# Strategic Task Force on Alcohol

# Interim Report

# May 2002

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# Interim Report

DEPARTMENT
OF HEALTH AND
CHILDREN
AN ROINN
SLÁINTE AGUS LEANAÍ

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## SECTION F - APPENDICES

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# SECTION A - INTRODUCTION

## 1. Background

The Commission on Liquor Licensing was established by the Minister for Justice, Equality and Law Reform in November 2000 to review the Liquor Licensing system in Ireland. The Commission published an Interim Report with a set of recommendations[1], one of which was the establishment of a task force. A High Level Inter-Departmental Working Group considered the report and certain actions were agreed by different Government Departments. The Department of Health and Children agreed to establish a Strategic Task Force on Alcohol.

## 2. Strategic Task Force

The Minister for Health and Children, Mr. Micheál Martin, T.D., expanded the brief of the Strategic Task Force outlining the following terms of reference and requested interim recommendations within three months of its first meeting.

### Terms of Reference

1. To review international research so as to identify evidence based measures effective in preventing alcohol related harm.

2. To examine the changes in alcohol consumption and related harm in the last decade.

3. To examine attitudes and actions that have influenced alcohol policy in Ireland since the publication of the National Alcohol Policy, 1996.

4. To recommend specific, evidence based, measures to Government to prevent and reduce alcohol related harm in Ireland.

5. The Task Force should produce interim recommendations on effective measures within three months of its first meeting.

Members of the Strategic Task Force represent Government Departments, state agencies and others who have an important role to play in preventing and reducing alcohol related harm in Irish society. The task force met four times and discussions were enhanced by papers presented by Dr. Robin Room* and Dr. Ann Hope*.

*Dr. Room, an international research expert on alcohol issues, was invited by the Minister for Health and Children to address the International Conference Alcohol Policy - A Public Health Perspective held in Dublin Castle in November 2001. A summary of his paper *Alcohol policy effectiveness* was presented to the Strategic Task Force on Alcohol. A second document was requested to examine the question *Would reducing the level of alcohol consumption reduce the rates of alcohol related harm? The state of evidence.* The full text of these two documents can be found in Appendices A and B.

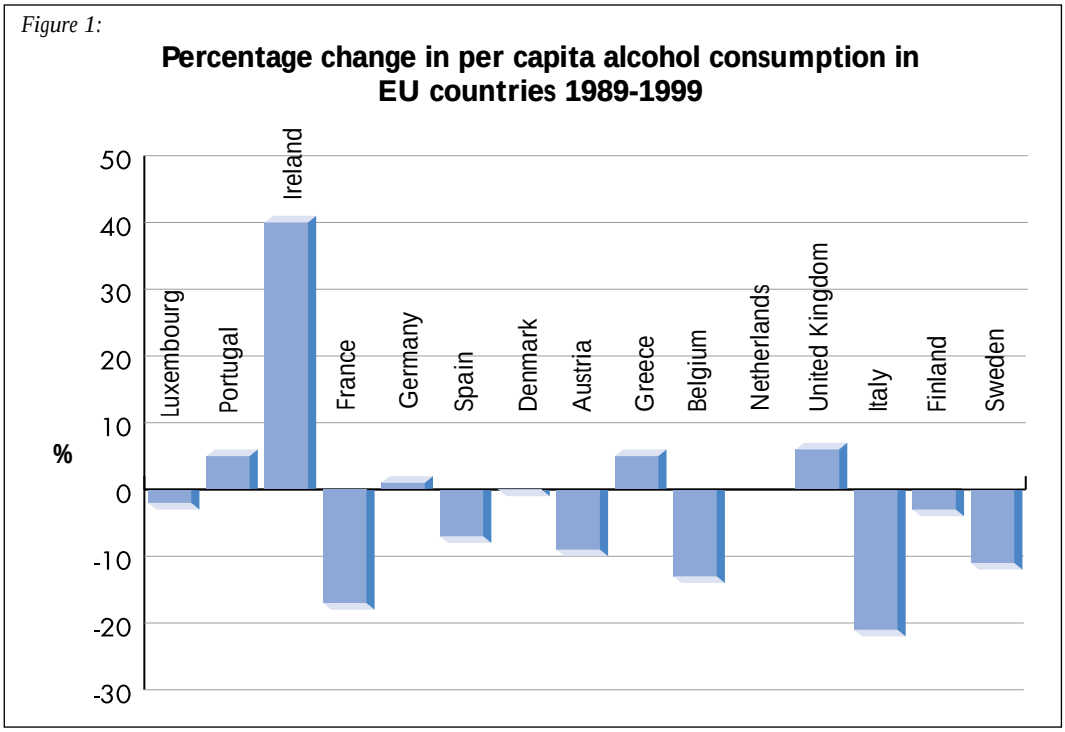
* Dr. Ann Hope is the National Alcohol Policy Advisor to the Department of Health and Children.

# Section B - Overview of Alcohol Consumption

## 3. Alcohol consumption in Ireland

In the last decade, Ireland has seen many changes which have influenced the context and nature of drinking and increased alcohol related harm. Against the backdrop of the fastest growing economy in Europe, Ireland has had the highest increase in alcohol consumption among EU countries. Between 1989 and 1999, alcohol consumption per capita in Ireland increased by 41%, while ten of the European Union Member States showed a decrease and three other countries showed a modest increase during the same period (Figure 1). Ireland's consumption continued to increase in 2000 and ranked second after Luxembourg for alcohol consumption with a rate of 11 litres of pure alcohol per head of population (Appendix C). The EU average for 2000 was 9.1 litres of pure alcohol per capita.

*Figure 1:*



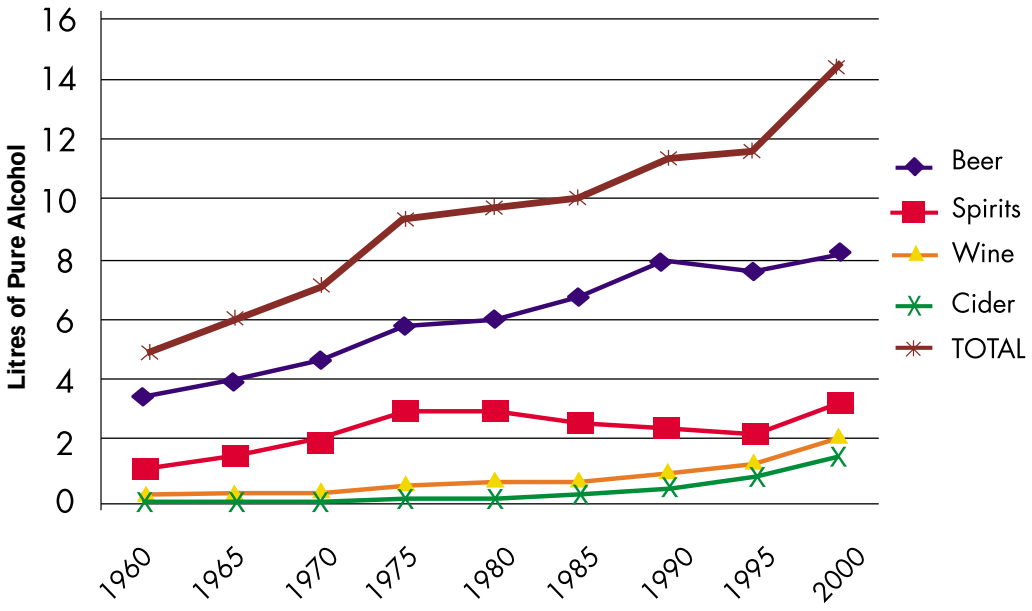

*Source: Ireland -Revenue Commissioners and Central Statistics Office; others World Drinks Trends.*

Alcohol consumption per adult, aged 15 years and over, is a more accurate reflection of consumption at the population level, given that children under 15 years are primarily non-drinkers and represent 21% of the population. In Ireland the trend in alcohol consumption per adult over the last forty years shows a gradual increase up to the mid 1990's. However since 1995 there has been a dramatic increase in consumption (Figure 2). In 2000 the total alcohol consumption per adult was 14.2 litres of pure alcohol.

While beer continues to dominate the alcohol market, although at a reduced share, the sales of wine and cider have seen substantial growth. Spirits consumption dropped between 1992 and 1995. However in 1996 there was a dramatic reversal with a 10% increase in spirit sales in that year and similar increased growth has continued to the present. The increase in spirits consumption is partly due to the new 'designer drinks' which are targeted at the young adult market and the popular party chasers such as 'vodka and red bull'. Cider showed the most consistent growth rate over the last decade and had a market share of about 9% in 2000.

*Figure 2:*

**Consumption of Beer, Spirits, Wine and Cider per adult (15 years and over), in litres of pure alcohol, Ireland 1960-2000.**




*Source: Revenue Commissioners and CSO Annual Reports*

## 4. Drinking Patterns

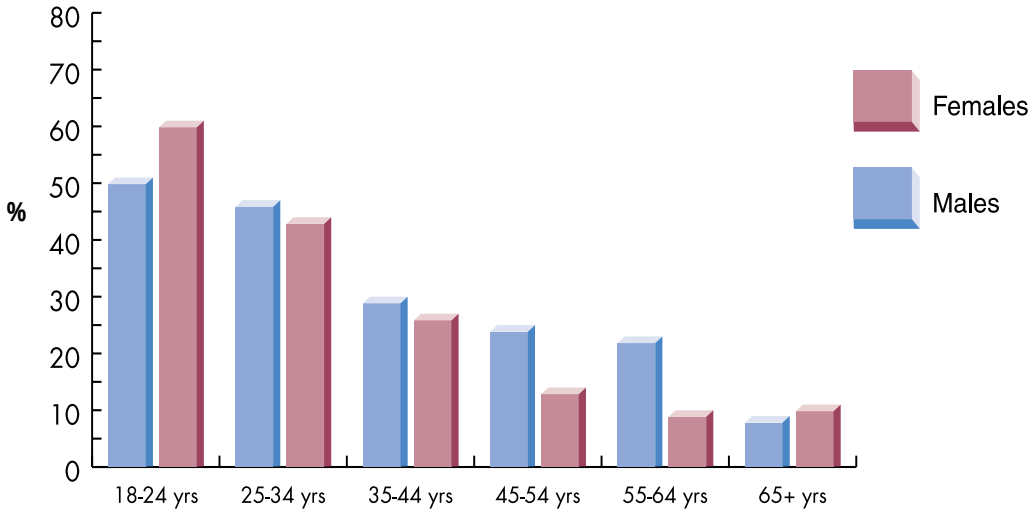
Drinking patterns have been influenced by societal changes, changing lifestyles and expectations, more disposable income, the lessening of parental control on young people and a strong focus on consumerism has ensured a dynamic relationship between market place and consumer.

### 4.1 Underage Drinking

Many adolescents experiment with alcohol, with rates of experimentation increasing steadily with age. The Health Behaviour in School-Aged Children (HBSC)[2] survey showed that over half of Ireland's young people begin experimenting with alcohol before the age of 12. In the younger age groups (under 15 years) more boys than girls are current drinkers, about one in five of the 12-14 year old boys are current drinkers. By the time they reach the 15-16 age group, half of the girls and two-thirds of the boys are current drinkers[3]. Some of these young drinkers are consuming large quantities of alcohol. Of particular concern is the level of binge drinking and drunkenness. One third of the 15-16 age group reported binge drinking (5 or more drinks in a row) 3 or more times in the last month and one-quarter reported having been drunk 3 or more times in the last month. The question must be posed where are these young people accessing alcohol? For the very young, under 15 years, they obtain alcohol by taking it from the drink supply at home, they are given it by parents or older siblings and friends who buy alcohol for them[4]. For the 15-17 year olds they access alcohol mainly through pubs, club/discos and off-licenses[3,4]. Drinking in someone else's home was also mentioned by all ages as a way to access alcohol.

*Figure 3:*

**High Risk Drinking per session for those aged 18 years and over**




*High risk drinking -70 grams or higher of pure alcohol for males; 50 grams or higher of pure alcohol for females*
*Source: SLÁN Survey, 1999*

## 4.2 Adult Drinking

The first national lifestyle survey (SLÁN) in 1999, commissioned by the Department of Health and Children, reported on the drinking habits of those aged 18 years and over. Important age differences emerged which showed that over half in the younger age group (18-24 years) were more likely to engage in binge drinking when they drank, but drank less frequently (fewer times per week) than older age groups (Appendix D). More females than males in the 18-24 age group were likely to engage in high risk drinking, both in terms of binge drinking and drinking over the recommended weekly upper limits[2] (Figure 3).

