental effects, including neurocognitive impairment.

Excessive alcohol consumption has various family and social harms.

The health harms are only part of the problem related to alcohol. There are wider personal and family impacts which have a negative effect on the individual and on society:

- Excessive alcohol use frequently leads to unsafe sex resulting in unplanned pregnancies and sexually transmitted diseases.
- 16% of child abuse and neglect cases are associated with adult alcohol problems and 1 in 11 Irish children are negatively impacted by a parent's drinking.
- Alcohol abuse is a factor in marital disharmony and break-up and in cases of domestic violence.
- From 2003 to 2005, over half of all drivers fatally injured in Road Traffic Accidents in Ireland had alcohol in their blood.
- For younger people, early onset alcohol use increases the risk of problem alcohol and drug use later in life.

Alcohol costs the state vast amounts of money and resources.

- Approximately 2000 beds every night in Irish Hospitals.
- Costs to the health system were estimated at €1.2bn in 2007.
- Alcohol-related crime costs the state €1.19bn (2007 estimates).
- Total cost in 2007 was estimated at €3.7bn. This is 1.9% of total GNP.
- Excessive alcohol consumption impacts work performance and is frequently the cause of absenteeism and physical injuries in workplace.

Despite the high societal and economic cost of problem alcohol use in Ireland, actions to reduce alcohol consumption and to address harmful drinking patterns have, to date, been limited. The Royal College of Physicians of Ireland believes that there are proven solutions to this problem which should be implemented immediately for the benefit of the individual and for society in general.

What are the proposed solutions?

Societal/Public Health Solutions

From a societal perspective, there are four areas where concrete, immediate actions could be put in place to limit alcohol consumption, thereby reducing alcohol-related harm.

We support the introduction of minimum pricing to prevent the sale of cheap alcohol.

- We support this recommendation of the Steering Group Report on a National Substance Misuse Strategy (NSMS).
- This is considered by the World Health Organisation to be one of most cost-effective actions to reduce excessive alcohol consumption.
- Studies show minimum pricing works - evidence from minimum pricing implemented in Canada showed reduction in deaths within 1 year.
- In Ireland excise increases in 2003 and 2002 on spirits and cider respectively, showed a corresponding decrease in consumption.
- A recent HRB survey indicates public support for minimum pricing.
- Minimum pricing will not affect the price of pint in the pub. Rather it will target off-trade sales where the cheapest alcohol is sold.

We support measures to reduce the availability of alcohol.

- Number of alcohol outlets should be reduced. The recommendation from NSMS report to allow HSE to object to the new licences/ renewal of licences should be implemented.
- Alcohol sales in off-trade outlets should be managed better and low cost sales promotions and discounts should be strictly controlled.
- Alcohol should be sold in zoned areas in mixed retail outlets.
- Sale and supply to minors should not be tolerated and there should be punitive fines with rigorous implementation and oversight for this.

We support measures to change the culture of excessive alcohol consumption.

- Alcohol advertising/marketing encourages people, particularly younger people to consume alcohol and contributes to a culture of acceptability in relation to excessive alcohol consumption.
- Alcohol sponsorship of sports events and organisations should be phased out.
- Stricter controls should be introduced on where and when alcohol advertising is placed, with a view to limiting exposure of minors to alcohol marketing.

We support dissemination of guidelines on low-risk levels of alcohol consumption.

- There is weak knowledge of standard drink measures and weekly low-risk consumption amounts.
- We support the NSMS stated guidelines for low-risk alcohol consumption and the recommendation on labeling of alcohol products sold in Ireland.

Medical Supports

There are a number of areas within our Health System where targeted actions can support alcohol harm reduction:

We propose that Alcohol Screening and Brief Interventions be embedded in clinical practice.

- Although screening and Brief Interventions are an effective way of dealing with harmful drinkers, there are currently no formal guidelines for screening and Bls in acute hospitals.
- Screening for hazardous, harmful and dependent drinking should be embedded into clinical care.
- Screening should be linked to the provision of brief intervention/brief advice by trained health care workers.
- There should be adequate access to tier two, three and four alcohol services for patients not responding to brief interventions.

We recommend that an integrated model of care be developed for treatment of alcohol-related health problems.

- There is an urgent need to develop clinical guidelines/standards/protocols for healthcare professionals across all relevant sectors of the health and social care system.
- Efforts are needed to strengthen links between the alcohol treatment services in hospitals and the community.
- Aftercare in the community should be supported and improved, particularly with respect to relapse prevention.
- The referral relationship between primary and secondary care needs to be improved.
- There is a need for outpatient detoxification services to be established.
- Alcohol-related mental illness should be included within the model of care.
- Acute hospitals should have an alcohol team led by a consultant or senior nurse, and incorporating at least one alcohol nurse specialist.

Funding

We recommend that the Government allocate specific funding for research into alcohol-related health harms, especially alcoholic liver disease.

- There is very little funding available for research into alcohol-related health harms, especially alcoholic liver disease.
- Dedicated funding is needed for independent front-line research in this area.
- The Government should use levies on the alcohol industry to support this research.

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