

# Health Service Executive Report

2016

## **Alcohol Treatment Services in Ireland:** How the public view them

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# 1. Introduction

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Alcohol-related harm in Ireland is extensive, with the health care system carrying a large part of the burden. The prevalence of hazardous and harmful drinking is exceptionally high in Ireland compared to other countries (WHO 2014). The research evidence shows that the most effective treatment is screening and brief intervention, with referral pathways for chronic abuse and dependency. The overall aim of this study was to examine the level of public support in Ireland for alcohol screening in key health settings and to assess if alcohol treatment services are deemed available and seen as adequate. This is the first national survey which has sought to gauge the level of support and awareness of a range of alcohol treatment services in Ireland.

# 2. Review of Literature

## 2.1 Harmful drinking patterns

Risky drinking has been a dominant feature of drinking patterns in Ireland during the last two decades (Kelleher et al 2003, Ramstedt & Hope 2005, Morgan et al 2009). The national lifestyle surveys (SLÁN) undertaken in 1998 and 2002 reported an increase in the proportion of adults, both men and women, who consumed six or more drinks in an average session (Kelleher et al, 2003). In the 2007 SLÁN survey, over half of drinkers reported harmful drinking, as measured using AUDIT-C (Morgan et al 2009). A comparison of drinking patterns with six other European countries in 2000 showed that drinkers in Ireland drank more than in other western European countries and many had risky drinking habits that led to adverse consequences (Ramstedt & Hope 2005). The EU surveys in 2007 and 2010 reported that Ireland had the highest proportion of risky drinkers (5+ drinks per occ) when compared to all other EU Member States (TNS Opinion & Social 2007, 2010). The most recent alcohol survey in Ireland shows that more than half (54%) of adult drinkers in the population are classified as harmful drinkers, using AUDIT-C (Long & Mongan 2014). According to information in the recent WHO report on alcohol, the prevalence of heavy episodic drinking among males in Ireland ranked third highest among EU28 countries and for females it was second highest (WHO 2014).

## 2.2 Alcohol related harm

The harmful use of **alcohol ranks among the top five risk factors for disease, disability and death** throughout the world (WHO 2014). It is a causal factor in more than 200 diseases and injury conditions. Drinking alcohol is associated with a risk of developing such health problems as alcohol dependence, liver cirrhosis, cancer and injuries and more recently is linked to infectious diseases (tuberculosis, HIV/AIDS).

Alcohol problems in Ireland continue to have significant health and social consequences as seen in mortality and morbidity rates, in crime statistics and in self-reported personal/interpersonal problems (DOH 2012). The burden from alcohol-related harm, as documented in Ireland, is not unique in Europe, as the burden from alcohol in the European region is the highest in the world (WHO 2011). However, the unique aspect for Ireland is the relatively short period of time during which the burden from alcohol increased substantially (Hope & Butler 2010). Alcohol related mortality in Ireland,

as measured by deaths recorded while in hospital (HIPE), has increased in the last two decades from 2.6 /100,000 population in 1995 to 7.1 in 2007 (Mongan et al 2011). Martin et al (2010) estimated that 1.8% of all deaths were caused by alcohol, having adjusted for a preventative effect. Alcohol accounted for a greater proportion of age-specific deaths in young people in comparison to older people. Alcohol related morbidity, as measured by hospital discharges, doubled between 1995 and 2008 (Mongan et al 2007; Mongan 2010) with chronic conditions the most common diagnosis and acute conditions accounting for almost one in five discharges. Alcohol related morbidity was significantly higher in men than women. Acute conditions were more common among younger people (18-29 age group) while chronic conditions and liver disease were more common among older age groups (Mongan 2010). However, significant increases in age-specific rates of liver disease among younger age groups have been reported and although the majority of alcohol liver discharges are male, a higher proportion of females are seen in the youngest age group (Mongan et al 2011). Alcohol related acute pancreatitis hospital admissions rose rapidly, in particular for women in the 20-29 age group (O Farrell et al 2007). Alcohol use during pregnancy had increased up to 2005 (Barry et al 2006). Drinking to intoxication is a key aspect in the proportion of rapes committed in Ireland, both in terms of perpetrator and the victim (Hanly et al 2009). The prevalence of treated problem alcohol use increased from 187.6 per 100,000 population in 2005 to 251.6 in 2010, as recorded by the National Drug Treatment Reporting System (Carew et al 2011).

The prevalence of alcohol abuse, in a general hospital inpatient population in Ireland, was reported as 30% of men and 8% of women who met the DSM-IV criteria for alcohol abuse or dependence, using different screening tools, one of which was the CAGE (Hearne et al 2002). A national study on alcohol and injuries in the emergency room part of a WHO Collaborative study, involving six hospitals and using the Rapid Alcohol Problems Screening (RASP) instrument, showed that on all four RAPS items (remorse, amnesia, performance, starter) patients presenting with alcohol related injuries were more likely to screen positive (report problems) than non-alcohol related injury patients. Those with alcohol related injuries also reported high levels of hazardous drinking both prior to injury and in their usual drinking habits (Hope et al 2005b). The NACD drug prevalence survey in Ireland found that almost one in five respondents scored positive on RAPS (RAPS2+) while 7% were positive

(RAPS3+) on the stricter alcohol dependency indicator (NACD 2012). A review of studies on the prevalence of alcohol use disorders (AUD) in EU countries and Norway, using diagnostic instruments DSM-IV and ICD-10, reported high variability of prevalence across countries, with higher rates among men than women (Rehm et al 2005). Alcohol abuse tended to be more prevalent in the younger age groups, but there was also great variability between countries. The researchers suggested this could be due to the psychosocial emphasis in the alcohol abuse measurement, which would most likely have a differing cultural meaning and interpretation between countries (Rehm et al 2005). In Australia and New Zealand the prevalence of AUDs was also highest among the youngest age groups (Mewton et al 2011; Wells et al 2006).

Social problems related to alcohol showed a dramatic increase over the last two decades, as measured by alcohol related offences of drunkenness, public order and assault. Between 1994 and 2002 drunkenness, public order and assaults offences increased followed by a decline in 2003 (Hope & Butler 2010). The sharp rise in public order and drunkenness offences was partly influenced by the introduction of the Criminal Justice Public Order Act in 1994 and the new recording system (PULSE) in late 1999 (An Garda Síochána Annual Reports 1994-2003). Between 2004 and 2007, assault offences (+21%) and public order offences (+51%) increased (Mongan et al 2009). The typical profile of the offender was male and young (18-24 age group). In 2007, the economic cost of alcohol related harm was estimated to be €3.7 billion, representing 1.9% of GNP (Byrne 2011).