# Section C - Evidence of Alcohol Related Harm

## 5. Alcohol related harm

The adverse effects of alcohol extend beyond physical health issues to mental, social and financial problems. There is a continuum of problems, which can affect everyone across the community. These problems range from a once off problem (fall, accident, fight, unprotected sex) to a recurring problem (poor work performance, financial hardship, relationship difficulties), chronic illness (cancer, liver damage) and to a sustained dependence (alcoholic disorder). Some of these problems, especially the acute problems, arise where the light or moderate drinker drinks to excess on a single drinking occasion, while others result from regular heavy drinking over a longer period of time. Therefore drinking patterns can have an important influence on the level and extent of alcohol related harm across the whole population. The list of harm indicators currently used in Ireland where alcohol use and abuse plays a substantial role are discussed under the following headings:

- Unintentional injuries / personal harm
- Personal relationships
- Interpersonal violence / public safety
- Drink driving
- Alcohol related mortality
- Mental health problems
- Cost of alcohol related problems

### 5.1 Unintentional Injuries / Personal Harm

Many falls, drowning and burns resulting in injury and death have been linked to alcohol consumption. In Australia, 34% of accidental falls were attributable to alcohol. In Ireland during 1997, 62,561 people were hospitalised due to accidents, poisoning and violence. Of those, accidental falls accounted for 23,475 people who were hospitalised in acute hospitals which required an average stay in hospital of 5.76 days[5].

A pilot study of alcohol related attendance in the emergency room showed that alcohol was a factor for one in four (25%) of those in attendance at the hospital Accident and Emergency Department and 13% were clinically intoxicated. The vast majority of patients where alcohol was involved were in attendance between 6pm and 8am[6]. In the Western Health Board region, over a one year period, 18 teenagers aged 14-17 years were treated in the Accident and Emergency Departments for alcohol overdose and 239 adolescents were treated by General Practitioners for alcohol problems[7].

As reported in the SLÁN survey, young adults were more likely to report experiencing negative consequences of someone else's drinking such as verbal abuse, being a passenger with a driver who had drunk alcohol and being hit or assaulted than were their older counterparts[2].

### 5.2 Personal Relationships

The social consequences of alcohol related harm not only affect the individual drinker but can also undermine relationships with partner/spouse, members of their family, friends and work colleagues. Alcohol problems in the family are prevalent throughout the European Union and are strongly related to frequency of intoxication. Children of problem drinking parents are particularly vulnerable to a range of problems and child neglect[8]. Problem drinking is an important contributory factor to marital difficulties in Ireland. Marriage counselling services reported that alcohol abuse was the primary presenting problem in up to 25% of cases[9]. Services dealing with the legal aspect of

marital breakdown reported that up to 34% of clients cited alcohol abuse as the main cause of their marital problem.[10]

Personal and social problems have also been experienced by young people as a result of their own alcohol use. Poor school performance, accidents, relationship problems and delinquency problems were experienced by Irish 15-16 year olds as a result of their drinking[3].

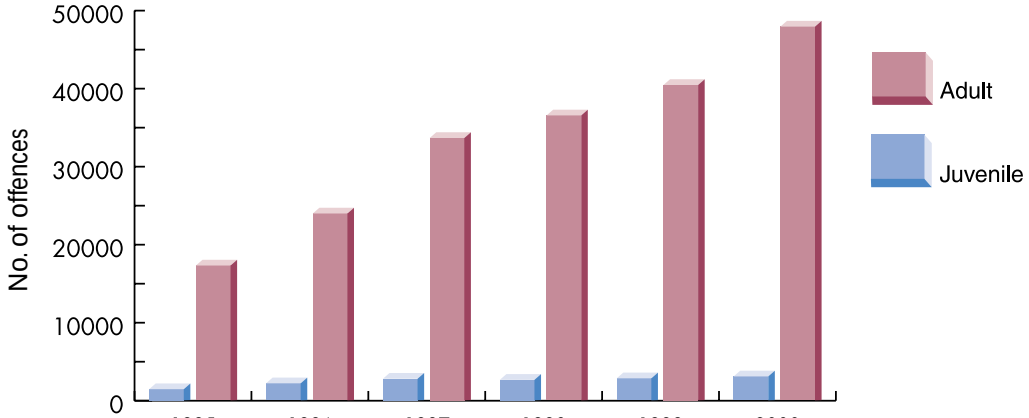
The link between alcohol use, unintentional and unprotected sex has been well documented internationally. A major Irish research project on crisis pregnancy identified alcohol as one of the factors that contributed to the incidences of unwanted pregnancies where drinking resulted in the non-use of condoms[11]. A study among school-going Irish teenagers, reported that 35% of the sexually active respondents said that alcohol was an influencing factor for them engaging in sex[12]. Alcohol use has also been identified as one of the main risk indicators in relation to teenage pregnancy. Unprotected sex gives rise to increased risk of sexually transmitted infections[13]. Among a group of 32 teenage girls attending a sexually transmitted disease clinic, nearly half reported that they had unprotected intercourse on at least one occasion when drunk[14]. During the last decade sexually transmitted infections have increased by 165% in Ireland. In 2000 there were approximately 8,900 STI's recorded[15].

## 5.3 Interpersonal violence / public safety

Excessive drinking increases the risk of drunkenness, fights, assaults and violence[16]. In Ireland there has been a steady increase since 1995 in assaults and public order offences. In the five-year period (1996-2000) these street violence offences increased by 97%. The Garda Commissioner highlighted the link between alcohol and the rise in street violence. He noted that in 2000 there were 62,000 incidents of public order offences of which 38,000 people were charged and the remaining 24,000 were cautioned†. The vast majority of public order cases are alcohol related[17]. This would indicate that at least 1,200 alcohol related incidents take place every week in Ireland. Serious assaults also increased during 2000, many of which were alcohol related, giving the total number of offences relating to street violence where proceedings were taken at 48,682 (Figure 4). These alcohol-related offences were committed by adults. Alcohol-related offences for juveniles also increased over the same period. Of particular concern is the increase in 'intoxication in public places' among teenagers which increased by 370% since 1996.

*Figure 4*

**Alcohol related offences for adults and juveniles 1995-2000**




| | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 |
|---|---|---|---|---|---|---|
| Juvenile | 2211 | 2962 | 3551 | 3412 | 3604 | 3846 |
| Adult | 18,062 | 24,730 | 34,407 | 37,301 | 41,201 | 48,682 |

*Source: Garda Síochána, Annual Reports*

† Garda Commissioner Byrne speaking at the Graduation Ceremony in the Garda College, Templemore February 2002.

## 5.4 Drink Driving

In Ireland alcohol is estimated to be associated with at least 30% of all road accidents and 40% of all fatal accidents[18]. At the current legal limit of 80mg/100ml a driver is six times more likely to have a collision. While the attitude to drinking and driving may have changed, some drivers continue to persist. The habit of driving after 2 or more alcoholic drinks continues to be more common among males. About one-third of males in the 25-54 age group reported this behaviour[2].

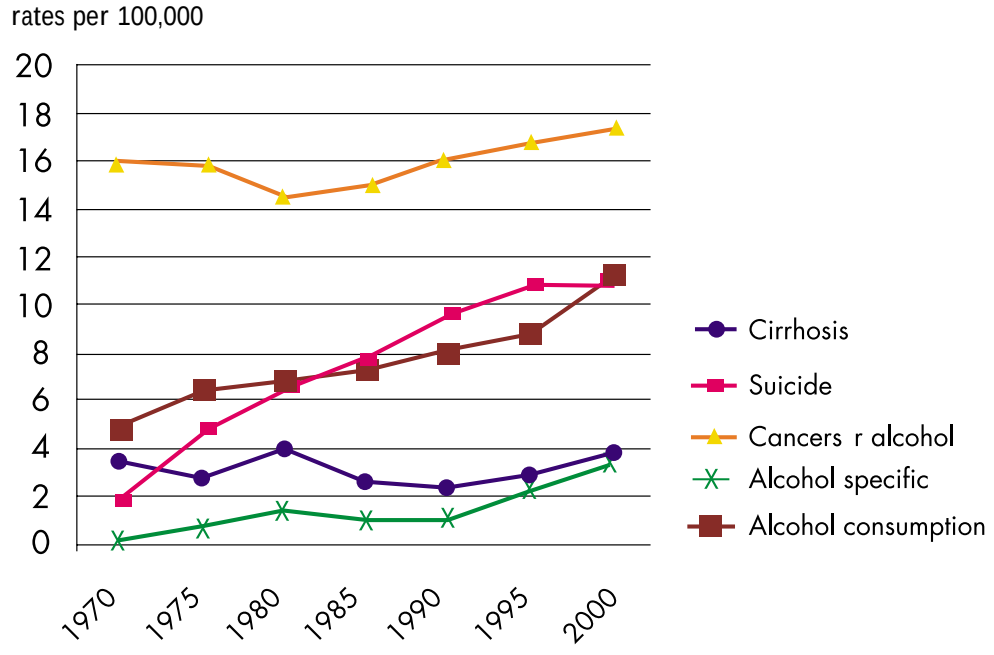
Drink driving offences dropped in 1995 to approximately 5,000 offences the year after the introduction of the lower BAC level of 80 mg/100ml, however since then a steady increase has been reported. In 2000 approximately 10,500 detections for drink driving were made by the Gardaí. The vast majority (93%) of detections were over the BAC legal limit and 62% of those were over twice the limit[19]. Overall there has been a decrease in the number of people killed and injured from road accidents since 1997. However, the number of people killed during the time period most associated with drink driving (9pm-4am) has not substantially decreased, which represents about one-third of all those killed[20].

## 5.5 Alcohol-related mortality

Many people die each year where alcohol is a contributory factor such as accidental falls, suicide, homicide and accidents[16]. There is also convincing evidence to show that regular alcohol consumption increases the risk of liver cirrhosis, cancers of the mouth, pharynx, larynx, oesophagus and liver. A comparison of alcohol related mortality and alcohol consumption in Ireland over the last thirty years show increases in cancers related to alcohol consumption, cirrhosis and other conditions specifically related to alcohol - alcohol poisoning, alcohol psychosis, alcohol dependency, toxic effect of alcohol and alcohol abuse (Figure 5). During the last decade the increase is consumption mirrors the increases in cancers relating to alcohol and in particular alcohol poisoning and alcohol dependency.

*Figure 5:*

**Alcohol Related Mortality & Alcohol Consumption (per capita) 1970-2000**




*Alcohol specific=alcohol poisoning, alcohol dependency, alcohol psychosis, alcohol abuse, toxic effect of alcohol.*
*Source:Vital statistics, CSO*

## 5.6 Mental Health

Alcohol abuse is a significant risk factor in suicide and compounds the other factors in suicide. There has been a sharp increase in male suicides especially among the 15-29 age group and overall it is the biggest cause of death for men aged 15-35 years[21]. Alcoholic disorders continue to be a main cause of admissions to psychiatric hospitals, especially for males. In 1999, out of all psychiatric hospital admissions, alcoholic disorders accounted for 26% of male admissions and 11% of female admissions[22]. Research in an Irish general hospital reported that 30% of all male patients and 8% of female patients were identified as having underlying alcohol abuse or dependency problems[23]. However, many of these cases were not detected by the admitting medical team. The study highlights the deficiencies and the under recording of alcohol related problems in the hospital setting.

## 5.7 Cost of Alcohol Related Problems

A paper commissioned as part of the European Comparative Alcohol Study (ECAS) estimated that alcohol related problems cost Irish society approximately € 2.4 billion (£1.9 billion) per year[24]. These include costs such as healthcare, road accidents, alcohol related crime and lost productivity. The real resource cost of alcohol related problems as estimated in Table 1 was 1.7% of Irish GDP in 1999.

*Table 1: Total costs of alcohol related problems in Ireland*

| | IRL £ million | € million |
|---|---|---|
| Healthcare costs | 220 | 279 |
| Costs of road accidents | 248 | 315 |
| Cost of alcohol related crime | 79 | 100 |
| Loss of output due to alcohol related absences from work | 814 | 1,034 |
| Alcohol related transfer payments | 318 | 404 |
| Taxes not received on lost output | 184 | 234 |
| | | |
| **TOTAL** | **£1,863 million** | **€ 2,366 million** |

# Section D - Alcohol Policy Measures in Ireland

## 6. Alcohol Policy

Alcohol policy is a growing area of debate in Europe and world-wide. The priority of any alcohol policy must be to protect the health, well being and the quality of life of the community as a whole. It is internationally recognised that there are key strategy areas that help to prevent and minimise alcohol-related harm. These are: regulating availability, through access, pricing and promotion; providing deterrence through penalties; limiting harm in the drinking environment and influencing demand by awareness, advocacy, education and training. However, no one measure can be effective in isolation, effective change requires a cohesive response addressing all elements shown to have value. Dr Gro Harlem Brundtland, Director General of the World Health Organisation (WHO), stressed that although drinking is a personal act and an individual responsibility, it is also a behaviour shaped by our societies for which society as a whole has a responsibility. She added, it is thus counterproductive to formulate health policy responses exclusively for the individual [25].

