



Tús Áite do  
Shábháilteacht **1** Othar  
Patient Safety **1** First



# Steering Group Report

On a National Substance Misuse Strategy  
February 2012



# **STEERING GROUP REPORT ON A NATIONAL SUBSTANCE MISUSE STRATEGY**

## **FOREWORD**

I am very pleased to introduce the report of the National Substance Misuse Strategy Steering Group. For the first time an integrated approach to substance misuse is envisaged, bringing together policy responses to alcohol use and misuse and to the misuse of other substances. This will be achieved by the implementation of the recommendations in this report which are focused on alcohol taken together with the National Drugs Strategy 2009–2016 such that these form one single, integrated policy response.

Ireland has had a long and sometimes difficult association with alcohol. As a society we must understand, accept and deal with the negative consequences that arise from our use and misuse of alcohol. The report outlines the scale of our alcohol consumption and its consequences, acknowledging clear evidence that an effective policy response requires action across a range of policy areas, many of which are outside the direct control of the health sector.

It is for this reason that I present these recommendations as a whole, very much in the hope that they will be adopted as Government policy. While in many areas individual measures might have been recommended that would go further, I regard the overall set of recommendations as reasonable and pragmatic, and I hope that they will help to significantly and positively alter Ireland's relationship with alcohol. It is my strong belief that these recommendations, taken together, provide a practical, pragmatic means to achieve this. I am, nevertheless, very conscious that to some the recommendations will be far-reaching and radical, whereas to others they will be seen not to have gone far enough.

It has been a pleasure for me to work with a wide range of stakeholders and experts in the development of this policy. I would like to take this opportunity to thank the members of the Steering Group for their commitment to the recommendations as set out in the report.

**Dr Tony Holohan**  
**Chairman to the Steering Group**

## INTRODUCTION

Alcohol plays a complex role in Irish society. It is associated with many aspects of Irish social and cultural life and is generally consumed for enjoyment, relaxation and sociability. The pub often plays an important role in community life and is an attraction for tourists. More broadly, alcohol plays a significant role in the Irish economy by generating employment, tax income and export income.

However, alcohol is no ordinary commodity. It has major public health implications and it is responsible for a considerable burden of health and social harm at individual, family and societal levels. Alcohol is a psychoactive substance that can impair motor skills and judgement, and its impacts on the individual can be at various points across a spectrum. It is a drug of dependence and can act as a gateway to the use of illicit drugs for some people. Polydrug use is now commonplace and those who drink alcohol and use other drugs place themselves at greater risk and make treatment responses more complicated. Binge drinking is also a common phenomenon in Ireland.

In recent years a significant shift has occurred in the share of alcohol sales, from pubs – which may provide a more controlled environment for the consumption of alcohol – to the off-trade sector<sup>i</sup> (specialist off-licences<sup>ii</sup> and mixed trade outlets<sup>iii</sup>). Particular concerns arise in respect of supermarkets and other mixed trade outlets providing increased availability of alcohol and the normalisation of alcohol among a range of products, and also in terms of these outlets using the discounting of alcohol products along with alcohol-based promotions to encourage people into their premises.

The Government decided in 2009 to include alcohol in a National Substance Misuse Strategy. Arising from this decision, a Steering Group (chaired by the Department of Health<sup>iv</sup>) was established to advise Ministers on a new Strategy. The Substance Misuse Strategy now being developed focuses on alcohol in particular and will be taken in conjunction with the National Drugs Strategy 2009–2016 as the overall National Substance Misuse Strategy until the end of 2016. Thereafter it is envisaged that a single combined document will be involved.

A key aim of this Strategy is the promotion of healthier lifestyle choices throughout society in relation to alcohol. Given the range of health problems that can arise from alcohol consumption, or to which alcohol can be a contributory factor, a population health approach is being taken with a focus on reducing alcohol-related harm and the amount of alcohol we drink. While personal responsibility is of central importance in the management of alcohol use, the State can play a crucial role by intervening to prevent problems through addressing factors that cause difficulties and also through tackling the negative consequences that arise when problems occur.

---

<sup>iii</sup> The off-trade comprises both specialist off-licences and mixed trade outlets as defined in footnotes 2 and 3.

<sup>ii</sup> Specialist off-licences are defined as retail outlets that primarily sell alcohol products which are purchased for consumption off the premises.

<sup>iii</sup> Mixed trade outlets are defined as retail outlets that combine a mix of food, grocery, petrol, or other products with alcohol sales. For the purposes of the report, this definition refers in particular to supermarkets, convenience stores and petrol stations.

<sup>iv</sup> Originally the Steering Group was jointly chaired by the Department of Health and Children and the Department of Community, Rural and Gaeltacht Affairs (which later became the Department of Community, Equality and Gaeltacht Affairs).

The following were the Terms of Reference of the Steering Group:

*The Steering Group will*

- *having reviewed existing policies and reports, including at EU and international level, set out an evidence-based framework which identifies effective policies and actions to tackle the harm caused to individuals and society by alcohol use\* and misuse.  
(\* 'alcohol use' in this context refers to the use of alcohol across the entire population. It does not imply that all alcohol use is harmful)*
- *decide on appropriate structures and frameworks for an effective and efficient implementation plan for the National Substance Misuse Strategy.*
- *align, as far as possible, these policies and actions with the existing five pillars of the National Drugs Strategy – supply, prevention, treatment, rehabilitation and research.*
- *make proposals for an overall National Substance Misuse Strategy to incorporate the National Drugs Strategy 2009–2016.*
- *submit proposals in regard to such a National Substance Misuse Strategy to the Minister for Health and Children and the Minister for Drugs<sup>v</sup> by the end of October 2010. Thereafter the proposals will be submitted to Government by the end of 2010.*

During the development of the National Drugs Strategy, a very extensive consultation process was undertaken, throughout which alcohol-related issues were continuously raised. The Steering Group therefore, in developing the current Strategy, decided to invite individuals and groups to submit their proposals in regard to alcohol without repeating the entire process. Such submissions (listed in Appendix 5), together with a range of reports and policy documents at national and international level, were considered by the Steering Group in reaching their conclusions.

In accordance with their Terms of Reference, the Steering Group have aligned their proposals with the five pillars of the National Drugs Strategy, and the recommended Actions are set out under these pillars.<sup>vi</sup> It is recognised that the Report is being launched in a climate of severe economic constraints where there is less likelihood of additional resources being made available. However, it is envisaged that the Strategy will cover the period until the end of 2016 and that all Actions can be progressed within that timescale, including through legislation and in tandem with other policies.

---

<sup>v</sup> Now incorporated in the role of the Minister for Health.

<sup>vi</sup> Minority Reports of both the Alcohol Beverage Federation of Ireland (ABFI) and Mature Enjoyment of Alcohol in Society Ltd (MEAS) can be found on the Department of Health website, [www.doh.ie](http://www.doh.ie).

## CHAPTER 1 BACKGROUND

### ALCOHOL AND THE IRISH POPULATION

While recognising that individuals are primarily responsible for their own behaviour, the State has a responsibility to preserve and protect public health and the general well-being of society. Alcohol plays a significant role in Irish society. The local pub has been, and continues to be, a significant element of the social fabric of communities and may play a role in addressing isolation issues. The alcohol industry and Irish pubs are an important component of the Irish economy, contributing to employment, manufacture, exports and tourism.

However, alcohol is no ordinary commodity. It is responsible for a wide range of health and social harms in society and places a significant burden on the resources of the State in dealing with the consequences of its use and misuse. While excessive alcohol consumption covers all social groups, alcohol-related hospital admissions are significantly skewed towards the poor and disadvantaged. A combination of interventions is needed to reduce alcohol-related harm across the entire population. The World Health Organization (WHO) notes that alcohol interventions targeted at vulnerable groups can prevent alcohol harm but that policies targeted at the whole population, while having a protective effect on vulnerable populations, also reduce the overall level of alcohol problems.<sup>1,2</sup> A population approach benefits those who are not in regular contact with the health services and those who have not been specifically advised to reduce their alcohol intake. It also helps prevent people from drinking harmful or hazardous quantities of alcohol in the first place.

In making its recommendations the Steering Group has taken account of the following key factors:

#### **The positive impact of alcohol on the Irish economy**

- 1. The alcohol industry provided an estimated 50,000 whole-time equivalent jobs in 2008.**
  - Eighty-seven per cent of jobs were in the on-trade sector<sup>vii</sup>, 5 per cent were in the off-trade and 7 per cent were in alcohol manufacturing, generating salaries and wages of an estimated €1.5bn.
  - Like other sectors, employment levels have declined, particularly in the on-trade where an estimated reduction of 26 per cent in jobs occurred between 2000 and 2008.
  - Pubs in Ireland constitute an important part of the tourism package.
- 2. The alcohol manufacturing industry had a turnover of €2.95bn in 2008.<sup>3</sup>**
  - The industry produced €1bn in exports, with a net trade surplus of €330m in 2009.
  - The industry also generated and supported jobs and activity in other sectors such as the purchasing of products for manufacture, catering and maintenance.

---

<sup>vii</sup> The on-trade is defined as outlets that sell alcohol for consumption on the premises – this refers in the main to pubs, but also to restaurants and hotels, and includes other hospitality and entertainment venues.

**3. Alcohol manufacturing and retail provided €2bn in VAT and excise revenues to the State in 2008.**

**Harmful alcohol consumption patterns in Ireland**

**1. Irish adults drink in a more dangerous way than nearly any other country.**

- The average Irish adult drank 11.9 litres of pure alcohol in 2010, corresponding to 482 pints of lager, 125 bottles of wine or 45 bottles of vodka. Given that 19 per cent of the adult population are abstainers, the actual amount of alcohol consumed per drinker is considerably more. While alcohol consumption has reduced since 2000, adults in 2010 were still drinking more than twice the average amount of alcohol consumed per adult in 1960.
- In an OECD Health Data report published in 2011 (see Table 1, Appendix 1), it was noted that Ireland's per capita alcohol consumption in 2009 was 11.3 litres per adult (15+ years) – the tenth highest of 40 countries in 2009 covered by the report. The OECD average was stated as 9.1 litres per adult in 2009.<sup>4</sup>
- If every adult (15+ years) restricted his/her alcohol consumption to the recommended maximum low-risk limit on every week of the year, the actual per capita consumption would be 9.2 litres of pure alcohol per adult (15+ years), or 23 per cent less than was consumed in 2010.
- Irish adults binge drink more than any other European country, with one-quarter of Irish adults reporting that they binge drink every week.<sup>5</sup>
- Over half of drinkers were identified as having a harmful drinking pattern. This equates to nearly one and a half million adults in Ireland drinking in a harmful pattern.<sup>6</sup>

**2. Irish children are drinking from a younger age and drinking more than ever before.**

- Over half of Irish 16 year old children have been drunk and one in five is a weekly drinker.<sup>7</sup>
- The average age of first alcohol use in children decreased from 15 years for children born in 1980 to 14 years for children born in 1990.<sup>8</sup>

**3. The pattern of alcohol purchasing in Ireland has shifted from the pub to the off-licence sector, and to supermarkets in particular.**

- There was a 161 per cent increase in the number of off-licences operating between 1998 and 2010 and over the same time period the number of pub licences decreased by 19 per cent. In 2010 the average cost of a 500ml can of lager from the off-licence was €1.77 while the average price of a pint of lager in the on-trade sector was €4.35.<sup>9</sup> The off-licence sector accounted for half of the alcohol market share in 2008 and, given the much cheaper price of alcohol in the off-licence, the volume of alcohol sold from the off-licence was much greater than that sold in the on-trade.
- Much of this increase was in mixed trade outlets which have used significant discounting of alcohol products along with alcohol price-based promotions to encourage people into their premises.
- Purchasing by distance sales from specialist off-licences and mixed trade outlets has become more widespread. There is some evidence to suggest that under-18 year olds are consuming alcohol purchased by distance sales from specialist off-licences and mixed trade outlets.

#### **4. Alcohol marketing leads to young people commencing drinking at a younger age and drinking more.**

- Exposure to alcohol advertising and promotion predicts both the onset of drinking among young non-drinkers and an increased level of drinking among existing young drinkers.<sup>10 viii</sup>
- Irish 16–21 year olds list alcohol advertisements as five of their top ten favourite advertisements.
- Four in ten 16–21 year olds have an alcohol branded item of clothing, with 26 per cent owning a rugby/football jersey that has an alcohol brand logo.<sup>11</sup>

### **The harms caused by alcohol use and misuse to individuals and to Irish society**

#### **1. Alcohol was responsible for at least 88 deaths every month in 2008.**

- The National Drug-Related Deaths Index recorded 4,321 deaths between 2004 and 2008 due to either alcohol poisoning or deaths in alcohol-dependent people. In 2008 this equated to 88 deaths each month. As this did not include all deaths due to alcohol in people who were not alcohol-dependent, the number is likely to be greater. Between 2004 and 2008 alcohol caused nearly twice as many deaths as all other drugs combined.<sup>12</sup>
- Over the five-year period 2000–2004 alcohol was estimated to cause 4.4 per cent of deaths (6,584 deaths) in Ireland.<sup>13</sup> This included deaths resulting from accidental and non-accidental injuries that occurred to individuals while under the influence of alcohol and from chronic conditions both wholly due to alcohol, such as alcoholic liver disease, or partially due to alcohol, such as liver cancer.
- One in four deaths in young men was estimated to be due to alcohol compared with one in 12 deaths due to cancer or one in 25 due to cardiovascular disease.<sup>13</sup>

#### **2. Alcohol is a contributory factor in half of all suicides.**

- Between 2000 and 2004 alcohol was estimated to be the major contributing factor in 823 suicides in Ireland.<sup>13</sup>
- A regional Irish study found that more than half of people who died from suicide had alcohol in their blood at time of death.<sup>14</sup>

#### **3. Alcohol is a factor in deliberate self-harm.**

- Alcohol was consumed in four out of ten episodes of self-harm in Ireland in 2010.<sup>15</sup>

#### **4. Alcohol increases the risk of more than 60 medical conditions.**

- Alcohol, even at low-risk levels of consumption, increases the risk of many major diseases including numerous cancers and gastrointestinal conditions.<sup>16</sup>

#### **5. Alcohol is associated with 2,000 beds being occupied every night in Irish acute hospitals, one-quarter of injuries presenting to emergency departments and over half of attendances to specialised addiction treatment centres.**

---

<sup>viii</sup> Alcohol Beverage Federation of Ireland (ABFI) wished it formally recorded that they disagree with this statement.



- Between 2000 and 2004 alcohol was estimated to lead to 10.3 per cent of bed-days (3,428,973 bed-days) in acute Irish hospitals.<sup>17</sup> In 2003–2004 28 per cent of injuries presenting to emergency departments were recorded as being due to alcohol.<sup>18</sup>
- Alcohol-related admissions from acute hospitals doubled between 1995 and 2008.<sup>19</sup>
- Alcohol was the main drug responsible for 7,866 admissions to specialised addiction treatment centres in 2010.<sup>20</sup>

**6. Alcohol is associated with harms to the baby and is a factor in unplanned pregnancies.**

- A range of disorders known as fetal alcohol spectrum disorders (FASD) are caused by mothers drinking alcohol in pregnancy.
- Alcohol is a significant factor in unplanned pregnancies.

**7. Alcohol misuse increases the risk of children requiring special care.**

- Alcohol was identified as a risk factor in three-quarters of Irish teenagers for whom social workers applied for admission to special care.<sup>21</sup>
- It is estimated that adult alcohol problems are associated with 16 per cent of child abuse and neglect cases.<sup>22</sup>

**8. Alcohol is a factor in the breakdown of relationships.**

- An Irish survey reported that up to 40 per cent of men and 20 per cent of women in distressed relationships were drinking excessively.<sup>23</sup> In another Irish study, 25 per cent stated that alcohol misuse was a factor in marital disharmony.<sup>24</sup>

**9. Alcohol and domestic abuse**

- A survey of domestic abuse in Ireland in 2005 found that alcohol was a trigger in one-third of cases of abuse. Alcohol was always involved for 27 per cent of the respondents who had experienced domestic abuse.<sup>25</sup> Domestic abuse that occurs in the context of alcohol use may be more likely to lead to injury.

**10. Alcohol and rape**

- A Rape and Justice in Ireland briefing paper by the Rape Crisis Network outlines research which indicates (i) 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; and (ii) that alcohol consumption affects decisions on whether to report alleged rapes.<sup>26</sup>

**11. Early onset of alcohol use increases the risk of problem alcohol and drug use later in life.**

- 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.

**12. Alcohol-related illness cost the healthcare system €1.2bn in 2007.**

- In 2007 it was estimated that alcohol led to costs of €500m in the acute hospital sector, €574m in GP and allied health services and €104m in mental health services.<sup>27</sup>

**13. Alcohol-related crime cost an estimated €1.19bn in 2007.**

- Almost half of the perpetrators of homicide were intoxicated when the crime was committed.
- Alcohol-related crime led to costs in policing, prison services, courts and justice support services estimated at over €1bn.<sup>27</sup>

**14. The cost of lost economic output due to alcohol was estimated to be €527m in 2007.**

- The estimated loss of productivity due to alcohol-related work absences was €330m and due to alcohol-related injuries was €197m in 2007.<sup>27</sup>

**15. Alcohol-related road accidents cost an estimated €530m in 2007.**

- However, there has been a 34 per cent reduction in road traffic deaths over the three-year period since the introduction of mandatory alcohol testing in 2006.<sup>28,29</sup>

For certain diseases, namely coronary heart disease, stroke and diabetes mellitus, alcohol consumption at very low levels can provide a protective effect in middle and older age groups, though at higher levels of consumption this protective effect is lost and the risk of disease increases.

**Conclusion**

The Steering Group considered the economic benefits of the alcohol industry to the Irish economy against the resultant health and social harms caused by alcohol use and misuse in Irish society. The members of the Steering Group were satisfied that the burden of health harms and the social consequences of harmful use of alcohol demanded the implementation of further measures to protect and preserve public health.

## **CHAPTER 2 SUPPLY PILLAR**

### **STRATEGIC AIMS AND OBJECTIVES**

The overall volume of alcohol consumption and the pattern of binge drinking predict the incidence of alcohol-related harm in Ireland. Price, availability and marketing of alcohol are key factors in its supply which in turn impacts on the volume and pattern of alcohol consumption.

The strategic objective with respect to supply is:

To ensure that the supply and price of alcohol is regulated and controlled in order to minimise the possibility and incidence of alcohol-related harm.

1. This will be achieved by:
  - (a) reducing the supply of cheap alcohol particularly from the off-trade;
  - (b) further controlling the availability of alcohol;
  - (c) preventing the sale of alcohol to children under 18 years of age;
  - (d) further restrictions on alcohol marketing and sponsorship; and
  - (e) further reducing the incidences of drink-driving.

### **BACKGROUND/EVIDENCE**

2. The pattern of supply of alcohol has changed greatly in the past number of decades in Ireland. The pace of this change has accelerated in the past few years. Overall, alcohol has become more affordable and there has been a shift from consuming alcohol in on-licence premises to purchasing alcohol from off-trade outlets for consumption at home.

#### **Share of alcohol sales between on-trade and off-trade**

3. The pub tradition is embedded in Irish society and culture. The local pub is often an important component of the social fabric of a community. Concern has been expressed at the number of pubs that have closed in recent years and the increase in the number of supermarkets, convenience stores and petrol stations now selling alcohol. The pub environment may provide a more 'controlled' environment as there is generally more of an emphasis on server responsibility. However, there are few or no restrictions on the amount of alcohol that can be purchased in one transaction in the off-trade and there are no controls on the volume or mix of alcohol that a person can consume once purchased. This raises concerns around the health consequences of selling and consuming alcohol in this way.
4. While there is a need to reduce the per capita consumption of alcohol in Ireland to protect the health of Irish citizens, measures to do so should differentially target purchases in the off-trade sector, as it maintains relatively few jobs and generates vastly less tax revenue than the on-trade sector. A further distinction exists between the specialist off-licence sector and the mixed trade sector. In recent times many mixed trading outlets (mainly supermarkets) are prepared to use substantial discounting of alcohol products and alcohol price-based promotions in order to encourage people into their premises.

5. Although Ireland has one of the highest excise duty regimes for alcohol in the European Union, alcohol remains relatively cheap and affordable here. Since 1996 the affordability of alcohol has increased by at least 50 per cent.<sup>30</sup> Also, analysis of CSO data indicates that there was an increase in the affordability of alcohol relative to disposable income between 2002 and 2007. In 2002 one week's disposable income would have purchased 162 cans of lager (500ml) from the off-trade, whereas in 2007 one week's disposable income would have purchased 234 cans (44 per cent increase).
6. The off-licence sector has grown substantially in recent years. An analysis of the drinks market, on behalf of the Drinks Industry Group of Ireland,<sup>3</sup> estimated that the off-trade share of the market was 49 per cent in 2009. According to the Revenue Commissioners, between 1998 and 2010 the number of pub licences issued decreased by 19 per cent, while the number of off-licences (including dealer licences) more than doubled. The increase in off-trade sales is most likely linked in a significant way to their cheaper prices – CSO data indicate that in 2010 the average price of a pint of lager from the on-trade was €4.35 while the average price of a 500ml can of lager from the off-trade was €1.77.
7. VAT now accounts for the vast bulk of tax generated by the sale of alcohol in the on-trade sector. Although excise returns are unaffected by the location of purchase, the VAT per unit is much higher in the on-trade sector, which is more labour intensive, compared to the off-trade. Therefore market moves from on-trade to off-trade sales result in a reduced VAT take from alcohol.
8. There is strong evidence that the price at which alcohol is sold is a determinant in promoting and selling alcohol.<sup>1</sup> Controls on alcohol pricing, including minimum pricing<sup>31</sup> and increasing taxes on alcohol products,<sup>2</sup> are effective policy measures to reduce alcohol-related harm in the population.
9. Since 2000 there have been three increases in excise duty rates; cider in December 2001, spirits in December 2002 and wine in October 2008. After each excise duty increase a decrease in consumption of the affected beverage was observed in the following years. In December 2009 excise duty was reduced. In 2010 alcohol consumption increased by 5.3 per cent.
10. The following measures have been shown to be effective in reducing the consumption of alcohol by the general population and specific at-risk groups (WHO):
  - controlling access to alcohol through limiting the times of sale;
  - controlling the number of outlets in a geographical area or based on population;
  - restricting sales to intoxicated people; and
  - restricting sales to children.
11. Delaying the age when a young person has his/her first drink reduces the risk of harmful use of alcohol in adulthood. Young people are particularly responsive to alcohol marketing and research has shown that, among young people, alcohol advertising and promotion predicts both the onset of drinking among non-drinkers and increases levels of consumption among existing drinkers. There is

a need to limit young people's exposure to alcohol marketing. This can be achieved through strengthened controls/restrictions on the overall volume of marketing and sponsorship. Many hold the view that a regulatory framework, with appropriate and timely sanctions, is essential to control the exposure of young people to alcohol marketing.

12. Drink-driving is a major public health issue. There is convincing evidence that low blood alcohol concentration (BAC) limits for drivers reduce the risk of being involved in a road traffic collision.<sup>1</sup> Since the introduction of Mandatory Alcohol Testing in 2006, there has been a 34 per cent reduction in road accident deaths.
13. While the majority of the members of the Steering Group favoured the use of fiscal measures to increase the price of alcohol and, in turn, reduce consumption, the Alcohol Beverage Federation of Ireland (ABFI) is opposed to this approach as it is not convinced that the evidence supports such measures. The alcohol industry does not believe that increasing excise duties and introducing a minimum price for alcohol will reduce alcohol misuse. It points to the significant economic benefits generated by the alcohol industry in Ireland. The industry feels that increasing the price at which alcohol is sold at this time potentially threatens Irish jobs, tax revenues and income from exports.