Population survey data provide insights on self-reported alcohol problems. A comparison across seven European countries showed that Irish drinkers experienced on average more negative consequences, such as regrets of things said and done due to their drinking, believed they should cut down, and reported that their drinking harmed their health, home-life, friendship and work, when compared with other Western European countries. The likelihood of self-reported alcohol-related problems was linked to volume of drinking and the frequency of heavy drinking occasions (binge drinking) (Ramstedt & Hope 2005). The national lifestyle survey (SLÁN) reported that one in ten drinkers felt their drinking had harmed their health in the previous 12 months, which was highest in young men from upper social classes (over one in three). Those who were binge drinkers were over 3 times more likely to report that their drinking

harmed their health (Morgan et al 2009). In the recent drug prevalence survey, one in eight people reported harm to health from their own drinking, with men and those younger in age the most likely to report (NACD 2012). High rates of alcohol problems were also reported among college students and linked to heavy drinking occasions (Hope, Dring & Dring, 2005a). In both the general and college populations, more young women reported alcohol-related violence in comparison to women in older age groups (Hope & Mongan 2011). Alcohol harm is not confined to the drinker but can extend to others around the drinker. A recent study on alcohol's harm to others in Ireland reported that over a quarter of the population reported harm as a result of someone else's drinking and in the case of each of two specific situations, one a vulnerable population (children) and the other economic (the workplace), one in ten reported harm due to other people's drinking (Hope 2014). While men generally experience more harm from others, in two domains (family and finance) women experience more harm.

## 2.3 Alcohol Treatment Services

The Health Service Executive (HSE) has set out the National Drug Rehabilitation Framework (Doyle and Ivanovic 2010). to assist services in planning and implementing a range of different approaches to ensure an 'Integrated Care Pathway' for those with alcohol and other drug problems. The Four Tier Model of service delivery provides the framework for the rehabilitation pathway. Screening and referral to specialist drug treatment services is a key part of Tier 1 intervention. Screening and advice are intended to be delivered in general healthcare settings such as emergency departments, liver units, antenatal clinics, pharmacies or in social care, education or criminal justice settings. A study tested the feasibility of screening and brief intervention (SBI) within four emergency departments in Ireland (Armstrong & Barry, 2014). A total of 944 patients were screened for hazardous and harmful alcohol use. The results showed that there was good co-operation from the public, with 94% of people agreeing to be screened. The screening tool detected that about half of those screened needed no intervention, while one-third needed brief advice, with one in ten requiring referral to specialist services.

# 3. Methodology

## 3.1 Data and Methods

The study design is an examination of the level of public support for alcohol screening in key health care settings and to assess if alcohol treatment services are deemed available and seen as adequate. This study was based on two cross-sectional national drinking surveys (2006, 2010). For the purpose of this study, the two survey data sets were combined (N=2,011) to allow for detailed analysis. A similar methodology was used across the two drinking surveys, that of a national quota sample of about 1,000 adults aged 18 years and over, using face to face interviews. For data collection, a multi-staged quota controlled probability sampling procedures was used, with randomly selected starting points. The response rate was 62%. The survey data was collected by experienced market research companies and funded by the Health Service Executive.

## 3.2 Measures

Four broad areas of alcohol treatment services were measured – alcohol screening across different health care settings, access to alcohol treatment services for adults, youth alcohol counselling services and support services for those who experience harm as a result of someone else’s drinking. A total of eight statements were used and linked to five-option responses for each statement - strongly agree, somewhat agree, somewhat disagree, strongly disagree and don’t know. The four broad areas were

1. Alcohol screening - **the role of health professionals asking patients about their drinking habits as standard practice** in three different settings; primary care, general hospital and maternity services.
2. **Availability and adequacy of alcohol treatment services** in their local health service area.
3. **Availability and adequacy of youth alcohol counselling services** in their local health service area.
4. **Support services for those affected by other people’s drinking** with the item – *“help is available for children and individuals who experience problems as a result of someone else’s drinking in your local health service areas”*.

Drinking pattern was measured by drinking status and the frequency of heavy episodic drinking (HED). **Drinking status** was defined as drinkers (consumed alcohol in last 12 months) and abstainers. **Heavy episodic drinking** was defined as drinking at least a bottle of wine or equivalent (75+ grams) on a drinking occasion. The equivalent drinking measures in Ireland to a bottle of wine (75g) translates to 4 pints of beer (78g) or 7 single measures of spirits 78g). The frequency responses were; every day, 4-5 times a week, 2-3 times a week, once a week, 2-3 times a month, about once a month, one or a few times a year, never, don’t know. The time frame was the past 12 months. Regular heavy episodic drinking was defined as those who consumed 75+ grams per occasion at least monthly.

**Alcohol’s harm to the drinker** was assessed using two measures; the negative social consequences of alcohol from own drinking (NCFOD) and RAPS a screening instrument for alcohol abuse. The time frame was the past 12 months. The negative consequences from own drinking (**NCFOD**) was measured using seven items –

- » got into a fight,
- » involved in accident,
- » should cut down,
- » harmed your health,
- » harmed your social life,
- » harmed your home life,
- » harmed your work.

The response choices were yes and no. The Rapid Alcohol Problems Screening (**RAPS**) instrument reflects behavioural symptoms of alcohol abuse. The RAPS measures 4 items

- » *remorse* (feelings of guilt/remorse after drinking),
- » *amnesia* (unable to remember behaviour while drinking),
- » *performance* (failed to do what was normally expected) and
- » *starter* (need a drink in morning).

A comparison of the RAPS4 and CAGE against DSM-IV criteria for alcohol dependency in a representative sample of the US adult population showed that RAPS4 outperformed CAGE (Cherpitel 2002). Sensitivity of the RAPS4 was higher (0.86) than CAGE (0.67) and performed equally well for men and women (0.88 vs. 0.85). A comparison of RAPS4 across 13 countries showed good sensitivity for tolerance in most of the countries, but was higher in countries which had high societal-level detrimental drinking patterns (Cherpitel et al 2005).

**Alcohol's harm as a result of someone else's drinking**, known as alcohol's harm to others (**AH20**) was measured using five items –

- » family problems,
- » assaults,
- » passenger with a drunk driver,
- » property damaged,
- » financial problems.