## 7. Irish National Alcohol Policy

The overall aim of the National Alcohol Policy, launched in 1996, is to reduce the level of alcohol-related problems and to promote moderation for those who wish to drink[26]. Since the publication of the National Alcohol Policy, several important initiatives have taken place, utilising the health promoting settings approach such as schools, informal youth sector and colleges. In addition, new research, training programmes and greater enforcement of regulations have been implemented.

### 7.1 Settings Approach

The settings approach, as outlined in the Health Promotion Strategy, means combining healthy policies in a healthy environment with complementary education programmes and initiatives[27]. The development of the national curriculum in health education (Social, Personal and Health Education), the promotion of school policies on alcohol and drugs, the greater involvement of parents and communities under the health promoting school concept ensures a comprehensive and effective long-term approach in education. Training and resource development continue to be an integral part of policy implementation. The Departments of Health and Children, Education and Science and the Regional Health Boards are the key players in these initiatives.

The National Youth Health Promotion Programme, with support from the Health Promotion Unit, initiated a national project which provided opportunities for young people (14-16 years) to explore their relationship with alcohol. The process culminated in the development of resource materials for youth leaders working with young people in the non-formal sector. *"Its your Choice"* illustrates creative ways of working with young people on alcohol awareness using arts and media based techniques. Training is provided for youth leaders to ensure the implementation of this initiative.

In the college setting, all universities and third level institutions came together to formulate a response to a growing concern about alcohol promotion practices on campus, high risk drinking among students and its impact on student academic achievement and student attrition. A framework for the development of a college

alcohol policy was developed[28] and provides guidelines for a comprehensive approach which includes measures on

- controlling marketing, promotion and sponsorship
- limiting harm in the drinking environment
- increasing awareness and education
- encouraging alternatives and choice
- providing campus support services

Each third level institution can adopt the guidelines to reflect the needs and aspirations of their own campus environment.

To support the developments in different settings a national alcohol awareness campaign is taking place to stimulate public debate on the issue of alcohol as well as specific messages to increase awareness of high risk drinking and its consequences.

### 7.2 Enforcing Deterrents

The publication of the Government Strategy for Road Safety 1998-2002 clearly indicated a commitment to tackling the issue of drink driving[29]. Greater enforcement, and the introduction of evidential breath testing have been shown to be effective in detecting drunk drivers. To address the growing problem of underage drinking the Government responded with legislation which provides for temporary closure of premises for selling alcohol to those under the legal age of 18 years.

### 7.3 Treatment

A pilot study Alcohol Aware Practice is currently under way to improve the detection rate and treatment of alcohol problems in general practice. It is an educational resource programme to raise awareness and teach clinical skills and includes screening and assessment techniques, treatment methods, brief intervention and prevention. It is organised by the Irish College of General Practitioners.

### 7.4 Supply Side Initiatives

A training initiative, the Responsible Serving of Alcohol (RSA) programme, for those who work in the bar trade and hospitality sector has been developed[30]. The aim is to limit harm in the drinking environment by not serving to intoxicated customers, mandating age card as standard practice and promoting alternative strategies to reduce drinking and driving. This initiative was developed by the Health Promotion Unit in the Department of Health and Children, in co-operation with the Drinks Industry Group of Ireland and the training organisation CERT. As a backdrop to the RSA development and to remind adults not to sell, buy or give alcohol to children, the national alcohol awareness campaign promoted a poster and media campaign to reinforce the message to 'Keep Kids Safe From Drink'.

### 7.5 Alcohol Marketing

A report entitled *The Impact of Alcohol Advertising on Teenagers in Ireland*, commissioned by the Health Promotion Unit, was published recently[31]. The findings of this study indicate that alcohol advertising has a strong attraction for teenagers, as it portrays lifestyles and images which are part of their social setting. Most believed that the alcohol advertisements were targeted at young people as the advertisements depicted dancing, clubbing, lively music and wild risqué activities which they consider synonymous with their social activities. The younger age group (12-14 years)

perceived the advertising messages as saying that alcohol can help them have fun, make friends and become popular and those that don't drink are missing out. The message from the alcohol advertisements for the older age group (15-17 years) was that social success and a good time results from alcohol use. The recommendations call for a reduction in the exposure of children and adolescents to alcohol advertising.

In Ireland, there are a number of voluntary self-regulatory codes relating to alcohol advertising including the RTÉ code, the Advertising Standards Authority of Ireland, the Poster Advertising Association of Ireland and the Cinema Association Limited. During the last decade, the drinks industry increased its visibility by sponsorship deals of many sporting and cultural activities throughout Ireland. The number of alcoholic beverages grew to include a range of new drinks, some of which had (alcopops) and have strong appeal to those underage and to young adults.

## 7.6 Availability

Since the publication of the National Alcohol Policy, an all party Dáil Select Committee examined licensing laws and recommended extending the opening hours. These changes were enacted in the Intoxicating Liquor Act 2000 making alcohol more available through longer opening hours and more exemptions. To reduce availability of alcohol to those underage, a voluntary age card was introduced in 1999 for those 18 years and over to ensure that young people purchasing alcohol were legally entitled to do so. The Garda Síochána have actively promoted this scheme and to date have issued approximately 55,000 age cards. Additional funding has been provided to increase awareness of the age card and to encourage licence holders to demand proof of age whenever there is a doubt concerning a young person's age.

## 7.7 Impact of measures to date

Attitudes and social norms towards alcohol, embedded in many aspects of Irish life, are slow to change. The development of the measures outlined followed best practice procedures, were evidence-based and had an inclusive consultation process to ensure support and sustainability. In the long-term this will increase the chances of success and have an impact on preventing and reducing alcohol related harm. Many of the measures in place have yet to reach their full potential, in terms of national widespread implementation.

However, almost all of the measures developed are poised to influence the demand side of alcohol, (information, education, training) while the supply side had few initiatives, with the exception of the RSA programme and the Temporary Closure Order, which contributed in a positive way to reducing harm. Between July 2001 and February 2002 Temporary Closure Orders were imposed in 82 cases. Along with the economic affluence, the extended opening hours most likely accelerated the upward trend in alcohol consumption and related harm. A basic rule of economics is that supply is related to demand. It is an interactive process where supply not only responds to demand but also stimulates demand by price incentives, advertising, promotions and increased product availability. Therefore, a balanced approach is required with appropriate measures which influence both supply and demand of alcohol, in a way that prevents and reduces alcohol-related harm.

# Section E - Further Measures Required

## 8. Recommendations from the Strategic Task Force on Alcohol to prevent and reduce alcohol related harm

### 8.1 Rationale

Reducing alcohol related harm has been acknowledged by the World Health Organisation as one of the most important public health actions that a country can do to improve quality of life[32]. The European Union has also identified alcohol as a key determinant in the burden of disease and has included alcohol in the Programme of Community action in the field of public health 2001-2006[33].

The overall level of alcohol related harm in a population very often relates to the level of alcohol consumption in that population. In Ireland, alcohol consumption has dramatically increased over the last number of years as have many of the alcohol-related harm indicators, in particular interpersonal violence and alcohol related mortality. Episodes of binge drinking and drinking to intoxication are now more common among 'social drinkers' in Ireland especially among young adults. The new public health evidence indicates that the predominant drinking patterns in a population can significantly add to the level of alcohol related harm[34]. Given this evidence, there is an urgency to protect public health by reducing the level of overall alcohol consumption and bringing forward alcohol policy measures that will influence the shape and total dynamic system of society's drinking. These measures must be integrated and mutually supportive in stemming the rising tide of alcohol related harm.

### 8.2 The Research Evidence

#### 8.2.1 Reducing overall alcohol consumption

New research studies undertaken in a European context in the last number of years have clearly demonstrated the importance of per capita consumption and its link to alcohol related harm. One of the conclusions drawn is that, given the current range of overall alcohol consumption in Europe, an increase in consumption at the aggregate or population level will increase alcohol related harm[34]. In addition, the extent of the harm experienced is strongly influenced by the drinking patterns in the culture. Where drinking to intoxication and regular binge drinking are part of the drinking culture then a greater amount of alcohol related harm will occur.

[‡]A recent study of 14 western European countries (the countries of the European Union excluding Greece and Luxembourg but including Norway), the European Comparative Alcohol Study (ECAS), examined the evidence from 1950-1995 of the relationship between year-to-year increases or decreases in the alcohol consumption level and year-to-year increases or decreases in deaths from a variety of causes where alcohol often is involved[35, 36]. Everywhere in western Europe reducing the per capita consumption of alcohol does reduce the rates of harm from causes that are alcohol related (cirrhosis, accidental deaths, homicide). The finding that the amount of harm from each litre of alcohol per capita varies from one end of Europe to another, underlines that characteristic drinking patterns in a culture are also important, along with the level of consumption.

[‡] Extracts from Room's paper *Would reducing the level of alcohol consumption reduce rates of alcohol-related harm? The state of evidence.* Prepared for the Strategic Task Force on Alcohol. Full text of paper is presented in Appendix A.

One of the conclusions of the ECAS study was while attention to drinking patterns is worthwhile, it is not a substitute for a focus on the general level of consumption in a population. From one end of Europe to the other, alcohol-related death rates are affected quite strongly by changes in the general level of alcohol consumption.

A focus on the public health implications of the general level of consumption makes particular sense in the Irish context, given that per-capita consumption has risen by 41% in ten years.

Table 2 shows the consumption per person aged 15 and above in Ireland and in the five main "Mediterranean wine cultures". Among the EU countries only France and Luxembourg now exceed Ireland's per-adult consumption level, and the total list of countries in the WHO Global Database with an estimated total consumption level per adult higher than Ireland's is just 11: Argentina, Croatia, France, Hungary, Latvia, Luxembourg, Mauritius, Moldova, Romania, Russia and Slovakia.

*Table 2. Ireland and the European wine cultures: estimated alcohol consumption per person aged 15 and above, in litres of pure ethanol (figures for 1998-99, except Ireland's which is for *2000)*

| | Recorded consumption 1998-99 | Unrecorded consumption estimate | Total consumption estimate |
|---|---|---|---|
| Ireland | 14.21 | 1.0 | 15.21 |
| France | 14.62 | 1.0 | 15.62 |
| Portugal | 14.06 | 1.0 | 15.06 |
| Spain | 12.28 | 1.0 | 13.28 |
| Greece | 9.39 | 2.0 | 11.39 |
| Italy | 8.84 | 1.5 | 10.34 |

*Source: WHO Global Alcohol Database, current data; WHO, 1999*

Factors involved in the sharp growth in alcohol consumption levels in Ireland presumably include increased affluence, the relative decline in alcohol taxes, and increased availability. Recent time-series analyses for Ireland and for other Western European countries confirm previous findings that mortality rates for a range of chronic health problems and casualties are affected, often quite strongly, by the overall level of alcohol consumption in a population. The fact that patterns of drinking in a population can also affect these relationships does not alter this fundamental finding. Data concerning rates of social problems from drinking is scarce, but are also likely to be affected by the overall level of alcohol consumption.

If the upward trend of 1995-1999 continues, Ireland will shortly have the highest level of consumption in western Europe. While alcohol problems rates generally respond quite quickly to rises or falls in consumption, the incidence of chronic health problems such as liver cirrhosis undoubtedly has a longer-term component, since it often takes a drinking career of 20 years to destroy a liver. An effective strategy to reduce the overall level of consumption now is thus likely to have a special impact in forestalling the build-up of cirrhosis and other chronic illnesses and problems brought on by sustained heavy drinking.

### 8.2.2 Alcohol Policy Effectiveness

An extensive review of the very substantial international literature on the effectiveness of different alcohol policy measures was recently undertaken[37]. In evaluating the evidence, the different kinds of measures were grouped into four degrees of effectiveness. The policy measures of proven high effectiveness or moderately strong effectiveness have to do with regulating the market availability of alcohol beverages and drinking-driving countermeasures (Table 3). Alcohol policy measures for which the research evidence is still limited but shows some effect are banning advertising, well-developed community mobilisation approaches and other availability measures such as server training. The policy measure for which there is considerable evidence of non-effectiveness on drinking behaviour and problems is alcohol education in schools. Other measures listed as having little evidence of any effect on drinking behaviour and problems include voluntary codes of bar practice, regulating the content of alcohol advertisements, the provision of alcohol-free activities as alternatives and warning labels on alcohol containers.