## **ACTIONS**

### **Taxation – excise duties**

14. Increasing excise duties is one of the most effective methods of reducing alcohol consumption. It is felt that such duties should be maintained at high levels as a means to controlling the overall level of consumption. Excise duty rates on higher alcohol content products should be maintained at a higher rate than those on lower alcohol products to discourage consumption of higher alcohol content beverages.
15. Within each alcohol product category, excise rates should be further linked to alcohol content. For example, low alcohol content beers should be subject to a lower excise rate than full strength beers. A reduced rate of excise duty, at 50 per cent of the full appropriate excise duty rate for beer and cider, was introduced in 2008 for beer and cider with an alcohol by volume (ABV) content of 2.8 per cent or less. However, retailers (on-trade or off-trade) are not compelled to pass on this price reduction to consumers. A mechanism needs to be identified to ensure that lower excise rates for lower alcohol products translates into a price-benefit that encourages people to drink low-alcohol or alcohol-free alternatives.
16. Bearing in mind the greater control on consumption exercised in the on-trade, and the overall social and economic contribution of that sector, it is recommended that the annual excise fee for the renewal of off-licences should be increased.

**Recommendation:**

Increase the price of alcohol over the medium term to ensure that alcohol becomes less affordable, using some or all of the following approaches:

- maintain excise rates at high levels;
- further increase excise rates for higher alcohol content products;
- increase the differential between excise rates applied to alcohol content levels in each alcohol product category;
- increase the annual excise fee for the renewal of off-licences.

**Below-cost sales**

17. The Groceries Order, which prohibited below-cost selling of products, was revoked by the Minister for Enterprise, Trade and Employment in March 2006, based on the belief that the Order kept prices of groceries at an artificially high level and because there were difficulties in monitoring compliance. This resulted in the control of pricing of alcohol products being removed. It allowed the mixed trade sector to sell alcohol at very low prices and to use this to attract customers into stores. The Department of Jobs, Enterprise and Innovation does not intend to re-introduce legislation on below-cost selling. Neither does this report propose below-cost selling restrictions on alcohol due to the difficulties in enforcing such legislation.

**Minimum pricing**

18. In order to tackle the very low cost at which alcohol is sold in the off-trade sector (particularly in supermarkets), a minimum pricing regime on alcohol products should be introduced. Such a regime would require that a minimum price be set for alcoholic drinks based on the number of grams of alcohol in the drink, and alcohol could not be sold below this price. It is recognised that there will be technical and operational challenges to be overcome in introducing this approach. This would mainly impact on the off-trade sector where, as indicated, prices are generally lower.

**Recommendation:**

Introduce a legislative basis for minimum pricing per gram of alcohol.

**Price per container**

19. There should be no price saving from multiple purchases of alcohol. For example, the price of two bottles of wine should be the price per container (bottle) multiplied by two, and a six-pack of beer should be the cost per container (bottle or can) multiplied by six. Any promotion or advertising of alcohol products would include the container price only. The Steering Group are of the view that this issue could be addressed through the commencement of Section 16 (1)(b) of the Intoxicating Liquor Act, 2008, as well as the introduction of a legislative basis for minimum pricing per gram of alcohol.

### **Happy hours**

20. Section 20 of the Intoxicating Liquor Act 2003 states that 'a licensee shall not supply intoxicating liquor on the licensed premises at a reduced price during a limited period on any day'. There is concern that some licensed premises now offer all-day drink promotions, which makes this legislation less effective.

### **Price-based promotions**

21. As stated previously, lower alcohol prices are used to attract customers, particularly in the mixed trade sector, such as supermarkets and convenience stores. Section 16 of the Intoxicating Liquor Act 2008 provides for the making of regulations that prohibit the sale or supply of alcohol at reduced prices, or free of charge, on the purchase of any quantity of alcohol or any other product. It also prohibits promotions which encourage customers to consume alcohol to an excessive extent, e.g. 'drink as much as you can' for a certain price or within a certain time. These regulations need to be made and an enforcement mechanism developed.

#### **Recommendation:**

With respect to Section 16 of the Intoxicating Liquor Act 2008 (sale, supply and consumption of alcohol)

- develop and implement an enforcement mechanism;
- make regulations under Section 16 (1) (b) and (c) of that Act.

22. The sale of alcohol at reduced prices, and the promotion of same, are matters of mutual interest between Ireland and Northern Ireland. Discussions should continue between the two jurisdictions at Ministerial and official level in this regard, and more broadly in relation to possibilities of developing an all-island initiative in relation to alcohol issues.

#### **Recommendation:**

Develop proposals for an all-island initiative in relation to alcohol issues including alcohol availability, treatment and health promotion.

## **AVAILABILITY OF ALCOHOL**

### **Licensing in the on- and off-licence sectors**

23. The Licensing Acts 1833-2011 set out the statutory framework which applies to the sale and supply of alcohol. The Courts generally determine if applicants meet qualifying criteria to hold a licence and An Garda Síochána enforce the licensing laws. An Garda Síochána and the Fire Authorities are notice parties to all new applications. Local residents and others can object to a licence. To apply for a new public house licence, for a public bar in a hotel, or for an off-licence, there is a requirement to extinguish an existing licence.

24. New licences are issued by the Office of the Revenue Commissioners on presentation of a court certificate. The relevant Court may refuse to grant the required court certificate on one or more of the following grounds:

- the character, misconduct or unfitness of the person applying;

- the unfitness or inconvenience of the premises;
  - the unsuitability of the premises for the needs of persons residing in the neighbourhood; and
  - the adequacy of the existing number of licensed premises of the same character in the neighbourhood.
25. The Intoxicating Liquor Act 2008 provides that objections to the granting of the court certificate for an off-licence may be made at the relevant court hearing by the local Garda Superintendent and local residents. The right to object to off-licences should be extended to include the Health Service Executive (HSE). The HSE was given the right to object to on-licences under the Intoxicating Liquor Act 1960 (Section 4).
26. Licences for the on- and off-trade are renewed annually, in September,<sup>ix</sup> and a Court hearing is required if there are objections to the renewal of a licence. The general public should be better informed on the methods and grounds for objecting to the granting or renewal of licences. The [forthcoming] Sale of Alcohol Bill is expected to provide for a comprehensive and accessible on-line electronic register of licensed premises. The Steering Group welcomed the availability by the Revenue Commissioners of the register of renewed liquor licences as at 1 September 2011 [www.revenue.ie/en/tax/excise/index.html](http://www.revenue.ie/en/tax/excise/index.html), and look forward to its continued development.
27. The [forthcoming] Sale of Alcohol Bill will modernise and streamline all the laws in relation to the sale and consumption of alcohol. One of its objectives is to promote coherence between the planning and licensing codes. As well as requiring compliance with planning laws, it is intended that Local Area Development Plans will specify the location of licensed premises in their area. The Bill will also broaden the category of those who can object to the granting or renewal of licences.

**Recommendation:**

Provide that the HSE may object to the granting of a court certificate for a new licence and to renewal of licences.

**Opening hours for the sale of alcohol in the on-trade sector**

28. Regular licensing hours for the on-trade are from 10.30 a.m. to 11.30 p.m. from Monday to Thursday and 10.30 a.m. to 12.30 a.m. on Friday and Saturday. Sunday hours are 12.30 p.m. to 11.00 p.m. An additional 30 minutes drinking-up time is permitted. No change in the regular on-trade opening hours is proposed.
29. Extended hours are permitted under a Special Exemption Order (SEO). SEOs expire on any Monday (except where the Monday is a public holiday) at 01.00 a.m., with permits for all other days expiring at 02.30 a.m. Under the Intoxicating Liquor Act 2003 a Local Authority may adopt a resolution concerning expiry times of SEOs, having consulted with An Garda Síochána and any other

<sup>ix</sup> Licences are renewed on the day of the last sitting of the district court held in the month of September. Details of the Annual Licensing court are provided on the website of the Courts Service [www.courts.ie](http://www.courts.ie).



persons, including health interests. The District Court is required to have regard to the terms of any such resolution when making an order in respect of premises located in the area involved. The Intoxicating Liquor Act 2008 includes specific requirements regarding the use of CCTV, requirements for security staff and compliance with fire safety standards for granting SEOs. It also applies regular closing times to premises functioning under a theatre licence. Such licence holders now require a SEO to cater for events involving the sale or supply of alcohol after regular on-trade hours. The Steering Group is not recommending any further changes to the conditions attached to SEOs at this time.

### **Opening hours for the sale of alcohol in the off-licence sector**

30. The Intoxicating Liquor Act 2008 restricts off-sales of alcohol to the period between 10.30 a.m. to 10.00 p.m. (12.30 p.m. to 10.00 p.m. on Sundays and Saint Patrick's Day). The Steering Group acknowledged the reduced hours of trade now operating in the off-trade outlets and does not recommend any further reduction in these hours at this time.

### **Statutory regulation of the off-trade sector**

31. Compared to the on-trade, which may be regarded as a more 'controlled' environment and where there is considered to be a greater emphasis on server responsibility, the off-trade is considered to be less controlled. The Steering Group notes that there is legislation in place in respect of the on-trade sector and recommends that a comparable statutory basis be introduced for the off-trade to address issues such as improved server responsibility.

#### **Recommendation:**

Introduce a statutory code of practice on the sale of alcohol in the off-licence sector.

### **Sale and display of alcohol in the off-trade sector**

32. Section 9 of the Intoxicating Liquor Act 2008 provides for the structural separation of alcohol from other products in mixed trading outlets. The then Minister for Justice, Equality and Law Reform deferred commencement of these provisions subject to achieving sector-wide compliance to the agreed Code of Practice on the Sale and Display of Alcohol in Mixed Trading Premises. This code, which was agreed with trade representatives and the Departments of Health and Children and Justice, Equality and Law Reform in 2008, sets out voluntary commitments on structural separation, advertising and training. It is subject to independent monitoring and submission of an annual implementation report to the Minister for Justice, Equality and Defence. Implementation of the code is overseen by the independently chaired Responsible Retailing of Alcohol in Ireland – a group comprised of representatives of the mixed traders. The third Compliance Report on the implementation of this code of practice was presented to the Minister for Justice, Equality and Defence on 30 September 2011.

33. Furthermore, in June 2011 the Minister for Justice, Equality and Defence stated his intention to seek the views of interested bodies on the findings of the third compliance report and on the voluntary approach to implementing the objective of structural separation in mixed trading premises. This consultation exercise will inform any decision on whether to commence the legal provisions on structural separation at section 9 of the 2008 Act. The Minister for Justice, Equality and Defence launched this public consultation in October 2011.
34. Section 17 of the Civil Law (Miscellaneous Provisions) Act 2011 is significant with respect to alcohol; it provides statutory support for codes of practice on the sale and supply of alcohol. While failure to comply with an approved code is not of itself an offence – and will therefore not attract a fine or a penalty – section 17 provides that non-compliance will constitute grounds on which an objection may be lodged to the renewal of the licence.
35. While the Steering Group acknowledges the visible change achieved in some mixed trading outlets through the implementation of codes of practice, members of the Group maintain their concerns that codes of practice, by their nature, may not be fully adhered to, and they would be in favour of restricting off-sales to specialist off-licences only. While the announcement of the Minister for Justice, Equality and Defence in June 2011 was acknowledged, the majority of the Steering Group nevertheless recommended the commencement of Section 9 of the Intoxicating Liquor Act 2008 in the short term as going some way towards addressing the easy availability of alcohol.

**Recommendation:**

Commence Section 9 (structural separation) of the Intoxicating Liquor Act 2008.<sup>x</sup>

**Sale of alcohol to intoxicated persons**

36. It is an offence for a licensee to supply, or to permit any person to supply alcohol to an intoxicated person. The licensee is further prohibited from permitting an intoxicated person to consume alcohol on the licensed premises or to admit an intoxicated person to the premises. It is an offence for a person (not being a licensee) to purchase or supply alcohol for consumption to an intoxicated person on a licensed premises. While the on-trade sector may be regarded as more controlled and is considered to have an emphasis on server responsibility, there is evidence from court cases that persons are being served alcohol and leaving pubs in an intoxicated state. However, it is also recognised that practices such as ‘pre-loading’ – where alcohol is consumed in private homes in addition to on a licensed premises – makes it difficult to determine the share of the harm that is attributable to the on-trade and the off-trade. The level of intoxication across the country is causing public safety concerns in communities. An Garda Síochána should give due priority to the enforcement of provisions concerning the sale or supply of alcohol to intoxicated persons and for the offence of being intoxicated on a licensed premises.

---

<sup>x</sup> The Minister for Justice, Equality and Defence is undertaking a review of the voluntary arrangements on structural separation in the mixed trading sector.

**Recommendation:**

Develop a system to monitor the enforcement of the provisions of the licensing laws:

- to ensure consistency of application across all Garda regions;
- concerning the sale, supply or delivery of alcohol to minors, with particular emphasis on age verification.

**Sale of alcohol in sports grounds and at other large public events**

37. The Steering Group considered the sale of alcohol in sports stadia and at other large public events such as public concerts. Many children and young people attend such large public events. There is a need to develop a statutory code of practice for these events with a strong and clear message on the responsibility of sports organisations, event promoters and concession holders to ensure compliance with the prohibition on underage drinking and the offence of supplying alcohol to an intoxicated person.

**Sales of alcohol to people under the age of 18 years**

**Minimum age for purchasing alcohol**

38. The Steering Group considered the minimum age for purchasing alcohol (currently 18) and concluded that there was no need to change this age.

39. The 'Test Purchasing of Alcohol Scheme' commenced in October 2010. This scheme permits An Garda Síochána to send a person who is 15, 16 or 17 years old into a licensed premises for the purposes of purchasing alcohol. If a sale takes place, the licensee of the premises risks being prosecuted. Test purchasing may be carried out in both on-licensed and off-licensed premises and is intended to assist An Garda Síochána in their enforcement activities.

**Garda national age card**

40. The Intoxicating Liquor Act 2003 requires persons aged 18–20 years to carry an age document (a Garda age card, passport, identity card of an EU member state or a driver's licence) in order to be in a bar of a licensed premises after 9.00 p.m. (10.00 p.m. from May to September). While it is not mandatory for 18–20 year olds to produce an age document to purchase alcohol, the law as it stands requires a licensee to be satisfied that a purchaser is over 18 years and when necessary to demand production of proof of age documentation. In this context, most members of the Steering Group believe that making production of an age document mandatory for 18–20 year olds in order to purchase alcohol would improve compliance with, and enforcement of, the statutory provisions relating to under-age persons.

**Secondary purchasing of alcohol for minors**

41. The Intoxicating Liquor Act 1988, as amended, states that it is an offence for a licensee to sell or supply alcohol to minors and for third parties to supply or deliver alcohol to minors (secondary purchasing). However, it is not illegal for a minor to consume alcohol in a private residence with the explicit consent of his/her parent or guardian. The European Schools Survey Project on Alcohol and Other Drugs (ESPAD) 2007 found that on their most recent drinking occasion 25 per cent of Irish 16 year olds said that older brothers/sisters or

friends bought alcohol for them. Some 16 per cent reported that were given alcohol by their parents.

42. The Intoxicating Liquor Act 2008 provides for the installation of a CCTV system as a condition for the grant or renewal of a certificate for an off-licence. This Act increased the fines for the sale, supply or delivery of alcohol to minors, which currently stand at €3,000 for the first offence and €5,000 for the second or subsequent offence. These offences also attract a compulsory closure order – from 2 days to 7 days for a first offence and from 7 to 30 days for a second or subsequent offence.

### **Distance sales**

43. The prohibition of the sale of alcohol to minors also applies to distance sales. The Steering Group is concerned with the practice of distance sales of alcohol, where alcohol is ordered and delivered to a residence, as there is anecdotal evidence that young people of less than 18 years of age are purchasing alcohol this way. Licensing law prohibits payment for alcohol on delivery. Due to the difficulties involved in enforcing this legislation, the Steering Group recommends that further restrictions should be imposed in respect of age authentication for distance deliveries of alcohol – possibly age authentication prior to online purchasing of alcohol, age verification at point of delivery and the introduction of a test delivery scheme.

**Recommendation:**

Consider, having regards to enforcement constraints, the possible need to strengthen the legislative controls on distance sales.

### **Vendor traceability – labelling of alcohol containers**

44. The possibility of imposing regulations to require specific labelling of alcohol containers as a means of combating secondary purchasing was considered. However, it is accepted that practical and legal issues preclude this approach.

### **Server training programmes**

45. There are benefits to having server training programmes in place for all those involved in the serving or sale of alcohol. A certain amount of server training is provided in both the on-trade and the off-trade sectors. The Steering Group is in favour of a set of standards being drawn up for such training courses. It should also be made a condition of the granting and renewal of a licence that licence holders and staff participate in such training programmes.

**Recommendations:**

Establish standards for server training programmes in the on-trade and off-trade sectors.

Provide that participation by licensees and staff in such programmes is a condition of the licensing process.

## MARKETING AND PROMOTION OF ALCOHOLIC BEVERAGES

### Alcohol marketing, communications and sponsorship codes of practice

46. The Group acknowledges the changes that have accrued as a result of the introduction of the Code of Practice on alcohol advertising and sponsorship. However, no research has been undertaken to demonstrate that people's attitudes around alcohol have changed. There is also concern in regard to the large volume of advertising moving to digital media, which is extremely difficult to regulate.
47. Codes of Practice on the placement of alcohol advertising were agreed between the alcohol industry, the advertising industry and the Department of Health. The purpose of these codes was to reduce the exposure of children and young people to alcohol marketing. The codes aim to limit the overall level of alcohol advertising and sponsorship across all media, and adherence and compliance with the codes is monitored by the Alcohol Marketing Communications Monitoring Body (AMCMB). The Codes of Practice were strengthened in July 2008 and are again under review by the Department of Health.
48. Other Codes of Practice on alcohol marketing in place in Ireland are the Broadcasting Authority of Ireland's Children's Advertising Code, the Advertising Standards Authority for Ireland (ASAI) Code, the Responsible Retailing of Alcohol in Ireland Code, and the MEAS Code.
49. The codes place restrictions on the volume and placement of all alcohol advertisements. All advertising content produced in Ireland or internationally for the Irish market must be pre-vetted to the ASAI standards and carry the Central Copy Clearance Ireland (CCCI) stamp of approval before acceptance by any media. The codes are based on audience profiling to ensure that alcohol advertising/marketing is not permitted unless the relevant medium has an adult audience profile of more than 75 per cent and alcohol advertising is limited to no more than 25 per cent of available space or time on any occasion. The Irish alcohol and advertising industries have given a commitment to have the codes apply to all advertising bought specifically for transmission to an Irish audience, irrespective of the media/channel location. This is in an attempt to have the new codes apply to TV stations licensed outside Ireland (called 'opt-out' channels) but who target Irish audiences through advertising.
50. The Broadcasting Act 2009 (Section 42) provides for the development of statutory advertising codes to address a range of matters. The Broadcasting Authority of Ireland (BAI) has responsibility for the development and implementation of these codes. Section 42 (2g) provides for statutory broadcast codes to regulate *'in particular advertising and other such activities which relate to matters likely to be of direct or indirect interest to children, protect the interests of children having particular regard to the general public health interests of children ...'*
51. The Broadcasting Authority of Ireland (BAI) is currently consulting with stakeholders concerning the development of advertising broadcast codes for food and non-alcoholic beverages, with a view to addressing legitimate

concerns over the advertising and marketing of food and beverages high in salt, sugar and fat.

52. In light of the statutory provision in the Broadcasting Act and the role of the BAI in the regulation of broadcasting, the steering group recommends that the BAI similarly develop and implement a broadcast code to address alcohol advertising and marketing to children. This code should include a provision setting a 9.00 p.m. watershed for alcohol advertising on television and radio.
53. Mature Enjoyment of Alcohol in Society Ltd (MEAS) is funded by the alcohol industry. Its stated aim is to promote the mature enjoyment of alcohol in society. The 'MEAS Code of Practice on the Naming, Packaging and Promotion of Alcoholic Drinks' requires drinks producers, distributors and licensees to ensure that alcohol is sold and promoted in a socially responsible manner and only to those of 18 years and over. All complaints within the scope of the code are decided on by an Independent Complaints Panel. The Panel's decisions are issued to the press, published on the MEAS website and included in the annual MEAS Code of Practice Report.
54. A majority of the Steering Group is in favour of stricter controls on alcohol marketing, primarily to protect children and young people. The Steering Group generally favours regulatory controls instead of codes as a means of protecting young people. A complete ban on all marketing would be the only way to ensure that children were protected. However, a legislative ban introduced in Ireland would only apply to media licensed in Ireland. It would not prevent newspapers, magazines, TV stations and radio stations from outside the State advertising on the Irish market. Engagement with EU colleagues is recommended to explore the feasibility of introducing common restrictions on alcohol advertising on a European level.

**Recommendations:**

Introduce mandatory age authentication controls on the advertising of alcohol on websites hosted in Ireland.

Investigate feasible approaches to, and subsequently implement controls on, the volume, content and placement of all alcohol marketing in digital media.

Engage with EU colleagues to explore the feasibility of introducing common restrictions on advertising on a European level.

**Recommendation:<sup>xi</sup>**

With a particular focus on impacting on the age of the onset of alcohol consumption, and the consumption levels of under-18 year olds, develop a statutory framework with respect to the volume, content, and placement of all alcohol advertising in all media in Ireland (including the advertising of pubs or clubs). This will involve the utilisation of existing legislation (such as the Broadcasting Act 2009) as well as the development of new legislation. Regard should be had to the impact of any statutory framework containing the provisions immediately below on Irish industry *vis-à-vis* firms from other jurisdictions.

At a minimum the legislation and statutory codes should provide for:

- a 9.00 p.m. watershed for alcohol advertising on television and radio;
- alcohol advertising in cinemas to only be associated with films classified as being suitable for over-18s;
- prohibition of all outdoor advertising of alcohol; and
- all alcohol advertising in the print media to be subject to stringent codes, enshrined in legislation and independently monitored.

**Promotion of alcohol to students of higher level colleges**

55. The Steering Group is concerned with the aggressive promotion of alcohol to students of many higher level colleges and institutions. The promotion of alcohol can take the form of price-based promotions or marketing of particular alcohol brands. The Steering Group deems these practices as inappropriate in education settings where large number of teenagers and young adults attend. The Steering Group considers that the implementation of Recommendation 3 of the Supply Pillar and Recommendation 2 of the Prevention Pillar (see Chapter 7) will aid these issues.

**Sport and other large event sponsorship by the alcohol industry**

56. The Code of Practice on Alcohol Marketing, Communications and Sponsorship places restrictions on alcohol sponsorship of sport. Provisions include:

- prohibiting the sponsorship of any event where 25 per cent or more of the audience is likely to be comprised of under-18s;
- prohibiting the alcohol industry from sponsoring any sporting competition, league or event in which under-18s take part;
- a ban on drinks sponsorship of any sports involving mechanically propelled vehicles, e.g. motor racing and rallying, or sports that focus on aggression, e.g. boxing or wrestling.

57. The Code of Practice states that in large venues (where the capacity is greater than 10,000 people), the total level of permanent, branded alcohol advertising cannot exceed 25 per cent of total signage available; furthermore, if such a stadium or venue were to hold an event where 25 per cent of the audience is likely to be comprised of people under the age of 18, everything possible should be done to cover all alcohol branding so that it is not visible.

---

<sup>xi</sup> The Alcohol Beverage Federation of Ireland wished it formally recorded that they disagree with this recommendation.