Demographic information on gender, age, marital status, region (for 2010 survey only) and social class was also obtained. Social class was defined according to the full job description of the chief income earner in the household and categorised into ABC1 (Upper), C2 (Middle) and DE (Lower).

### 3.3 Analysis

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The five-option responses to the eight statements relating to alcohol treatment services were categorised into agree, disagree, and don't know. The frequency of heavy episodic drinking was reduced into five categories for analysis (several time/wk, once a week, 1-3 times a month, few times a year and never heavy drinking). The seven negative consequences from own drinking was combined into one categorical variable (1+ harm to drinker), as well as examined individually. The RAPS instrument was examined using graded composite scores; alcohol problems (RAPS1+ score), alcohol abuse (RAPS2+ score) and alcohol dependency (RAPS 3+ score).

Descriptive statistics were used to examine the overall level of support for alcohol screening across different health care settings and awareness of access to alcohol treatment services for adults, youth alcohol counselling services and support services for those who experience harm as a result of someone else's drinking. The Chi-square test was used to examine differences in demographics, drinking pattern, alcohol harm from own drinking (NCFOD), alcohol abuse (RAPS) and alcohol harm experienced due to other people's drinking (AH20). Binary logistic regression was used to develop a profile of those supportive of alcohol screening in the three health care settings, taking into account demographics, drinking patterns and alcohol harm. For the regression analyses, statements relating to alcohol screening in health care setting were categorised into agree and disagree and regular heavy episodic drinking was defined as those who consumed 75+ grams per occasion at least monthly.



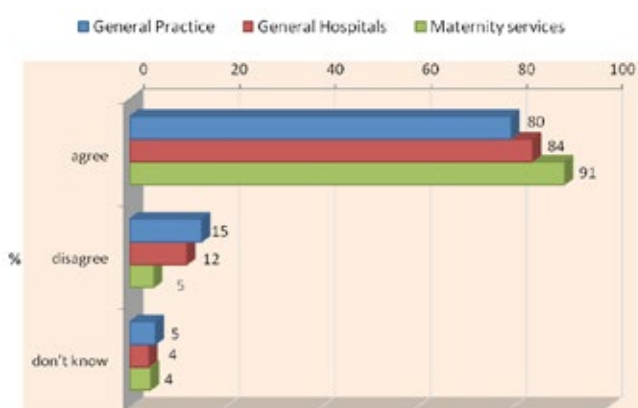
# 4. Results

The socio-demographics characteristics of survey respondents are presented in Appendix 1. The demographics are similar across the two surveys and for the combined total, with one exception. In 2010, a higher proportion of participants were married than single. Overall, 78% of respondents consumed alcohol in the last 12 months and over half (55%) were regular heavy episodic drinkers, defined as consuming 75+gram of alcohol per occasion at least monthly.

## 4.1 Alcohol screening in health care settings

Overall, the vast majority of respondents agreed that intervention by health professionals regarding patients' drinking habits in different health care settings should take place (Figure 1). The highest level of support for asking all patients about their drinking habits as standard practice was in maternity services (91%), followed by general hospitals (84%) and in primary care (80%). Although low, there was a relatively higher level of opposition (disagree), for alcohol screening in primary care (15%) and in the general hospital (12%) in comparison to maternity services (5%). Differences in level of support emerged when examined by demographics, drinking pattern and alcohol harm.

### Alcohol Screening in Health Care settings



**Figure 1:** Support for alcohol screening in health care settings

### 4.1.2 Demographics

In primary care, a higher proportion of married people (82%) in comparison to single people (77%) agreed that general practitioners (GPs) should ask all patients about their drinking habits as standard practice (Table 1). Across regions of Ireland, those living in Dublin were less supportive of GP intervention in comparison to the Rest of Leinster (79% vs 87%). In the general hospital setting, support for health professional intervention on drinking habits differed across most of the demographic characteristics. More women than men were supportive (86% vs 82%) of alcohol screening, those younger were less supportive and support was higher among those from lower social classes (87%) in comparison with other classes. Those living in Dublin (81%) were less supportive of health professional intervention in general hospital compared to other regions. In maternity services, more women than men supported alcohol screening by health professionals as standard practice. A higher proportion of people from Connaught/Ulster, although small (7%), disagreed and a similar proportion from Dublin were unsure (don't know response).

### 4.1.3 Drinking pattern

Those who were abstainers were more supportive of health professionals asking all patients about their drinking habits as standard practice in all three health care settings examined in comparison to drinkers (consumed alcohol in past 12 months) (Table 1). Respondents who were heavy drinkers, defined as drinking large quantities of alcohol (75+ grams/occ) several times a week, were less supportive of alcohol screening by health professionals in primary care, general hospital and maternity services in comparison to other less frequent heavy drinkers. However, among heavy drinkers, the majority (70%-86%) were in favour of health professionals asking about drinking habits, in all health care settings, although there was some opposition from a minority of heavy drinkers, where about one in five (20%) heavy drinkers opposed such alcohol screening in primary care and in general hospital settings.

**Table 1: Level of support for intervention by Health Professionals regarding patients' drinking habits, as standard practice in different health care settings**

	N	General practitioners (GPs) should ask all patients about their drinking habits as standard practice			Health Professionals in General Hospital should ask all patients about their drinking habits			Health Professionals in Maternity services should ask all patients about their drinking habits		
		agree	disagree	dk	agree	disagree	dk	agree	disagree	dk
<b>Overall</b>	2011	79.7	15.0	5.3	84.1	11.9	4.0	90.8	5.0	4.3
<b>Gender</b>										
Men	994	79.3	15.2	5.5	81.9	13.5	4.6	88.7	5.0	6.2
Women	1017	80.1	14.7	5.1	86.2	10.4	3.3*	92.7	4.9	2.4**
<b>Age group</b>										
18-24 yrs	285	74.0	17.9	8.1	80.3	14.1	5.6	91.2	3.5	5.3
25-34 yrs	457	79.4	15.1	5.5	81.4	13.8	4.8	88.6	5.9	5.5
35-49 yrs	561	81.6	14.1	4.3	86.6	10.9	2.5	91.1	5.2	3.7
50-64 yrs	413	80.9	14.5	4.6	83.6	12.8	3.6	90.3	5.3	4.4
65+	295	80.3	14.2	5.4	88.4	7.5	4.1*	93.5	3.7	2.7
<b>Marital status</b>										
Married	1082	82.1	13.0	4.9	85.3	11.0	3.7	91.9	4.9	3.2
Single	929	77.0	17.2	5.8*	82.7	13.0	4.3	89.5	5.1	5.5
<b>Social class</b>										
ABC1 (upper)	788	79.1	15.5	5.5	83.0	13.3	3.7	90.2	5.0	4.8
C2 (middle)	627	77.8	16.1	6.1	81.8	13.7	4.5	90.8	5.1	4.1
DE (lower)	595	82.55	13.1	4.4	87.9	8.2	3.9*	91.4	4.9	3.7
<b>Region<sup>^</sup></b>										
Dublin	288	79.2	12.2	8.7	80.9	10.8	8.3	89.9	2.8	7.3
Rest of Leinster	264	87.5	9.8	2.7	89.8	8.7	1.5	95.5	3.0	1.5
Munster	276	85.1	12.3	2.5	87.3	10.5	2.2	94.2	3.6	2.2
Connaught/Ulster	179	82.1	14.0	3.9*	86.0	10.6	3.4**	89.4	6.7	3.9**