*Table 3: Alcohol Policy Effectiveness*

| Policy measure | Proven High effectiveness | Proved effectiveness | Some effect | No effect |
|---|---|---|---|---|
| Regulate physical availability | - Minimum drinking age<br>- Alcohol control enforcement<br>- Server liability | - Limit hours & days of sales<br>- Government run retail stores | - Server training and tavern mgt policies<br>- Limit number of sale outlets | - Voluntary code of bar practice |
| Drink-driving countermeasures | - Lower BAL<br>- Random breath testing<br>- Immediate license suspension | - Zero BAL for young drivers | | |
| Taxation | | - Increased taxes | | |
| Alcohol promotions | | | - Banning advertising | - Advertising content regulations<br>- Warning labels |
| Community action approach | | | Community mobilisation | |
| Education & persuasion | | | | - Alcohol education in schools |
| Promoting Alternatives | | | | Alcohol-free activities |

*Source: Summary from Room's paper Appendix B*

## 8.3 Framework

Ireland, a member of the WHO European region, has endorsed the European Charter on Alcohol[38], the European Alcohol Action Plan[39, 32] and the Declaration on Young People and Alcohol[40] (Appendix E). These documents have provided ethical principles and goals for advancing alcohol policy and a template of strategies for alcohol action. Ireland has also adopted the EU Council Recommendation[33] on the drinking of alcohol by young people, in particular children and adolescents (Appendix F). Therefore, the recommendations of the Strategic Task Force on Alcohol in Ireland will be framed using the ten strategy areas for alcohol action outlined in the WHO European Charter on Alcohol. These strategies are based on sound scientific evidence[41].

- Regulate availability
- Discourage drink driving
- Ensure effective treatment services
- Protect public, private and working environments
- Implement control on alcohol promotions
- Foster responsibility of the alcohol beverage industry
- Provide information and education
- Enhance society's capacity to respond to alcohol related harm
- Support non-governmental organisations
- Formulate a broad-based alcohol policy and monitor progress

However, for the purposes of this first report priority has been given to a limited number of areas for action. Further reports will bring forward recommendations for all of the ten strategies areas and will form part of the National Alcohol Policy review as committed to in the Irish National Health Strategy[42].

## 8.4 Specific Objectives

Alcohol is used on many social occasions, to enjoy with a meal, to celebrate success or to relax with friends. But when alcohol is consumed in inappropriate settings or circumstances or where individuals drink too much or become intoxicated the risk of harm increases. Alcohol is also a psychoactive drug and for some is an addictive substance.

To prevent and reduce alcohol related harm in Ireland the following have been identified as key priority objectives:

- To reduce total alcohol consumption at the population level to the EU average[±].
- To reduce harmful consumption of alcohol at an individual level, especially binge drinking and regular heavy drinking.
- To provide greater protection for children and adolescents from the pressures to drink.
- To prevent and reduce the risk of alcohol related harm on the roads.
- To prevent and reduce the risk of alcohol related harm in the drinking environment.

[±] Mr. Pat Barry, representing the Drinks Industry Group of Ireland, submitted a Minority Report covering this issue *inter alia,* which can be found in Note 1 on page 23.

## 8.5 Measures to achieve these objectives

As an initial step towards achieving the specific objectives outlined, the following set of targeted measures need to be implemented without delay. Additional medium to long-term measures will be addressed in subsequent recommendations. The main thrust of these measures is to protect public health and public safety as well as creating an environment that helps people to make healthy choices.

In making these recommendations the Task Force is cognisant of the fact that it has not made an attempt to address the resource implications of implementing the recommendations. This has not been possible because of the very tight timeframe given to the Task Force to produce this Interim Report.

However, the Task Force intend to return to this important subject in subsequent reports.

### R1. Regulate Availability

1.1 Increase alcohol taxes and use the additional Exchequer revenue to implement the recommendations set out in this report.

1.2 Establish a National ID card scheme for the entire population in such a manner that cards can also be used for proof of age purposes in connection with the sale of alcohol. In the meantime promote the existing age card scheme. An obligation should be placed on all licencees to demand the age card for the purchase of alcohol by young people.

1.3 Maintain licensing measures which restrict greater availability of alcohol sale outlets (both on-licences and off-licences). The criteria for the granting of any new license should include the need to protect public health and safety, the risk of access for under-age persons, the need to reduce density of premises (in relation to size and location), the need for adequate control and supervision and the incidence of alcohol-related problems in the area.

1.4 Make provision in legislation for a Health Board, to have the right on public health grounds, to object to the granting of new licenses, license renewal, exemptions or to set specific conditions for licenses in their region.

### R2. Reduce Drink Driving

2.1 Introduce random breath testing and promote high visibility enforcement.

2.2 Lower the blood alcohol limit to .50 mg % in line with most other European countries.

2.3 Lower the blood alcohol limit for provisional drivers to zero (this action is provided for in the Road Traffic Act 1994).

### R3. Limit harm in drinking environments

3.1 Target Hot Spots, by mapping the locations where disturbance and violence occur, through a co-ordinated approach between appropriate services such as the Gardaí, emergency services, the health boards and local alcohol outlets.

3.2 Ensure greater enforcement of the laws that prohibit the serving of alcohol to intoxicated customers**.

3.3 Restrict alcohol sales promotions that encourage high risk drinking such as free alcohol, below cost sales promotions and 'happy hours'.

3.4 Mandate the Responsible Serving of Alcohol programme as a condition of license renewal.

**R4. Protect children and reduce pressure on adolescents to drink**

4.1 Reduce the exposure of children and adolescents to alcohol marketing.

a) Limit where alcohol advertisements can be placed: TV, radio, cinema, magazines, schools, youth centres, public transport, public buildings, etc.

b) Ensure the content of alcohol advertisements does not appeal to children or adolescents.

c) Ban drinks industry sponsorship of children and adolescents' leisure-time activities.

d) Set-up a steering group in co-operation with drinks and advertising industries to establish an independent monitoring mechanism to ensure compliance with codes and regulations.

4.2 Actively encourage all national sports organisations to promote alcohol-free sporting environments for children and adolescents.

4.3 Restrict children at certain times and circumstances from licensed premises, as it exposes them at an early age to a form of alcohol promotion, which is unnecessary, potentially damaging and undermines the aim of better health for children.

**R5. Provide information, education and services**

5.1 Raise awareness of alcohol issues and promote a greater understanding of the importance of public health alcohol policy.

5.2 Develop the delivery of information and skills in the school and out of school setting as part of an overall health promoting approach.

5.2 Expand the provision of alcohol policy developments for out-of-school settings and develop support mechanisms for the implementation and monitoring of such policies.

5.3 Discourage high risk drinking for those who wish to consume alcohol.

5.4 Expand appropriate health and social services to provide for people who experience problems as a result of other people's or their own drinking.

**R6. Research and Monitor Data**

6.1 Put in place a systematic data collection procedure for the key harm indicators.

6.2 Continue to identify appropriate research to further our understanding of alcohol issues in Ireland.

** Recommended in the Garda Youth Policy Advisory Group Report 2001

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# Note 1

## Drinks Industry Group of Ireland position on Report of Government Task Force on Alcohol - related harm.

The Drinks Industry Group which was represented on the Government Task Force has serious concerns about certain aspects of the report now being presented to the Minister for Health and Children. While many of these already have been articulated at the meetings of the Task Force, nevertheless, it appreciates the opportunity presented to it in having some comments appended to the report.

Throughout the discussions leading up to the finalisation of the report, the industry has consistently stressed that the contention that a reduction in overall consumption of alcohol will lead to a reduction in alcohol related-harm is an incorrect one. Indeed, it has strongly questioned the evidence presented to the Task Force by Professor Robin Room of Stockholm University which gave rise to this contention and which has substantially influenced the nature of the Group's final report.

The industry is concerned that this flawed position has led to certain proposals being adopted which, it strongly believes, will have little or no material effect on the issue under consideration (i.e. a reduction in alcohol-related harm). It does not significantly recognise, for example that the abuse of alcohol rather than its use is the key issue. Thus it will penalise the vast majority of people who consume, enjoy and benefit from the moderate consumption of alcohol. Also, of course, it may adversely impact on certain commercial aspects of the industry.

The proposal to increase alcohol taxes and use these to implement the recommendations of the Task Force is a broad brush approach which will not effectively tackle the specific issues of concern. For example higher prices brought about by increased taxation will not influence alcohol abuse or misuse. Empirical evidence shows that some of the countries with the highest tax rates also have the highest per capita consumption. And it is commonly understood that problem consumers are less easily discouraged by price.

Increases in taxation have other serious implications also. They may lead to increased smuggling and, of course, will also impact on the Consumer Price Index with economic implications for the country.

Such an approach must be considered also in the context of the already very high level of taxation applied to alcohol products in Ireland (second only to Denmark within the EU). These generate substantial revenues for Government (Excise and VAT receipts amount to almost €1.5 billion annually and these exclude the substantial monies paid by the industry in corporation tax, PRSI and income tax.

The Drinks Industry Group fully supports the aim of the Task Force to reduce the incidence of drink driving. However it questions the effectiveness of lowering the blood alcohol level to .50 mg %, particularly in view of the fact that over 60% of those currently detected are more than twice the existing limit. A number of other European countries (including Britain) recently have opted against lowering the blood alcohol levels and instead have placed greater emphasis on enforcement of the existing limit.

The Drinks Industry Group welcomes many other actions proposed by the Task Force but is disappointed that greater emphasis has not been placed on substantially increasing educational programmes aimed at securing a better understanding of the proper use of alcohol particularly amongst at risk groups. It has consistently indicated that it is prepared to play a significant role in such activities.

# Appendix A
# Would Reducing The Level of Alcohol Consumption Reduce Rates of Alcohol-Related Harm? The State of The Evidence

**Professor Robin Room**

Centre for Social Research on Alcohol and Drugs
Stockholm University

## Alcohol-related harms and their measurement

Drinking is causally related to a long list of both social and health problems. These problems are both short-term — primarily related to a particular intoxication occasion — and long-term — primarily reflecting levels of drinking over time. Alcohol-related problems occur to many others besides the drinker him - or herself: to those hurt in a drinking-driving crash, to family members in the form of neglect or abuse, to strangers, friends and family in the form of alcohol-fuelled violence.

The statistics we have on alcohol-related social and health problems primarily come from the community agencies charged with responding to the problems — from the health system, the police, and welfare and employment agencies. The statistics least affected by changes in social attention to alcohol problems, are the records of death; deaths are usually a matter of concern everywhere. For that reason, mortality data is the most widely available data on alcohol-related harm.

While there is no adequate comparative measure of the relative magnitude of social and health problems attributable to drinking, some comparisons can be made. These comparisons are, however, incomplete; estimates of the relative burden of alcohol problems in social and health services, for instance, do not take account of private costs and problems, such as disruption of family life or work roles, except as they come to the attention of public agencies.

Cost-of-illness studies of the economic costs attributable to alcohol include estimates of the "direct costs" of health and social services used by those with alcohol-related problems. Typically, the ongoing costs to society for handling these cases is estimated to be larger in the social welfare and criminal justice sectors than in the health sector. For instance, an estimate for 2001/2002 for Scotland (Catalyst, 2001:3) estimated alcohol-attributable health care costs of £95.6 million (GBP), social work service costs of £85.9 million (GBP), and criminal justice and fire services costs of £267.9 million (GBP).

Based on a series of surveys in Northern California of those seen by different social and health systems, the proportions were estimated of those reporting "problem drinking"• who came for services, though not necessarily concerning their alcohol problems. Of those with "problem drinking" 41.0% were seen by the criminal justice system, 8.0% by the social welfare system, 42.1% by the general health system (primary health clinics and emergency rooms, both private and public), 3.1% by the public mental health system, and 5.9% by public alcohol or drug treatment agencies (Weisner, 2001). In that county, thus, the resources devoted to dealing with social problems related to drinking are at least as extensive as those devoted to health problems related to drinking.

• defined as having at least two heavy drinking occasions, a serious social consequence of drinking, or a dependency symptom

A third way of estimating the relative burden of health and social harm is from survey research responses, where the attribution is by the drinker or those around the drinker. In terms of experiences reported as occurring during the previous year in a Canadian survey, for instance, 7.2% of Canadians reported that they had been pushed, hit or assaulted by someone who had been drinking, 6.2% had had friendships break up as a result of someone else's drinking, and 7.7% reported they had had family problems or marriage difficulties due to someone else's drinking. In the same study, 2.3% reported their own drinking had had a harmful effect on their home life or marriage in the past year, and 3.7% that it had harmed their friendships or social life, while 5.5% reported that it had harmed their physical health (recalculated from pp. 258, 274 of Eliany et al., 1992). Social problems due to someone's drinking thus seemed to extend more broadly in the population than health problems due to drinking.

These three probes into the issue of the scope and relative size of alcohol-related problems all point to the conclusion that social problems from drinking, and problems for others besides the drinker, are at least as important as health problems for the drinker him/herself. It should be borne in mind, then, that the problems covered in the discussion which follows are only a part of the whole range of alcohol-related problems.

## What happens to problem rates when there are changes in consumption?

### The limiting case:

A telling example of how much difference the level of alcohol consumption can make in a population is when there is a substantial and sudden shift in the consumption level. In March, 1985, the government of the former Soviet Union announced an anti-alcohol campaign, including a substantial reduction in alcohol availability (White, 1996). The campaign lasted for about 3 years. While there was a great deal of illegal distilling during the campaign, the best estimate is that there was a net reduction in consumption of about 25% (Shkolnikov & Nemtsov, 1997). During that period, the age-standardized death rates in Russia were reduced as follows (calculated from Leon et al., 1997):

*Table 1. Reduction in age-standardized death rates in Russia between 1984 and 1987*

| | Males | Females |
|---|---|---|
| Deaths from all causes | 12% | 7% |
| Alcohol-specific causes | 56% | 52% |
| Accidents and violence | 36% | 24% |
| Pneumonia | 40% | 32% |
| Other respiratory diseases | 20% | 22% |
| Infectious and parasitic diseases | 25% | 23% |
| Circulatory diseases (including heart disease) | 9% | 6% |

*(Source: calculated from Leon et al., 1997)*

The figures for deaths from all causes imply that, for each litre decrease in per-capita consumption of alcohol, the overall death rate dropped by 3.4% for males and 2.2% for females.