58. In 2008 the Department of Health and Children established a Working Group to deliver on the commitment in the Programme for Government to 'Discuss the question of the sponsorship of sporting events by the alcohol industry with a view to phasing it out'. The Group's report records the views of the national sporting organisations, the alcohol industry, and statutory and voluntary sectors. Two main views emerged: those who argued for the elimination of alcohol sponsorship of sport to protect the health of young people in particular, and those who felt that there are huge economic, social and health benefits accruing from sport and that the support provided by the alcohol industry was integral to the survival of mainstream sport.
59. The alcohol industry is also involved in the sponsorship of a number of high-profile public events such as theatrical, music and comedy events. The association of an alcohol brand with such events facilitates the advertising of the event in the media. For example, the advertising of spirits on Irish TV and radio is banned but this can be circumvented through sponsorship of events.
60. The Steering Group noted the view expressed by the WHO in 2009 that statutory regulation of commercial communications seems to be more effective than self-regulation in limiting appropriate exposure of commercial communications to children and young people.
61. Bearing in mind the financial contribution that the drinks industry makes to sport and other large events, but balancing this with the requirement to decouple the association between sports and culture with alcohol in order to protect public health, a majority of the Steering Group recommends that drinks industry sponsorship of sport and other large public events in Ireland should be phased out through legislation by 2016 and that such sponsorship should not be increased in the intervening period. The alternative proposal of the Departments of Transport, Tourism and Sport and Arts, Heritage and the Gaeltacht is that the sporting bodies should examine the issue of alcohol sponsorship with a view to securing alternative sources of sponsorship.
62. The challenge is to achieve a balance to ensure that the move away from reliance on alcohol sponsorships is managed so as not to cause unintended negative consequences to the economic, social and health benefits derived from sport and tourism in Ireland.

Recommendation<sup>xii</sup>:

Drinks industry sponsorship of sport and other large public events in Ireland should be phased out through legislation by 2016. In the intervening time, it should not be increased.

**Alcohol sponsors' names on children's sportswear**

63. The name of an alcohol sponsor appearing on sports clothes or equipment in children's sizes is deemed to be inappropriate by the Steering Group. The Group recognises the good practice of the Irish alcohol industry in this regard.

---

<sup>xii</sup> The Department of Transport, Tourism and Sport and the Department of Arts, Heritage and the Gaeltacht dissent from this recommendation.



## **DRINK DRIVING AND LOWER BLOOD ALCOHOL CONCENTRATION**

64. The Road Traffic Act 2010 reduced the BAC limit for licensed drivers to 50mg/100ml, and to 20mg/100ml for professional and learner permit holders and novice drivers in their first two years on a full driving licence. These provisions were commenced and came into effect on 28 October 2011.
65. Legislation was introduced in 2006 to permit a limited form of random breath testing – Mandatory Alcohol Testing. Since its introduction road deaths have fallen. The Steering Group acknowledges that the enforcement of Mandatory Alcohol Testing by An Garda Síochána has made a significant contribution to reducing road deaths and serious injuries; in addition, with effect from 1 June 2011, the Road Traffic Act 2011 provides for the Mandatory Alcohol Testing of drivers involved in all collisions resulting in injury.
66. The Steering Group recommends that driver rehabilitation programmes for repeat driving offenders, and those at high risk of offending, should be introduced. Alcohol ignition interlocks should be provided as a sentencing option for those convicted of repeat drink driving offences. Such sanctions have been used in the US, Canada, Australia and Sweden.

### **Recommendation:**

Introduce the following measures to further counter drink-driving:

- introduce appropriate hospital procedures to provide alcohol testing of drivers who are taken to hospital following fatal/injury collisions;
- introduce driver rehabilitation programmes for repeat drink-driving offenders and those at high risk of re-offending;
- provide for the use of alcohol ignition interlocks as a sentencing option for those convicted of repeat drink-driving offences;
- monitor and regularly publish the volume of driver alcohol testing, including mandatory alcohol testing, undertaken by An Garda Síochána on a county and national basis.

## **SOCIAL RESPONSIBILITY LEVY**

67. The Steering Group recommends the introduction of a ‘social responsibility’ levy through which the alcohol industry would contribute to the cost of social marketing, and awareness campaigns in relation to social and health harms caused by alcohol. The levy could also be used to contribute to the funding of sporting and other large public events that help provide alternatives to a drinking culture for young people.

### **Recommendation:<sup>xiii</sup>**

Introduce a ‘social responsibility’ levy on the drinks industry.<sup>xiv</sup>

<sup>xiii</sup> The Alcohol Beverage Federation of Ireland (ABFI) and Mature Enjoyment of Alcohol in Society (MEAS) wished it formally recorded that they disagree with this levy.

<sup>xiv</sup> For the purposes of the ‘social responsibility’ levy, the drinks industry may include some or all of those involved in the manufacturing, distribution and retailing of alcohol.

## CHAPTER 3 PREVENTION PILLAR

1. Individuals are primarily responsible for their own behaviour, but the State has a responsibility to foster the well-being of its citizens. While drinking alcohol is part of social life, it is an intoxicant and a drug, and the risks associated with it are well documented. There is no clear level of drinking below which alcohol-related injuries, accidents or diseases do not occur. Alcohol-related harm increases with the amount of alcohol consumed. Previous approaches to the reduction of alcohol harm have focused on particular groups such as those with alcohol dependency or young people. They have also relied on general health promotion and information campaigns, an approach still favoured with industry. However, a population approach benefits those who are not in regular contact with the health services and those who have not been specifically advised to reduce their alcohol intake. It also helps prevent people from drinking harmful or hazardous quantities of alcohol in the first place. To reduce alcohol harm the focus needs to be on low-risk drinking, and in this context a key aim of the Strategy is the promotion of healthier lifestyle choices throughout society in relation to alcohol, by:
  - delaying the initiation of alcohol use by children and young people through assisting their personal development and through the development of alternative activities for children and youth; and
  - influencing and raising awareness among the general population and specific risk groups.
2. Previous guidelines were based on what constitutes a typical or 'standard drink' and the 'units of alcohol' contained therein. UK units of alcohol were not the same as those in Ireland. In many countries including Ireland one standard drink is now considered to contain 10 grams of alcohol. The HSE's report on the standard drink in Ireland has shown the range of alcohol products available and the difficulty in determining the amount of alcohol consumed.
3. The previous low-risk drinking guidelines based on the UK units were 14 units for women and 21 units for men. However, these need to be translated into the Irish standard drinks (10 grams), with the result that the low-risk guidelines should now be 11 standard drinks for women and 17 standard drinks for men. On a weekly basis this translates to 112 grams of pure alcohol per week for women and 168 grams of pure alcohol per week for men.
4. There is also a need to develop more detailed clinical guidelines for health professionals, setting out appropriate treatment strategies.
5. In addition, the guideline values should be specified as a clear health warning label on alcohol products sold in Ireland, along with health warnings in relation to the risk of alcohol consumption in pregnancy, and the calorific content. In this regard, the Steering Group acknowledges the ongoing discussions at EU level around a common approach to including calorific content on alcohol beverage labels.

**Recommendations:**

The alcohol screening tools used by health professionals should reflect the Irish standard drink (10 grams). The low-risk weekly guidelines for women should be to consume less than 112 grams of pure alcohol per week (11 standard drinks per week) and for men to consume less than 168 grams per week (17 standard drinks per week). Develop and implement more detailed clinical guidelines for health professionals relating to the management of at-risk patients.

Labels on alcohol products sold in Ireland should include the number of grams of alcohol per container, along with calorific content and health warnings in relation to consuming alcohol in pregnancy.

6. International evidence, including the WHO review of 32 alcohol strategies and interventions, found that programmes such as education in schools and public service announcements did not have a direct positive effect on drinking patterns, and the WHO recommends that prevention programmes should form only part of a comprehensive strategy to tackle alcohol-related harm.<sup>1,32</sup>
7. Therefore a fully integrated approach is needed to promote greater social responsibility and prevention and awareness-raising. In order to effectively develop this, all elements of the statutory sector, the community and voluntary sectors and other key stakeholders need to work in partnership and to consider how they can positively influence healthier choices across society.
8. The media, in their broadest context, are considered particularly well-placed to present informed and factual information to a very wide proportion of the population. This could positively and effectively improve society's understanding and perception of alcohol use and the risks associated with alcohol-related harms.
9. In addition, there is a wide range of awareness-raising and prevention programmes in place in Ireland. However, the challenge is to ensure greater co-ordination of these activities, whether undertaken by statutory, commercial, community or voluntary organisations, with a view to maximising their impact. Prevention measures should also be tailored to the needs of specific target groups across a range of settings.
10. There is a need for a community-wide, inclusive and coordinated approach to promote greater social responsibility and prevention and awareness-raising. High levels of social capital (encompassing input from families, community engagement, volunteering, and overall positive community spirit and identity) can act as a buffer against harmful use of alcohol. Conversely, the lack of social capital in a community can act as an early warning in regard to alcohol problems and/or anti-social behaviour. Communities should be supported to develop the evidence-based skills and methodologies to implement community mobilisation programmes with a view to increasing public awareness and discussion of alcohol problems, and to build community capacity to respond to alcohol problems at a local level. This should be done within the existing networks of community development projects and services.

11. Given the concerns about Fetal Alcohol Spectrum Disorder (FASD), a comprehensive awareness campaign on a national and community level is needed to increase public knowledge regarding the risks and impacts of drinking during pregnancy and to discourage the consumption of alcohol during pregnancy.
12. Given that the internet, and digital media more broadly, is increasingly being used as a marketing tool by the drinks industry, the adoption of an evidence-based social marketing approach to alcohol prevention programmes is now considered essential. This is to be achieved by:
  - using the ‘marketing mix’ to ensure the identification of the most appropriate media for the target audience;
  - targeting particular alcohol associated problems such as underage drinking and related anti-social behaviour/ public order offences and excessive drinking more generally with its health consequences;
  - targeting specific risk groups such as pregnant women, members of the Traveller community, homeless people, members of the lesbian, gay, bi-sexual and trans-gender (LGBT) community, prisoners and sex workers;
  - channelling initiatives through education, community, health and workplace settings; and
  - using culturally sensitive methods and appropriate language.
13. The HSE, in partnership with the community and voluntary sector, hosts [www.drugs.ie](http://www.drugs.ie), the State-funded national drug and alcohol information and support website in Ireland. There is a need to significantly further develop and strengthen the position of the drugs.ie website as the national point of call for anyone seeking information and support relating to substance misuse issues.
14. Much progress has been made to achieve this shared goal through a broad range of online developments that the drugs.ie project has delivered on to date, including: redevelopment of the site to reflect current trends in web design; dedicated areas on the site for national drug/alcohol awareness campaigns; digital media support and social media initiatives dedicated to the promotion of campaigns; development of drugs.ie specific social media channels on the major social network sites; the production and delivery of over 50 online videos relating to drugs and alcohol in Ireland; development of a communications strategy including the drugs.ie eBulletin; development of content in 10 foreign languages; and the management of Ireland’s only online interactive support/chat service for drug and alcohol issues – LiveHelper.
15. Two current initiatives which will further bolster the position of the site as the national resource for drug and alcohol information and support are: (i) an extensive redevelopment of the site’s national directory of drug and alcohol services and (ii) the development of an online self-assessment tool and brief interventions for alcohol use. This will also include a version for social network websites and it will be possible to replicate this across other online channels.

16. Alcohol Action Ireland host [www.alcoholireland.ie](http://www.alcoholireland.ie) which is one of Ireland's largest independent dedicated websites for sourcing information around the provision of alcohol services in Ireland.
17. Mature Enjoyment of Alcohol in Society Limited (MEAS) is a registered charity established in 2002 by the alcohol manufacturers, distributors and licensed trade associations in Ireland as an independent not-for-profit company with no commercial remit. It operates [www.drinkaware.ie](http://www.drinkaware.ie), a social marketing initiative with the stated aim of promoting the responsible use of alcohol, while challenging anti-social drinking behaviour. A broad range of organisations support the programme, including the Gardaí, Local Authorities and the Road Safety Authority. However, the majority of the Steering Group<sup>xv</sup> is concerned about the role of MEAS in promoting responsible drinking, as MEAS is funded by the alcohol industry.

**Recommendation:**

Seek greater co-ordination of prevention activities at both national and local levels. Such activities should, where feasible, utilise Information and Communication Technology and consider a social marketing approach, to target:

- underage drinking;
- drink-related anti-social behaviour/public order offences;
- excessive drinking generally;
- those who are pregnant or likely to become pregnant; and
- other specific at-risk groups.

18. Through a co-operative effort between all stakeholders, there is scope to further develop drug and alcohol policies, whilst ensuring that the implementation and effectiveness of the policies are monitored where public funding has been provided:

**(i) Schools**

A total of 80 per cent of primary schools and 70 per cent of post-primary schools have confirmed that they have alcohol and drug policies in place (these percentages are based on returns received, so the actual figures may vary somewhat). There is a need to evaluate the quality of these policies and the degree to which they are actively implemented.

**(ii) Higher-level institutions**

All universities and institutes of technology have alcohol policies in place. Most third-level institutions run health promotion weeks which include a focus on drugs and alcohol and include events and materials that are designed to promote a healthy lifestyle. A review of the implementation of college alcohol policies and an assessment of their impact on student alcohol use, as allowed for under many college policies, should be undertaken.

**(iii) Youth organisations and services**

Much work has been done with respect to the development of alcohol and drug policies in youth settings through funding provided by the Youth Service Grant

---

<sup>xv</sup> The Department of Transport, Tourism and Sport was not part of the majority in this case.

Scheme and the Young People's Facilities and Services Fund and through the work of a range of youth work organisations.

There is a need to continue this development throughout all youth organisations within the National Quality Standards Framework for Youth Work which was launched by the Minister for Children and Youth Affairs in July 2010.

**(iv) Sport organisations**

Sporting bodies can have a significant influence on the attitudes of people, particularly children, youth and young adults, to alcohol. They can do this through the range of sporting activities that they provide, through their attitudes to alcohol and through the development of alcohol and drug policies for their organisations. While some sporting organisations, such as the GAA, have moved forward in regard to alcohol and drug policies, there is scope for much more development in this area across sporting bodies.

**(v) Community services**

As part of the framework to develop community mobilisation, community and voluntary organisations who deal with significant numbers of the population should be encouraged to develop alcohol and drug policies to cover their dealings with any aspect of alcohol use and misuse.

**(vi) Workplaces**

While many employers in both the public<sup>xvi</sup> and private sectors have alcohol and drug policies in place, the ratification of a National Alcohol Workplace Policy by IBEC and ICTU has yet to be finalised. Currently all public sector employers, and many private sector employers, operate Employee Assistance programmes designed to both identify and help employees who have problems, including alcohol-related issues. There is a need to finalise a National Alcohol Workplace Policy and to further develop programmes such as the Employee Assistance programmes.

19. In September 2011, the Health and Safety Authority published an information sheet for employers and employees on requirements relating to intoxicants at work under health and safety legislation.

**Recommendation:**

Further develop a co-ordinated approach to prevention and education interventions in relation to alcohol and drugs as a co-operative effort between all stakeholders in:

- educational institutions (including third level);
- sporting organisations;
- community services;
- youth organisations and services; and
- workplaces.

---

<sup>xvi</sup> A drugs and alcohol policy applicable to all civil servants (including prison officers) and contract staff, was put in place in 2009.

20. Parents and other family members can have a significant role, both positive and negative, in influencing drinking habits among young people. There is a need to consider the further development of prevention initiatives in relation to alcohol use and misuse in families. This can be developed at a broad level for all families through the delivery of approved parenting skills programmes and the provision of workshops aimed at educating parents and guardians on alcohol issues affecting young people. A more targeted approach aimed at families deemed more at risk would include the continued development of alcohol misuse prevention measures aimed at families through existing mechanisms such as the Home School Community Liaison Scheme and Family Resource Centres, as well as through relevant voluntary organisations. These initiatives promote encouragement and support between family members and within families, as well as peer support both between families and within families.

**Recommendation:**

Further develop prevention measures aimed at families in relation to alcohol misuse (including prevention measures in relation to parental alcohol problems and the effect of this on children):

- at a broad level for all families; and
- aimed at families deemed to be at risk.

21. There is clear evidence that early school leaving increases the risk of harmful alcohol consumption. Maximising successful school completion rates can lead to a reduction in the risk of commencing/continuing harmful alcohol use. Approaches to counter early school leaving is a central pillar of the Government's education and social inclusion policies, and the issue should be addressed through existing Department of Education and Skills (D/E&S) programmes and through the further development of youth services that focus on at-risk youth.

22. The D/E&S delivers the Social Personal Health Education (SPHE) Programme at primary (4 or 5 to 12 year olds), junior secondary level (13–15 year olds) and in Youthreach programmes. The implementation of SPHE in primary schools is supported by the Professional Development Service for Teachers which provides training, advice and support to schools. There is a dedicated SPHE Support Service for post-primary schools and Youthreach centres for education which is operated jointly with the Department of Health and the HSE. SPHE is designed to build the esteem and confidence of young people through developing their life skills. Promoting responsible attitudes to alcohol is an integral part of the curriculum. SPHE is an important component of the overall prevention effort in regard to harmful use of alcohol. The D/E&S continues to evaluate and strengthen its implementation by seeking to have schools implement the recommendations of the SPHE evaluation<sup>33</sup> in post-primary schools and Inspectors' reports on SPHE in relation to all schools.

23. Further improvements to the programme could be made by introducing national standards for SPHE teacher training and national guidelines for educational materials. There is a commitment in the Programme for Government 2011–2016 to update drug-awareness programmes in schools and, in that regard, the D/E&S has established a Working Group to examine the resource materials being used in that curriculum, especially those most relevant to substance use education. The Group has representatives from the Department of Health and the Department of Children and Youth Affairs as well as from the D/E&S and is expected to complete a report by the end of 2011. Efforts should continue to be made to integrate the SPHE message into the overall curriculum and across the whole school environment.

**Recommendation:**

Continue the development and monitoring of SPHE in schools and Youthreach centres for education through:

- implementing the recommendations of (i) Inspectors' reports in relation to all schools and Youthreach centres for education and (ii) the SPHE evaluation (NUIG 2007) in post-primary schools;
- rolling-out a senior cycle school programme; and
- introducing (i) national guidelines for educational materials and (ii) national standards for teacher training, in relation to SPHE.

24. A key theme to emerge from the public consultation meetings undertaken in the development of the National Drugs Strategy 2009–2016 was the importance of access to drug-free and alcohol-free recreational facilities in order to provide alternative outlets for young people.

25. The Department of Children and Youth Affairs (D/CYA) supports the work of youth services at a national level and works with the representative body, National Youth Council of Ireland, with a view to maximising the efficiency, effectiveness and impact of the services involved. The D/CYA has developed protocols for alcohol-free and drug-free youth café development and is providing a total of €1.5m for small-scale refurbishment/enhancement of existing cafés. These facilities should provide for weekend and late night opening where appropriate. The youth involved should be actively engaged in the development and management of the programmes and venues. Activities should seek to be inclusive, culturally sensitive and multi-lingual where appropriate.

26. Youth organisations afford an opportunity to promote alcohol-awareness and prevention messages and peer-led approaches that empower young people with the knowledge and confidence to make informed decisions about their behaviour in relation to alcohol use.

27. International evidence suggests that, while diversion activities provided by youth organisations may have a role to play in preventing substance misuse, there is a need to have further complementary structured programmes of supports. These should include the development of brief intervention programmes – along the lines of Applied Suicide Intervention Skills Training (ASIST) – and referral to other services. In this context there is a need for



education, community and prevention services to improve links with other services with a view to identifying appropriate referral routes.

28. It is important that alcohol and other drug issues remain central to the ongoing development of services for youth at risk. Services should target the needs of specific risk groups, e.g. Traveller youth and new communities. Since 2001 the Young Person's Facilities and Services Fund (YPF SF) has been a key mechanism for developing youth facilities for young persons at risk of alcohol and other substance misuse. A number of key issues need to continue to be developed and pursued in this context, including:
- increased access to school facilities in out-of-school hours;
  - guaranteed access to these facilities for the most at-risk young people;
  - ensuring that appropriate supervision and support is in place; and
  - weekend and late night access.

**Recommendation:**

Encourage the provision of alcohol-free venues for young people, with an emphasis on those most at risk (e.g. Youth cafés, alcohol-free music and dance venues and sports venues) with:

- the young people being centrally involved in the development and management of the programmes and venues;
- late night and weekend opening; and
- increased access to school facilities in out-of-school hours.

29. Other schemes aimed at youth at risk include the Special Projects for Youth (SPY), the Garda Juvenile Diversion Programme and the Garda Youth Diversion Projects. These programmes have an important role to play in the area of alcohol prevention. A brief interventions approach, with referral to specialist services where required, should be incorporated into all the above programmes.

**Recommendation:**

Develop and incorporate a drugs/alcohol intervention programme, with referral to specialist services where required, into schemes aimed at youth at risk, including the Special Projects for Youth (SPY), the Garda Juvenile Diversion Programme and the Garda Youth Diversion Projects.

## CHAPTER 4 TREATMENT AND REHABILITATION PILLAR

In developing this chapter, the Steering Group was aware that the Treatment and Rehabilitation Chapter of the National Drugs Strategy 2009–2016 was written in the knowledge of the proposed combining of strategies in relation to drugs and alcohol. Consequently, recommendations are largely in line with those contained in the National Drugs Strategy.

The Steering Group considers that the 4-tiered model approach adopted in relation to drugs should also be utilised in relation to alcohol.

### Strategic aim

To develop a national recovery-based treatment and rehabilitation service built on quality standards which actively promotes and encourages early intervention to accessible services within the 4-tiered model approach based on integrated care pathways.

### Implementation

1. The Steering Group is recommending the development of a clinical and organisational governance framework for all alcohol treatment and rehabilitation services in line with the HSE Report of the Working Group Examining Quality and Standards for Addiction Services (2009), and subject to a timeframe for compliance.
2. In order to implement a governance framework the Steering Group is recommending the establishment of a Directorate team with responsibility for building the necessary infrastructure for the implementation of the strategic aim to improve access to interventions and treatment for clients with alcohol/substance use disorders.
3. The Directorate will take cognisance of the fact that the specific needs of service users are accommodated in various settings that may not be fully integrated. Treatment interventions should be tailored to the varying needs of individuals including the potential for access to substance-specific treatment and services.

### Quality standards, clinical governance and training

4. There is a need to develop a clinical and organisational governance framework for all treatment and rehabilitation services in line with the Report of the Working Group Examining Quality and Standards for Addiction Services (2008), which has been adopted by the HSE. As part of this, regulatory standards for all substance misuse services dealing with alcohol should also be put in place and implemented.
5. There is a need to coordinate training provision within a single national substance misuse framework, e.g. the HSE National Addiction Training Programme (NATP). This will encompass the development, or further development, of national training standards for all staff (statutory, voluntary and community) involved in the provision of substance misuse treatment and rehabilitation services. Training would include:

- a specific tailored module on screening and brief interventions on alcohol for different service providers at undergraduate, graduate, postgraduate and in-service levels;
- the ongoing provision of training in key working, care planning and case management to support all service providers. Other training needs to meet current and emerging demands in the alcohol/substance misuse services should be provided according to available resources; and
- the on-going up-skilling of service providers as necessary to enable them to deal effectively with families (including specifically with children where this arises) who are trying to cope with a family member's alcohol use.

A regulatory framework on a statutory basis for the provision of counselling in substance misuse services should be developed, as has already been recommended in the National Drugs Strategy.

**Recommendation:**

Establish a Clinical Directorate to develop the clinical and organisational governance framework that will underpin treatment and rehabilitation services. The Directorate will also build the necessary infrastructure required to improve access to appropriate interventions and treatment and rehabilitation services for clients with alcohol/substance use disorders.

**Recommendation:**

The Directorate should co-ordinate the provision of training within a single national substance misuse framework, i.e. National Addiction Training Programme.

**Treatment and rehabilitation services**

6. Treatment for alcohol problems has traditionally focused on individuals with moderate to severe alcohol dependence. It is now recognised that this exclusive focus needs to be broadened to include the large group of drinkers whose problems are less severe. Brief interventions are effective for many. They should be carried out in general community settings and delivered by non-specialist, trained personnel and are associated with good outcomes and cost-effectiveness.
7. For people with moderate to severe alcohol dependency more intensive, alcohol-focused treatment in specialist alcohol/addiction services is most appropriate. Effective treatment for this client group requires availability and accessibility of tier 3 and tier 4 services, staffed by accredited therapists who deliver evidence-based, outcome-oriented interventions to meet varying needs.
8. Arising from the recommendations of the Report of the Working Group on Drugs Rehabilitation (2007), the National Drugs Rehabilitation Implementation Committee has agreed a National Rehabilitation Framework Document which outlines 'a framework through which service providers will ensure that individuals affected by drug misuse are offered a range of integrated options tailored to meet their needs and create for them an individual rehabilitation pathway'. The Framework Document places the provision of rehabilitative support within the 4-tier model where service delivery can be achieved through

cross- and intra-sector collaboration within the HSE and between other statutory sectors in partnership with the community and voluntary sectors. The Steering Group endorses this approach.