\* $p < .05$ ; \*\* $p < .01$ ; <sup>^</sup>Regional analysis based on 2010 data.

**Table 2: Level of support for intervention by Health Professionals asking patients' drinking habits in different health care settings by drinking pattern and alcohol harm**

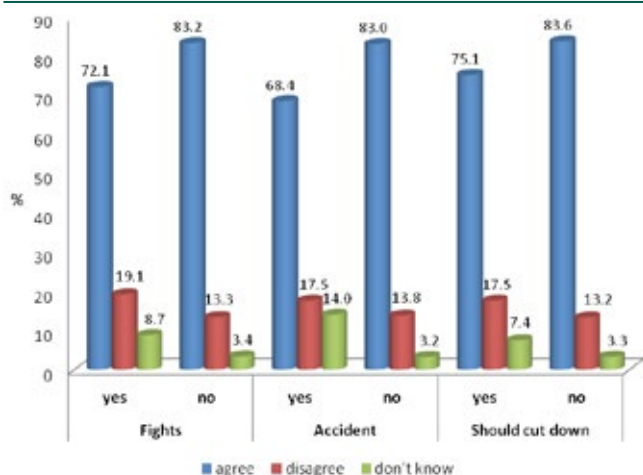
	N	General practitioners (GPs) should ask all patients about their drinking habits as standard practice			Health Professionals in General Hospital should ask all patients about their drinking habits			Health Professionals in Maternity services should ask all patients about their drinking habits		
		agree	disagree	dk	agree	disagree	dk	agree	disagree	dk
<b>Drinking status</b>										
Abstainers	436	89.0	6.0	5.0	92.2	4.1	3.7	94.3	3.2	2.5
Drinker	1575	77.1	17.5	5.4**	81.9	14.1	3.7**	89.8	5.5	4.8*
<b>Heavy episodic drinking (HED)</b>										
Several times/wk	204	70.4	19.2	10.3	72.9	19.7	7.4	85.8	5.4	8.8
Once a week	348	76.1	16.4	7.5	80.5	13.5	6.0	88.2	4.3	7.5
1-3 times/mt	322	79.8	16.5	3.7	83.2	13.0	3.7	91.9	4.7	3.4
Few times a year	287	81.5	14.3	4.2	85.0	12.2	2.8	88.2	7.3	4.5
Never heavy drinking	415	76.4	20.5	3.1**	84.3	14.0	1.7**	92.3	5.8	1.9**
<b>Negative consequences from own drinking (NCFOD)</b>										
1+ Harms to drinker	512	76.0	16.8	7.2	78.1	15.6	6.3	88.1	5.1	6.8
No	984	78.9	16.8	4.3	83.7	13.3	2.9**	91.0	5.5	3.6*
<b>Alcohol abuse</b>										
RAPS2+	315	73.7	17.5	8.9	75.2	17.1	7.6	85.1	6.3	8.5
No problems	1261	78.0	17.5	4.5**	83.6	13.3	3.2**	90.9	5.2	3.9**
<b>Alcohol dependency</b>										
RAPS3+	148	78.4	14.9	6.8	75.7	17.6	6.8	84.6	7.4	8.1
No problems	1427	77.0	17.7	5.3	82.6	13.7	3.8	90.3	5.3	4.5
<b>Alcohol's harm to others</b>										
AH20 1+	562	79.5	14.2	6.2	82.8	13.1	4.1	89.2	6.0	4.8
No AH20	1449	79.8	15.3	5.0	84.7	11.5	3.9	91.3	4.6	4.1

\* $p < .05$ ; \*\* $p < .01$

#### 4.1.4 Alcohol harm

Those who reported one or more of the seven negative consequences due to their own drinking (NCFOD) were less supportive of alcohol screening by health professionals in the general hospital and in maternity services, while there was no significant difference in support for general practitioners in primary care asking about the drinking habits of patients (Table 2). When the negative consequences due to their own drinking were examined individually, the results showed that those who reported getting into a fight, been involved in an accident or felt they should cut down on their drinking were less supportive of health professional intervention on drinking habits in all three health care settings compared to those who did not report such harms (appendix 2). Although small, a higher proportion of those reporting these harms (fight, accident, should cut down), were unsure (don't know) if health professionals should ask about drinking habits, suggesting the potential for health professional persuasion.

#### Alcohol screening in General Hospital by reported harms due to own drinking



**Figure 2:** Alcohol screening in General Hospitals by reported harms due to own drinking

Those who reported that their drinking had harmed their work were less supportive of health professional intervention (70% vs 83%) in the general hospital setting. Those who screened positive for alcohol abuse, (RAPS2+ score) were less supportive of health professionals asking about drinking habits in the three health care settings (Appendix X). However, there was no significant difference between those who screened positive for alcohol dependency (RAPS 3+ score) versus

others in level of support for alcohol screening in any of the health care settings examined. In relation to alcohol's harm to others (AH20), there was no difference in the level of support for health professional intervention for those who reported harm as a result of someone else's drinking (AH20) compared to others, across all the health care settings.