### The cross-cultural range of effects:

It seems that Russian drinking patterns, and particularly the drinking patterns of Russian men, are especially harmful in terms of the amount of harm associated with each litre of alcohol consumed. In this respect, Russia and a number of the other countries of the former Soviet Union are probably towards the upper limit.

A recent study of 14 western European countries (the countries of the European Union excluding Greece and Luxembourg but including also Norway), the European Comparative Alcohol Study (ECAS), examined the evidence from the 46 years 1950-1995 of the relation between year-to-year increases or decreases in the alcohol consumption level and year-to-year increases or decreases in deaths from a variety of causes where alcohol often is involved

(Norström, 2001a, 2001b). The analyses used ARIMA time series methods (Auto-Regressive Integrated Moving Average - see http://www.geocities.com/Colosseum/5585/mprev.html for explanation). The researchers pooled the countries into three groups, a northern Europe group (Finland, Norway and Sweden), a southern Europe group with wine as the dominant beverage (France, Italy, Portugal and Spain), and a middle group of 7 countries, including Ireland.

For liver cirrhosis mortality, for accidental deaths, and for homicide, the researchers found a significant effect from changes in alcohol consumption in all three country groups (Table 2). They also found a systematic gradient in the size of the effects, with higher effects in northern and lower in southern Europe. These results support the idea that cultures do vary in how much difference subtracting or adding a litre of per-capita consumption will make to rates of problems from alcohol, but that everywhere in western Europe reducing the per-capita consumption of alcohol does reduce the rates of harm from these three indicative causes of death (though not always for female deaths from homicide).

*Table 2. Percentage change in mortality for a one-litre increase in per capita alcohol consumption. Pooled estimates for 3 regions of Europe from country-specific ARIMA analyses for 1950-1995. (Source: Norström, 2001b)*

| | Northern Europe | Mid-Europe (includes Ireland) | Southern Europe |
|---|---|---|---|
| **Males:** Cirrhosis | 31.7* | 9.1* | 9.8* |
| Accidents | 9.0* | 3.4* | 2.3* |
| Homicide | 17.7* | 10.5* | 7.1* |
| **Females:** Cirrhosis | 16.9* | 5.2* | 10.6* |
| Accidents | 9.6* | 2.8* | 1.9* |
| Homicide | 8.1 | 6.7* | 1.8 |

** significant relationship (p<.05)*

The finding that the amount of harm from each litre of alcohol per-capita varies from one end of Europe to another underlines that characteristic drinking patterns in a culture are also important, along with the level of consumption. This kind of finding often brings suggestions and even campaigns to change a nation's drinking culture, for instance to resemble the characteristic drinking patterns of southern European "wine cultures". In Scandinavia, this persistent "dream of a better society", as Olsson calls it (Olsson, 1990), recurs from decade to decade. But the experience has been, instead, that in a given culture the characteristic drinking patterns are deep-rooted and resistant to change; when new drinking habits are encouraged, they often add onto the old ones, rather than replace them. Examples of a successful shift in a national drinking culture to less problematic drinking patterns are few indeed (Room, 1992).

The ECAS findings in any case support the conclusion that, while attention to drinking patterns may be worthwhile, it is not a substitute for a focus on the general level of consumption in a population. From one end of Europe to the other, alcohol-related death rates are affected quite strongly by changes in the general level of consumption.

**Findings for Ireland**

The findings specifically for Ireland fit broadly into the patterns found by the ECAS researchers for what we have termed the "mid-Europe" group of countries (Table 3). Male deaths from homicide seem to be particularly strongly associated with changes in the level of consumption in Ireland. On the other hand, any effects of changes in consumption on male and female suicide rates in Ireland were too weak to reach statistical significance. Effects on alcohol-specific causes (explicitly alcohol-related deaths, from alcoholic psychosis, alcoholism or alcohol poisoning) appeared quite strong, but failed to reach statistical significance, perhaps reflecting a relatively small number of deaths recorded in these categories.

*Table 3. Percentage change in mortality for a one-litre increase in per capita alcohol consumption. Estimates for Ireland from ARIMA analyses for 1950-1995. (Source: Norström, 2001b)*

| | Males | Females |
|---|---|---|
| Cirrhosis | 6.7* | 4.8 |
| Accidents | 7.5* | 7.6* |
| Homicide | 20.6* | 4.8 |
| Suicide | 3.1 | 1.1 |
| Alcohol-specific causes | 13.7 | 14.8 |

** significant relationship (p<.05)*

Some of the ECAS analyses went on to specify the relative strength of the relationship for different age and gender categories (Ramstedt, 2001; Skog, 2001). Among males, the effect of an increase in consumption in the population as a whole was strongest on cirrhosis mortality for those aged 45-64, and on deaths from accidental injury for those aged 50-69. Among females, the effect was greatest for cirrhosis on those aged 15-44, and for accidents also for those aged 50-69.

A limitation of these kinds of analyses is that the per-capita consumption data is only available for the population as a whole. Since males typically account for two-thirds or more of the consumption, for instance, this means that changes in male consumption tend to dominate what happens to overall consumption. It is thus to be expected that relations with male death rates are more often significant than relations with female deaths, as in Table 3.

## Ireland's alcohol consumption level in an international perspective

A focus on the public health implications of the general level of consumption makes particular sense in the Irish context, given that per-capita consumption has risen by 41% in ten years.

Table 4 shows the consumption per person aged 15 and above in Ireland and in the five main "Mediterranean wine cultures". In recent years, old assumptions about where drinking is heaviest in Europe have been overturned by the continuing drop in per-adult consumption in the traditional wine cultures (Simpura, 1998). At this point, only France, still on its long slow glide down from its consumption levels in the early 1950s, exceeds Ireland in per-adult drinking levels. In fact, among the EU countries only it and Luxembourg now exceed Ireland's per-adult consumption level, and the total list of countries in the WHO Global Database with an estimated total consumption level per adult higher than Ireland's is just 11: Argentina, Croatia, France, Hungary, Latvia, Luxembourg, Mauritius, Moldova, Romania, Russia and Slovakia.

*Table 4. Ireland and the European wine cultures: estimated alcohol consumption per person aged 15 and above, in litres of pure ethanol (figures for 1998-99, except Ireland's which is for 2000)*

| | Recorded consumption 1998-99 | Unrecorded consumption estimate | Total consumption estimate |
|---|---|---|---|
| Ireland | 14.21 | 1.0 | 15.21 |
| France | 14.62 | 1.0 | 15.62 |
| Portugal | 14.06 | 1.0 | 15.06 |
| Spain | 12.28 | 1.0 | 13.28 |
| Greece | 9.39 | 2.0 | 11.39 |
| Italy | 8.84 | 1.5 | 10.34 |

*(Source: WHO Global Alcohol Database, current data; see WHO, 1999)*

Factors involved in the sharp growth in alcohol consumption levels in Ireland presumably include increased affluence, the relative decline in alcohol taxes, and increased availability. In a way, the new situation in Ireland sheds light on an old puzzle. In a book originally published in 1976, Richard Stivers (2000) analyzed the reputation and the reality of high rates of alcohol consumption and problems in the Irish-American community, already marked in the 19th century (Room, 1968), both in the U.S. and wherever the Irish diaspora settled and prospered. But, Stivers pointed out, there seemed to be a much lower level of problems with drinking in Ireland. While there was some dispute within Ireland about the national rates of alcohol problems (Walsh and Walsh, 1973), by international standards the consumption and problems seemed low. In the 1950s, for instance, per-adult consumption levels in Ireland were about one-third what they are today in Ireland, and only 3 of the current EU member countries had lower consumption levels (Leifman, 2001).

Perhaps the experience of the diaspora in past generations was a pointer to what might happen in Ireland itself, if and when Ireland might become, as it has now, an affluent society.

## Conclusions

Recent time-series analyses for Ireland and for other Western European countries confirm previous findings that mortality rates for a range of chronic health problems and casualties are affected, often quite strongly, by the overall level of alcohol consumption in a population. The fact that patterns of drinking in a population can also affect these relationships does not alter this fundamental finding.

Data is much scarcer concerning rates of social problems from drinking, but these, too, are likely to be affected by the overall level of alcohol consumption.

Per-capita consumption rates have risen quite sharply in Ireland in recent years. If the upward trend of 1995-1999 continues, Ireland will shortly have the highest level of consumption in Western Europe. While alcohol problems rates generally respond quite quickly to rises or falls in consumption, the incidence of chronic health problems such as liver cirrhosis undoubtedly has a longer-term component, since it often takes a drinking career of 20 years to destroy a liver. An effective strategy to reduce the overall level of consumption now is thus likely to have a special impact in forestalling the build-up of cirrhosis and other chronic illnesses and problems brought on by sustained heavy drinking.

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# Appendix B

# Alcohol Policy Effectiveness[1]

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All governments have de-facto alcohol policies, even if the term is never used. To a greater or lesser extent, there will be rules about the purity and form of alcoholic beverages, about the conditions of their sale as a commodity, and about how drinkers can and cannot behave while drinking.

Alcohol policies can affect rates of alcohol problems. This effect operates in both directions: policies which are oriented to public health and order can reduce rates of problems, while policies which are oriented otherwise can increase rates of problems. Decisions made by governments at every level — local, regional, national, and supranational - thus have the potential to both reduce and to increase rates of alcohol-related problems.

## The target of policies and prevention: drinking, intoxication, or harm from drinking?

We may think of alcohol policies as having three possible goals (Bruun, 1971; Moore and Gerstein, 1981). One possible goal is to affect decisions about drinking at all. A minimum purchasing-age law, for instance, is intended to discourage younger teenagers from drinking at all. A second possible goal is to affect the manner and circumstances of drinking. A policy may aim to discourage drinking in inappropriate circumstances — for instance, the school or the workplace — or to discourage getting intoxicated. If a policy could successfully prevent intoxication, many serious alcohol-related problems would be prevented. A third possible goal is to insulate the drinker - and those around the drinker - from harm. Again, the crucial issue here is often intoxication. Policies can help to protect others from the intoxicated person, as well as to protect intoxicated persons themselves from harm.

In a public health perspective, these three goals are not alternatives to one another. Rather, they are in most cases complementary. The third goal, to reduce the harm when drinking or intoxication occurs, will be an appropriate public health goal in all circumstances. Keeping drinking from becoming hazardous or out of hazardous situations is an appropriate goal in most societies concerning all who choose to drink and are of legal drinking age. When efforts to prevent hazardous drinking fail, strategies to limit the harm from drinking need to kick in. Keeping drinking from happening at all may be an appropriate goal for children or teenagers under legal drinking age, as well as for others in particular circumstances. But if and when drinking nevertheless occurs, there is a need for measures to prevent hazardous drinking, and, as a back-up, measures to insulate the hazardous drinking from actual harm.

## Strategies of alcohol prevention

Simplifying somewhat, there are seven main strategies which have been used by governments to minimize alcohol problems (Room, 2000). One strategy is to educate or persuade people not to use or about ways to use so as to limit harm. A second strategy, a kind of negative persuasion, is to deter drinking-related behaviour with the threat of penalties. A third strategy, operating in the positive direction, is to provide alternatives to drinking or to drink-connected activities. A fourth strategy is in one way or another to insulate the user from harm. A fifth strategy is to regulate availability of alcohol or the conditions of its use. A sixth strategy is to work with social or religious movements oriented to reducing alcohol problems. And a seventh strategy is to treat or otherwise help people who are in trouble with their drinking. Apart from the help it provides to the individual drinker, treatment provision could possibly reduce the overall rates of alcohol-related problems in a society.

[1]Prepared for presentation at an international conference, *Alcohol Policy: A Public Health Perspective,* Dublin Castle, Ireland, 20 November 2001.

## The research literature on the effectiveness of different alcohol policies

There is by now a very substantial literature on the effectiveness of different alcohol policies. The literature is uneven in coverage: some policies have been intensively studied, while others have received very little research attention. And the results, even from the good studies, are not always the same for a given policy, presumably reflecting variations in the social context and implementation of the policy.

Despite these limitations, the research literature is sufficient for us to make judgements about the degree of effectiveness of a number of alcohol policy measures. I have grouped 19 different kinds of measures into four degrees of effectiveness: policy measures which are of proven high effectiveness; policy measures of proven effectiveness, but with a moderately strong effect; policy measures which probably have some effect, but where the research findings are still limited; and policy measures were the research literature suggests they are not effective, at least in the relatively short run for which effects can best be measured.