### **Screening and brief interventions (SBI): tier 1 and tier 2**

9. The 2007–2012 Programme for Government indicated an intention to: ‘Provide early intervention programmes in all social, health and justice services to ensure early detection and appropriate responses to high risk drinking’. The Steering Group fully supports this approach.
10. Screening should facilitate identification of people with hazardous and harmful alcohol use who require brief, time-limited interventions, and identify those people who need to be referred for more comprehensive assessment.
11. Where screening has identified a person as drinking at hazardous and harmful levels, opportunistic brief interventions should be offered, particularly in cases where the person has not already sought treatment or assistance. These interventions aim to inform people that they are drinking at levels that increase their likelihood of developing a dependence disorder, and to encourage and support them to decrease consumption to low-risk levels.
12. The establishment of evidence-based national screening and brief intervention protocols in tier 1 and tier 2 services is recommended. The protocol will encompass (i) screening, (ii) initial assessment, (iii) referral pathways to tiers 3 and 4 as appropriate and the development of the necessary resources as part of a tool kit. In order to examine the effectiveness of such protocols it is suggested that they be rolled-out as part of their normal work practice in primary care and in emergency departments, maternity services and general hospital services. These interventions will be supported through an appropriate implementation plan and training programme to be rolled-out nationally in 2012–2013 based on the National Guideline for the Education and Training of Nurses (2011). This will commence with training of nurses in the first instance and thereafter should be extended to all tier 1 and tier 2 community, voluntary, health, social and criminal justice settings such as:
  - health clinics and community-based health services;
  - community and voluntary services;
  - mental health services;
  - educational, criminal justice and other community-based initiatives;
  - youth and sports organisations;
  - later life services.

The Steering Group takes cognisance of the learning that will emanate from the evaluation of the 10 pilot areas within the National Drugs Rehabilitation Framework pilot settings, which will incorporate screening tools.

13. While the HSE would be key to the implementation of such interventions, almost all sectors would have a role in ensuring their delivery, including the Irish College of General Practitioners, the Royal College of Physicians in Ireland, the College of Psychiatry of Ireland, primary care, the voluntary and community sectors, An Garda Síochána and the Irish Prison Service.

14. Considering that 1.5 million people have a harmful drinking pattern, the Directorate will work with relevant sectors to build capacity, establish delivery arrangements and develop information systems to track the implementation of the screening and brief interventions (SBIs) and should identify specific targets for (a) training of service providers in SBI and (b) delivery of specific SBI targets according to population areas. The aim of training is to encourage health and social services staff to implement SBIs as part of their normal work practice.

**Recommendation:**

Develop early intervention guidelines for alcohol and substance use across all relevant sectors of the health and social care system. This will include a national screening and brief intervention protocol for early identification of problem alcohol use.

**Maternity services**

15. Prenatal alcohol exposure can affect the foetus in a number of ways through the occurrence of a wide range of disorders classified under the umbrella term Fetal Alcohol Spectrum Disorder (FASD). The most serious effects are the intellectual disabilities associated with the adverse impact of alcohol on fetal brain development and the central nervous system. Damage to the brain is often, though not always, accompanied by distinctive facial deformities, physical and emotional developmental problems, memory and attention deficits, and a variety of cognitive and behavioural problems. There is currently no diagnosis or assessment of children born with FASD which are estimated to prevail in 1.3 per cent of Ireland's population ([www.fasd.ie](http://www.fasd.ie)).
16. The results of a Coombe Hospital study (1988–2005) reported that 63 per cent of women consumed alcohol during pregnancy.<sup>34</sup> It is estimated that at least 4,500 children each year are at risk from maternal alcohol use. Health professionals in the maternity hospital setting are ideally placed to screen patients for their alcohol use and to convey clear messages through a brief conversation about the risks of the use of alcohol during pregnancy and to offer, as appropriate, help and a referral pathway in reducing alcohol consumption.
17. The impact of prenatal alcohol exposure is far-reaching and transgenerational but largely under-diagnosed. Under-recognition and under-reporting of FASD is an issue worldwide, but particularly in Ireland where, despite specific dysmorphic features, the rarest but most easily ascertained of the conditions, FASD is likely to be under-diagnosed.<sup>35</sup> Furthermore, FASDs are not reportable conditions in Ireland.
18. It is essential to raise awareness of the risks of drinking during pregnancy (Recommendation 1 of Prevention Pillar; see Chapter 7) in all tier 1 and tier 2 settings, particularly in primary care, so that hazardous or harmful drinking can be identified, allowing for change. Screening for alcohol consumption should begin at the first antenatal visit for all pregnant women and be reviewed throughout the pregnancy.
19. Pregnant women who are alcohol dependent should be prioritised for immediate access to tier 3 and tier 4 services.

Recommendations:

Policies and clinical protocols should be implemented in all healthcare settings to prevent, assess and respond to issues arising in relation to pregnant women affected by alcohol use.

Strengthen FASD surveillance in maternity hospitals through the Eurocat reporting system and promote greater awareness amongst healthcare professionals of FASD so as to improve the diagnosis and management of children born with FASD.

**Specialist treatment: tier 3 and tier 4 interventions**

20. The National Drugs Strategy highlighted the need to prioritise the further development of tier 3 and tier 4 services in order to deliver a comprehensive treatment and rehabilitation service. While it acknowledges the financial constraints pertaining, it saw this objective as being achievable over the lifetime of the Strategy up to 2016. It was also envisaged that particular opportunities in this regard might arise through the restructuring of the HSE and the reconfiguration of the mental health services.
21. While the HSE is key to the implementation of tier 3 and tier 4 specialist services, the voluntary and community sectors, the Irish College of General Practitioners, the Royal College of Physicians in Ireland, and the College of Psychiatry of Ireland also have key roles in their delivery.
22. The choice of interventions to address a client's alcohol dependency includes the following: cognitive behavioural interventions, community reinforcement approach, coping and social skills training, pharmacotherapies when combined with psychosocial therapies, detoxification, relapse prevention, neuro-psychological assessment and self-help groups. These can be provided in the community or in residential settings, with the latter considered a more effective option for people who need structured, long-term support, particularly those with moderate to severe dependence and limited social supports.
23. There is a need to develop and broaden the range of evidence-based psychosocial interventions providing specialised addiction counselling, addressing the person's psychological, emotional, behavioural and personal/family issues based on SMART (Specific, Measurable, Attainable, Realistic, Time-bound) objectives. The provision of such interventions should be based on a comprehensive needs assessment.
24. The specialist assessment and management of individuals presenting with alcohol use disorders may require interagency care planning and case management, depending on the severity and complexity of dependence. Thus a comprehensive care plan with integrated care pathways, and appropriate communication and joined-up planning between the agencies providing the services, is essential. A fully integrated approach is vital to ensure outcome-based treatment.
25. Access to residential services should be made available on the basis of need rather than on the basis of geographic location and/or an ability to pay for services. This will mean that tier 4 providers should become national providers

of residential treatment services rather than catchment-based services and that these providers should be contracted by the HSE through a national service level arrangement (NSLA). The HSE would take responsibility for the allocation and monitoring of all State funding under this NSLA. There are particular gaps within the South, West, Midlands and the border counties.

**Recommendations:**

Develop regulatory standards for all tier 3 and tier 4 services with regard to substance misuse.

Develop and broaden the range of evidence-based psychosocial interventions in tier 3 and tier 4 services.

**Recommendation:**

Collate and publicise information on alcohol treatment and rehabilitation services.

**Aftercare**

26. Ongoing support and assistance is essential following a phase of treatment to sustain gains achieved during treatment and to lessen the potential for relapse. Aftercare services will vary in proportion to needs, but can include planned interactions to (i) provide the client with a supportive network; (ii) help the person to access the internal resources needed (such as resilience, coping skills and physical health) to help maintain abstinence; (iii) ensure referral and links to a range of external services and supports; (iv) help the individual to negotiate challenges. Aftercare can be provided in a number of settings. For example, individuals may be referred to self-help programmes or other local community support programmes. Virtually all residential rehabilitation providers have aftercare services. There is also potential for primary care staff to provide this function through ongoing follow-up as part of addressing other health-related issues.

27. Step-down or half-way house care may be required as a follow-on from residential treatment. These facilities address the ongoing rehabilitation needs of the client and provide extended care while ongoing training, education, accommodation and welfare needs are addressed.

**Adolescent services**

28. In light of the evidence of increases in harmful use of alcohol and related problems among under-18s, there is a need to ensure that adequate and appropriate treatment services are made available. Within this cohort, there may be an opportunity to intervene in the early stages of problem substance use. In many cases there will also be underlying personal problems that need to be addressed. In such instances, early intervention is a critical and effective factor in minimising the risk of the development of more severe problem substance use.

29. There is a need to develop alcohol and drugs treatment and rehabilitation services at a national level for people under 18 years of age who are experiencing substance misuse problems.

**Recommendation:**

Using the recommendations of the *Report of the Working Group on Treatment of Under-18 year olds presenting to Treatment Services with Serious Drug Problems (2005)* as a template:

- identify and address gaps in child and adolescent service provision;
- develop multi-disciplinary child and adolescent teams; and
- develop better interagency co-operation between addiction and child and family services.

**Alcohol withdrawal and detoxification**

30. A national protocol on alcohol detoxification should be established. The expansion of nurse prescribing in alcohol detoxification to enable nurses to prescribe for alcohol withdrawals is seen as a necessary action to facilitate this.
31. A key component of a tier 3 service is the availability of community detox for those clients assessed with severe and complex alcohol dependency problems. The development of multidisciplinary primary care teams and mental health teams is essential to support this.
32. A certain number of dedicated detox beds particularly for at-risk groups should be provided. The HSE Working Group on Residential Rehabilitation recommends that where inpatient detoxification is required, it should be, as a rule, provided in dedicated units. The use of general hospital or psychiatric beds for detoxification should be the exception since the evidence base indicates better outcomes from specialist units.<sup>36</sup> However, in some areas, a pragmatic approach may be to locate these detox beds in general hospitals for the purposes of detox where a patient is at serious risk of delirium tremens. There are significant gaps in the provision of specialised in-patient detoxification units across the country.
33. A clinical audit of existing voluntary detox services is required. A successful audit will determine approved services for HSE service level agreements.

**Recommendation:**

Develop a specialist detoxification service that:

- promotes the expansion of nurse prescribing in alcohol detoxification;
- provides clinical detox in-patient beds for clients with complex needs; and
- provides community detox for those with alcohol dependency problems.

**Chronic illness and alcohol-related brain injury (ARBI)**

34. The contribution of alcohol to chronic illnesses is well documented. This should be considered in the development of strategies for chronic disease where alcohol is known to be a contributory factor. Individuals with chronic illnesses linked to alcohol dependency should, as part of their care plan, be facilitated to access treatment for their alcohol dependency by medical staff. The development of comprehensive care plans around the treatment of alcohol misuse should be done in conjunction with treatment of the chronic illness. This treatment plan requires a case management approach.



35. It is recommended that acute hospital provision with specialist 'addiction' support will be needed for those with complex needs, e.g. pregnancy, hepatitis, liver disease and HIV (NHS Health Advisory Service: 4-tier model of care) or if there is an acute medical problem.
36. Alcohol-related brain injury (ARBI) is a term used to describe the physical impairment to the brain sustained as a result of alcohol consumption. Having ARBI is not the same as having an intellectual disability, nor is it the same as having dementia. A number of conditions may be associated with ARBI. A report commissioned by the North West Alcohol Forum<sup>37</sup> defined them as follows:
- peripheral neuropathy – this leads to reduced sensation in feet and legs (and sometimes the hands);
  - hepatic encephalopathy – severe alcohol-related liver disease can cause an acute disturbance of brain function, with confusion initially, but may develop to coma;
  - frontal lobe dysfunction – this part of the brain is important for planning and organising, judgement, problem-solving, flexible thinking and behaving in socially appropriate ways;
  - Korsakoff's amnesic syndrome (also called Korsakoff's psychosis);
  - Wernicke's encephalopathy.
37. There is a need to ensure that appropriate training and education is available to those professionals working in primary, community and acute settings in the management of alcohol dependency to ensure the prevention of ARBI and other chronic related illnesses.

**Recommendations:**

Alcohol liaison nurses should be assigned to all general hospitals for the purpose of coordinating care planning and/or screening and brief interventions for patients with alcohol-related disorders/illnesses.

Develop care pathways and models of best practice for the management of ARBI.

**Mental health**

38. Mental health problems which coexist with alcohol misuse can have a significant impact on the treatment and long-term outcome of the alcohol-related problem. However, depression and anxiety can often develop as a consequence of alcohol misuse. At assessment there is no reliable way of determining whether a coexisting mental health problem is primary or secondary to alcohol misuse. This means that symptoms of coexisting mental disorders need to be monitored throughout the course of assessment and treatment. A common presentation in alcohol misuse is suicidal ideation. This needs to be assessed and actively managed as part of an overall risk management process through for example the UK's National Institute for Health & Clinical Excellence (NICE) guidelines (2011) for assessment of alcohol misuse and coexisting mental health disorders.

39. For patients presenting with co-morbid conditions, the interface between the mental health service and the drug and alcohol treatment and rehabilitation services requires clarity. The overall objective is to ensure an integrated approach to treatment and to ensure that patients are treated in the most appropriate setting.
40. Medically managed in-patient detox residential treatment settings are required (similar to Cuan Dara), capable of providing treatment to patients with complex needs. However, patients with a severe, acute mental illness co-morbid with a complex or severe substance misuse problem are best managed in an acute psychiatric unit in a psychiatric hospital. Where such patients have a co-morbid diagnosis, then staff with addiction expertise from the local tier 3 or tier 4 addiction service should in-reach to that unit and be actively involved in the patients' care plan, addressing their addiction needs.
41. The responsibility of the community mental health service is to respond to the needs of people with both problems of addiction and mental health disorders. The mental health strategy, *A Vision for Change* (2006), recognises that the majority of individuals with co-morbid conditions should be managed by their local community mental health team (CMHT). Recommendation 15.3.1 of that strategy outlines that mental health services for both adults and children are responsible for providing a mental health service to those individuals who have co-morbid substance abuse and mental health problems.

**Recommendations:**

Develop joint protocols between mental health services and drug and alcohol services with the objective of integrating care planning to improve the outcomes for people with co-morbid, severe mental illness and substance misuse problems.

Establish a forum of stakeholders to progress the recommendations in *A Vision for Change* in relation to establishing clear linkages between the addiction services, primary care services, community mental health teams and specialist mental health teams to facilitate the required development of an integrated approach to service development, including:

- developing detoxification services;
- ensuring availability of, and access to, community-based appropriate treatment and rehabilitation services through the development of care pathways; and
- ensuring access to community mental health teams where there is a coexisting mental health condition.

**Family services**

42. Family support is an umbrella term covering a wide range of interventions. Families and other significant persons are integral to the treatment and rehabilitation of those affected by substance misuse. The Steering Group supports the recommendations pertaining to families in the *Report of the Working Group on Drugs Rehabilitation (2007)*, as they see the recommendations as being applicable to alcohol also. The recommendations in question refer to the active encouragement of family participation in the

rehabilitation process, training of service providers in this regard, informing family members to enable them to better participate in the recovery effort and generally tapping into the potential of families to aid the recovery process. The Family Support Policy within the Quality Standards in Alcohol and Drugs Services (QuADS) framework supports the emphasis on family involvement in the recovery process.

43. There is a need to ensure that evaluation is part of all family support interventions, based on key outcome indicators to show effectiveness of enhanced family and child well-being, with programmes targeted towards measurable change outcomes and recommended, as appropriate, for adoption through the tier system and all Regional Drugs Task Force (RDTF) and Local Drugs Task Force (LDTF) areas.
44. The continued development of coherent interagency working between treatment, rehabilitation, social, family and childcare services is required to address the needs of families facing alcohol dependency problems. A whole-family approach which includes the provision of supports and services directly to children where necessary is essential.
45. Early intervention with families is an important step in reducing the impacts of harmful drinking of a family member. It is necessary, therefore, to put in place referral procedures to appropriate services for the families involved. There is a need to develop improved interagency working in this regard, specifically through the development of joint local protocols between addiction services and child and family services. This approach will involve development of coherent and effective interagency working between treatment, rehabilitation, social, family and childcare services and will encompass a whole-family approach, including the provision of supports and services directly to children where necessary. Staff training that promotes understanding of the needs of children and families affected by substance misuse, and of the development of skills in joint working (including interagency of protocols) between addiction and child and family services will support this.
46. Self-help, e.g. Al-Anon, Al-Ateen and peer-led family support groups, provide increased value to families coping with addiction, by sharing experiences and supporting each other. Guidelines such as the Family Support Network's Good Practice Guidelines for Peer-Led Family Support Groups are essential supports to enable groups to evolve, evaluate their work, and share ideas and learning.
47. Family skills training programmes such as the Strengthening Families Programme currently implemented by the LDTFs and RDTFs, Le Chéile Young Persons Programme, Probation Service, and community and voluntary organisations help parents and young people to build new, healthy parent/child communication skills that develop positive relationships within families and address family behaviour management. Such programmes should be encouraged.
48. Further policy integration needs to be built between key family support service providers such as the HSE, the D/CYA, An Garda Síochána, the Irish Youth

Justice Service, the Probation Service, the Family Support Network and voluntary and community services.

49. A pilot short-stay respite programme for families of problem drinkers should be developed. Subsequent expansion of the initiative will depend on the evaluation of the pilot in line with recommendations under Section 4.20 of the *Report of the Working Group on Drugs Rehabilitation (2007)*.

### **Children affected by parental drinking**

50. Alcohol problems can result in serious negative effects on the health, development and welfare of families. Living with one or more problem drinkers causes particular problems for children and it is vital that supports and services are available to them. A NACD Report, *A Family Affair? Supporting Children Impacted by Parental Substance Misuse (2011)*, addresses future research and data needs including how existing data sources could assist in ascertaining the number of children with substance misusing parents.
51. In some cases children are being cared for by guardians who are often family members. Calls have been made by the Family Support Network for the establishment of an expert working group to examine and resolve difficulties being experienced by guardians in accessing support and services.
52. There is also a need for the greater development, promotion and awareness-raising of available child-friendly supports for children living with family alcohol/substance use problems, including age appropriate educational materials.

### **Children First Guidelines**

53. It will be necessary to ensure that all staff in all services fulfil their responsibilities as outlined in the Children First Guidelines, with appropriate arrangements for referral to social, family and childcare service providers. The D/CYA will have a key role to play in this area. Training is required to ensure a coherent approach across the sectors.

#### **Recommendations:**

Develop a comprehensive outcome and evidence-based approach to addressing the needs of children and families experiencing alcohol dependency problems. This would include a whole-family approach, including the provision of supports and services directly to children where necessary. This approach should be guided by, and coordinated with, all existing strategies relating to parenting, children and families and in accordance with edicts from the Minister for Children and Youth Affairs and the Family Support Agency.

Explore the extent of parental problem substance use through the development of a strategy, along the lines of the Hidden Harm Report in Northern Ireland, and respond to the needs of children of problem substance users by bringing together all concerned organisations and services. This could be developed through links with Cooperation and Working Together (CAWT) for health gain and social well-being in border areas.

Develop family support services, including:

- training of service providers in dealing with families of service users and

- encouraging family participation;
- access to information about addiction and the recovery process for family members;
- peer-led family support groups to assist families to cope with problematic drinking;
- evidence-based family and parenting skills programmes;
- the reconciliation of problem drinkers with estranged family members where possible; and
- the development of a short-stay respite programme for families of problem drinkers.

### **Probation and prison settings**

54. Alcohol is a significant criminogenic factor in offending behaviour. The Probation Service responds to this through its Alcohol and Offending Programme, involving HSE and community and voluntary addiction staff, and currently operating in two areas. The Steering Group recommends the expansion of this type of alcohol intervention programme, incorporating a treatment referral option, for those who come to the attention of An Garda Síochána and the Probation Service due to behaviour caused by harmful use of alcohol. This programme is aimed at the reduction of alcohol re-offending among individuals arrested for alcohol-related crime.
55. Continue the expansion of treatment and rehabilitation services in prisons to include treatment for prisoners who have alcohol dependency. Develop protocols for the seamless provision of treatment and rehabilitation services for people with alcohol problems as they move between prison and the community.

#### **Recommendations:**

Develop a drugs/alcohol intervention programme, incorporating a treatment referral option, for people (primarily youth and young adults) who come to the attention of An Garda Síochána and the Probation Service, due to behaviour caused by substance misuse.

Continue the expansion of treatment and rehabilitation services in prisons to include treatment for prisoners who have alcohol dependency. Develop protocols for the seamless provision of treatment and rehabilitation services for people with alcohol problems as they move between prison and the community.

### **Services for specific groups**

56. Particular focus needs to be put on addressing the treatment and rehabilitation needs of a number of specific groups: members of the Traveller community; members of the lesbian, gay, bisexual and trans-gender community; homeless people; new communities; and sex workers. This should be facilitated by engagement with representatives of these groups. In this regard, the Steering Group acknowledges the progress being made by the HSE, including through its Intercultural Health Strategy (2008). Approaches identified in the National Homeless Strategy with respect to homeless people, and in the National Drugs

Strategy 2009-16 with respect to prisoners and sex-workers, are also endorsed by the Steering Group.

57. There are nine Regional Homeless Forums which are at various stages of developing and implementing regional homeless action plans. These action plans are in line with the Government's Programme for Recovery which emphasises a housing first approach to homelessness. This requires not only a housing intervention but an integrated approach to support individuals in implementing an agreed care/support plan which often includes addiction. The synergy from a policy and operational perspective that the Forums have with alcohol and substance misuse services is essential.

**Recommendations:**

Address the treatment and rehabilitation needs of the following specified groups in relation to the use of alcohol: members of the Traveller community; members of the lesbian, gay, bisexual and trans-gender community; new communities; and sex workers. This should be facilitated by engagement with representatives of these communities and/or services with working with the communities, as appropriate.

Implement the actions, by the appropriate agencies, in the Homeless Strategy: National Implementation Plan (DEHLG, 2008).

## CHAPTER 5 RESEARCH AND INFORMATION PILLAR

1. In its communication on reducing alcohol-related harm to the European Parliament in 2006, the EU Commission identified the need to develop, support and maintain a common alcohol evidence base across Europe by obtaining comparable data on alcohol consumption, on the social, health and economic impacts of alcohol and on the effectiveness of alcohol policy measures. The 1996 National Alcohol Policy and the 2004 Strategic Task Force on Alcohol recommended the establishment of an independent research and monitoring unit. It was envisaged that this would extend knowledge and build capacity in alcohol research by examining drinking patterns, alcohol-related harm, the effectiveness of alcohol policy measures and other relevant areas. The National Drugs Strategy 2009–2016 identified the need for the Department of Health and Children to consider the development of appropriate harmful alcohol use indicators and associated data collection mechanisms. It also recommended the putting in place of a unique person identifier to facilitate the development of reporting systems.
2. The strategic objective with respect to research and information is:

to ensure the availability of valid, timely and comparable data on alcohol use and its related outcomes to inform policy development and service delivery to address issues pertaining to alcohol use.

3. This will be addressed by
  - developing, implementing and maintaining monitoring systems at different levels that provide valid, timely and comparable data on alcohol consumption, alcohol-related consequences and the effects of responses to alcohol-related harm;
  - strengthening the knowledge base on the extent of alcohol use and alcohol-related harm in Ireland, and on effective interventions to treat, reduce and prevent harm; and
  - securing effective dissemination and appropriate application of the information.

