A Focus on Alcohol & Health in Cork and Kerry

A Report of the Director of Public Health

Department of Public Health, HSE South

2019

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Foreword

I welcome this report from the Public Health team in Cork and Kerry, and its timely focus on alcohol.

Reducing the harmful use of alcohol is a key outcome for Healthy Ireland, which will bring significant benefits to the physical and mental health of our population. The Public Health (Alcohol) Act is the first legislation to address alcohol as a public health issue and to recognise the health and other harms caused by alcohol as consumed in Ireland. It provides the foundation for our future work to reduce these harms, as the measures in the Act were designed in recognition that the harms of alcohol make it unlike other grocery products, that consumers should be able to make informed choices about their drinking, and that it is time that children and young people's relationship with alcohol was comprehensively addressed.

In addition to the types of services and interventions outlined in the report, the wide promotion of resources such as the HSE's askaboutalcohol.ie website, and the excellent new Parent's Guide, will help empower people to consider the changes they can make to protect the physical and mental health of their own families.

Healthy Ireland aims to build healthier communities across the country, and so the translation of national policies into local action is a key objective. This can only be achieved through partnership working between a wide range of stakeholders, including the people living in those communities, to help mobilise, and sustain, a local response to the many factors that affect our health and wellbeing.

This report illustrates the importance of that local, collaborative approach in a very real way, and paints a picture for the people of Cork and Kerry not only on the issues to be addressed, but importantly, the strategies underway and supports available to help reduce the harmful impact of alcohol on their families and communities.

The Healthy Cities and Counties initiative under Healthy Ireland aims to support this collaborative approach, and there is already great work underway in Cork and Kerry, driven by the energy of many people who care deeply about the health and wellbeing of their communities.

Working together we can continue to build a culture where health and wellbeing is prioritised by all, for all.

Kate O'Flaherty
Head of Health and Wellbeing
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I am delighted to introduce my first report as the Director of Public Health for HSE South. The last annual DPH report was published in 2004 and therefore, I am pleased to be able to reintroduce it this year with the support of the team and notably Judy Cronin, Heather Hegarty and Ros Condon. They have incorporated contributions from several others and I would like to also acknowledge their contributions.

When I shared my desire of publishing an annual report, the suggestion of a themed report came from the department and for various reasons we describe in the report, we decided to focus on Alcohol.

In recent times, the public discourse around alcohol centred around the Public Health (Alcohol) Bill, now an Act. I am privileged and proud to work in an environment where our political, clinical and public health leaders spoke with one voice to protect the health of our population through legislative reform.

It is now time to do more collectively within our respective regions and I envisage this report to be a vehicle to generate further conversations to enable our population to lead healthier, happier and more fulfilling lives without the harms caused by misuse of alcohol.

Dr Augustine Pereira
Director of Public Health & Medical Officer of Health
HSE South Cork and Kerry

Executive Summary

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

However, alcohol is no ordinary commodity. It has major public health implications and it is responsible for a considerable burden of health and social harm at individual, family and societal levels.

There have been massive shifts in levels of consumption over the past few decades, driven by availability, price and marketing. Since the mid twentieth century, the average annual intake of alcohol per person over the age of 15 years in Ireland has almost trebled from 4.9 litres in 1960 to 14.3 litres in 2001, when consumption peaked.

Latest figures from 2016 show that it's now at 11.5 litres and that we had the fourth highest level of alcohol consumption out of 36 DECD countries. There are patterns of drinking in certain groups and societies that surpass EU averages and we cannot be complacent. These consumption habits have contributed to an increase in alcohol-related harm in the southern counties of Cork, Kerry and Cork City, manifesting as alcohol-related hospital admissions, mortality and morbidity.

Overall, there are causal relationships between alcohol consumption and over 60 types of disease and injury (ref: HI Outcomes Framework, 2018). This report highlights some of the harm caused by alcohol to health. Although not comprehensive, this report shines a light on the impact of Alcohol on certain vulnerable groups in society and aims to focus minds of public and practitioners alike on actions that we can take to minimise the impact on individuals and societies.