#### Box 1: Summary of key groups more supportive or less supportive of Alcohol Screening in :

Primary Care	General Hospital	Maternity Services
Level of overall support 80%	Level of overall support 84%	Level of overall support 91%
Individual variables		
More supportive those married abstainers	More supportive women lower social classes abstainers	More supportive women those living in Munster and Rest of Leinster abstainers
Less supportive those living in Dublin heavy drinkers those screened positive for alcohol abuse	Less supportive those younger in age those living in Dublin heavy drinkers those who report 1+ harms due to own drinking those screened positive for alcohol abuse	Less supportive heavy drinkers those who report 1+ harms due to own drinking those screened positive for alcohol abuse

Logistic regression was undertaken to develop a profile of those most supportive of alcohol screening in the three health care settings, taking into account the demographics, drinking patterns and alcohol harm indicators.

- » Those more likely to support alcohol screening in Primary Care were abstainers and married people. (OR 3.49, CI 2.23-5.49,  $p < .001$  for abstainers); OR 1.45, CI 1.11-1.89,  $p < .01$  for married people)
- » Those most likely to support alcohol screening in the General Hospital setting were abstainers (OR 3.19, CI 1.89-5.40,  $p < .001$ ). Those less likely to support health professional intervention were those in upper and middle social classes (OR 0.55, CI 0.37-0.80,  $p < .01$ ).
- » Those most likely to support alcohol screening in Maternity Services were abstainers (OR 2.07, CI 1.11-3.86,  $p < .05$ ).

## 4.2 Availability and adequacy of alcohol treatment services

Just four in ten respondents (40%) agreed that alcohol treatment services were available in their local health service area and a similar number (42%) were unaware (don't know) if alcohol treatment services were available. However, only one in five (21%) agreed that alcohol treatment services were adequate, one in four (25%) believed treatment services were not adequate and over half (53%) were unaware (Figure 3). The region where respondents lived was the only demographic variable which showed significant differences both for availability and adequacy of treatment services (Appendix X). Those who lived in Dublin were significantly ( $p < .01$ ) less aware of the availability of alcohol treatment services in their local health service area when compared to others regions, with two-thirds (67%) saying they did not know if treatment services were available.

### Alcohol Treatment Services



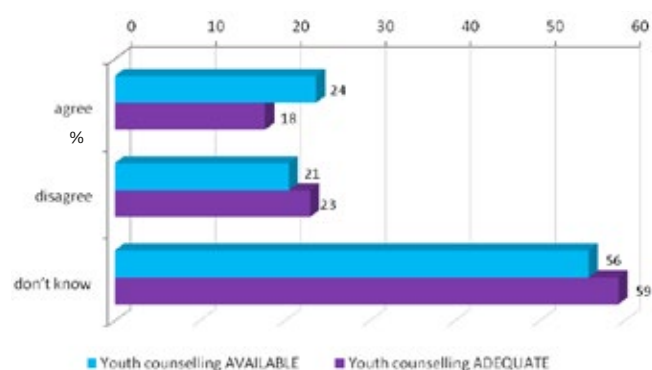
**Figure 3:** Alcohol treatment services, AVAILABILITY and ADEQUACY of services

There was no difference in drinking pattern or in alcohol harm in relation to awareness of availability of treatment services. Those who lived in Dublin had the lowest level of agreement (9%) in terms of adequacy of alcohol treatment services and the highest proportion of respondents who did not know (72%). Respondents living in Munster had the highest proportion (26%) who believed that alcohol treatment services in their local health service area were inadequate. Those who reported one or more harms as a result of someone else's drinking (AH20) had a higher proportion (30%) who said that alcohol treatment services were not adequate in their local health area.

## 4.3 Availability and adequacy of YOUTH alcohol counselling services

Approximately, one in four (24%) agreed that youth alcohol counselling services in their local health area were available, one in five (20%) disagreed and over half (56%) said they were not aware of such services. Less than one in five (18%) said that youth alcohol counselling services were adequate and 59% did not know. Those living in the Dublin region had the lowest proportion who agreed that youth alcohol counselling services were available (12%) or adequate (7%) and had the highest number of respondents who did not know (two-thirds). There were no significant differences in terms of drinking pattern or alcohol harm indicators.

### Youth Alcohol Counselling Services



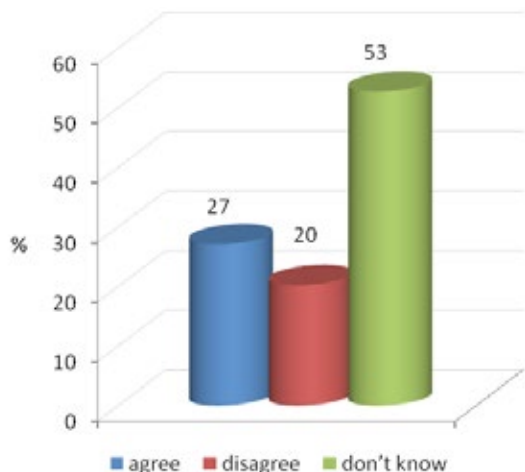
**Figure 4:** Youth alcohol counselling services: AVAILABILITY and ADEQUACY of services

## 4.4 Availability of support for those experiencing harm from other people's drinking

Just over one in four (27%) respondents agreed that help was available for children and individuals who experience problems as a result of someone else's drinking in their local health service area, while one in five (20%) disagreed and over half (53%) did not know. More women than men agreed that support services were available (30% vs 25%). Just one in ten (11%) respondents living in Dublin agreed that support services were available in their local area for those with problems due to other people's drinking, while the majority (71%) were unaware (did not know). Almost two-thirds (64%) of heavy drinkers did not know if help was available in their local area for children and individuals who experience problems as a result of someone else's drinking. Just

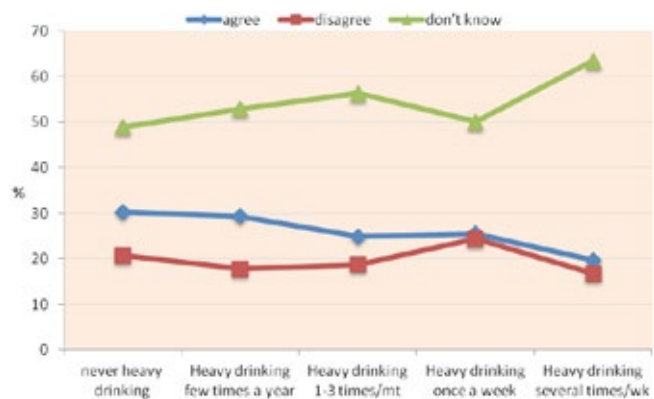
one in five (20%) heavy drinkers were aware of support services for those who experience harm from other people drinking.