### Recommendation:

Continue to implement and develop, as appropriate, epidemiological indicators and the associated data collection systems, to identify:

- prevalence and patterns of alcohol use and misuse among the general population;
- prevalence and patterns of alcohol use among specific sub-groups;
- demand for alcohol treatment;
- alcohol-related deaths and mortality of alcohol users;
- public expenditure; and
- harm reduction.

### **Prevalence and patterns of alcohol use and misuse among the general population**

4. Per capita consumption of alcohol is calculated on an annual basis, using data from the Revenue Commissioners. A number of surveys collect data on the patterns of alcohol use in the general population. For adults these include the survey of lifestyle, attitudes and nutrition in Ireland, SLÁN (a national survey carried out by the Department of Health of the lifestyle, attitudes and nutrition of people living in Ireland) The most recent SLÁN survey was carried out in 2007, and includes questions on alcohol and the use of licit and illicit drugs. The NACD all-island Drug Prevalence Surveys (2002–2003, 2006–2007 and the 2010–2011 iteration which is currently being carried out) also includes more in-depth alcohol questions. Child alcohol consumption is reported in the Health Behaviour in School Children Survey (HBSC – children aged 11 to 17) and in the European School Survey Project of Alcohol and Drugs (ESPAD – children in their 16th year) a survey carried out every four years across 40 European countries.
5. Per capita consumption will continue to be calculated on an annual basis, using data from the Revenue Commissioners. Patterns of consumption should continue to be measured through the above surveys on a regular basis. Consideration should be given to undertaking a further survey specifically on alcohol. The aim would be to have more detail on attitudes to alcohol, quantity and patterns of consumption and health and social outcomes both to the drinker and to people other than the drinker.

### **Prevalence and patterns of alcohol use and misuse among specific sub-groups**

6. While surveys have been conducted on college students, the homeless, members of the Traveller community and pregnant women in recent years, data on these sub-groups are not collected on a regular basis. Periodic monitoring of alcohol use in specific at-risk populations should be carried out.

### **Attitudes to alcohol**

7. Research into alcohol-related attitudes and behaviours across the population, and within specific groups, would be worthwhile. This might include young people, pregnant women, older people and other more specific sub-groups within Irish society (e.g. foreign nationals, Travellers, and homeless people).

### **Alcohol-related deaths**

8. The Central Statistics Office (CSO) records all deaths in Ireland and this information can be used to identify deaths where alcohol is noted as the cause. The National Drug-Related Deaths Index (NDRDI) collects data on alcohol-related deaths or those who were alcohol dependent and died from a medical consequence of alcohol. Its sources include the Coroner Service, the Hospital In-Patient Enquiry (HIPE) system, the National Drug Treatment Reporting System (NDTRS) and the General Mortality Register. These databases should be further developed to include information on deaths partially caused by alcohol.



### **Alcohol-related health consequences**

9. Hospitalisations in general hospitals due to alcohol are collected by the Hospital In-Patient Enquiry (HIPE) system. However, this system does not collect data on alcohol-related Emergency Department presentations, or on hospitalisations where alcohol is partially, but not entirely, the cause. HIPE should be further developed not only to collect data on diseases fully caused by alcohol, but to measure the number of hospitalisations due to diseases and injuries where alcohol is partially the cause. Data collection systems in Emergency Departments need to be further developed to record information on alcohol.

### **Alcohol-related social consequences**

10. The Health Research Board (HRB) Report on the consequences of alcohol use utilised existing data sources to examine the social consequences of alcohol use which include the relationship between alcohol use and the family, and the impact of alcohol use on education, employment and crime. These areas need to be monitored regularly and consideration should be given to the further development of national surveys, such as the CSO's Crime and Victimisation Surveys, to achieve this. The Garda PULSE system should be used to monitor public order offences associated with alcohol.
11. Currently no Irish data are available on children whose health, welfare and development are affected by a parent's harmful alcohol or drug use. There is a particular need for a comprehensive examination of the extent and impact of parental alcohol problems on child welfare. *Counting Our Children (2004)* identified children with parents who drink heavily as a gap in our knowledge about Irish childhoods. It identified the SLÁN survey as an opportunity to count children living with parents who report harmful drinking patterns. The Interim Childcare Dataset as currently structured does not attempt to capture the prevalence of parental alcohol problems in child welfare/ child protection referrals and reports.

### **Demand for treatment and rehabilitation**

12. Hospitalisations in psychiatric hospitals due to alcohol are collected by the National Psychiatric Inpatient Reporting System (NPIRS). This should be further developed to measure the number of hospitalisations due to psychiatric diseases where alcohol is partially the cause.
13. The National Drug Treatment Reporting System (NDTRS) is a database on the treatment of alcohol misuse in Ireland. It collects data from outpatient services (including alcohol treatment centres and some psychiatric services) and from inpatient specialised residential centres (for the treatment of addictions). Coverage should be extended to all treatment centres.
14. With respect to activities being undertaken in primary care settings, and given the future focus on developing a Brief Interventions approach, there is a need to put data systems in place to capture the current situation and to monitor progress through future developments. Data requirements and data development should be considered further as the programmes are developed.

15. All health databases collecting information on alcohol should be client-based. Central to this is the introduction of a unique identifier for clients to facilitate the movement from a case-based reporting system to an outcome-orientated monitoring of the progression of individuals, while respecting the privacy rights of the individuals concerned.

### **Alcohol and the economy**

16. A fuller understanding of the economic impact of the alcohol industry in Ireland should be developed through the regular analysis of existing data sources, and through the development of additional data sets where gaps are identified. Issues such as the size of the market (covering levels of employment, levels of taxation, export income, number, type and location of liquor licences, pricing practices, type and range of alcoholic beverages on sale), changes in the market (e.g. changes in the proportion of sales through the on-trade and the off-trade, prevalence of low alcohol beers, new types of drinks), the impact of cross-border sales and marketing practices should be reviewed.
17. An estimate of the level of public expenditure on the direct and indirect consequences of alcohol use is essential to enhance our understanding of the impact of alcohol in society. Initially an estimate based on health-related and justice-related expenditure, and readily identifiable expenditures in other Departments/State agencies, should be considered. Research into the financial costs in the workplace arising from alcohol use should be considered.
18. There is strong international evidence that, among young people, marketing of alcohol encourages the onset of drinking among non-drinkers and increases levels of consumption among existing drinkers. Further research on the impact of marketing on Irish adolescents (including the impact of voluntary or statutory codes where relevant) would be worthwhile as an aid to policy development.

### **Evaluating progress under the National Substance Misuse Strategy**

19. It is important to evaluate the impact of alcohol policy and other measures recommended in this strategy through:
- establishing criteria for all alcohol-funded initiatives against which effectiveness can be evaluated;
  - evaluating the effectiveness of the alcohol initiatives implemented, within the supply, prevention, treatment and rehabilitation pillars, selecting a number of initiatives for evaluation each year

**Recommendation:**

Develop and prioritise a research programme, revised on an annual basis, to examine the economic, social and health consequences of alcohol and the impact of alcohol policy measures.

### **National and international collaboration**

20. There is a need to:

- have a complete collection of existing publications on the alcohol situation in Ireland, and the responses thereto;
- disseminate information among policy makers and service providers, particularly around what constitutes good practice; and
- develop and implement a system for monitoring the impact of alcohol research findings.

21. The Department of Health, the Health Research Board, the National Advisory Committee on Drugs, and others engaged in research in Ireland, should further develop links with each other, and with international agencies, to share and exchange alcohol-related information and research and to investigate opportunities to develop collaborative research projects.

**Recommendation:**

Disseminate alcohol research findings and models of good practice to all relevant statutory, community and voluntary sector organisations.

## CHAPTER 6 MONITORING AND IMPLEMENTATION

1. Like many social policy issues, tackling alcohol-related harm requires a cross-departmental and cross-sectoral approach. This was reflected in the membership of the Steering Group. The issues and recommendations raised in this report are primarily public health matters, requiring a whole-population approach for successful implementation. The central aim is to reduce the amount of alcohol we drink (to an annual per capita consumption of 9.2 litres of pure alcohol by people over the age of 15). At the same time, harmful alcohol use is associated with polydrug use and many of the treatment and rehabilitation service providers deliver services to both groups. Also, alcohol can act as a gateway to the use of illicit drugs for some people.
2. Against this background it was decided by Government to develop a National Substance Misuse Strategy incorporating alcohol and drugs. The National Substance Misuse Strategy, as recommended in this report, focuses on alcohol in particular and, if agreed, will be taken in conjunction with the National Drugs Strategy 2009–2016 as the overall National Substance Misuse Strategy until the end of 2016.
3. An implementation framework will be put in place to best facilitate the effective and efficient implementation of the National Substance Misuse Strategy.
4. The Department of Health will play the lead role in the implementation of the Strategy. This will include on-going interaction with the Departments of Justice and Equality, Education and Skills and Children and Youth Affairs, at ministerial as well as at official level.
5. It is proposed that a process be put in place at national level involving relevant Departments and agencies, as well as the community and voluntary sectors, to monitor and support the implementation of the Strategy and to put forward proposals where necessary to deal with any situations arising in relation to alcohol use and misuse. A majority of the Steering Group favours the utilisation of the current Oversight Forum on Drugs (which could be reconstituted to incorporate alcohol) as part of this process. Such a Forum would be chaired by the Minister with responsibility for the National Drugs Strategy and would meet on a quarterly basis.
6. The negative effects of alcohol use are keenly felt by the individuals involved, their families and local communities. It is therefore proposed that a process be put in place at a more local level through Drugs Task Forces to monitor the situation regarding alcohol and to liaise with the process at national level. Reports from the Drugs Task Forces to the Oversight Forum on Alcohol are envisaged in this regard.

7. The overall impact of the implementation of a new Strategy will be reviewed periodically, with particular reference to the following six key performance indicators:
- annual per capita consumption of pure alcohol by people over the age of 15;
  - the number of on-licences, specialist off-licences and mixed trading outlets in operation, and the market share of the three types of operation, on a regional basis;
  - the level of enforcement of the provisions of the intoxicating liquor legislation on a regional basis across the country;
  - levels of alcohol-related crime on a regional basis;
  - levels of alcohol-related morbidity (involving standardised data collection from the Hospital In-Patient Enquiry (HIPE) database, the National Drug Treatment Reporting System (NDTRS), the National Psychiatric In-Patient Reporting System (NPIRS), Emergency Departments and voluntary sector treatment facilities; and
  - the number of alcohol-related deaths (directly and indirectly related to alcohol).

## CHAPTER 7 RECOMMENDATIONS

<b>SUPPLY PILLAR</b>		
1	<p>Increase the price of alcohol over the medium term to ensure that alcohol becomes less affordable, using some or all of the following approaches.</p> <p>Excise duties:</p> <ul style="list-style-type: none"> <li>• maintain excise rates at high levels;</li> <li>• further increase excise rates for higher alcohol content products;</li> <li>• increase the differential between excise rates applied to alcohol content levels in each alcohol product category; and</li> <li>• increase the annual excise fee for the renewal of off-licences.</li> </ul> <p>Minimum pricing: Introduce a legislative basis for minimum pricing per gram of alcohol.</p>	D/Finance
2	Introduce a 'social responsibility' levy on the drinks industry. <sup>xvii,xviii</sup>	D/H
3	<p>With respect to Section 16 of the Intoxicating Liquor Act 2008 (sale, supply and consumption of alcohol),</p> <ul style="list-style-type: none"> <li>• develop and implement an enforcement mechanism; and</li> <li>• make regulations under Section 16 (1), (b) and (c) of that Act.</li> </ul>	D/H, D/J&E
4	Commence Section 9 (structural separation) of the Intoxicating Liquor Act 2008. <sup>xix</sup>	D/J&E
5	Develop proposals for an all-island initiative in relation to alcohol issues including alcohol availability, treatment and health promotion.	D/H (lead), D/J&E
6	Introduce a statutory code of practice on the sale of alcohol in the off-licence sector.	D/H
7	Provide that the HSE may object to the granting of a court certificate for a new licence and to renewal of licences.	D/J&E

<sup>xvii</sup> The Alcohol Beverage Federation of Ireland (ABFI) and Mature Enjoyment of Alcohol in Society (MEAS) wished it formally recorded that they disagree with this levy.

<sup>xviii</sup> For the purposes of the 'social responsibility' levy, the drinks industry may include some or all of those involved in the manufacturing, distribution and retailing of alcohol.

<sup>xix</sup> The Minister for Justice, Equality & Defence is undertaking a review of the voluntary arrangements on structural separation in the mixed trading sector.

8	<p>Establish standards for server training programmes in the on-trade and the off-trade.</p> <p>Provide that participation by licensees and staff in such programmes is a condition of the licensing process.</p>	<p>D/H</p> <p>D/J&amp;E</p>
9	<p>Develop a system to monitor the enforcement of the provisions of the intoxicating liquor legislation:</p> <ul style="list-style-type: none"> <li>• to ensure consistency of application across all Garda regions; and</li> <li>• concerning the sale, supply or delivery of alcohol to minors, with particular emphasis on age verification.</li> </ul>	Garda Síochána
10	<p>Consider, having regard to enforcement constraints, the possible need to strengthen the legislative controls on distance sales.</p>	D/J&E (lead), Garda Síochána
11	<p>Introduce the following measures to further counter drink-driving:</p> <ul style="list-style-type: none"> <li>• introduce appropriate hospital procedures to provide alcohol testing of drivers who are taken to hospital following fatal/ injury collisions;</li> <li>• introduce driver rehabilitation programmes for repeat drink-driving offenders and those at high risk of re-offending;</li> <li>• provide for the use of alcohol ignition interlocks as a sentencing option for those convicted of repeat drink driving offences; and</li> <li>• monitor and regularly publish the volume of driver alcohol testing, including mandatory alcohol testing, undertaken by An Garda Síochána on a county and national basis.</li> </ul>	<p>D/TT&amp;S (lead), RSA, HSE (<i>Lead on Bullet Point 1</i>)</p> <p>Garda Síochána</p>
12	<p>Engage with EU colleagues to explore the feasibility of introducing common restrictions on advertising at a European level.</p>	D/H
13	<p>With a particular focus on impacting on the age of the onset of alcohol consumption, and the consumption levels of under-18 year olds, introduce a statutory framework with respect to the volume, content, and placement of all alcohol advertising in all media in Ireland (including the advertising of pubs or clubs). This will involve the utilisation of existing legislation (such as the Broadcasting Act 2009) as well as the development of new legislation. Regard should be made to the impact of any statutory framework containing the provisions immediately below on Irish industry <i>vis-à-vis</i> firms from other jurisdictions.</p>	D/H (lead)

<sup>xx</sup> The Alcohol Beverage Federation of Ireland wished it formally recorded that they disagree with this recommendation.

	<p>At a minimum the legislation and statutory codes should provide for:</p> <ul style="list-style-type: none"> <li>• a 9.00 p.m. watershed for alcohol advertising on television and radio;</li> <li>• alcohol advertising in cinemas to only be associated with films classified as being suitable for over-18s;</li> <li>• prohibition of all outdoor advertising of alcohol; and</li> <li>• all alcohol advertising in the print media to be subject to stringent codes, enshrined in legislation and independently monitored.<sup>xx</sup></li> </ul>	
14	<p>Introduce mandatory age authentication controls on the advertising of alcohol on websites hosted in Ireland.</p> <p>Investigate feasible approaches to, and subsequently implement controls on, the volume, content and placement of all alcohol marketing in digital media.</p>	D/H (lead)
15	<p>Drinks industry sponsorship of sport and other large public events in Ireland should be phased out through legislation by 2016. In the intervening time, it should not be increased.<sup>xxi</sup></p>	D/H (lead)

---

<sup>xxi</sup> The Department of Transport, Tourism and Sport and the Department of Arts, Heritage and the Gaeltacht dissent from this recommendation.



<b>PREVENTION PILLAR</b>		
1	<p>Seek greater co-ordination of prevention activities at both national and local levels. Such activities should, where feasible, utilise Information and Communication Technology and consider a social marketing approach, to target:</p> <ul style="list-style-type: none"> <li>• underage drinking;</li> <li>• drink-related anti-social behaviour/ public order offences;</li> <li>• excessive drinking generally;</li> <li>• those who are pregnant or likely to become pregnant; and</li> <li>• other specific at-risk groups.</li> </ul>	HSE (lead), Depts and agencies, voluntary, community and commercial sectors
2	<p>Further develop a co-ordinated approach to prevention and education interventions in relation to alcohol and drugs as a co-operative effort between all stakeholders in:</p> <ul style="list-style-type: none"> <li>• educational institutions (including third level);</li> <li>• sporting organisations;</li> <li>• community services;</li> <li>• youth organisations and services; and</li> <li>• workplaces.</li> </ul>	<p>HSE and D/CYA (Co-leads), Gardaí, DTFs</p> <p>(i) D/E&amp;S (ii) D/TTAS (iii) D/CYA (iv) D/JE&amp;I</p>
3	<p>The alcohol screening tools used by health professionals should reflect the Irish standard drink (10 grams). The low-risk weekly guidelines for women should be to consume less than 112 grams of pure alcohol per week (11 standard drinks per week) and for men to consume less than 168 grams per week (17 standard drinks per week). Develop and implement more detailed clinical guidelines for health professionals relating to the management of at-risk patients.</p> <p>Labels on alcohol products sold in Ireland should include the number of grams of alcohol per container, along with calorific content and health warnings in relation to consuming alcohol in pregnancy.</p>	D/H, HSE, professional bodies
4	<p>Continue the development and monitoring of SPHE in schools and Youthreach centres for education programmes through:</p> <ul style="list-style-type: none"> <li>• implementing the recommendations of (i) Inspectors' reports in relation to all schools and Youthreach centres for education and (ii) the SPHE evaluation (NUIG 2007) in post-primary schools;</li> <li>• rolling-out a senior cycle school programme; and</li> <li>• introducing (i) national guidelines for educational materials and (ii) national standards for teacher training, in relation to SPHE.</li> </ul>	D/E&S(lead)

5	<p>Encourage the provision of alcohol-free venues for young people, with an emphasis on those most at risk (e.g. Youth cafés, alcohol-free music and dance venues and sports venues), with:</p> <ul style="list-style-type: none"> <li>• the young people being centrally involved in the development and management of the programmes and venues;</li> <li>• late night and weekend opening; and</li> <li>• increased access to school facilities in out-of-school hours.</li> </ul>	D/CYA (lead), D/E&S
6	<p>Further develop prevention measures aimed at families in relation to alcohol misuse (including prevention measures in relation to parental alcohol problems and the effect of this on children):</p> <ul style="list-style-type: none"> <li>• at a broad level for all families; and</li> <li>• aimed at families deemed to be at risk.</li> </ul>	HSE (lead), D/CYA, D/E&S
7	<p>Develop and incorporate a drugs/alcohol intervention programme, with referral to specialist services where required, into schemes aimed at youth at risk, including the Special Projects for Youth (SPY), the Garda Juvenile Diversions Programme and the Garda Youth Diversion Projects.</p>	An Garda Síochána (lead), D/CYA, HSE, community and voluntary youth services

<b>Treatment and Rehabilitation</b>		
1	Establish a Clinical Directorate to develop the clinical and organisational governance framework that will underpin treatment and rehabilitation services. The Directorate will also build the necessary infrastructure required to improve access to appropriate interventions and treatment and rehabilitation services for clients with alcohol/substance use disorders.	HSE Directorate (lead), ICGP, CPI, voluntary and community sectors
2	Develop early intervention guidelines for alcohol and substance use across all relevant sectors of the health and social care system. This will include a national screening and brief intervention (SBI) protocol for early identification of problem alcohol use.	HSE Directorate (lead), voluntary and community sectors
3	Implement policies and clinical protocols in all healthcare settings to prevent, assess and respond to issues arising in relation to pregnant women affected by alcohol use.	HSE Directorate (lead), Primary Care, ICGP
4	Strengthen FASD surveillance in maternity hospitals through the Eurocat Reporting system and promote greater awareness among healthcare professionals of FASD so as to improve the diagnosis and management of FASD.	
5	Develop regulatory standards for all tier 3 and tier 4 services with regard to substance misuse.	HIQA (lead)
6	Develop and broaden the range of evidence-based psychosocial interventions in tier 3 and tier 4 services.	HSE Directorate (lead), voluntary and community sectors
7	Using the recommendations of the 'Report of the Working Group on Treatment of Under-18 year olds Presenting to Treatment Services with Serious Drug Problems' (2005) as a template: <ul style="list-style-type: none"> <li>• identify and address gaps in child and adolescent service provision;</li> <li>• develop multi-disciplinary child and adolescent teams; and</li> <li>• develop better interagency co-operation between addiction and child and family services.</li> </ul>	HSE (lead)
8	Develop a specialist detoxification service that: <ul style="list-style-type: none"> <li>• promotes the expansion of nurse prescribing in alcohol detoxification;</li> <li>• provides a number of clinical detox in-patient beds for clients with complex needs; and</li> <li>• provides community detox for those with alcohol dependency problems.</li> </ul>	HSE Directorate (lead), voluntary and community sectors

9	<p>Assign alcohol liaison nurses to all general hospitals for the purpose of coordinating care planning and/or screening and brief interventions for patients with alcohol-related disorders/illnesses.</p> <p>Develop care pathways and models of best practice for the management of ARBI.</p>	HSE Directorate
10  11	<p>Develop joint protocols between mental health services and drug and alcohol services with the objective of integrating care planning to improve the outcomes for people with co-morbid severe mental illness and substance misuse problems.</p> <p>Establish a forum of stakeholders to progress the recommendations in <i>A Vision for Change</i> in relation to establishing clear linkages between the addiction services, primary care services, community mental health teams and specialist mental health teams to facilitate the required development of an integrated approach to service development, including:</p> <ul style="list-style-type: none"> <li>• developing detoxification services;</li> <li>• ensuring availability of, and access to, community-based, appropriate treatment and rehabilitation services through the development of care pathways; and</li> <li>• ensuring access to community mental health teams where there is a co-existing mental health condition.</li> </ul>	HSE Directorate (lead)
12  13  14	<p>Develop a comprehensive outcomes and evidence-based approach to addressing the needs of children and families experiencing alcohol dependency problems. This would involve a whole-family approach, including the provision of supports and services directly to children where necessary. This approach should be guided by and coordinated with all existing strategies relating to parenting, children and families and in accordance with edicts from the Office for the Minister for Children and the Child and Family Support agency.</p> <p>Explore the extent of parental problem substance use through the development of a strategy, along the lines of the Hidden Harm Report in Northern Ireland, and respond to the needs of children of problem substance use by bringing together all concerned organisations and services. This could be developed through links with Cooperation and Working Together (CAWT), dedicated to health gain and social well-being in border areas.</p> <p>Develop family support services, including:</p> <ul style="list-style-type: none"> <li>• access to information about addiction and the recovery process for family members;</li> <li>• peer-led family support groups to help families cope with problematic drinking;</li> <li>• evidence-based family and parenting skills programmes;</li> <li>• the reconciliation of problem drinkers with estranged family members where possible; and</li> <li>• the development of a short-stay respite programme for families of problem drinkers.</li> </ul>	HSE Directorate (lead), D/CYA, voluntary and community sectors, Family Support Network

15	Develop a drugs/alcohol intervention programme, incorporating a treatment referral option, for people (primarily youth and young adults) who come to the attention of the Gardaí and the Probation Service, due to behaviour caused by substance misuse.	D/J&E, Probation Service
16	Continue the expansion of treatment and rehabilitation services in prisons to include treatment for prisoners who have alcohol dependency. Develop protocols for the seamless provision of treatment and rehabilitation services for people with alcohol problems as they move between prison and the community.	
17	Address the treatment and rehabilitation needs of the following specified groups in relation to the use of alcohol: members of the Traveller community; members of the lesbian, gay, bisexual and trans-gender community; new communities; and sex workers. This should be facilitated by engagement with representatives of these communities, and/or services working with the communities, as appropriate.	HSE Directorate (lead)
18	Implement the actions, by the appropriate agencies, in the Homeless Strategy: National Implementation Plan (DEHLG 2008).	D/ECLG (lead), CDT on Homelessness
19	Co-ordinate the provision of training within a single national substance misuse framework, i.e. National Addiction Training Programme.	HSE Directorate (lead)
20	Collate, develop and promote greater awareness of information on alcohol treatment and rehabilitation services.	HSE Directorate (lead)

	<b>RESEARCH PILLAR</b>	
1	<p>Continue to implement and develop, as appropriate, epidemiological indicators and the associated data collection systems, to identify:</p> <ul style="list-style-type: none"> <li>• prevalence and patterns of alcohol use and misuse among the general population;</li> <li>• prevalence and patterns of alcohol use among specific sub-groups;</li> <li>• demand for alcohol treatment;</li> <li>• alcohol-related deaths and mortality of alcohol users;</li> <li>• public expenditure; and</li> <li>• harm reduction.</li> </ul>	HRB & NACD (joint leads)
2	<p>Develop and prioritise a research programme, revised on an annual basis, to examine the economic, social and health consequences of alcohol and the impact of alcohol policy measures.</p>	HRB & NACD (joint leads)
3	<p>Disseminate alcohol research findings and models of good practice to all relevant statutory, community and voluntary sector organisations.</p>	HRB & NACD

## Appendix 1 Evidence Base

### Alcohol consumption in Ireland

#### *Per capita consumption*

Per capita consumption is a good indicator of alcohol-related harm in a country.<sup>xxii</sup> International evidence indicates that the higher the average consumption of alcohol at the individual level and in a population, the higher the incidence of alcohol-related problems for both.