Three of the policy measures of proven high effectiveness have to do with the market availability of alcoholic beverages. The research literature strongly supports the effectiveness of well-enforced minimum drinking ages in holding down harm to teenagers. However, most of this literature, it should be mentioned, is from North America, where mixing drinking with automobile-oriented teenage cultures creates a particularly lethal combination. Enforcement of alcohol control laws, and holding servers liable for damages when they serve an already intoxicated patron, is another set of policy measures which seem to have high effectiveness. These measures can also be seen as a harm reduction strategy. The evidence is also quite strong that higher rates of taxes, and thus of prices for alcoholic beverages, are effective in reducing rates of alcohol-related problems.

The drinking-driving countermeasures evaluation literature identifies three policy measures as having high effectiveness. One is reduced maximum blood-alcohol levels for driving. A study from Sweden, where the BAL has been reduced to 0.2 per mille (.02%), shows that there was a measurable reduction in traffic accidents even when the reduction was from the already low rate of 0.5 per mille to 0.2 per mille. A second measure, well evaluated particularly in Australia, is the institution on a regular basis of random breath testing (RBT) traffic check-points. And a third measure of proven effect, at least in jurisdictions where decisions on drinking-driving arrests can be delayed in the courts, is immediate administrative license suspensions, which greatly strengthen the celerity dimension in the general deterrence of drinking-driving.

For three other availability measures, there is a substantial literature which on balance finds them effective. One of these is limiting the hours and days of sale of alcoholic beverages. A second measure is running retail outlets for alcoholic beverages as a government responsibility. And a third effective measure, inconceivable as it may be in our era of consumer sovereignty, is rationing the availability of alcoholic beverages, which targets in particular the heavier drinkers who are most at risk of alcohol problems.

A fourth drinking-driving measure for which the evidence of effectiveness is now accumulating is to restrict the driver's license of novice drivers, including requiring no drinking before driving for young drivers.

Then there are a set of four alcohol policy measures for which the research evidence is still limited, but which probably have some effect. These include another availability measure with a harm reduction orientation, server training and tavern management policies. Limiting the number and concentration of sales outlets also seems to have an effect at least in some circumstances. Outright bans on alcohol advertising also seem likely to have some effect, as can well-considered community mobilization approaches.

Lastly, let us turn to the alcohol policy measures for which there is considerable evidence of non-effectiveness. Alcohol education in schools has probably the best-developed evaluation literature in the alcohol problems prevention field; the overall result is a finding that this measure has little or no measurable effect on drinking behaviour and problems (Paglia and Room, 1999). For the other measures listed, the evidence is not so strong. But the general finding is that for such measures as voluntary codes of bar practice, providing alcohol-free activities as an alternative to drinking, regulating the content of alcohol advertising, and putting warning labels on alcoholic beverage containers, there is little evidence of any effect on drinking behaviour and problems.

## The effectiveness vs. the political popularity of the strategies

While the whole range of strategies may be seen as an appropriate part of public health-oriented alcohol policies, they are, then, not all equally effective. The list of the most effective approaches, in terms of demonstrated effects on rates of alcohol problems in the population as a whole, are alcohol control measures such as taxes and regulating availability, some harm reduction approaches that insulate use from harm, and deterrence, particularly in the context of drinking-driving.

If we compile a list, on the other hand, of the approaches which are most popular with the general public and with politicians, in many countries the most popular approaches tend to be education, particularly education of school children; providing alternatives to drinking; and providing treatment. Deterrence for drinking-driving also has some popularity. As we can see, there is a real conundrum: what is most effective generally is not what is politically popular.

We may well ask, why is there such a lack of correspondence between what is popular and what is effective? One simple answer, of course, is that effective strategies are opposed because they will hurt economic interests. The alcoholic beverage industry has learned that it can live quite comfortably with school education. Some educational messages, indeed, may even help its interests. "Drinking is an activity for grown-ups, so don't do it until you are an adult", for instance, cements in the symbolic meaning of drinking as a claim for adult status. But the lack of correspondence reflects other factors as well. Strategies which are effective but unused are often unused because they conflict with competing values and ideologies in the society or in the spirit of the times.

## Controlling the conditions of sale

In the remainder of this presentation, I will focus on one particular set of alcohol policy measures: controls on the conditions of sale of alcohol, including alcohol taxes, limits of the time and place of sale, and restraints on the seller. These controls generally affect the availability of alcohol, but also include strategies to separate the drinking from harm.

## Who is affected how much by alcohol controls?

One can still find uninformed statements that heavy drinkers will not be affected by alcohol controls — they will find a way to get their alcohol anyway, and it is only lighter drinkers who will be affected. But in reality, it is often the opposite which happens - heavy drinkers will be disproportionately affected by alcohol control measures. This can be illustrated by what happened in four big alcohol policy changes in European countries during the last century. We take as our indicator of the effects of the policy changes on heavy drinkers what happened to the number of cases of delirium tremens (DTs), or to deaths from alcohol-specific causes, in the year after the policy change. We compare the size of these changes among heavy drinkers with the overall change in the total alcohol consumption of the population (see Table 1 page 35).

The first case is the huge increase in spirits taxes, accompanied by some increase in beer taxes, in Denmark in 1917. Alcohol consumption overall fell by 76%, but the rate of DTs fell by 93% and the rate of chronic alcoholism deaths by 83% (Bruun et al., 1975).

The second case is the abolition of the individualized alcohol ration-book system in Sweden in 1955. Alcohol consumption rose by 25% in the following year, but cases of DTs increased by 438% (Norström, 1987).

The third case is when Finland greatly increased the availability of alcohol in 1969 by allowing beer to be sold in grocery stores. While alcohol consumption went up by 46%, deaths from alcohol-related causes went up by 58% (Mäkelä et al., forthcoming).

The fourth case is the anti-alcohol campaign in the Soviet Union in 1985-1988. Alcohol consumption in Russia in 1987, including unrecorded consumption, was estimated to be down 34% from 1984. But deaths from alcohol-specific causes were down by 54% (Shkolnikov & Nemtsov, 1997; Leon et al., 1997). Although in political terms, the campaign was a failure, in public health terms, it had substantial positive effects for as long as it lasted. These four cases are of especially dramatic changes in alcohol controls. But it is clear from careful studies of more limited changes that here, too, it is often drinkers who are most at risk of harming themselves or others who are affected by changes in alcohol taxes, in the number of alcohol sales outlets, or in days or hours of sale. Often, even where there is no change in the overall level of consumption, there will be changes in such indicators as rates of domestic violence or of injuries treated in emergency hospitals (Mäkela et al., forthcoming).

It is unlikely that any European society will soon repeat the package of anti-alcohol initiatives taken in the former Soviet Union in the mid-1980s. The package, imposed as a last impulse of the command economy, rapidly became extremely unpopular, and was abandoned by 1988. But even unpopular measures can teach us something about the operation of alcohol policy measures. The lesson is that the drinking patterns of very heavy drinkers are not immune to alcohol control measures; such measures, in fact, often affect heavy and hazardous drinkers especially strongly.

### Effects of controlling public drinking environments

While countries vary in how much of drinking is in public places like taverns or restaurants, commonly such public drinking places are the venue of much drinking by young persons (particularly those above the minimum drinking age). A common finding in general-population surveys, also, is that heavy drinkers are disproportionately represented among the patrons of public drinking places (Clark, 1985). Public drinking places, including particularly those frequented by young drinkers, are also a common source of trouble and disturbance in their neighborhoods (Hauritz et al., 1998).

Reflecting these factors, and that in many countries those selling alcoholic beverages by the drink are licensed by the government, and thus can be made to take some responsibility for what happens on their premises, there is now a growing literature on experiments in controlling the public drinking environment as a way of reducing alcohol-related problems (Graham, 2000). In Graham's words, from the results in the literature "it seems likely that the greatest effects will be achieved by combining training of bar staff, education of patrons, development of lower-risk policies [in the drinking place], and enforcement of regulations aimed at decreasing risks related to drinking in licensed premises".

### Conclusions

The main goal of alcohol policies should be to reduce levels of alcohol-related harm, both to the drinker and to others. The means to this end may be preventing drinking altogether, or limiting or shaping it, or buffering the drinker from harm. The policies need to be based on the basis of an assessment of the dimensions of alcohol-related harm in the target population (taking into account delayed harm), and their effectiveness should be measured and monitored in terms of changes in rates of alcohol-related harm.

Within the broader spectrum of alcohol policies, regulatory approaches to the alcohol market have shown considerable success in limiting and shaping potentially harmful drinking. Regulatory authorities can efficiently enforce the rules as a condition of licences to sell. Regulations can also shape public drinking environments, and the drinking within them, so as to minimize rates of alcohol-related problems. The success of such regulatory approaches depends on active enforcement, with licensees held to account for their actions in selling alcoholic beverages and providing public drinking places, and with a popular consensus supporting regulation and enforcement. Maintaining this consensus may require continuing efforts at public persuasion.

Saltz et al. (1995) note that policy and other environmental approaches to prevention enjoy some natural advantages. Such approaches are not dependent on persuading individual drinkers; and their effects may not decay over time. Moreover, the approaches work directly and indirectly by reflecting social norms and reflecting what is and is not acceptable. The positive impact of such policies on alcohol consumption as well as subsequent harm is supported by consistent scientific evidence (Edwards et al., 1994).

Along with efforts to reduce drinking, there is a substantial need for well-evaluated trials of approaches which acknowledge the realities of drinking and intoxication in the society, and either attempt to shape the use so as to minimize the risk of harm, or attempt to shape the social and physical environment of use to insulate the user from harm. There will often be a need for an accompanying campaign to explain the rationale for these initiatives.

The lesson of the research literature on the effects of alcohol policy measures is that governments and other social actors can take measures which substantially reduce the rates of alcohol problems in their society. Conversely, there is also ample opportunity to take actions which sound good, but which the research literature suggests have little or no effect. While much research remains to be done, we already know quite a lot about the strategies and measures which are needed to have an effective alcohol policy.

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*Table 1. Differential effects of dramatic alcohol policy changes on problematic drinkers*

| Country, date, policy change | **Change in total consumption in next year** | **Change in alcohol problem indicators** | |
|---|---|---|---|
| | | Indicator | Change in next year |
| Denmark, 1917: Huge increase in spirits taxes, some increase in beer taxes | -76% | Cases of DTs (Delirium Tremens)<br><br>Chronic alcoholism deaths | -93%<br><br>-83% |
| Sweden, 1955: Abolition of *motbok* (alcohol rationing) | 25% | Cases of DTs | 438% |
| Finland, 1969: Beer into grocery stores | 46% | Deaths from alcohol-specific causes | 58% |
| Russia, 1985-88: Less availability in anti-alcohol campaign | -34%* | Deaths from alcohol-specific causes | -54%* |

*comparison 1987 vs. 1984. Change in total consumption includes estimated change in unrecorded consumption.

*Sources: Denmark: Bruun et al., 1975, Sweden: Norström, 1987 Finland: Mäkela et al., forthcoming, Russia: Shkolnikov & Nemtsov, 1997; Leon et al., 1997*

# Appendix C
# Alcohol consumption per capita, in litres of pure alcohol, 1989-2000 - EU Countries

| | 1989 | 1991 | 1993 | 1995 | 1997 | 1999 | 2000 |
|---|---|---|---|---|---|---|---|
| Luxembourg | 12.5 | 12.3 | 12.0 | 11.9 | 11.4 | 12.2 | 12.1 |
| **Ireland*** | **7.6** | **8.0** | **8.2** | **8.7** | **9.9** | **10.7** | **11.1** |
| Portugal | 10.4 | 11.6 | 10.7 | 11.0 | 11.3 | 11.0 | 10.8 |
| France | 12.8 | 11.9 | 11.5 | 11.5 | 10.9 | 10.7 | 10.5 |
| Germany | 10.4 | 10.9 | 10.4 | 9.9 | 10.8 | 10.6 | 10.5 |
| Spain | 10.8 | 10.4 | 9.9 | 10.2 | 10.2 | 9.9 | 10.0 |
| Denmark | 9.6 | 9.9 | 9.7 | 10.0 | 9.9 | 9.5 | 9.5 |
| Austria | 10.3 | 10.3 | 10.1 | 9.8 | 9.5 | 9.3 | 9.4 |
| Greece | 8.4 | 8.6 | 9.2 | 9.0 | 8.8 | 8.9 | 8.0 |
| Belgium | 9.5 | 9.4 | 9.6 | 9.1 | 9.1 | 8.2 | 8.4 |
| Netherlands | 8.2 | 8.2 | 7.9 | 8.0 | 8.2 | 8.2 | 8.2 |
| United Kingdom | 7.6 | 7.4 | 7.4 | 7.3 | 8.1 | 8.1 | 8.4 |
| Italy | 9.9 | 8.4 | 8.7 | 8.8 | 8.0 | 7.7 | 7.5 |
| Finland | 7.6 | 7.4 | 6.8 | 6.6 | 7.0 | 7.3 | 7.1 |
| Sweden | 5.6 | 5.5 | 5.3 | 5.3 | 5.1 | 4.9 | 4.9 |