### Support services available for AH20



**Figure 5:** AVAILABILITY of support services for those who experience problems due to others drinking

### Support services available for AH20 by drinking pattern



**Figure 6:** AVAILABILITY of support services for those who experience problems due to others drinking by drinking pattern

# 5. Discussion

The vast majority of respondents agreed that alcohol screening by health professionals should take place across different health care settings- maternity services, general hospital and primary care. Alcohol screening in the general hospital was supported more by women and by those in lower social classes, while those younger in age and those living in Dublin were less supportive. For alcohol screening in primary care, those who were married were more supportive and those living in Dublin were less supportive. In particular there was support for screening by general practitioners from those whose drinking had harmed their health or their home life. In relation to drinking pattern and alcohol harms, those who were the heavier drinkers, that is heavy drinking several times each week, showed less support for alcohol screening and also had a higher proportion who were undecided in the three health care settings. This suggests the potential role of health professionals in persuasion and engagement with patients regarding their drinking habits. A similar pattern of relative resistance was observed among those who reported one or more social harms due to their own drinking or who screened positive for alcohol abuse across all health care settings. However, among those who screened positive for alcohol dependency no resistance was evident, suggesting that those who are seriously in need of treatment are willing and supportive of alcohol screening by health professionals in the three health care settings. Those who reported getting into a fight due to their own drinking, been involved in an accident or felt they should cut down on their drinking were less supportive of health professional intervention on drinking habits in all three health care settings. This may reflect their unwillingness to acknowledge to health professionals the link between their drinking and such social harms and so avoid being challenged to reflect on their harmful drinking pattern. All the above comments are about relative support for asking about alcohol in healthcare settings. The picture is of support from 70% as a minimum for any setting, rising to over 90% in some settings.

The emergency room in general hospitals are dealing with such alcohol related presentations on a regular basis (Hope et al 2005b). This suggests an opportunistic 'teaching moment' may be missed when health professionals do not ask patients about their drinking habits. The willingness of patients in the emergency room to be screened for alcohol was documented in a feasibility study in four Irish hospitals and illustrated its importance in identifying those in need of brief intervention or referral (Armstrong & Barry 2014). The

data for the Armstrong and Barry study was collected in 2009. The percentages of the population judged to benefit from brief intervention or onward referral services in that study were very similar to the results in the diary study carried out by the Health Research Board (Long and Mongan 2014), based on data collected in 2013. This re-inforces the recommendation in the the Steering Group Report on a National Substance Misuse Strategy (Department of Health 2012) to roll out brief intervention in multiple settings. There is strong research evidence that screening and brief intervention for hazardous and harmful drinking is an effective measure in reducing alcohol related harm (Chisholm et al 2004, Babor et al 2010, Anderson et al 2012).

A striking feature of the findings in this study was the lack of awareness of the availability of a range of alcohol treatment services in local health service areas. In terms of adult alcohol treatment services, four in ten were aware of the availability of such services while a similar number were unaware. For youth alcohol counselling services, the majority were unaware of the availability of such services, with just one in four aware. Those living in Dublin were less aware than other regions of the availability of both adult and young alcohol treatment services. Awareness was also low of support services for children and adults who experience problems as a result of someone else's drinking. These findings may reflect that alcohol treatment services are not on the ground in local health service area or that communication regarding alcohol services is low. An inventory of alcohol treatment services for 2006,2010 and 2014 is given in Appendix 3. A third possible explanation could be that those who experience or are affected by alcohol problems are reluctant to approach service providers in their local area. Those who have damaging drinking patters (hazardous or harmful drinking) may not recognise that their current drinking pattern increases their risk of a range of negative health and social consequences. Therefore, alcohol screening and brief intervention, with referral where appropriate, across a wide range of health and social services as recommended in several alcohol reports ( DOH 1996, 2004, 2012) needs to be rolled out as a priority to maximise the public health benefit and to improve the quality of life of individuals and their families. The very high support among the public for alcohol to be asked about in healthcare settings is a strong mandate for the recommendations in the the Steering Group Report on a National Substance Misuse Strategy (Department of Health 2012) to be put into operation.

# 6. Policy Implications

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The two major findings in this study, where the vast majority are supportive of alcohol screening but the majority are unaware of alcohol treatment services in local health areas, will be very relevant in planning for future services in relation to alcohol. It will help inform the Health Service Executive in planning, implementing and ensuring that alcohol screening is supported and delivered across a range of health services. The recent finding of between 150,000 and 175,000 possible alcohol dependent individuals highlights the need to gear up statutory and voluntary service providers to meet the needs that will be presented. As part of this it also highlights the need for an information campaign to increase public awareness of the availability of alcohol treatment services and encouragement to use such services. The forthcoming HSE website and health information campaign on alcohol and alcohol harm in 2017 is important in this regard. The directory of drug and alcohol services on [drugs.ie/directory](http://drugs.ie/directory) should be advertised through the network of existing structures such as local Health Service Executive services, local and regional drugs task forces and the voluntary treatment network. The effective delivery of alcohol screening and early intervention, to over half of the general population identified as harmful drinkers (Long & Mongan 2014), will significantly reduce the burden and associated cost of alcohol related problems in Ireland.



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# 8. Appendices

## Appendix 1: Characteristics of respondents in 2006 and 2010 and combined total sample

Year		2006	2010	Total
	N	1003	1008	2011
<b>Gender</b>		%	%	
	Men	49.7	49.2	49.4
	Women	50.3	50.8	50.6
<b>Age group</b>				
	18-24 yrs	16.0	12.3	14.1
	25-34 yrs	22.0	23.5	22.7
	35-49 yrs	27.0	28.8	27.9
	50-64 yrs	20.5	20.7	20.6
	65+ yrs	14.6	14.7	14.6
<b>Marital status</b>				
	Married	48.9	58.7	53.8
	Single	51.1	41.3	46.2*
<b>Social class</b>				
	ABC1 (upper)	37.0	41.3	39.1
	C2(middle)	31.0	31.4	31.2
	DE (lower)	32.0	27.3	29.6
<b>Region<sup>^</sup></b>				
	Dublin	28.6	28.6	28.6
	Rest of Leinster	26.2	26.2	26.2
	Munster	27.4	27.4	27.4
	Connaught/Ulster	17.8	17.8	17.8