The consumption of alcohol in Ireland increased by 192 per cent between 1960 and 2001, from an average of 4.9 litres pure alcohol per adult, defined as those aged 15 years of age and over, to 14.3 litres. Since this peak, consumption has reduced and in 2010 alcohol consumption per adult was 11.9 litres; this corresponds to 45 (700ml) bottles of vodka, 125 (750ml) bottles of wine or 482 pints of beer (ABV 4.3 per cent). As 19 per cent of the adult population abstain from alcohol completely, those who drink alcohol consume even greater quantities (56 bottles of vodka, 154 bottles of wine, 595 pints of beer). The 2010 level is 145 per cent higher than the average amount of alcohol consumed per adult in 1960.

The Department of Health has recommended that men consume no more than 168g of pure alcohol and women no more than 112g of pure alcohol per week. Per capita consumption is based on the entire population over 15 years. If every adult (15+ years) restricted his/her alcohol consumption to the recommended maximum low-risk limit on every week of the year, the actual per capita consumption would be 9.2 litres of pure alcohol per adult (15+ years), or 23 per cent less than was consumed in 2010.

However, there is no safe level of alcohol consumption for 15–17 year olds. They should therefore drink no alcohol.

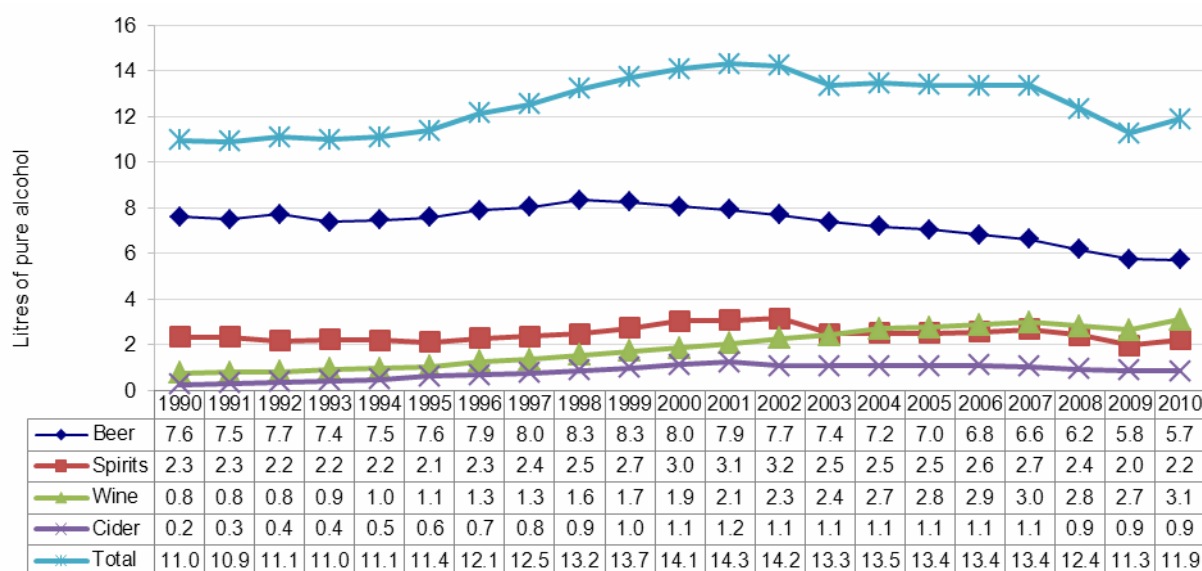
#### *Type of alcohol consumed*

There have been changes in the market share of individual alcoholic drinks. In 1990 beer accounted for 69 per cent of all alcohol consumed. Spirits accounted for 21 per cent, wine for 7 per cent and cider for 2 per cent. In 2010 beer accounted for just 48 per cent of all alcohol consumed, followed by wine (26 per cent), spirits (18 per cent) and cider (8 per cent).

---

<sup>xxii</sup> Per capita alcohol consumption is calculated using data from the Revenue Commissioners and the Central Statistics Office (CSO). The volume of sales generated for each beverage type (beer, spirits, wine and cider) is provided by the Revenue Commissioners. These sales figures represent the volume of alcohol beverages released from warehouse and where excise duty has been paid. Beer and spirits are provided in litres of pure alcohol. Wine is provided in litres of alcohol and converted to pure alcohol based on an ABV (alcohol by volume) of 12.5 per cent. Cider is converted to pure alcohol based on an ABV of 4.5 per cent, as most cider sold in Ireland is at this alcoholic strength.

**Figure 1 Alcohol consumption by adults in Ireland, by beverage type, 1990–2010**



The OECD Health at a Glance report, published in November 2011 (Table 1 below), included details of the per capita alcohol consumption in 2009 across 40 OECD countries, as well as the change in consumption patterns since 1980. The change reported for Ireland shows an increase of 18 per cent over the 19 years. Ireland's per capita consumption in 2009 was 11.3 litres per adult (15+ years), which was tenth highest out of the 40 countries surveyed in 2009. The OECD average consumption for 2009 was reported as 9.1 litres per adult.<sup>4</sup>

**Table 1: Health at a Glance 2011: OECD Indicators**

OECD Country	Litres per capita (15 years and over)	Change in consumption levels 1980–2009 %
France	12.3	-37%
Portugal	12.2	-18%
Austria	12.2	-16%
Czech Republic	12.1	+3%
Estonia	12.0	n.a
Luxembourg	11.8	-14%
Hungary	11.8	-21%
Slovenia	11.5	n.a
Russian Fed.	11.5	+45%
<b>Ireland</b>	<b>11.3</b>	<b>+18%</b>
United Kingdom	10.2	+9%
Poland	10.2	-11%



Switzerland	10.1	-25%
Denmark	10.1	-14%
Australia	10.1	-22%
Spain	10.0	-46%
Finland	10.0	+27%
Germany	9.7	-32%
Belgium	9.7	-28%
Netherlands	9.4	-18%
New Zealand	9.3	-21%
Greece	9.2	-19%
<b>OECD</b>	<b>9.1</b>	<b>-9%</b>
Slovak Republic	9.0	-38%
Korea	8.9	n.a
United States	8.8	-15%
Chile	8.6	-21%
Canada	8.2	-23%
Italy	8.0	-52%
Sweden	7.4	+10%
Japan	7.4	+4%
Iceland	7.3	+70%
South Africa	7.2	+17%
Norway	6.7	+12%
Brazil	6.2	+188%
Mexico	5.9	+74%
China	4.4	+159%
Israel	2.5	-11%
Turkey	1.5	-17%
India	0.7	+47%
Indonesia	0.1	-25%

### ***Location of alcohol purchasing***

The pattern of alcohol purchasing in Ireland has shifted from the pub to the off-licence sector and to supermarkets in particular. There was a 161 per cent increase in the number of full off-licences between 1998 and 2010, and over the same time period the number of pub licences decreased by 19 per cent (Revenue Commissioners, statistical reports) (Table 2). Much of this increase was in mixed trade outlets (supermarkets, convenience stores and garage forecourts), which have used large discounting of alcohol products and alcohol price-based promotions to encourage people into their premises.

**Table 2 Number of licences issued in Ireland 1998–2010 by licence type**

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
<b>Pubs</b>	10,395	9,788	7,421	11,272	9,869	9,713	9,946	9,225	9,541	9,402	8,857	9,067	8,393
<b>Spirit retailers off-licence*</b>	589	543	361	792	808	785	983	1,070	1,170	1,342	1,487	1,770	1,537
<b>Wine-only off-licences<sup>^</sup></b>	483	550	448	1,284	2,023	2,392	2,790	3,026	3,485	3,691	3,718	3,705	3,206

Source: Statistical reports 1998–2010, Revenue Commissioners

\* These retailers may also sell beer and wine and can be referred to as full off-licences.

<sup>^</sup> Figures for 1998–2000 are from the Revenue Commissioners records. However, the wine-only off-licence was created under Section 36 of the Intoxicating Liquor Act 2000. Further legislation was introduced in 2008, requiring applicants for a wine-only off-licence to acquire a court certificate.

There is a statistically significant positive relationship between alcohol affordability and consumption across the European Union (EU), that is, as alcohol becomes more affordable consumption increases and vice versa.<sup>1</sup> In 2010 the average cost of a 500ml can of lager from the off-licence sector was €1.77 while the average price of a pint of lager in the on-trade was €4.35.<sup>9</sup> The off-licence sector accounted for half of the alcohol market share in 2008<sup>3</sup> and, given the much cheaper price of alcohol in the off-licence, the volume of alcohol sold from the off-licence was much greater than that sold in the on-trade.

Purchases by distance sales from off-licences and retailers have become more widespread. There is evidence that under-18 year olds are consuming alcohol purchased by distance sales and from on-licence and off-licence retailers.<sup>38</sup>

### ***Alcohol drinking in adults***

Patterns of drinking, especially drinking to intoxication, play an important role in causing alcohol-related harm. The evidence suggests that the majority of Irish drinkers engage in excessive or problematic drinking patterns. In a 2009 Eurobarometer survey of 29 European countries, Ireland topped the country scale for heavy drinking by a considerable margin, with 26 per cent usually consuming at least five drinks per drinking occasion. The most recent SLÁN survey indicated that, while 19 per cent of the adult population do not drink, 10 per cent of drinkers reported consuming alcohol over the then recommended weekly limit, defined as 210g of pure alcohol for men and 140g of pure alcohol for women.<sup>6</sup> In addition, 28 per cent engaged in weekly binge drinking, defined as consuming at least 60g of alcohol on a single occasion, and over half of drinkers (56 per cent) had a positive AUDIT-C score,<sup>xxiii</sup> which equates to harmful drinking patterns. Based on 2006 Census figures, this suggests that 1,453,250 people in Ireland aged 18 or over drink harmfully. We know that survey self-reported alcohol consumption greatly underestimates total alcohol consumption,<sup>39</sup> therefore the consumption data reported above should be taken as an underestimate of the true level of alcohol consumption in Ireland.

<sup>xxiii</sup> The Alcohol Use Disorders Identification Test – Consumption (AUDIT-C) identifies those with harmful drinking patterns by examining frequency of drinking, volume consumed and binge drinking.

### ***Alcohol drinking in young people***

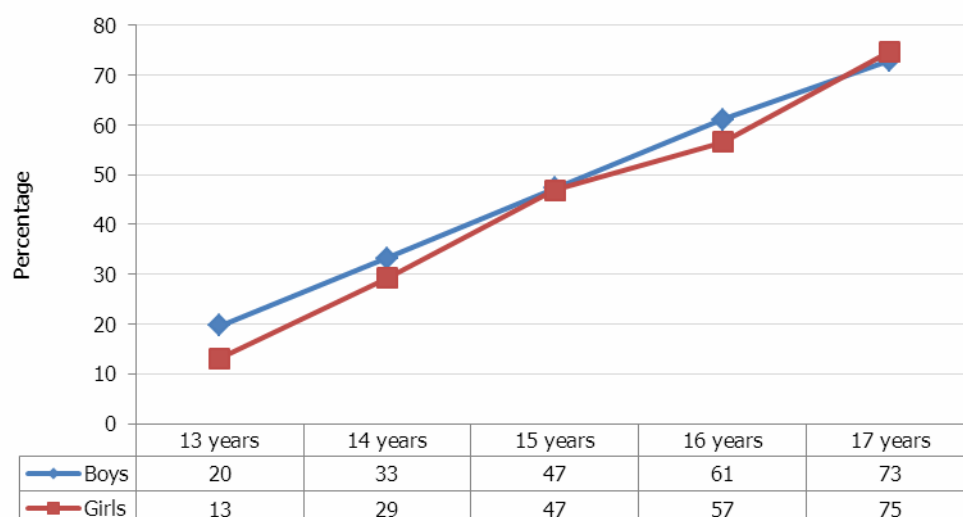
Because of the relative immaturity of the adolescent brain compared to that of an adult, excessive drinking is especially hazardous for young people. The American Medical Association<sup>40</sup> reported that an adolescent need drink only half as much as an adult to experience the same negative effects and that even occasional binge drinking can damage the young brain. Adolescent drinkers are more likely to perform poorly in school, and to experience social problems. The US Surgeon General has highlighted that the developing adolescent brain is particularly susceptible to long-term negative consequences of alcohol use and that recent studies show that alcohol consumption has the potential to trigger long-term biological changes that have detrimental effects on the developing adolescent brain, including neurocognitive impairment.<sup>41</sup> In addition, people who begin drinking before the age of 15 are four times more likely to develop alcohol dependence at some time in their lives than those who have their first drink at age 20 or older.<sup>42</sup>

The 2006 HBSC survey of schoolchildren found that by 16 years of age, one in five teenagers were weekly drinkers (Table 3), over half reported having ever been drunk (Figure 2) and one in seven had been drunk at least 10 times, with consumption and drunkenness increasing with each year of age.<sup>7,43</sup>

**Table 3 Self-reported weekly alcohol use by schoolchildren, by age and gender (HBSC 2006)**

<b>Age</b>	<b>Boys %</b>	<b>Girls %</b>	<b>All %</b>
13 years	3	1	2
14 years	9	7	8
15 years	14	14	14
16 years	22	20	21
17 years	37	31	34
18 years	43	36	40

**Figure 2 Proportion of schoolchildren reporting having ever been drunk, by age and gender (HBSC 2006)**



Data from the 2002–2003 and 2006–2007 National Drug Prevalence Surveys indicated that the median age of first alcohol use among Irish drinkers decreased from 15 to 14, for those born between 1980 and 1984 and for those born between 1990 and 1991.<sup>8</sup>

Research on alcohol use amongst sportsmen over 16 years of age in the largest amateur sporting organisation in Ireland – the Gaelic Athletic Association (GAA), with 320,000 playing members – found high levels of alcohol use and misuse. Most players (90 per cent) were current drinkers and over half of these reported weekly binge drinking. The average age at which respondents reported consuming their first drink was 15.2 years. Those who started drinking at 18 years of age or older were 66 per cent less likely to report regular binge drinking. Many drinkers reported alcohol-related harms in the previous year, including being in a fight (32 per cent), being in an accident (19 per cent) and attending an Emergency Department (12 per cent). Binge drinking increased the risk of being in a fight or having an accident.<sup>44</sup>

### ***Alcohol use in children as a gateway drug***

A survey of older adolescents in Ireland indicated that those with the most serious drug and alcohol problems had commenced alcohol use at a much earlier age than their counterparts without significant drug or alcohol problems.<sup>45</sup> This mirrors international research which indicates that early age of onset of regular drinking increases the risk of both later alcohol and later drug abuse.<sup>46-49</sup> Alcohol is increasingly being recognised as the ‘gateway’ drug, particularly in cultures where it is typically consumed in a binge-type pattern by both adults and adolescents, such as Ireland.<sup>48,50</sup>

### ***Alcohol drinking in pregnancy***

Alcohol increases the risk of unplanned pregnancy. 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.<sup>51</sup>

Maternal drinking during pregnancy can damage the developing fetal brain and result in fetal alcohol spectrum disorder (FASD), which is associated with a range of physical, cognitive and behavioural effects. According to figures from the Coombe Women's Hospital, almost two-thirds of Irish pregnant women consume alcohol.<sup>34</sup> Another Irish study reported that 54 per cent of women admitted to drinking alcohol following a positive pregnancy test, with 8 per cent of these women consuming more than 50g of pure alcohol per week.<sup>52</sup> There is still uncertainty as to the intensity and timing of the alcohol exposure needed to produce any type or degree of fetal impairment.<sup>53</sup>

### ***Alcohol drinking in marginalised groups***

The All Ireland Traveller Health Study Team found that more Travellers abstain from alcohol (40 per cent) than the general population. However, those who do drink, drink heavily, with 66 per cent of male Traveller drinkers and 42 per cent of female Traveller drinkers consuming six or more drinks per drinking occasion.<sup>54</sup>

There is a long-standing relationship between alcohol use and homelessness, and Irish research has shown that alcohol is the drug of choice in the homeless population and is the prime reason for 13 per cent becoming homeless.<sup>55</sup>

Prison populations include substantial proportions of men and women who are heavy drinkers or have alcohol-related problems. A study of Irish prisoners found a lifetime prevalence of harmful use of alcohol or dependence of 60 per cent among remand prisoners.<sup>56</sup>

Irish and international studies have shown high levels of harmful use of alcohol among lesbian, gay, bisexual and trans-gender (LGBT) communities, with LGBT people two to three times more likely than heterosexual people to suffer from alcohol addiction.<sup>57</sup>

### ***Polydrug use***

Polydrug use can be defined as concurrent drug use, which involves a person using at least two substances during the same time period. It is associated with a number of negative consequences including mental and physical ill-health, violence, aggression and a range of social problems. Polydrug use is more likely to result in accidents and death (including death from overdose) than when a single substance is consumed. Data from the 2006–2007 drug prevalence survey show that 2.6 per cent of adults (aged 15–64) reported using both alcohol and another illegal drug in the previous month and 3.3 per cent used both alcohol and another legal drug (excluding tobacco).<sup>58</sup> According to NDTRS figures, 19 per cent of those reporting alcohol as their main problem substance in 2008 also reported problem use of another drug.<sup>59</sup> Of those who reported any drug (excluding alcohol) as their main problem substance, 44 per cent also reported problem use of alcohol.<sup>60</sup> In 2008 there were 150 deaths from alcohol poisoning; 70 of these were polysubstance poisonings.<sup>12</sup> HIPE data show that in 2008, 11 per cent of alcohol-related discharges also had a drug-related diagnosis. Half of these discharges occurred among 15–34 year olds.<sup>19</sup>

## **Factors that influence initiation of drinking, continuing to drink and patterns of drinking**

### ***Risk and protection factors for alcohol use among young people***

Haase and Pratschke studied the risk and protective factors in relation to harmful alcohol use among Irish 16–18 year olds.<sup>50</sup> For both early school leavers and students attending school, having a family member who drank alcohol in the previous month, most/all friends drinking alcohol and aggressive or ‘acting out’ behaviour were predictors of drinking alcohol. Supportive teachers or a positive school experience reduced the risk of drinking alcohol in school attendees.

### ***Impact of alcohol marketing on young people***

Young people are aware of alcohol advertisements and this awareness increases with age. The WHO states that the effects of exposure to alcohol marketing seem to be cumulative and can contribute to the normalising of drinking alcohol and eventually to increased levels of harmful use of alcohol in the population.<sup>1</sup> International and Irish research has shown the importance of alcohol advertising in shaping youth attitudes, perceptions and expectancies about alcohol use, which then influence youth decisions to drink.<sup>61-64</sup>

Young people have a particularly high awareness of, and exposure to, sports sponsorship.<sup>65</sup> Marketing through sports sponsorship has been shown to attract young males, the group most likely to be heavier drinkers. Research from New Zealand has shown that sports players who received sponsorship at individual, team or club level were more likely to be hazardous drinkers and had an average AUDIT (Alcohol Use Disorders Identification Test) score 2.4 points higher than those who received no sponsorship.<sup>66</sup>

A systematic review of longitudinal studies with a total sample size of over 38,000 found evidence that exposure to alcohol advertising and promotion predicts both the onset of drinking among non-drinkers and increased levels of consumption among existing drinkers.<sup>10</sup>

A small survey in Ireland found similar results to the international literature, with 16–21 year olds having a very high awareness of advertising and sponsorship. Awareness of advertising was highest for TV (93 per cent), followed by radio (31 per cent), outdoor advertising (25 per cent), online (10 per cent) and print (8 per cent). Guinness was the second favourite advertisement, and alcohol brands made up five of the top ten favourite advertisements in 2010.<sup>11</sup> Four in ten surveyed reported owning an alcohol branded item of clothing, with 25 per cent owning a rugby/football jersey with an alcohol branded logo.

Findings in Ireland also confirm that alcohol marketing is occurring in new media and using innovative techniques such as games and iPhone applications: four of the top ten Irish Facebook pages are for alcohol brands<sup>67</sup> and 45 per cent of young people have either seen an ad or pop-up for an alcohol product or received an online quiz about alcohol or drinking on Facebook or Bebo.<sup>11</sup>

## **Economic contribution of alcohol in Ireland**

A study commissioned by the Drinks Industry Group of Ireland<sup>3</sup> made the following conclusions:

- Personal expenditure on beverages was €7.185 billion in 2009.
- Manufacturing in the drinks industry had a turnover of €2.95 billion in 2008, with €1 billion in drinks exports and €330 million trade surplus in 2009. It employed 4,263 people, and paid out €1.1 billion on materials for further processing and energy.
- In 2009 the retail segment of the drinks market comprised approximately 9,067 full on-licences, 1,770 spirits off-licences and 3,705 wine off-licences (wine outlets generally include the spirit outlets). The off-licence share made up 35 per cent of market value in 2009 and about 55 per cent of the volume of alcohol.
- The on-trade provided 43,629 full-time job equivalents, 87 per cent of all direct drinks-related employment, and the off-licence provided approximately 2,850 full-time job equivalents, 5 per cent of all direct drinks-related employment. The on-trade sector has been the worst performing sector within the alcohol industry, with large employment declines in recent years. This has been caused by market changes and new regulations.
- Alcohol manufacturing and retail industry provided €2 billion in VAT and excise receipts to the State.

## **Alcohol-related harm**

Alcohol is causally related to more than 60 medical conditions.<sup>16</sup> Alcohol increases the risk of most diseases even at low levels of consumption. For example, alcohol consumption even at low-risk levels increases the risk of cancers. For certain diseases, namely coronary heart disease, stroke and diabetes mellitus, alcohol consumption among middle and older aged adults at low-risk levels can provide a protective effect, though at higher levels of consumption this protective effect is lost and the risk of disease may even increase.<sup>16</sup>

Volume of consumption, as well as patterns of drinking, especially irregular heavy drinking, determines the burden of disease caused by alcohol. Research has shown that all-cause mortality in male drinkers who are occasional heavy drinkers is twice as high as for those who consumed the same amount of alcohol in a more even fashion.<sup>68</sup> Binge drinking increases impulsivity, reduces inhibition and distorts behaviour, which is associated with an increased risk of accidental and non-accidental injury, including assault, homicide and suicide.<sup>69</sup>

Alcohol-related harm is not confined to the minority of heaviest drinkers in the population. In reality, it is the much greater number of low- to medium-volume drinkers in a population who drink to excess on occasion that account for much of the acute alcohol-related problems, such as aggression, violence, injuries, and poor work performance, which are often associated with episodes of intoxication.<sup>70-72</sup> Also, even though individually these drinkers are at a lower risk of chronic outcomes than high-risk drinkers, because there are so many more of them in the population they account for the greatest numbers of negative outcomes.