*Source: *Revenue Commissioners and CSO, Ireland; World Drink Trends.*

# Appendix D

# Adult Drinking Patterns

**SLÁN Survey (1999)**

| | 18-24 yrs | 25-34 yrs | 35-44 yrs | 45-54 yrs | 55-64 yrs | 65+ yr |
|---|---|---|---|---|---|---|
| Regular drinkers (last month) | | | | | | |
| Male | 90.7 | 88.9 | 85.7 | 79.1 | 69.5 | 60.8 |
| Female | 88.2 | 82.2 | 78.2 | 67.4 | 52.0 | 38.5 |
| Non-drinkers | | | | | | |
| Male | 4.1 | 5.5 | 5.5 | 8.0 | 16.3 | 23.2 |
| Female | 5.9 | 7.3 | 8.6 | 16.8 | 29.1 | 40.8 |
| Drink Weekly | | | | | | |
| Male | 81.4 | 79.2 | 78.2 | 70.1 | 71.0 | 66.8 |
| Female | 73.0 | 61.6 | 59.1 | 53.1 | 42.6 | 36.5 |
| Drink 5+ days per week | | | | | | |
| Male | 4.9 | 6.9 | 14.2 | 17.7 | 26.1 | 26.3 |
| Female | 4.2 | 3.5 | 6.0 | 16.0 | 16.3 | 33.0 |
| *High risk drinking per session | | | | | | |
| Male | 51.5 | 46.8 | 30.3 | 24.5 | 23.4 | 9.1 |
| Female | 61.3 | 44.0 | 26.1 | 13.8 | 10.3 | 11.1 |
| **Over recommended weekly upper limits | | | | | | |
| Male | 35.5 | 29.9 | 24.7 | 22.7 | 31.4 | 16.2 |
| Female | 38.4 | 20.0 | 12.6 | 16.1 | 13.2 | 21.2 |
| ***Driven a car after consuming 2 or more drinks in the last year | | | | | | |
| Male | 16.8 | 30.1 | 36.1 | 31.9 | 25.5 | 10.1 |
| Female | 6.4 | 12.8 | 16.7 | 11.2 | 7.4 | 2.7 |
| As a result of someone else's drinking, in the last year | | | | | | |
| Verbally abused | | | | | | |
| Male | 20.3 | 10.0 | 6.3 | 5.1 | 6.5 | 1.7 |
| Female | 17.6 | 11.0 | 6.9 | 6.7 | 4.7 | 1.0 |
| Family/marital difficulties | | | | | | |
| Male | 6.7 | 6.5 | 5.8 | 5.5 | 4.9 | 1.2 |
| Female | 11.2 | 11.3 | 9.5 | 7.2 | 5.9 | 2.4 |
| Passenger with drunk driver | | | | | | |
| Male | 16.7 | 10.3 | 3.8 | 3.4 | 5.2 | 2.5 |
| Female | 13.6 | 6.6 | 3.4 | 3.0 | 3.4 | 1.9 |
| Financial trouble | | | | | | |
| Male | 6.5 | 4.3 | 2.9 | 3.2 | 4.5 | 1.2 |
| Female | 4.7 | 4.2 | 3.3 | 3.2 | 3.1 | 0.7 |
| Hit or assaulted | | | | | | |
| Male | 10.0 | 3.8 | 1.2 | 1.9 | 1.6 | 1.0 |
| Female | 3.2 | 2.7 | 1.5 | 1.5 | 0.9 | 0.3 |

* High risk drinking (70 grams or higher of pure alcohol for males; 50 grams or higher of pure alcohol for females).

**Weekly upper limits - (14 standard drinks for females; 21 standard drinks for males)

***based on those who drive

*Special thanks to Sharon Friel, NUI Galway for assistance.*

# Appendix E

## E1 World Health Organisation

### EUROPEAN CHARTER ON ALCOHOL

#### Ethical principles and goals

In furtherance of the European Alcohol Action Plan, the Paris Conference calls on all Member States to draw up comprehensive alcohol policies and implement programmes that give expression, as appropriate in their differing cultures and social, legal and economic environments, to the following ethical principles and goals, on the understanding that this document does not confer legal rights.

1. All people have the right to a family, community and working life protected from accidents, violence and other negative consequences of alcohol consumption.

2. All people have the right to valid impartial information and education, starting early in life, on consequences on health, the family and society.

3. All children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption and, to the extent possible, from the promotion of alcoholic beverages.

4. All people with hazardous or harmful alcohol consumption and members of their families have the right to accessible treatment and care.

5. All people who do not wish to consume alcohol, or who cannot do so for health or other reasons, have the right to be safe guarded from pressures to drink and be supported in their non-drinking behaviour.

# Appendix E

## E2 World Health Organisation

### TEN STRATEGIES FOR ALCOHOL ACTION

Research and successful examples in countries demonstrate that significant health and economic benefits for the European Region may be achieved if the following ten health promotion strategies for action on alcohol are implemented to give effect to the ethical principles and goals listed above, in accordance with the differing cultures and social, legal and economic environment in each Member State.

1. Inform people of the consequences of alcohol consumption on health, family and society and of the effective measures that can be taken to prevent or minimize harm, building broad educational programmes beginning in early childhood.

2. Promote public, private and working environments protected from accidents and violence and other negative consequences of alcohol consumption.

3. Establish and enforce laws that effectively discourage drink-driving.

4. Promote health by controlling the availability, for example for young people, and influencing the price of alcoholic beverages, for instance by taxation.

5. Implement strict controls, recognizing existing limitations or bans in some countries, on direct and indirect advertising of alcoholic beverages and ensure that no form of advertising is specifically addressed to young people, for instance through the linking of alcohol to sports.

6. Ensure the accessibility of effective treatment and rehabilitation services, with trained personnel, for people with hazardous or harmful alcohol consumption and members of their families.

7. Foster awareness of ethical and legal responsibility among those involved in the marketing or serving of alcoholic beverages, ensure strict control of product safety and implement appropriate measures against illicit production and sale.

8. Enhance the capacity of society to deal with alcohol through the training of professionals in different sectors, such as health, social welfare, education and the judiciary, along with the strengthening of community development and leadership.

9. Support non-governmental organisations and self-help movements that promote healthy lifestyles, specifically those aiming to prevent or reduce alcohol-related harm

10. Formulate broad-based programmes in Member States, taking account of the present European Charter on Alcohol; specify clear targets for and indicators of outcome; monitor progress; and ensure periodic updating of programmes based on evaluation.

# Appendix E

## E3 World Health Organisation

### DECLARATION ON YOUNG PEOPLE AND ALCOHOL, 2001

The European Charter on Alcohol, adopted by Member States in 1995, sets out the guiding principles and goals for promoting and protecting the health and wellbeing of all people in the Region. This Declaration aims to protect children and young people from the pressures to drink and reduce the harm done to them directly or indirectly by alcohol. The Declaration reaffirms the five principles of the European Charter on Alcohol.

- All people have the right to a family, community and working life protected from accidents, violence and other negative consequences of alcohol consumption.
- All people have the right to valid impartial information and education, starting early in life, on the consequences of alcohol consumption on health, the family and society.
- All children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption and, to the extent possible, from the promotion of alcoholic beverages.
- All people with hazardous or harmful alcohol consumption and members of their families have the right to accessible treatment and care.
- All people who do not wish to consume alcohol, or who cannot do so for health or other reasons, have the right to be safeguarded from pressures to drink and be supported in their non-drinking behaviour.

#### Rationale

Health and wellbeing are a fundamental right of every human being. Protecting and promoting the health and wellbeing of children and young people are central to the United Nations Convention on the Rights of the Child and a vital part of WHO's HEALTH 21 policy framework and of UNICEF's mission. In relation to young people and alcohol, WHO's European Alcohol Action Plan 2000-2005 identifies the need to provide supportive environments in the home, educational institutions, the workplace and local community, to protect young people from the pressures to drink and to reduce the breadth and depth of alcohol-related harm.

#### Youth environments

The globalization of media and markets is increasingly shaping young people's perceptions, choices and behaviours. Many young people today have greater opportunities and more disposable income but are more vulnerable to selling and marketing techniques that have become more aggressive for consumer products and potentially harmful substances such as alcohol. At the same time, the predominance of the free market has eroded existing public health safety nets in many countries and weakened social structures for young people. Rapid social and economic transition, civil conflict, poverty, homelessness and isolation have increased the likelihood of alcohol and drugs playing a major and destructive role in many young people's lives.

#### Drinking trends

The main trends in the drinking patterns of young people are greater experimentation with alcohol among children and increases in high-risk drinking patterns such as "binge drinking" and drunkenness, especially among adolescents and young adults, and in the mixing of alcohol with other psychoactive substances (polydrug use). Among young people there are clear links between the use of alcohol, tobacco and illegal drugs.

## The cost of youth drinking

Young people are more vulnerable to suffering physical, emotional and social harm from their own or other peoples' drinking. There are strong links between high-risk drinking, violence, unsafe sexual behaviour, traffic and other accidents, permanent disabilities and death. The health, social and economic costs of alcohol-related problems among young people impose a substantial burden on society.

## Public health

The health and wellbeing of many young people today are being seriously threatened by the use of alcohol and other psychoactive substances. From a public health perspective, the message is clear: there is no scientific evidence for a safe limit of alcohol consumption, and particularly not for children and young adolescents, the most vulnerable groups. Many children are also victims of the consequences of drinking by others, especially family members, resulting in family breakdown, economic and emotional poverty, neglect, abuse, violence and lost opportunities. Public health policies concerning alcohol need to be formulated by public health interests, without interference from commercial interests. One source of major concern is the efforts made by the alcohol beverage industry and hospitality sector to commercialize sport and youth culture by extensive promotion and sponsorship.

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## Declaration

By this Decleration, we, participants in the WHO European Ministerial Conference on Young People and alcohol, call on all member states, intergovermental and nongovermental organizations and other interested parties to advocate for and invest in the health and wellbeing of young people, in order to ensure that they enjoy a good quality of life and a vibrant future in terms of work, leisure, family and community life.

Alcohol policies directed at young people should be part of a broader societal response, since drinking among young people to a large extent reflects the attitudes and practices of the wider adult society. Young people are a resource and can contribute positively to resolving alcohol-related problems.

To complement the broader societal response, as outlined in the European Alcohol Action Plan 2000-2005, it is now necessary to develop specific targets, policy measures and support activities for young people. Member States will, as appropriate in their differing cultures and social, legal and economic environments:

### 1. Set the following targets that should be achieved by the year 2006:

- reduce substantially the number of young people who start consuming alcohol;
- delay the age of onset of drinking by young people;
- reduce substantially the occurrence and frequency of high-risk drinking among young people, especially adolescents and young adults;
- provide and/or expand meaningful alternatives to alcohol and drug use and increase education and training for those who work with young people;
- increase young people's involvement in youth health-related policies, especially alcohol-related issues;
- increase education for young people on alcohol;
- minimize the pressures on young people to drink, especially in relation to alcohol promotions, free distributions, advertising, sponsorship and availability, with particular emphasis on special events;
- support actions against the illegal sale of alcohol;
- ensure and/or increase access to health and counselling services, especially for young people with alcohol problems and/or alcohol-dependent parents or family members;
- reduce substantially alcohol-related harm, especially accidents, assaults and violence, and particularly as experienced by young people.

2. Promote a mix of effective alcohol policy measures in four broad areas:

- **Provide protection:** Strengthen measures to protect children and adolescents from exposure to alcohol promotion and sponsorship. Ensure that manufacturers do not target alcohol products at children and adolescents. Control alcohol availability by addressing access, minimum age and economic measures, including pricing, which influence under-age drinking. Provide protection and support for children and adolescents whose parents and family members are alcohol-dependent or who have alcohol-related problems.

- **Promote education:** Raise awareness of the effects of alcohol, in particular among young people. Develop health promotion programmes that include alcohol issues in settings such as educational institutions, workplaces, youth organizations and local communities. These programmes should enable parents, teachers, peers and youth leaders to help young people learn and practise life skills and address the issues of social pressure and risk management. Furthermore, young people should be empowered to take responsibilities as important members of society.

- **Support environments:** Create opportunities where alternatives to the drink culture are encouraged and favoured. Develop and encourage the role of the family in promoting the health and wellbeing of young people. Ensure that schools and, where possible, other educational institutions are alcohol-free environments.

- **Reduce harm:** Promote a greater understanding of the negative consequences of drinking for the individual, the family and society. Within the drinking environment, ensure training for those responsible for the serving of alcohol and enact/enforce regulations to prohibit the sale of alcohol to minors and intoxicated persons. Enforce drink-driving regulations and penalties. Provide appropriate health and social services for young people who experience problems as a result of other people's or their own drinking.