\* $p < .05$ ; <sup>^</sup>Regional data for 2010

## Appendix 2: Level of support for intervention by Health Professionals regarding patients' drinking habits in different health care settings by alcohol problems

Base: Consumed alcohol in past 12 months	N	General practitioners (GPs) should ask all patients about their drinking habits as standard practice			Health Professionals in General Hospital should ask all patients about their drinking habits			Health Professionals in Maternity services should ask all patients about their drinking habits		
		agree	disagree	dk	agree	disagree	dk	agree	disagree	dk
<b>Negative consequences from own drinking (NCFOD)</b>										
1+ Harms to drinker	512	76.0	16.8	7.2	78.1	15.6	6.3	88.1	5.1	6.8
No	984	78.9	16.8	4.3	83.7	13.3	2.9**	91.0	5.5	3.6*
Got into fight	184	72.3	16.8	10.9	72.1	19.1	8.7	85.2	4.9	9.8
No	1371	77.8	17.5	4.7**	83.2	13.3	3.4**	90.2	5.5	4.2**
Involved in accident	114	69.3	15.8	14.9	68.4	17.5	14.0	78.1	7.0	14.9
No	1438	77.8	17.7	4.5**	83.0	13.8	3.2**	90.5	5.4	4.0**
Should cut down	338	74.3	17.2	8.6	75.1	17.5	7.4	85.2	5.6	9.2
No	1538	78.8	16.8	4.5*	83.6	13.2	3.3**	90.9	5.4	3.7**
Harmed your health	212	81.6	15.1	3.3	81.2	16.0	2.8	88.3	7.0	4.7
No	1342	76.5	17.8	5.7	82.0	13.8	4.2	89.9	5.2	4.8
Harmed social life	155	78.7	15.5	5.8	77.6	16.7	5.8	85.3	7.7	7.1
No	1398	76.9	17.7	5.4	82.3	13.8	3.9	90.2	5.2	4.6
Harmed home life	102	85.3	9.8	4.9	82.4	12.7	4.9	88.3	6.8	4.9
No	1440	76.7	17.9	5.4	82.0	14.0	4.0	90.1	5.3	4.6
Harmed your work	121	71.9	19.8	8.3	70.2	23.1	6.6	88.4	6.6	5.0
	1419	77.5	17.4	5.1	82.9	13.2	3.9**	89.9	5.3	4.9
<b>Alcohol abuse</b>										
RAPS1+	582	74.1	18.4	7.6	77.0	17.2	5.8	88.1	5.5	6.4
No problems	994	78.9	17.0	4.1**	84.8	12.2	3.0**	90.7	5.4	3.8
RAPS2+	315	73.7	17.5	8.9	75.2	17.1	7.6	85.1	6.3	8.5
No problems	1261	78.0	17.5	4.5**	83.6	13.3	3.2**	90.9	5.2	3.9**
RAPS3+	148	78.4	14.9	6.8	75.7	17.6	6.8	84.6	7.4	8.1
No problems	1427	77.0	17.7	5.3	82.6	13.7	3.8	90.3	5.3	4.5

\* $p < .05$ ; \*\* $p < .01$

## Appendix 3: Alcohol Treatment Services – the availability and adequacy of services in local area

	N	Alcohol treatment services are AVAILABLE in local health service area			Alcohol treatment services are ADEQUATE in local health service area		
		Agree	Disagree	dk	Agree	Disagree	dk
<b>OVERALL</b>	2011	40.0	16.7	43.3	21.1	25.4	53.4
<b>Gender</b>							
Men	994	39.8	17.4	42.8	21.8	25.4	52.9
Women	1018	40.2	16.0	43.8	20.6	25.5	54.0
<b>Age group</b>							
18-24 yrs	284	37.7	13.7	48.6	19.7	22.9	57.4
25-34 yrs	457	38.9	17.5	43.5	23.4	24.7	51.9
35-49 yrs	562	40.9	16.4	42.7	20.5	26.2	53.3
50-64 yrs	414	41.5	19.6	38.9	23.7	27.8	48.4
65+	294	39.8	15.0	45.2	16.3	24.1	59.5
<b>Marital status</b>							
Married	1082	39.0	17.1	43.9	20.1	25.3	54.5
Single	928	41.2	16.2	42.7	22.3	25.5	52.2
<b>Social class</b>							
ABC1 (upper)	628	37.4	18.0	44.5	19.5	26.1	54.3
C2 (middle)	788	43.5	15.8	40.8	23.8	22.0	54.2
DE (lower)	596	39.8	15.9	44.3	20.5	28.2	51.3
<b>Region<sup>^</sup></b>							
Dublin	288	18.4	14.6	67.0	8.7	19.4	71.9
Rest of Leinster	265	48.3	10.6	41.1	28.4	18.2	52.4
Munster	276	42.0	17.8	40.2	19.9	26.1	54.0
Connaught/Ulster	180	38.3	10.0	51.7**	28.5	11.2	60.3**
<b>Drinking status</b>							
Abstainers	436	41.7	18.3	39.9	21.8	27.1	51.0
Drinkers	1576	39.5	16.3	44.3	20.9	24.9	54.1
Heavy episodic drinking							
Several times/wk		32.8	17.2	50.0	15.8	24.6	59.6
Once a week		37.1	19.3	43.7	21.5	27.8	50.7
1-3 times/mt		40.2	15.9	43.9	22.4	25.5	52.0
Few times a year		43.6	12.5	43.9	23.7	20.9	55.4
Never heavy drinking		41.3	16.3	42.3	19.8	25.3	54.9

	N	Alcohol treatment services are AVAILABLE in local health service area			Alcohol treatment services are ADEQUATE in local health service area		
		Agree	Disagree	dk	Agree	Disagree	dk
<b>Alcohol abuse RAPS</b>							
RAPS1+	583	39.1	17.3	43.6	21.1	26.6	52.2
No problems	1429	40.4	16.4	43.2	21.1	25.0	53.9
RAPS2+	316	36.4	17.4	46.2	19.4	24.8	55.9
No problems	1696	40.7	16.6	42.7	21.5	25.5	53.0
RAPS3+	149	34.9	19.5	45.6	19.5	24.2	56.4
No problems	1862	40.4	16.5	43.1	21.3	25.6	53.2
<b>Negative consequences due to own drinking</b>							
1+ harms to drinker	511	35.8	17.6	46.6	20.0	25.0	55.0
No harms	984	39.6	16.4	44.0	21.4	23.9	54.7
<b>Alcohol's harm to others</b>							
AH20 1+	563	41.0	19.4	39.6	22.0	29.8	48.1
No AH20	1448	39.6	15.7	44.7	20.8	23.7	55.5**