Older people are vulnerable to the effects of alcohol, due to age-related physiological changes (including a higher blood alcohol concentration for a given dose due to a reduction in total body water and changes in hepatic metabolism), co-morbid medical or psychiatric conditions, interactions with medications, poor nutrition and social isolation as well as many years of exposure to alcohol leading to increased lifetime risk of alcohol-related health risks.<sup>73</sup>

Although the health-related consequences of harmful use of alcohol often dominate public discussion on alcohol-related problems, it has been estimated that alcohol-related social problems such as family disharmony, public disorder, violence and reduced work performance can impose as much of a burden as the health consequences.<sup>74</sup> Alcohol-related harm is not restricted to the individual drinker, but has negative consequences for families, innocent bystanders and the wider community.

### ***Alcohol-related deaths in Ireland***

Based on the National Drug-Related Index (NDRDI), a census of alcohol and drug-related deaths (such as those due to accidental or intentional overdose) and deaths among alcohol dependants and drug users in Ireland revealed that between 2004 and 2008 there were 4,321 alcohol-related deaths and deaths of people who were alcohol-dependent.<sup>12</sup> This compared with 2,384 deaths due to all other drugs combined. It should be noted that while it is likely that this database identified the majority of illicit drug user deaths, whether direct or indirect, it is likely that it did not identify all indirect alcohol-related deaths. This is due to the fact that many alcohol-related deaths occur in people not identified as harmful users. Also, as most indirect alcohol-related deaths are due to chronic diseases that take many years to develop, it is very difficult to identify, at the individual level, which deaths were due to alcohol. This is a common problem with risk factors for chronic disease. For example, while smoking causes lung cancer, smoking is not the cause of all lung cancers and it is impossible to say at the individual level which cases of lung cancer were due to smoking. The same applies to alcohol. Therefore the alcohol-related deaths recorded by NDRDI should be considered an underestimate.

Deaths due to alcohol in people who were alcohol-dependent increased by 60 per cent over a four-year period – from 517 deaths in 2004 to 826 deaths in 2008 (Table 4). While this may be a genuine increase, it may also be due to improvements in data collections and data coding.



**Table 4 Alcohol-related deaths and deaths in those who were alcohol-dependent by cause of death, 2004–2008 (n=4,321)**

	2004	2005	2006	2007	2008	2004–2008
Alcohol poisoning	125	116	111	170	150	672
Deaths in alcohol-dependent people (medical, trauma, other poisoning)	517	585	739	767	826	3,434
Other*	14	25	30	62	84	215
<b>Total</b>	<b>656</b>	<b>726</b>	<b>880</b>	<b>999</b>	<b>1,060</b>	<b>4,321</b>

\*This category includes deaths that were non-poisonings and that occurred in non-dependent people; however, alcohol was implicated in their death.

Source: National Drug-Related Deaths Index (NDRDI), Health Research Board. The NDRDI collects data on alcohol-related deaths and deaths in those who are alcohol-dependent from several sources including the Coroner Service, the Hospital In-Patient Enquiry (HIPE) scheme and the General Mortality Register (GMR).

Using another methodology to count all deaths, both deaths wholly due to the harmful effects of alcohol and that proportion of deaths partially due to the harmful effects of alcohol, over the five-year period 2000–2004, alcohol was estimated to have caused 4.4 per cent of Irish deaths (6,584 deaths), and 10.8 per cent of all-cause person years of life lost (PYLL) (131,245 deaths). Alcohol was estimated to have prevented 2.7 per cent of deaths (3,967 deaths) and 1.5 per cent of all-cause PYLL (18,285 deaths). This resulted in an estimated net effect of 1.8 per cent of deaths caused (2,616 deaths) and 9.3 per cent of all-cause PYLL (112,959 deaths) due to the effects of alcohol. Chronic conditions accounted for 69 per cent and acute conditions for 31 per cent of deaths. Conditions not wholly attributable to alcohol accounted for 83 per cent of deaths compared to 17 per cent of deaths wholly caused by alcohol. Alcohol accounted for a much greater proportion of age-specific deaths in young people compared with older people, with 27 per cent of deaths in 20–24 year old males and 18 per cent of deaths in 20–24 year old females being attributed to alcohol.<sup>13</sup>

Between 2000 and 2004 alcohol was estimated to be the major contributing factor in 823 suicides, with alcohol being the major contributing factor in just under half of young male suicides.<sup>13</sup> Another study of people from three counties in Ireland who died as a result of suicide, found that more than half had alcohol in their blood, with those aged under 30 more likely to have had alcohol in their blood at the time of death.<sup>14</sup>

#### ***Alcohol-related hospital discharges in Ireland***

In 2008 there were 18,400 discharges in public hospitals recorded as being wholly due to alcohol, which accounted for 3.6 per cent of all bed-days (161,016 bed-days).<sup>19</sup> This compares to 9,254 discharges in 1995, an increase of 99 per cent in just 13 years. Males accounted for 74 per cent and females for 26 per cent of all discharges. However, among those aged 17 or under, males accounted for 55 per cent of discharges and females for 45 per cent of discharges. Chronic conditions accounted for 82 per cent and acute conditions for 18 per cent of alcohol-related discharges.

Using another methodology to count all hospitalisations, the proportion wholly due to the harmful effects of alcohol and the proportion partially due to the harmful effects of alcohol, over the five-year period 2000–2004, alcohol was estimated to have caused

10.3 per cent of all bed-days (3,428,973 bed-days) and prevented 1.6 per cent of bed-days (529,239 bed-days), giving a net number of bed-days due to alcohol of 8.7 per cent (2,899,734 bed-days). Chronic conditions accounted for 95 per cent of bed-days (3,262,408 bed-days) due to the harmful effects of alcohol. Conditions not wholly due to alcohol accounted for 67 per cent bed-days (2,297,412 bed-days) due to the harmful effects of alcohol.<sup>17</sup>

### ***Acute alcohol-related consequences in Ireland***

Alcohol consumption can increase impulsivity, reduce inhibition and distort behaviour, which may lead to accidents, non-accidental injury, self-harm and suicide. In Ireland, a number of studies have identified the link between alcohol consumption and negative acute consequences:

- Hope et al. reported that over one quarter of all injuries presenting to Emergency Departments were alcohol-related, 48 per cent of which occurred to people aged under 30 years of age.<sup>18</sup>
- A study examining alcohol's contribution to fatal traumatic brain injury in Ireland found that there was a positive blood alcohol level in 50 per cent of people who died from a fall, in 48 per cent of drivers and in 29 per cent of pedestrians who died in road traffic accidents.<sup>75</sup>
- The National Registry of Deliberate Self-Harm reported that there were 11,966 presentations of deliberate self-harm, involving 9,630 individuals, to Emergency Departments in 2010. There was evidence of alcohol consumption in 41 per cent of episodes of deliberate self-harm.<sup>15</sup>
- A study on rape in Ireland found that alcohol consumption among complainants was high – over 80 per cent had consumed alcohol around the time of the offence, with 45 per cent described as severely intoxicated. In addition, the majority of suspects were intoxicated at the time of the offence, with 41 per cent severely intoxicated and 27 per cent moderately intoxicated.<sup>26</sup>

### ***Treatment for alcohol use disorders***

The National Drug Treatment Reporting System (NDTRS) collects data on treated problem alcohol use from outpatient services (including alcohol treatment centres and some psychiatric services) and specialised addiction residential centres. The overall number of cases reporting alcohol as their main problem substance increased by 42 per cent between 2005 and 2010, from 5,526 to 7,866 (Table 5).<sup>20</sup> This increase may be attributed to an increase in the number of people presenting for treatment, or it may reflect the increase in the number of treatment centres participating in the NDTRS.

However, not all alcohol treatment services in Ireland participate in the NDTRS and therefore these numbers should be considered an underestimate.

**Table 5 Number (%) of cases treated, by treatment status (NDTRS 2005–2010)**

Treatment status	2005	2006	2007	2008	2009	2010
	Number (%)					
<b>All cases</b>	<b>5526</b>	<b>5876</b>	<b>7312</b>	<b>7940</b>	<b>7816</b>	<b>7866</b>
Previously treated cases	2230 (40)	2345 (40)	3110 (43)	3606 (45)	4220 (54)	4178 (53)
New cases	3228 (58)	3432 (58)	3736 (51)	3833 (48)	3524 (45)	3583 (46)
Treatment status unknown	68 (1)	99 (2)	466 (6)	501 (6)	72 (1)	105 (1)

Source: HRB 2011

Between 2005 and 2010 the number of admissions to psychiatric inpatient facilities with a diagnosis of alcoholic disorder decreased by 40 per cent, from 2,995 to 1,798 (Table 6).<sup>76-81</sup>

**Table 6 Number of admissions to psychiatric inpatient facilities with an alcoholic disorder (NPIRS 2005–2010)**

	2005	2006	2007	2008	2009	2010
	Number (%)					
<b>All admissions</b>	2995	2767	2699	2497	1,993	1,798
First admissions	962 (32)	851 (31)	808 (30)	789 (32)	679 (34)	637 (35)

Source: The National Psychiatric In-Patient Reporting System (NPIRS). This collects data on admissions and discharges from psychiatric inpatient facilities in Ireland.

### ***Drink-driving in Ireland***

Drink-driving contributes to injuries, disabilities and death to both drivers and innocent road users. All levels of blood alcohol concentration (BAC) are associated with a higher risk of crashes (relative to a BAC of zero), and the risk of injury increases exponentially with markedly higher BACs. For a driver with a BAC of 50mg/100ml which is the current BAC limit, the risk of crashing a vehicle is 1.4 times that for a driver with a BAC of zero.<sup>53</sup>

From 2003–2005, 611 drivers were fatally injured in road traffic accidents (RTAs) in Ireland. Blood alcohol levels were recorded in 397 of these drivers, of whom 184 (46.3 per cent) had a BAC over 80mg/100ml. Those aged 20–24 years were most likely to be over the legal limit.<sup>82</sup> Legislation allowing random breath testing was introduced in Ireland in 2006 and has been effective in reducing road deaths; in 2009 there were 240 road deaths compared to 368 in 2006, a decrease of 35 per cent.<sup>28,29</sup>

In 2007, 19,864 drink driving offences were recorded.<sup>83</sup>

### **Social consequences and harm caused to others due to the harmful use of alcohol in Ireland**

Irish survey data indicate that social harms as a result of someone else's drinking were higher than those reported from an individual's own alcohol use.<sup>6,83</sup> While men

experienced more social harms from their own drinking than did women, family and money problems were reported by more women than men. One in ten men and 8 per cent of women reported having property vandalised as a result of someone else's drinking.<sup>83</sup>

### ***Alcohol-related harm to the family in Ireland***

Parental alcohol problems can, and do, have serious and negative effects on the health, development and welfare of children. Living with a problem drinker can severely affect children since they can do little to protect themselves from the direct or indirect consequences of parental drinking. Inappropriate caring arrangements are often taken on by children such as looking after younger siblings and the parent(s) with alcohol problems. It can also lead to children being cared for by other family members such as siblings, grandparents, uncles and aunts. Child abuse can be another direct consequence of parental alcohol use. In the UK, parental alcohol use is a factor in 50 per cent of child protection cases.<sup>84</sup> There are no valid or reliable published data on this issue available for Ireland, although an unpublished one-county study in 1999 found that 43 per cent of children in care were there because of parental addiction, primarily alcohol dependency.<sup>85</sup>

A survey of Irish adults on the impact of their parents' drinking during their childhood reported that almost one in 10 who had parents who drank alcohol at all during their childhood often felt ashamed of, or embarrassed by, their parent's drunken behaviour, or had often witnessed conflict between their parents when they were drinking or related to their drinking.<sup>86</sup> Across the EU it is estimated that between 7 per cent and 12 per cent of children have parents with alcohol abuse and dependence<sup>87</sup> which implies that up to 109,476 Irish children aged 14 years or younger are affected by parental alcohol problems.

Harmful use of alcohol by teenagers is associated with applications for special care, with 75 per cent of the applications made by social workers for special care admissions identifying alcohol misuse as a risk factor in the teenagers for whom the admission was sought.<sup>21</sup>

Harmful use of alcohol can cause or exacerbate marital disharmony and can lead to the break-up of relationships or the family unit. An Irish study reported that up to 40 per cent of men and 20 per cent of women in distressed relationships were drinking excessively.<sup>23</sup> In another Irish study, 25 per cent stated that alcohol abuse was a factor in marital disharmony.<sup>24</sup>

An Irish study examining the extent of the problems of domestic violence found that among those who experienced severe domestic abuse, while 36 per cent of cases of the abusive behaviour had no specific trigger, 34 per cent of cases had alcohol identified as a potential trigger. In one-quarter of severe abuse cases, alcohol was always involved.<sup>25</sup>

### ***Alcohol-related crime in Ireland***

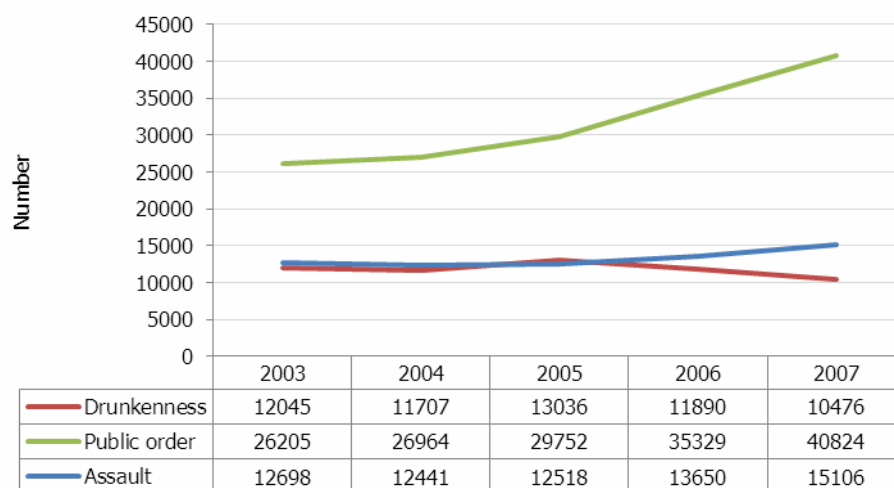
There are significant links between alcohol consumption and rates of criminal violence: international studies show that alcohol is involved in 35–85 per cent of assaults and homicides.<sup>88</sup> A number of factors contribute to the relationship between alcohol and

crime, including the effects of alcohol, the characteristics of the drinker, the drinking situation and the cultural context of both drinking and criminal behaviour.

In Ireland, 46 per cent of perpetrators convicted of homicide between 1972 and 1991 were intoxicated when the crime was committed.<sup>89</sup> A more recent study estimated that between 2000 and 2004 alcohol was a major factor in 71 homicides.<sup>13</sup>

Analysis of Garda PULSE (Police Using Leading Systems Effectively) data for the years 2003–2007 revealed that the total number of drunkenness, public order and assault offences increased by 30 per cent, from 50,948 to 66,406 (Figure 3).<sup>83</sup> The 18–24 year old age group was responsible for two-fifths of offences. Although public order and assault offences are not necessarily alcohol-related, there is sufficient international evidence supporting a strong relationship between alcohol consumption and these offences. There has been a small decrease in the number of drunkenness offences but an increase in public order and assault offences. This does not necessarily imply a genuine decrease in drunkenness. As An Garda Síochána only record the most serious offences, it is possible that some drunkenness offences are classified as public order offences as this is the more serious offence. Other Irish research has also shown a strong association between alcohol consumption and public order offending.<sup>90</sup> In 2007 minors accounted for 10,037 offences. For both adults and minors approximately half of all offences occurred at the weekend and just under half of adult offences occurred between midnight and 4.00 am.

**Figure 3 Trends in drunkenness, public order and assault offences (PULSE 2003–2007)**



### ***Alcohol-related workplace problems in Ireland***

Harmful use of alcohol can result in substantial economic costs or loss of labour-market productivity, in part through the direct health-related consequences of alcohol use, such as physical injuries in the workplace, and through absenteeism. Australian research has shown that alcohol-related absenteeism is not restricted to chronic heavy drinkers, but includes the much larger number of non-dependent drinkers who binge drink periodically.<sup>91</sup> High-risk drinkers were up to 22 times more likely to be absent from work because of their alcohol use compared to low-risk drinkers.

An Irish Business and Employers Confederation<sup>92</sup> survey, published in August 2011, reported that 4 per cent of companies cited alcohol and alcohol-related illnesses as a leading cause of short-term absence for men, while the figure is 1 per cent for females. Some 40 per cent of short-term absences occurred around the weekend. According to the most recent SLÁN survey, one in ten Irish drinkers aged 18–29 reported that their drinking had impacted negatively on their work or study in the previous year.<sup>6</sup>

### **Economic cost of alcohol in Ireland**

In 2007 the overall cost of harmful use of alcohol was estimated to be €3.7 billion, representing 1.9 per cent of GNP that year.<sup>27</sup> This estimate is based on the methods used in similar reports from other developed countries, including the UK, and used data from surveys and surveillance systems. A breakdown of these costs is presented in Table 7. These estimates include just the *tangible* costs of harmful use of alcohol and are an underestimate insofar as sufficient data are not available in Ireland to calculate some of the tangible costs included in estimates from other countries. No attempt is made to calculate the human or emotional costs of alcohol. When the unquantified human costs are considered, estimates of the tangible costs greatly understate the true cost of harmful use of alcohol to society.

**Table 7 Overall cost of harmful use of alcohol in Ireland in 2007**

	€ million	% of total cost
Cost to the healthcare system of alcohol-related illnesses	1,200	32
Cost of alcohol-related crime	1,189	32
Cost of alcohol-related road accidents	526	14
Cost of output lost due to alcohol-related absence from work	330	9
Cost of alcohol-related accidents at work	197	5
Cost of alcohol-related suicides	167	5
Cost of alcohol-related premature mortality	110	3
<b>Total</b>	<b>3,710</b>	<b>100</b>

## References

1. WHO Regional Office for Europe (2009) *Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm*. Copenhagen: World Health Organization.
2. WHO Regional Office for Europe (2009) *Handbook for action to reduce alcohol-related harm*. Copenhagen: World Health Organization.
3. Foley A (2010) *The economic contribution of the drinks industry*. Dublin: Drinks Industry Group of Ireland.
4. OECD (2011) *OECD Health Data 2011*.  
[http://stats.oecd.org/index.aspx?DataSetCode=HEALTH\\_STAT](http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT) Accessed 2 December 2011.
5. TNS Opinion and Social (2010) *EU citizens' attitudes towards alcohol. Special Eurobarometer 331*. Brussels: European Commission.
6. Morgan K, McGee H, Dicker P, Brugha R, Ward M, Shelley E, *et al.* (2009) *SLAN 2007: Survey of lifestyle, attitudes and nutrition in Ireland. Alcohol use in Ireland: a profile of drinking patterns and alcohol-related harm from SLAN 2007*. Dublin: Department of Health and Children.
7. Doyle P, Molcho M and Nic Gabhainn S (2009) *HBSC Ireland: age related patterns in alcohol consumption and cannabis use among Irish children between 1998-2006. Short report*. Galway: Health Promotion Research Centre, National University of Ireland.
8. Smyth BP, Kelly A and Cox G (2011) Decline in age of drinking onset in Ireland, gender and per capita alcohol consumption. *Alcohol Alcohol*. 46: 478-84.
9. CSO (2011) *National Average Price (Euro) by Consumer Item and Month*  
[http://www.cso.ie/px/pxeirestat/Dialog/varval.asp?ma=CPM04&ti=National%20Average%20Price%20\(Euro\)%20by%20Consumer%20Item%20and%20Month&path=/px/pxeirestat/Database/Eirestat/Consumer%20Prices/&lang=1](http://www.cso.ie/px/pxeirestat/Dialog/varval.asp?ma=CPM04&ti=National%20Average%20Price%20(Euro)%20by%20Consumer%20Item%20and%20Month&path=/px/pxeirestat/Database/Eirestat/Consumer%20Prices/&lang=1)  
Accessed 18 September 2011.
10. Anderson P, de Bruijn A, Angus K, Gordon R and Hastings G (2009) Impact of alcohol advertising and media exposure on adolescent alcohol use: a systematic review of longitudinal studies. *Alcohol Alcohol*. 44: 229-43.
11. Alcohol Action Ireland (2010) *Have we bottled it? Behaviour and attitudes survey*. Presented at the *Have We Bottled It? Alcohol Marketing and Young People* conference, Dublin, 15 September 2010
12. Lyons S, Lynn E, Walsh S, Sutton M and Long J (2011) *Alcohol-related deaths and deaths among people who were alcohol dependent in Ireland, 2004 to 2008*. Dublin: Health Research Board.
13. Martin J, Barry J, Goggin D, Morgan K, Ward M and O'Suilleabhain T (2010) Alcohol-attributable mortality in Ireland. *Alcohol Alcohol*. 45: 379-86.
14. Bedford D, O'Farrell A and Howell F (2006) Blood alcohol levels in persons who died from accidents and suicide. *Irish Medical Journal*. 99: 80-3.
15. National Suicide Research Foundation (2011) *National Registry of Deliberate Self Harm annual report 2010. Annual Report*. Cork: National Suicide Research Foundation.
16. Rehm J, Room R, Graham K, Monteiro M, Gmel G and Sempos CT (2003) The relationship of average volume of alcohol consumption and patterns of drinking to burden of disease: an overview. *Addiction*. 98: 1209-1228.

17. Martin J, Barry J and Skally M (2011) Alcohol Attributable Hospitalisations and Costs in Ireland, 2000-2004. *Ir Med J.* 104: 140-4.
18. Hope A, Gill A, Costello G, Sheehan J, Brazil E and Reid V (2005) *Alcohol and injuries in the accident and emergency department - a national perspective.* Dublin: Department of Health and Children.
19. Mongan D (2010) The burden of alcohol-related morbidity on hospital services. *Drugnet Ireland.* pp. 9-12.
20. Carew A, Bellerose D and Lyons S (2011) *Treated problem alcohol use in Ireland, 2005 to 2010. HRB Trends Series 11.* Dublin: Health Research Board.
21. Brierley M (2010) *Tracing and tracking of children subject to a special care application. CAAB research report No. 8.* Dublin: Children Acts Advisory Board.
22. Anderson P and Baumberg B (2006) *Alcohol in Europe: a public health perspective.* London: Institute of Alcohol Studies.
23. McKeown K, Lehane P, Rock R, Haase T and Pratschke J (2002) *Unhappy marriages: does counselling help?* Kildare: Accord.
24. O'Connor C (2001) *Marital counselling research project.* Dublin: Department of social community and family affairs.
25. Watson D and Parsons S (2005) *Domestic abuse of women and men in Ireland.* Dublin: Stationery Office.
26. Hanly C, Healy D and Scriver S (2009) *Rape and justice in Ireland. A national study of survivor, prosecutor and court responses to rape.* Dublin: The Liffey Press
27. Byrne S (2011) *Costs to society of problem alcohol use in Ireland.* Dublin: Health Service Executive.
28. An Garda Síochána (2006) *Annual Report of An Garda Síochána 2006.* Dublin: An Garda Síochána.
29. An Garda Síochána (2009) *Annual Report of An Garda Síochána 2009.* Dublin: An Garda Síochána.
30. Rabinovich L, Brutscher P, de Vries H, Tiessen J, Clift J and Reding A (2009) *The affordability of alcoholic beverages in the European Union. Understanding the link between alcohol affordability, consumption and harms.* Cambridge, UK: RAND Europe.
31. Meier P, Brennan A, Purshore R, Taylor K, Rafia R, Booth A, *et al.* (2008) *Independent review of the effects of alcohol pricing and promotion: Part B: Modelling the potential impact of pricing and promotion policies for alcohol in England: Results from the Sheffield alcohol policy model* Sheffield: University of Sheffield.
32. Babor T, Caetano R, Casswell S, Edwards G, Giesbrecht N, Graham K, *et al.* (2003) *Alcohol: No ordinary commodity - research and public policy.* New York: Oxford University Press
33. Nic Gabhainn S, O'Higgins S, Galvin M, Kennedy C and Barry M (2007) *The Implementation of SPHE at Post Primary Level: a case study approach. Executive Summary. Report to Social, Personal & Health Education Support Service.* Galway: NUIG.