3. Establish a broad process to implement the strategies and achieve the targets:

- **Build political commitment** by developing comprehensive countrywide plans and strategies with young people, with targets to reduce drinking and related harm, particularly in the different segments of the youth population, and evaluate (with young people) progress towards them.

- **Develop partnerships with young people** especially, through appropriate local networks. Look to young people as a resource and promote opportunities for young people to participate in shaping the decisions that affect their lives. Special emphasis should be placed on reducing inequalities, particularly in health.

- **Develop a comprehensive approach** to addressing the social and health problems experienced by young people in connection with alcohol, tobacco, drugs and other related issues. Promote an intersectoral approach at national and local level, to ensure a sustainable and more effective policy. When promoting the health and wellbeing of young people, take into consideration their varying social and cultural backgrounds, and particularly those of groups with special needs.

- **Strengthen international co-operation** among Member States. Many of the policy measures need to be reinforced at the international level, if they are to be fully effective. WHO will provide leadership by establishing appropriate partnerships and utilizing its collaborative networks across the European Region. In this regard, cooperation with the European Commission is of particular relevance.

The WHO Regional Office, through its European Alcohol Information System, will monitor, evaluate (with the involvement of young people) and report on progress in the European Region towards meeting the commitments made in this Declaration.

# Appendix F

# EU Council Recommendation of 5 June 2001 on the drinking of alcohol by young people, in particular children and adolescents

Official Journal L 161 , 16/06/2001 P. 0038 - 0041 (2001/458/EC)

**THE COUNCIL OF THE EUROPEAN UNION,**

Having regard to the Treaty establishing the European Community, and in particular Article 152(4), second subparagraph thereof,
Having regard to the proposal from the Commission,
Having regard to the opinion of the European Parliament(1),
Whereas:

(1) In accordance with point (p) of Article 3(1) of the Treaty, the activities of the Community shall include a contribution to the attainment of a high level of health protection.

(2) In accordance with Article 152 of the Treaty, a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities.

(3) Health education and information are expressly mentioned in Article 152 of the Treaty, and constitute a priority for Community action in public health.

(4) The Resolution on alcohol abuse, adopted by the Council and the representatives of the Governments of the Member States, meeting within the Council on 29 May 1986(2), states that the increase in alcohol abuse is causing serious concern for public health and social welfare, that the production, sale and distribution of alcoholic beverages is an important factor in the economy of most Member States, that, at European level, a joint initiative is advisable in the field of prevention of alcohol abuse, and that the Commission in weighing carefully the interests involved, shall conduct a balanced policy to this end, and, where necessary, submit proposals to the Council.

(5) In the Communication from the Commission on the health strategy of the European Community and the proposal for a Decision of the European Parliament and the Council adopting a programme for action in the field of public health (2001 to 2006), alcohol is one of the areas mentioned in which particular measures and actions could be undertaken(3).

(6) The present recommendation represents a first step towards the development of a more comprehensive approach across the Community (as embodied in the Council's conclusions of 5 June 2001 on a Community strategy to reduce alcohol-related harm).

(7) One of the objectives of the programme of community Action on health promotion, information, education and training (European Parliament and Council Decision No 645/96/EC(4) is the promotion of examination, assessment and exchange of experience and support for actions concerning measures to prevent alcohol abuse and the health and social consequences thereof. This Programme thus offers a basis for the follow-up and monitoring of the proposed measures.

(8) Within the programme of Community action on health monitoring (European Parliament and Council Decision No 1400/97/EC)(5) one of the areas in which health indicators may be established is alcohol consumption. This may be particularly helpful to support the implementation of the proposed measures.

(9) Under the programme of Community action on injury prevention (European Parliament and Council Decision No 372/1999/EC)(6) account will be taken of injury associated with

alcohol abuse as part of the actions undertaken, which could be useful to support the collection of data needed for the implementation of the proposed measures.

(10) In the communication from the Commission "entitled Priorities in EU road safety"(7) drinking and driving is identified as one of the top priorities where concerted action could reduce the significant death toll on EU roads. The Council in its conclusions of 5 April 2001 took note of the Commission's recommendation concerning maximum permitted blood alcohol content for drivers of motorised vehicles, which specifically identifies the problem of young drivers and riders, and encouraged Member States to consider carefully all the proposed measures.

(11) Directive 2000/13/EC(8) of the European Parliament and of the Council on the approximation of the laws of the Member States relating to the labelling, presentation and advertising of foodstuffs provides for the further determination of rules on the listing of the ingredients on labels of alcoholic beverages. This measure had been proposed by the Commission because, inter alia, more and more alcoholic beverages whose composition and presentation are geared to sales to young people had come onto the market in recent years. It is important that young people should be able, using the information presented on the products, to know what they are drinking. Moreover, common legislation on the labelling of alcoholic beverages is essential for the expansion and preservation of the internal market in these products.

(12) According to Article 15 of Council Directive 89/552/EEC on the coordination of certain provisions laid down by law, regulation or administrative action in Member States concerning the pursuit of television broadcasting activities, as amended by Council Directive 97/36/EC(9), television advertising for alcoholic beverages shall comply with a set of criteria, with a specific reference to the protection of minors.

(13) In implementing the recommended measures, it must be kept in mind that restrictions to cross-border commercial communication services must be compatible with Article 49 of the Treaty and must therefore be proportional to the general interest objectives they pursue such as the protection of public health and consumers.

(14) It has to be noted that any decision to remove offending products emanating from another Member State is subject to Decision 3052/95/EC(10) establishing a procedure for the exchange of information on national measures derogating from the principle of the free movement of goods within the Community. It must be notified and its proportionality justified to the Commission as required by that Decision.

(15) Without prejudice to any national legislation or measures, producers and retailers should be urged to establish or enforce self-regulatory controls over, and to agree on standards for, all forms of promotion, marketing and retailing of alcoholic beverages, irrespective of the medium used, in the framework of codes of conduct.

(16) Self-regulation of advertising for alcoholic beverages, which has the support of the relevant interested parties, such as producers, advertisers and media and which is already working in a number of Member States, often in close cooperation with governments and non-governmental organisations, can play an important role with regard to the protection of children and adolescents from alcohol related-harm. Youth organisations could also make an important contribution in this context.

(17) There is statistical evidence in some Member States of changes in the drinking patterns amongst adolescents which are of particular concern, namely: an increase in binge drinking and heavy drinking among minors, a trend towards significant, unsupervised consumption of alcohol outside the family environment at an earlier stage, an increasing consumption by young girls in some Member States, and a trend to consume alcohol in combination with other drugs. The available information needs, however, to be further developed.

(18) There is a clear need in the Community for improved research as to the causes, the nature and the scale of the problems, caused by the drinking of alcohol by young people, in particular children and adolescents, through, inter alia, more extensive and consistent data collection.

(19) In accordance with Article 5 of the Treaty, efforts to achieve the objective of a contribution by the Community towards ensuring a high level of health protection must be undertaken in accordance with the principle of subsidiarity, and in accordance with the principle that Community action shall not go beyond what is necessary to achieve the objectives of the Treaty. The recommended measures must therefore take account of past and current measures implemented in the Member States, and be proportionate to their public health objective.

(20) A continuous assessment of the measures undertaken should be carried out, with particular regard to their effectiveness and the achievements at both national and Community level,

**RECOMMENDS THAT:**

**I.** In formulating their strategies and taking regulatory or other action appropriate to their individual circumstances, in the framework of a common approach across the Community, with respect to young people and alcohol, and with particular regard to children and adolescents, Member States, with the support as appropriate of the Commission, should:

1. promote research into all the different aspects of problems associated with alcohol consumption by young people and, in particular, children and adolescents, in order to better identify and evaluate measures to deal with these problems;

2. ensure that the development, implementation and evaluation of comprehensive health promotion policies and programmes targeted at children, adolescents, their parents, teachers and carers, at local, regional, national and European level, should appropriately include the alcohol issue, with a particular emphasis on settings such as youth organisations, sporting organisations and schools, and taking into account existing experiences for instance the "health-promoting school";

3. produce and disseminate to interested parties evidence-based information on the factors which motivate young people, in particular children and adolescents, to start drinking;

4. foster a multisectoral approach to educating young people about alcohol, in order to help prevent the negative consequences of its consumption, involving as appropriate, the education, health and youth services, law enforcement agencies, relevant non-governmental organisations and the media;

5. support measures to raise awareness of the effects of alcohol drinking, in particular on children and adolescents, and of the consequences for the individual and the society;

6. increase young people's involvement in youth health-related policies and actions, making full use of the contributions which they can make, especially in the field of information, and encourage specific activities which are initiated, planned, implemented and evaluated by young people;

7. encourage the production of advisory materials for parents to help them discuss alcohol issues with their children, and promote their dissemination via local networks such as schools, health care services, libraries, community centres as well as via the Internet;

8. further develop specific initiatives addressed to young people on the dangers of drink-driving, with a specific reference to settings such as leisure and entertainment venues, schools and driving schools;

9. take action as a matter of priority against the illegal sale of alcohol to under-age consumers and, where appropriate, require a proof of age;

10. support notably the development of specific approaches on early detection and consequent interventions aimed at preventing young people becoming alcohol-dependent.

**II.** Member States should, having regard to their different legal, regulatory, or self-regulatory environments, as appropriate:

1. encourage, in cooperation with the producers and the retailers of alcoholic beverages and relevant non-governmental organisations, the establishment of effective mechanisms in the fields of promotion, marketing and retailing;

(a) to ensure that producers do not produce alcoholic beverages specifically targeted at children and adolescents;

(b) to ensure that alcoholic beverages are not designed or promoted to appeal to children and adolescents, and paying particular attention inter alia, to the following elements:
- the use of styles (such as characters, motifs or colours) associated with youth culture,
- featuring children, adolescents, or other young-looking models, in promotion campaigns,
- allusions to, or images associated with, the consumption of drugs and of other harmful substances, such as tobacco,
- links with violence or antisocial behaviour,
- implications of social, sexual or sporting success,
- encouragement of children and adolescents to drink, including low-price selling to adolescents of alcoholic drinks,
- advertising during, or sponsorship of, sporting, musical or other special events which a significant number of children and adolescents attend as actors or spectators,
- advertising in media targeted at children and adolescents or reaching a significant number of children and adolescents,
- free distribution of alcoholic drinks to children and adolescents, as well as sale or free distribution of products which are used to promote alcoholic drinks and which may appeal in particular to children and adolescents;

(c) to develop, as appropriate, specific training for servers and sales persons with regard to the protection of children and adolescents and with regard to existing licensing restrictions on the sale of alcohol to young people;

(d) to allow manufacturers to get pre-launch advice, in advance of marketing a product or investing in a product, as well as on marketing campaigns before their actual launch;

(e) to ensure that complaints against products which are not being promoted, marketed or retailed in accordance with the principles set out in points (a) and (b) can be effectively handled, and that, if appropriate, such products can be removed from sale and the relevant inappropriate marketing or promotional practices can be brought to an end;

2. urge the representative producer and trade organisations of alcoholic beverages to commit themselves to observe the principles described above.

**III.** The Member States, with a view to contributing to the follow-up of this recommendation at Community level, and acting as appropriate in the context of the programme of action in the field of public health, should report, on request to the Commission on the implementation of the recommended measures,

**INVITES THE COMMISSION IN COOPERATION WITH MEMBER STATES:**

1. to support the Member States in their efforts to implement these recommendations, especially by collecting and providing relevant comparable data, and by facilitating the exchange of information and best practices;

2. to promote further research at Community level into the attitudes and motivations of young people, in particular children and adolescents, in regard of alcohol consumption and monitoring of ongoing developments;

3. to follow-up, assess and monitor the developments and measures undertaken in the Member States and at Community level, and to ensure in this context a continuous, constructive and structured dialogue with all interested parties;

4. to report on the implementation of the proposed measures, on the basis of the information provided by Member States, no later than the end of the fourth year after the date of adoption of this recommendation and then regularly thereafter, to consider the extent to which the proposed measures are working effectively, and to consider the need for revision or further action.

5. to make full use of all Community policies, particularly of the programme of action in the field of public health, in order to address the matters covered in this recommendation.

*Done at Luxembourg, 5 June 2001.*

*For the Council*
*The President*
*L. Engqvist*

(1) Opinion given on 16 May 2001.
(2) OJ C 184, 23.7.1986, p. 3.
(3) OJ C 337 E, 28.11.2000, p. 122.
(4) OJ L 95, 16.4.1996, p. 1.
(5) OJ L 193, 22.7.1997, p. 1.
(6) OJ L 46, 20.2.1999, p. 1.
(7) OJ L 43, 14.2.2001, p. 31.
(8) OJ L 109, 6.5.2000, p. 29.
(9) OJ L 202, 30.7.1997, p. 60.
(10) OJ L 321, 30.12.1995, p. 1.