\* $p < .05$ ; \*\* $p < .01$

## Appendix 4: Youth Alcohol Counselling Services– the availability and adequacy of services in local area

	N	Youth alcohol counselling services are AVAILABLE in local health service area			Youth alcohol counselling services are ADEQUATE in local health service area		
		Agree	Disagree	dk	Agree	Disagree	dk
<b>Overall</b>	2011	23.7	20.5	55.8	17.7	23.0	59.3
<b>Gender</b>							
Men	993	23.3	21.9	54.9	18.4	23.6	57.9
Women	1018	24.1	19.2	56.8	16.9	22.4	60.7
<b>Age group</b>							
18-24 yrs		22.1	18.6	59.3	17.9	20.7	61.4
25-34 yrs		26.5	20.1	53.4	19.1	23.7	57.2
35-49 yrs		23.8	21.4	54.8	18.1	25.1	56.8
50-64 yrs		25.8	20.8	53.4	19.8	22.2	58.0
65+		17.6	21.0	61.4	11.2	21.7	67.1
<b>Marital status</b>							
Married		22.6	21.3	56.1	16.9	23.8	59.3
Single		25.0	19.6	55.4	18.4	22.3	59.3
<b>Social class</b>							
ABC1 (upper)		22.1	22.4	55.5	16.8	23.8	59.5
C2 (middle)		23.1	17.5	56.4	19.4	21.3	59.2
DE (lower)		23.2	21.1	55.7	16.8	24.0	59.2
<b>Region<sup>^</sup></b>							
Dublin		12.2	14.6	73.3	7.3	18.8	74.0
Rest of Leinster		33.2	14.7	52.1	27.3	17.0	55.7
Munster		21.0	22.1	56.9	14.5	22.8	62.7
Connaught/Ulster		27.8	8.3	63.9**	23.9	8.3	67.8**
<b>Drinking status</b>							
Abstainers	436	23.9	21.8	54.3	19.3	23.4	57.2
Drinkers	1576	23.6	20.1	53.3	17.1	23.0	59.9
<b>Heavy episodic drinking</b>							
Several times/wk		21.7	15.8	62.6	15.8	20.7	63.5
Once a week		23.2	24.4	52.4	18.1	28.4	53.4
1-3 times/mt		23.0	20.8	56.2	19.0	20.9	60.1
Few times a year		24.0	16.0	59.9	15.0	22.0	63.1
Never heavy drinking		25.1	21.0	54.0	16.9	21.9	61.2

	N	Youth alcohol counselling services are AVAILABLE in local health service area			Youth alcohol counselling services are ADEQUATE in local health service area		
		Agree	Disagree	dk	Agree	Disagree	dk
<b>Alcohol abuse - RAPS</b>							
RAPS1+	582	22.9	21.0	56.2	15.6	25.8	58.6
No problems	1429	24.0	20.3	55.7	18.4	22.0	59.6
RAPS2+	315	22.9	20.0	57.1	14.9	24.8	60.3
No problems	1695	23.8	20.6	55.6	18.1	22.8	59.1
RAPS3+	149	18.1	20.8	61.1	14.2	25.0	60.8
No problems	1862	24.1	20.5	55.4	17.9	22.9	59.2
<b>Negative consequences due to own drinking</b>							
1+ harms to drinker		21.5	21.3	57.1	16.6	23.7	59.7
No harms		24.4	19.5	56.1	17.7	22.0	60.3
Harm to others							
AH201+		24.9	21.5	53.6	17.8	26.1	56.1
No AH20		23.2	20.1	56.7	17.5	21.9	60.6

\* $p < .05$ ; \*\* $p < .01$



## Appendix 5: Availability of support services for CHILDREN and individuals who experience problems as a result of someone else's drinking (AH20 services)

	N	Help is available for children and individuals who experience problems as a result of someone else's drinking in local area		
		Agree	Disagree	dk
<b>OVERALL</b>		27.1	20.2	52.7
<b>Gender</b>				
Men		24.5	20.7	54.7
Women		29.5	19.8	50.7*
<b>Age group</b>				
18-24 yrs		29.1	17.5	53.3
25-34 yrs		25.8	20.3	53.9
35-49 yrs		28.1	21.5	50.4
50-64 yrs		27.3	22.7	50.0
65+		24.7	16.9	58.3
<b>Marital status</b>				
Married		25.9	20.2	53.9
Single		28.3	20.3	51.3
<b>Social class</b>				
ABC1 (upper)		25.7	20.3	54.0
C2 (middle)		28.1	18.3	53.6
DE (lower)		27.7	22.1	50.2
<b>Region<sup>^</sup></b>				
Dublin		11.5	17.4	71.2
Rest of Leinster		32.6	14.0	53.4
Munster		25.0	19.9	55.1
Connaught/Ulster		33.3	8.9	57.8**
<b>Drinking status</b>				
Abstainers	436	28.7	21.1	50.2
Drinkers	1576	26.6	20.0	53.4
Heavy episodic drinking				
Several times/wk	203	19.7	16.7	63.5
Once a week	349	25.5	24.4	50.1
1-3 times/mt	321	24.9	18.7	56.4
Few times a year	287	29.3	17.8	53.0
Never heavy drinking	416	30.3	20.7	49.0*

	N	Help is available for children and individuals who experience problems as a result of someone else's drinking in local area		
		Agree	Disagree	dk
<b>Alcohol abuse (RAPS)</b>				
RAPS 1+	582	24.4	21.0	54.6
No problems	1429	28.1	19.9	51.9
RAPS 2+	315	27.9	19.7	52.4
No problems	1696	26.8	20.4	52.8
RAPS 3+	148	29.1	20.9	50.0
No problems	1962	26.9	20.2	53.0
<b>Negative consequences due to own drinking</b>				
1+ harms to drinker		25.2	20.0	54.8
No harms		26.3	19.9	53.8
Harm to others				
AH20 1+		29.1	22.2	48.7
No AH20		26.2	19.5	54.2

\* $p < .05$ ; \*\* $p < .01$



# Building a Better Health Service

CARE COMPASSION TRUST LEARNING