Public Health Messages

Alcohol and Pregnancy

Pregnancy needs to be alcohol free to prevent Foetal Alcohol Spectrum Disorders. **There is no safe amount and no safe time for alcohol during pregnancy.** The risk of Foetal Alcohol Spectrum Disorders (FASD) is a dose related effect. There is no low risk drinking of alcohol during pregnancy; there is only a reduced risk and even this risk is too high. Ideally a woman would abstain from alcohol when she is trying to conceive a baby. This provides the best chance for healthy foetal brain growth and development.

About 40% of pregnancies are not planned and women who may have had the occasional drink before they realised they were pregnant should not be worried. The brain continues to grow and develop throughout pregnancy. The adult brain can show signs towards recovery during alcohol free periods. This provides grounds for hope that the foetal brain can also recover during the alcohol-free remaining period of the pregnancy. It remains very worthwhile therefore to stop drinking alcohol at any stage of pregnancy and cutting out alcohol completely after knowing you're pregnant. This is both the safest and healthiest approach for the unborn baby as no amount of alcohol has been shown to be safe to consume during pregnancy. Achieving an alcohol-free pregnancy does not happen without making a conscious decision to do so, and maintaining an alcohol-free pregnancy requires the support of others. With a bit of fore thought, family, friends and social networks can do much to help.

Alcohol and Young People

To understand the public health message it is necessary to first have an understanding of what motivates young people to consume alcohol and to continue to do so in a harmful way. Studies have shown that availability of alcohol whether that be in the community, school or at home and having friends who drink alcohol impact on the likelihood of a young person trying alcohol. The home environment is also highly influential on a young person's likelihood of drinking alcohol with adolescents brought up in a house with one or more parents who abuse alcohol more likely to end up involved in substance misuse. Therefore it can be surmised that tackling alcohol misuse in children and young people must be multifactorial in approach.

The 2018 introduction of the Public Health (Alcohol) Act goes some way towards targeting alcohol misuse across the sectors in Irish society. Reducing visibility of alcohol will aid in denormalising alcohol as a common purchase in supermarkets and corner shops. Increasing the price with minimum unit pricing will help in particular with young people as it will make previously cheap bottles of alcohol unaffordable for school going children. Restrictions on advertising alcohol particularly at sporting events will impact exposure to alcohol to young people all over the country.

In order to communicate public health messages to reduce alcohol consumption and its negative societal and health impacts for young people we must;

- engage with youth societies and organisations
- use social media platforms
- develop online tools with easy to access and easy to understand information about alcohol
- work with parents on how best engage with their children about alcohol

Alcohol and Sexually Transmitted Infection (STI)

Sexually transmitted infections (STIs) are preventable. Diagnosis of an STI can be cured in some instances; however, some STIs and their effects remain with you for life. Unfortunately they are known to increase the risk of serious complications later in life, such as cancer, HIV, pelvic inflammatory disease, infertility, birth complications, ectopic pregnancy and even stillbirth.

The link between alcohol consumption, sexual behaviour and STI/HIV infection is complex. Research indicates that there is a link between alcohol consumption and sexual risk taking which can lead to STI's. Notably there has been an increase in the diagnosis of STI's in Ireland, particularly in those aged 20 years or under. This is a Public Health concern that needs highlighting and addressing.

Effective preventive action like preventive media messages, campaigns and regulations will help raise awareness of risk. There is a need for more alcohol health risk education programmes with a focus on sexual risk prevention.

Relationships and Sexuality Education (RSE) in school curriculum to focus on risk taking behaviours and health harm including the compounding effect of mixing risky behaviours such as alcohol and sex.

Alcohol and Cancers

Alcohol causes cancer of the mouth, pharynx, larynx, oesophagus, liver, bowel and female breast and there is a dose response relationship in this causative pathway meaning that the more we drink the greater our risk of alcohol-related cancer. There is no safe level of drinking for health. As the risk of cancer increases in line with alcohol consumption, the only way to reduce the risk of an alcohol-related cancer is to reduce alcohol consumption or avoid it completely.