34. Barry S, Kearney A, Lawlor E, McNamee E and Barry J (2007) *The Coombe Women's Hospital study of alcohol, smoking and illicit drug use, 1988-2005*. Dublin: Coombe Women's Hospital.
35. Mullaly A, Cleary B, Barry J, Fahey T and Murphy D (2011) Prevalence, predictors and perinatal outcomes of peri-conceptual alcohol exposure - retrospective cohort study in an urban obstetric population in Ireland. *BMC Pregnancy and Childbirth* 11: 27.
36. O'Gorman A and Corrigan D (2007) *Report of the HSE working group on residential treatment and rehabilitation (substance users)*. Dublin HSE
37. North West Alcohol Forum (2011) *Assessment of incidences of alcohol-related brain injury (ARBI) in the HSE West (Donegal, Sligo, Leitrim) and Western Health and Social Care Trust areas*. Donegal: North West Alcohol Forum.
38. Hibell B, Guttormsson U, Ahlström S, Balakireva O, Bjarnason T, Kokkevi A, et al. (2009) *The 2007 ESPAD report: substance use among students in 35 European countries*. Stockholm: The Swedish Council for Information on Alcohol and Other Drugs (CAN) and the Pompidou Group of the Council of Europe.
39. Rehm J (1998) Measuring quantity, frequency, and volume of drinking. *Alcohol Clin Exp Res*. 22: 4S-14S.
40. American Medical Association (AMA) (2002) *Harmful consequences of alcohol use on the brains of children, adolescents and college students*.
41. U.S. Department of Health and Human Services (2007) *The Surgeon General's call to action to prevent and reduce underage drinking*. U.S. Department of Health and Human Services: Office of the Surgeon General.
42. Grant BF and Dawson DA (1997) Age at onset of alcohol use and its association with DSM-IV alcohol abuse and dependence: results from the National Longitudinal Alcohol Epidemiologic Survey. *Journal of Substance Abuse*. 9: 103-10.
43. Nic Gabhainn S, Kelly C and Molcho M (2007) *The Irish Health Behaviour in School-aged Children (HBSC) study 2006*. Dublin: Department of Health and Children.
44. O'Farrell AM, Allwright SP, Kenny SC, Roddy G and Eldin N (2010) Alcohol use among amateur sportsmen in Ireland. *BMC Res Notes*. 3: 313.
45. Palmer D and O'Reilly G (2008) *Young people, alcohol and drugs*. Cork: Juvenile Mental Health Matters.
46. Pitkanen T, Lyyra A-L and Pulkkinen L (2005) Age of onset of drinking and the use of alcohol in adulthood: A follow-up study from age 8-42 for females and males. *Addiction* 100: 652-661.
47. DeWit DJ, Adlaf EM, Offord DR and Ogborne AC (2000) Age at first alcohol use: a risk factor for the development of alcohol disorders. *Am J Psychiatry*. 157: 745-50.
48. O'Malley PM, Johnston LD and Bachman JG (1998) Alcohol use among adolescents. *Alcohol Health Res World*. 22: 85-93.
49. Wells JE, Horwood LJ and Fergusson DM (2004) Drinking patterns in mid-adolescence and psychosocial outcomes in late adolescence and early adulthood. *Addiction*. 99: 1529-41.

50. Trutz Haase and Pratschke J (2010) *Risk and Protection Factors for Substance Use among Young People: A comparative study of early school-leavers and school-attending students*. Dublin: National Advisory Committee on Drugs.
51. Rundle K, Leigh C, McGee H and Layte R (2004) *Irish contraception and crisis pregnancy study: A survey of the general population*. Dublin: Crisis pregnancy agency.
52. Donnelly JC, Cooley SM, Walsh TA, Sarkar R, Durnea U and Geary MP (2008) Illegal drug use, smoking and alcohol consumption in a low-risk Irish primigravid population. *Journal of Perinatal Medicine*. 36: 70-2.
53. Babor T, Caetano R, Casswell S, Edwards G, Giesbrecht N, Graham K, et al. (2010) *Alcohol: No ordinary commodity - research and public policy. Second Edition*. New York: Oxford University Press
54. All Ireland Traveller Health Study Team (2010) *All Ireland Traveller Health Study* Dublin: School of Public Health, Physiotherapy and Population Science, University College Dublin.
55. Lawless M and Corr C (2005) *Drug use among the homeless population in Ireland*. Dublin: National Advisory Committee on Drugs.
56. Linehan SA, Duffy DM, Wright B, Curtin K, Monks S and Kennedy HG (2005) Psychiatric morbidity in a cross-sectional sample of male remanded prisoners. *Irish Journal of Psychological Medicine* 22: 128-132.
57. Mayock P, Bryan A, Carr N and Kitching K (2009) *Supporting LGBT Lives: A Study of the Mental Health and Well-Being of Lesbian, Gay, Bisexual and Transgender people*. Dublin: National Office of Suicide Prevention.
58. National Advisory Committee on Drugs and Public Health Information and Research Branch (2009) *Drug use in Ireland and Northern Ireland: 2006/2007 drug prevalence survey: polydrug use results. Bulletin 5*. Dublin: National Advisory Committee on Drugs.
59. Carew A (2010) *Treated problem alcohol use in Ireland: 2008 figures from the National Drug Treatment Reporting System*. Dublin: Health Research Board.
60. Carew A (2010) *Treated problem drug use in Ireland: 2008 figures from the National Drug Treatment Reporting System*. Dublin: Health Research Board.
61. National Youth Council of Ireland (2009) *Get 'em young: Mapping young people's exposure to alcohol marketing in Ireland*. Dublin: NYCI.
62. Tapert SF, Cheung EH, Brown GG, Frank LR, Paulus MP, Schweinsburg AD, et al. (2003) Neural response to alcohol stimuli in adolescents with alcohol use disorder. *Arch Gen Psychiatry*. 60: 727-35.
63. Austin EW, Chen MJ and Grube JW (2006) How does alcohol advertising influence underage drinking? The role of desirability, identification and skepticism. *J Adolesc Health*. 38: 376-84.
64. Gordon R, Mackintosh AM and Moodie C (2010) The Impact of Alcohol Marketing on Youth Drinking Behaviour: A Two-stage Cohort Study. *Alcohol Alcohol*. 45: 470-480.
65. Gordon R, Moodie C, Eadie D and Hastings G (2010) Critical social marketing - The impact of alcohol marketing on youth drinking: Qualitative findings. *International Journal of Nonprofit and Voluntary Sector Marketing*. 15: 267-275.

66. O'Brien KS and Kypri K (2008) Alcohol industry sponsorship and hazardous drinking among sportspeople. *Addiction*. 103: 1961-6.
67. Kenny P (2010) *Alcohol marketing: reviewing the evidence and pushing the boundaries of "interactivity"*. Presented at the *Have We Bottled It? Alcohol Marketing and Young People* conference, Dublin, 15 September 2010
68. Rehm J, Greenfield TK and Rogers JD (2001) Average volume of alcohol consumption, patterns of drinking, and all-cause mortality: results from the US National Alcohol Survey. *Am J Epidemiol*. 153: 64-71.
69. World Health Organization (2004) *Global Status Report on Alcohol 2004* Geneva: WHO.
70. Poikolainen K, Paljärvi T and Makela P (2007) Alcohol and the preventive paradox: serious harms and drinking patterns. *Addiction*. 102: 571-578.
71. Rossow I and Romelsjo A (2006) The extent of the 'prevention paradox' in alcohol problems as a function of population drinking patterns. *Addiction*. 101: 84-90.
72. Gmel G, Klingemann S, Muller R and Brenner D (2001) Revising the preventive paradox: the Swiss case. *Addiction*. 96: 273-84.
73. Institute of Alcohol Studies (2010) *Alcohol and the elderly*. London: IAS.
74. Room R, Graham K, Rehm J, Jernigan D and Monteiro M (2003) Drinking and its burden in a global perspective: policy considerations and options. *European Addiction Research* 9: 165-175.
75. O'Toole O, Mahon C, Lynch K and Brett FM (2009) Is the contribution of alcohol to fatal traumatic brain injuries being underestimated in the acute hospital setting? *Irish Medical Journal*. 102: 207-209.
76. Daly A, Walsh D, Ward M and Moran R (2006) *Activities of Irish psychiatric units and hospitals 2005*. Dublin: Health Research Board.
77. Daly A, Walsh D and Moran R (2007) *Activities of Irish psychiatric units and hospitals 2006*. Dublin: Health Research Board.
78. Daly A, Walsh D and Moran R (2008) *Activities of Irish psychiatric units and hospitals 2007*. Dublin: Health Research Board.
79. Daly A and Walsh D (2009) *Activities of Irish Psychiatric Units and Hospitals 2008*. HRB Statistics Series 7. Dublin: Health Research Board.
80. Daly A, Walsh D and Moran R (2010) *Activities of Irish Psychiatric Units and Hospitals 2009*. HRB Statistics Series 9. Dublin: Health Research Board.
81. Daly A and Walsh D (2011) *Activities of Irish Psychiatric Units and Hospitals 2010*. HRB Statistics Series 15. Dublin: Health Research Board.
82. Bedford D, McKeown N, O'Farrell A and Howell F (2009) Alcohol levels in killed drivers and pedestrians on Irish roads 2003-2005: A national study. *Irish Medical Journal*. 102: 310-314.
83. Mongan D, Hope A and Nelson M (2009) *Social consequences of harmful alcohol use in Ireland*. HRB Overview Series 9. Dublin: Health Research Board.
84. Prime Minister's Strategy Unit (2004) *Alcohol harm reduction strategy for England*. London: Prime Minister's Strategy Unit.
85. Butler S (2002) Addiction problems, addiction services, and social work in the Republic of Ireland. *Straussner, Shulamith Lala Ashenberg (Ed) Harrison, Larry (Ed)*. (2002). International aspects of social work practice in the addictions. (pp. 31-48). 161 pp. Binghamton: US: Haworth Social Work Practice Press.

86. Alcohol Action Ireland (2009) *Keeping it in the family. Parental drinking among 18-40 year olds: prevalence and impact*. Dublin: Alcohol Action Ireland.
87. Eurocare and COFACE (1998) *Alcohol problems in the family. A report to the European Union*. England: Eurocare.
88. Klingemann H and Gmel G (2001) *Mapping the social consequences of alcohol consumption*. Dordrecht: Kluwer Academic Publishers
89. Dooley E (1995) *Homicide in Ireland 1972-1991*. Dublin: Department of Justice.
90. National Crime Council (2003) *Public order offences in Ireland*. Dublin: National Crime Council.
91. Roche AM, Pidd K, Berry JG and Harrison JE (2008) Workers' drinking patterns: the impact on absenteeism in the Australian work-place. *Addiction*. 103: 738-48.
92. IBEC (2004) *Employee Absenteeism: A Guide to Managing Absence*. Dublin: IBEC - the Irish Business and Employers Confederation.

## Appendix 2 Glossary of Terms

Advertising Standards Authority for Ireland	–	ASAI
Alcohol Beverage Federation of Ireland	–	ABFI
Alcohol by Volume	–	ABV
Alcohol Marketing Communications Monitoring Body	–	AMCMB
Alcohol Related Brain Injury	–	ARBI
Alcohol Use Disorders Identification Test – Consumption	–	AUDIT-C
Applied Suicide Intervention Skills Training	–	ASIST
Blood Alcohol Concentration	–	BAC
Broadcasting Authority of Ireland	–	BAI
Central Copy Clearance Ireland	–	CCCI
Central Statistics Office	–	CSO
Closed Circuit Television	–	CCTV
College of Psychiatry of Ireland, The	–	CPI
Community Mental Health Team	–	CMHT
Co-operation and Working Together	–	CAWT
Department of Children and Youth Affairs	–	D/CYA
Department of Community, Rural and Gaeltacht Affairs	–	D/CRGA
Department of Education and Skills	–	D/E&S
Department of Environment, Community and Local Government	–	D/ECLG
Department of Environment, Heritage and Local Government	–	D/EHLG
Department Health	–	D/H
Department of Jobs, Enterprise and Innovation	–	D/JE&I
Department of Justice and Equality	–	D/J&E
Department of Transport, Tourism and Sport	–	D/TT&S
European School Survey Project on Alcohol and other Drugs	–	ESPAD
European Union	–	EU
Fetal Alcohol Syndrome Disorder	–	FASD
Gaelic Athletics Association	–	GAA
General Practitioner	–	GP
Gross National Product	–	GNP
Health Behaviour in School-Aged Children survey	–	HBSC
Health Information and Quality Authority	–	HIQA
Health Research Board	–	HRB

Health Service Executive	–	HSE
Home School Community Liaison scheme	–	HSCL
Hospital In-Patient Enquiry	–	HIPE
Human Immunodeficiency Virus	–	HIV
Irish Business and Employers Confederation	–	IBEC
Irish College of General Practitioners	–	ICGP
Irish Congress of Trade Unions	–	ICTU
Lesbian, Gay, Bisexual, Transgender	–	LGBT
Local Drugs Task Forces	–	LDTFs
Mature Enjoyment of Alcohol in Society	–	MEAS
National Addiction Training Programme	–	NATP
National Advisory Committee on Drugs	–	NACD
National Drug Related Deaths Index	–	NDRDI
National Drug Treatment Reporting System	–	NDTRS
National Drugs Rehabilitation Implementation Committee	–	NDRIC
National Drugs Strategy	–	NDS
National Health and Lifestyle Survey	-	SLÁN
National Health Service	–	NHS
National Institute for Health and Clinical Excellence	–	NICE
National Psychiatric In-Patient Reporting System	–	NPIRS
National Service Level Agreement	–	NSLA
National University of Ireland, Galway	–	NUIG
National Youth Council of Ireland	–	NYCI
Person Years of Life Lost	–	PYLL
Police Using Leading Systems Effectively	–	PULSE
Regional Drugs Task Forces	–	RDTFs
Responsible Retailing of Alcohol in Ireland	–	RRAI
Road Traffic Accident	–	RTA
Screening and Brief Interventions	–	SBI
Social Personal Health Education	–	SPHE
Special Exemption Order	–	SEO
Special Projects to assist disadvantaged Youth	–	SPY
Specific, Measurable, Attainable, Realistic, Time-bound	–	SMART
United Kingdom	–	UK

Value Added Tax	–	VAT
World Health Organization	–	WHO
Young People’s Facilities and Services Fund	–	YPFSF

### **Appendix 3 Section 16 of the Intoxicating Liquor Act 2008**

*Regulations relating to sale, supply and consumption of intoxicating liquor.*

#### **16.**

(1) Subject to *subsection (2)*, the Minister may make regulations—

- (a) prohibiting or restricting a person from advertising or promoting the sale or supply of intoxicating liquor at a reduced price or free of charge on the purchase of any quantity of intoxicating liquor or of any other product or service;
- (b) prohibiting or restricting a licensee from selling or supplying intoxicating liquor at a reduced price or free of charge to any person on the purchase by that person, or by any other person, of any quantity of intoxicating liquor or of any other product or service;
- (c) prohibiting or restricting a person from doing or permitting, for the purposes of promoting that person's business or any event or activity taking place in a place other than a place used as an occupied private residence, anything that is intended or likely to encourage persons in that place to consume intoxicating liquor to an excessive extent.

(2) In making regulations under this section, the Minister shall have regard to the need to reduce the consumption by persons of intoxicating liquor to an excessive extent and, without prejudice to the generality of that need, in particular have regard to—

- (a) the need to reduce the risk of a threat to public order arising from the consumption of intoxicating liquor to an excessive extent;
- (b) the health-related risks arising from the consumption of intoxicating liquor to an excessive extent; and
- (c) in the case of advertising referred to in *subsection (1)* where the Minister is satisfied that the medium used for the advertising, or the nature of the advertising, or both, is intended or likely to encourage the consumption of intoxicating liquor to an excessive extent, the need to prohibit or restrict such advertising.

(3) Regulations made under this section may be expressed to apply by reference to one or more of the following:

- (a) a class or classes of licensed premises;
- (b) a class or classes of non-licensed premises (other than occupied private residences);
- (c) a class or classes of intoxicating liquor; and



- (d) a class or classes of advertising.
- (4) (a) A person who contravenes regulations made under this section is guilty of an offence.
- (b) A person guilty of an offence under *paragraph (a)* is liable—
- (i) on summary conviction, to a fine not exceeding €5,000, or
- (ii) on conviction on indictment, to a fine not exceeding €100,000.
- (5) Every regulation made under this section shall be laid before each House of the Oireachtas as soon as may be after it is made and, if a resolution annulling it is passed by either House within the next subsequent 21 days on which that House has sat after the regulation is laid before it, it shall be annulled accordingly, but without prejudice to the validity of anything previously done under it.
- (6) For the purposes of this section, the sale or supply of intoxicating liquor at a reduced price or free of charge includes—
- (a) the award, whether directly or indirectly, of bonus points, loyalty card points, or any similar benefit, to any person arising from the purchase by that person, or by any other person, of any intoxicating liquor;
- (b) the use of any such points or benefit, whether directly or indirectly, to obtain intoxicating liquor, or any other product or service, at a reduced price or free of charge; and
- (c) the use, whether directly or indirectly, of bonus points, loyalty card points, or any similar benefit, arising from the purchase of any product or service to obtain intoxicating liquor at a reduced price or free of charge.
- (7) This section shall also apply in relation to a club registered under the Registration of Clubs Acts 1904 to 2008 as if references in this section to a licensee were references to the secretary of such a club and with any other necessary modifications.

#### Appendix 4 Membership of Steering Group<sup>xxiv</sup>

Name	Organisation
Dr Tony Holohan (Co-Chair) Dr John Devlin Robbie Breen ( <i>Replaced during process by:</i> ) Liam McCormack	Department of Health
Kathleen Stack (Co-Chair from Dec 2009 to June 2010) John Collins (Co-Chair from June 2010 to May 2011) Michael Conroy Eddie Arthurs (until April 2011)	Department of Community, Rural and Gaeltacht Affairs ( <i>Department of Health from May 2011</i> )
Kathleen Connolly	Department of Justice, Equality and Law Reform
John Moloney	Department of Education and Skills
Theresa Donohue Meetings also attended by: <ul style="list-style-type: none"> <li>• Rob Walsh</li> </ul>	Department of Environment, Community and Local Government
Albert O'Donoghue	Department of Children and Youth Affairs
Conor O'Malley ( <i>Replaced during process by:</i> ) Michelle O'Mahony Meetings also attended by: <ul style="list-style-type: none"> <li>• Betty Griffin</li> <li>• Sabina O'Donnell</li> </ul>	Department of Arts, Sport and Tourism ( <i>In May 2011 the functions of that Department were transferred to the Department of Transport, Tourism and Sport and Department of Arts, Heritage and the Gaeltacht</i> )
Eddie Matthews Professor Joe Barry William Ebbitt	Health Service Executive

<sup>xxiv</sup> Originally the Steering Group was jointly chaired by the Department of Health and Children and the Department of Community, Rural and Gaeltacht Affairs (which later became the Department of Community, Equality and Gaeltacht Affairs). Following the transfer of the functions of the Office of the Minister for Drugs into the Department of Health in May 2011, the Steering Group was solely chaired by the Department of Health.

Meetings also attended by: <ul style="list-style-type: none"> <li>• Joe Doyle</li> </ul>	
Michael O'Sullivan Meetings also attended by: <ul style="list-style-type: none"> <li>• Eva Micheau</li> </ul>	An Garda Síochána
Dr Eamonn Keenan Dr William Flannery	The College of Psychiatry of Ireland
Dr Declan Bedford	Royal College of Physicians in Ireland
Rolande Anderson	Irish College of General Practitioners
Fergus McCabe	Community Sector
Tony Geoghegan Willie Collins	Voluntary Sector
Noel Brett	Road Safety Authority
Denis Bradley	National Advisory Committee on Drugs
Fiona Ryan Meetings also attended by: <ul style="list-style-type: none"> <li>• Cliona Murphy</li> </ul>	Alcohol Action Ireland
Sadie Grace Meetings also attended by: <ul style="list-style-type: none"> <li>• Megan O'Leary</li> </ul>	Family Support Network
Kieran Sludds	Health and Safety Authority
James Doorley	Youth Council of Ireland
Rosemary Garth ( <i>Replaced during process by:</i> ) Kathryn D'arcy	Alcohol Beverage Federation of Ireland
Fionnuala Sheehan	MEAS Ltd
Jean Long Deirdre Mongan	Health Research Board
Secretariat: Linda O'Rourke  Clare O'Reilly	Department of Community, Rural and Gaeltacht Affairs ( <i>Department of Health after 1 May 2011</i> ) Department of Health

## **Appendix 5 List of Written Submissions received**

### **Personal Submissions:**

Dr Brion Sweeney  
Norman Warden  
Marie Claire Van Hout  
Joe O'Neill  
Maurice Fitzgerald  
James Moran  
Patrick McCarthy  
Anne Timoney  
Ronan

### **Organisations:**

Alcohol Action Ireland  
Alcohol Beverage Federation of Ireland  
Alcohol and Substance Abuse Prevention (A.S.A.P.) Programme, GAA  
Ana Liffey Drug Project  
Ballymun Local Drugs Task Force  
Barnardo's  
Bill W Club  
Blanchardstown Local Drugs Task Force  
Canal Communities LDTF  
Cavan RAPID Drug & Alcohol Working Group  
Civic Alcohol Forum, Derry City Council  
Clare Social Inclusion Measures Group  
Clondalkin Local Drugs Task Force  
Consultant Psychiatrists in Adolescent Addiction (CPSAA)  
Cork Local Drugs Task Force  
Cork HSE South  
Co. Cork Youth Council and Comhairle na nÓg  
Crosscare Drug and Alcohol Programme  
Dental Health Foundation  
Donegal parents  
Dublin North East Local Drugs Task Force  
Dun Laoghaire Rathdown Local Drugs Task Force  
Faculty of Addictions Psychiatry, The College of Psychiatry of Ireland  
Faculty of Public Health Medicine, Royal College of Physicians of Ireland  
Family Therapy Team, Family Therapy and Consultation Service, HSE West  
Fetal Alcohol Spectrum Disorders (FASD)  
Finglas/Cabra Local Drugs Task Force  
Foróige  
Galway City Partnership  
Greater Blanchardstown Response to Drugs  
Health Service Executive  
Health Research Board  
HSE Addictions Services Dublin/North East  
HSE South East  
Inishowen Youth Council of the Comhairle na nÓg in Donegal  
Irish College of General Practitioners

Irish Hospice Foundation  
Irish National Teachers' Organisation  
Licenced Vintners Association  
LDTF Co-ordinators Network  
Merville & District Alcohol Awareness  
National Youth Council of Ireland  
North Inner City Local Drugs Task Force  
North West Stakeholders (North West Alcohol Forum and North West Regional Drugs Task Force)  
North West Alcohol Forum  
Office of the Minister for Children and Youth Affairs – Teenagers' Views on Solutions to Alcohol Misuse  
PARC Road Safety Group  
Rise Foundation of Ireland, The  
SharingPoint  
SIPTU  
South Dublin Joint Policing Forum – Cllr William Lavelle, Mr Jim Lawlor  
Southern Regional Drugs Task Force  
Traveller Specific Drugs Initiative, Pavee Point  
Traveller Visibility Group, The Traveller Support Project on Drugs and Alcohol  
Vintners Federation of Ireland  
White Oaks Treatment Centre

An Oral Submission was made to members of the Steering Group on 26 January 2011 by the Institute of Advertising Practitioners in Ireland (representing RTÉ; National Newspapers of Ireland; Independent Broadcasters of Ireland; TV3; Setanta Ireland; Carlton Screen Cinema; Outdoor Media Association; Advertisers Association of Ireland; Regional Newspapers and Printers Association of Ireland; and Magazines Ireland).