The risk of cancer of the mouth, pharynx, larynx and oesophagus from alcohol consumption in combination with smoking tobacco is far greater than either drinking alcohol or smoking alone and is said to be multiplicative- implying that one risk substantially increases the risk from the other if it's concurrent.

Consumption of just one standard drink per day is associated with a 9% increase in the risk of developing breast cancer, compared to non-drinkers, while consuming 3 to 6 standard drinks per day increases the risk of breast cancer to 41%.

The cancer risks from alcohol are the same, regardless of the type of alcoholic beverage consumed (e.g. wine, beer or spirits). It has been established that ethanol, and not any other ingredients of alcoholic beverages, is the ingredient that mainly causes cancer, with acetaldehyde (a toxic chemical produced when our bodies break down alcohol) likely to be the most important biological carcinogen. Screening and early identification of patients with problem alcohol drinking using validated tools like AUDIT-C is cost-effective and will save lives.

Alcohol and Self Harm

Public health activities have an important role in addressing alcohol related self-harm, and general population campaigns to reduce alcohol consumption may be effective in reducing suicidal behaviour associated with alcohol. A review of population-level interventions to reduce alcohol-related harm concluded that there is a pattern of support for regulatory or statutory enforcement interventions (Xuan et al, 2016). Alcohol policies and suicide in general supported the protective effect of restrictive alcohol policies on reducing suicide. Furthermore, it has been estimated that reducing Irish adolescents' heavy drinking could reduce their rate of self-harm by 17% (Rossow et al., 2007).

The recently accepted Public Health Alcohol Act will contribute to reducing suicide and self-harm in Ireland, and will complement objective 3.2 of Connecting for Life - Ireland's National Strategy to Reduce Suicide, 2015-2020 - which is to support the Substance Misuse Strategy to address the high rate of alcohol and drug misuse.

Alcohol and Driving

There is no safe level of drink driving. Even one drink can increase the risk of a fatal road traffic collision. Above the legal alcohol limit (50mg alcohol per 100ml blood), drivers are more likely to speed and to have problems judging distances. Motorcyclists have reduced ability to drive in a straight line. Passengers should never get into a car with anyone who has been drinking, and if possible they should stop them from driving.

Even below the legal limit, drivers are twice as likely to be involved in a collision. With just a small amount of alcohol (20mg-50mg per 100ml blood) in your body, the ability to judge the distance and speed of oncoming vehicles is impaired. Drivers are also likely to take greater risks such as dangerous overtaking or driving too close to other cars.

It takes time for alcohol to leave the body, and nobody should drive after a big night out. It takes one hour for the effects of half a pint (or a small glass of wine) to wear off. That means after 3 full pints, 3 large glasses of wine or 3 double measures of spirits motorists should wait 6 hours before driving. A person who has been drinking all night and only had a few hours of sleep will still be over the legal alcohol limit in the morning.

Pedestrians and other road users are at risk of serious or fatal collisions after excessive alcohol consumption. Pedestrians are at greatest risk in the hours of darkness, especially on weekend nights, and on rural roads. High-visibility clothing should always be worn if walking home after a night out.

The consequences of drink driving are devastating both for drivers and the victims. If convicted of driving over the alcohol limit, it can result in disqualification from driving and a heavy fine or jail sentence.

Conclusions

As can be seen from the key messages above, there is no safe level of drinking for health. There is a need for more awareness raising campaigns highlighting the harm that can be caused by alcohol misuse. Within a culture where alcohol seems a part of everyday life, the concept that this can cause harm would need to be thoughtfully introduced to different audiences based on our understanding of behaviours and attitudes to drinking in various age groups and cohorts. The Public Health (Alcohol) Act 2018 goes some way towards enabling an environment where the harmful effects of alcohol misuse can be conveyed across the sectors in Irish society.

Reducing visibility of alcohol will aid in denormalising alcohol as a common purchase item in supermarkets and corner shops. Increasing the price with minimum unit pricing will help in particular with young people as it will make previously cheap bottles of alcohol unaffordable for school going children. Restrictions on advertising alcohol particularly at sporting events will impact exposure to alcohol to young people all over the country.

Alcohol harm is evident across the life-course and has impacts across individuals, families and communities. There is no silver bullet solution but what we do know is that a **"public health-led"** system response that is **person centered** is the best way forward. Working in partnership across agencies and a cross-sectoral approach is key to success. In Cork and Kerry, every effort is being made to work collaboratively to reduce alcohol harm across the region.

Welcome and Introduction

The Department of Public Health in HSE South is responsible for the delivery of:

- Measurable health improvement;
- Health Protection including actions for the surveillance, prevention and control of infectious diseases, environmental hazards, and response to emergencies that threaten health;
- Public health input to health and care service planning and commissioning;
- Reduction of heath inequalities

It works with all agencies within the counties of Cork, Kerry and the city of Cork to achieve these outcomes for the population.

The work of the department is mandated [under infectious diseases legislation; Primary Legislation – Health Act, 1947 *and* Health Act, 1953] through the Medical Officer of Health function which includes the responsibility for the investigation, prevention and control of notifiable infections and outbreaks; human epidemiology in Ireland as respects affecting or threatening to affect injuriously the public health and an advisory role to other authorities. This calls for work across all domains of Public Health – health protection, health promotion, health service improvement, all underpinned by a good understanding of the epidemiology and evidence base.

Communicable diseases have consequences in terms of preventable deaths and disability that affect people, generally within shorter timeframes compared to non-communicable diseases. When resources are stretched, health services unsurprisingly focus its attention on more urgent and pressing demands on it. The public health departments in the country have not been immune to such impacts in more recent years.

The Crowe Howath Review was commissioned by the Department of Health and published its report in December 2018. The Review recommends that a new national operational plan for the development of the public health function should be created. This includes public health function across the Health Service Executive, Academia, Institute of Public Health, Health Information and Quality Authority, National Cancer Registry of Ireland and the Faculty of Public Health in Ireland.

These recommendations are further supported by Sláintecare Report which advocates that health service delivery should be underpinned by robust evidence and evaluation. This view is further supported by Scally Report on the National Cervical Screening Programme which recommends that the skills of public health physicians must be deployed across the domains of public health medicine and the health services in general.

The Crowe Horwath report proposes a radically new Public Health service with function and model of delivery which is currently being developed. These changes, integrated with the reforms on foot of Sláintecare report and aligned to the vision of Health Ireland would enable the departments of Public Health to have the resources and the capacity to focus on all aspects of health with the aim of improving and protecting health and limiting overall burden of disease in the population.

A Focus on Alcohol and Health

Alcohol has a complex social, cultural and economic relationship in society playing a significant part in our everyday lives. It is associated with many aspects of Irish social and cultural life and is generally consumed for enjoyment, relaxation and sociability.

However, alcohol has major health implications and it is responsible for a considerable burden of disease and social harm. Recent consumption habits highlight the concerning trends amongst all and in particular women and young people who experience disproportionate harm. When we look back into history, we see that alcohol consumption and societal harm has been an issue that has generated debate amongst policy makers and legislators.

The Global Burden of Disease (GBD) Study determined that alcohol use was the seventh leading risk factor for mortality, morbidity and disability globally in 2016[1]. In the population aged 15-45, alcohol use was the leading risk factor. Two point eight million deaths were attributable to alcohol use, a figure which corresponds to 2.2% of total deaths in females and 6.8% of total deaths in males.

In terms of overall disease burden globally, "alcohol use led to 1.6% of total DALYs (Disability-Adjusted-Life-Years) among females and 6·0% among males. Among the population aged 15–49 years, alcohol use caused 8·9% of attributable DALYs for men and 2·3% for women".

In terms of global alcohol consumption, 32.5% are current drinkers in 2016[1]. That's around 2.4 billion drinkers of whom approximately 0.9 billion drinkers are female and 1.5 billion drinkers are male[1]. The population average of standard drinks consumed daily among high-income nations was 1.9 standard drinks among females and 2.9 among males[1].

The Global Burden of Disease Study, however, concluded "there is no safe level of alcohol consumption for improving health"!

Ireland

Drawing on the same GBD 2016 Study, alcohol use in Ireland is the fifth leading risk factor for DALYs, "contributing to approximately 6.8% of total DALYs overall (3.7% and 9.7% of total DALYs in females and males, respectively). Similar to the global trend, alcohol use was the leading risk factor for the most productive age-group (15-49 years of age) contributing to 8.1% of total DALYs (4.2% and 12.1% of total DALYs among females and males, respectively). There has been 9.8% increase in total DALYs in the age-group 15-49 between 1990 and 2016, which is worrying"[1].

Alcohol use was the fourteenth leading cause of death in Ireland in 1990, but raised to being the **sixth leading cause of death in 2016.** Alcohol use caused 6.9% of total deaths in 2016 in Ireland (an additional 1000 more deaths in 2016 as compared to 1990)[1]. Approximately, 2,150 deaths (44/100,000 in 2016 vs. 32/100,000 in 1990) were attributed to alcohol in 2016, of which 1,570 deaths were in males. 325 (15%) of these deaths were in the age-group 15-49 in 2016.

At the national rate (44/100,000), this would mean **304 deaths are attributable to alcohol in Cork and Kerry in 2016** which amounts to a death due to alcohol nearly every day of the year. It highlights the avoidable deaths and disability in our population and therefore to understand more, this report focuses on alcohol and the impact it has on the health of the people living in Cork and Kerry. "A focus on Alcohol & Health in Cork & Kerry" aims to shine a light on the dangerous trends in alcohol consumption; harm caused by alcohol on health with a focus on some less known effects; the services that support people struggling with problem drinking patterns and makes recommendations on ambitions for improving population health.

Chapter 1

The People of Cork & Kerry

The People of Cork & Kerry

Our population

The counties of Cork & Kerry comprising the HSE-South has an area of almost 1.25 million hectares (or over 12,000 square km), include Ireland's highest mountain, stunning rivers and lakes including Ireland's highest lake, some 2000km of coastline as well as hosting Ireland's most southerly and most westerly points. Cork County is the largest county in Ireland and the HSE-South region has 23 inhabited islands.

This large and disparate geography raises the need to plan effectively for the region's growing population. Travel time for example, from remoter towns to Cork City can take upwards of two hours. The population too is varied, in age, composition and geography.

The 2016 census told us there are **690,575** people living in the region, an increase of **3.9%** since the previous census in 2011; of whom 125,657 live in Cork City. The remainder live in large and small urban centres, remote rural areas and **1,747** live on 23 inhabited islands (an increase of 6.3% since 2011)[2]. As with the geography, the demography across the region is not homogenous and the socio-demographic trends, and therefore the challenges, vary within the region.

Cork & Kerry in numbers

690,575
People living in Cork & Kerry

64
Aged 100+

24,880
Unable to work due To illness or disability

12%
Non-Irish nationals

95,346
Have a disability

53.7
Dependent on every 100 of working age (15-64)

13,583
From Rest of World

449,376
Aged 15-64

150K
Aged 65+ in 2031

14.3%
Aged 65+

60%
Reported their health as very good

26,041
More people since 2011

23
Inhabited islands

10,224
Aged 85+

8766
Births

60,874
From UK

4899
Deaths

3,110
Irish Travellers

30,451 Carers

94,396
Aged 15+ in education

126,309
Aged 15+ have Fetac Level 6 or higher

30,942
Walk to school or work

2,971
Speak Irish in and out of school

10,935
Foreign language speakers can't speak English

194,382
Travel to school or work by car

423
Households have no water supply

169,313
Households have a computer

65,293
Private rented households

24,414
Aged 65+ live alone

50,240
Do not have internet

98,163
Households have at least 1 car

61,826
Live alone

18,108
Empty Nest families

31,016
Divorced or separated

19,203
Live in communal establishments

8,867
Live in areas of extreme disadvantage

57,601
Families with children <15

457
Households have no sewerage facility

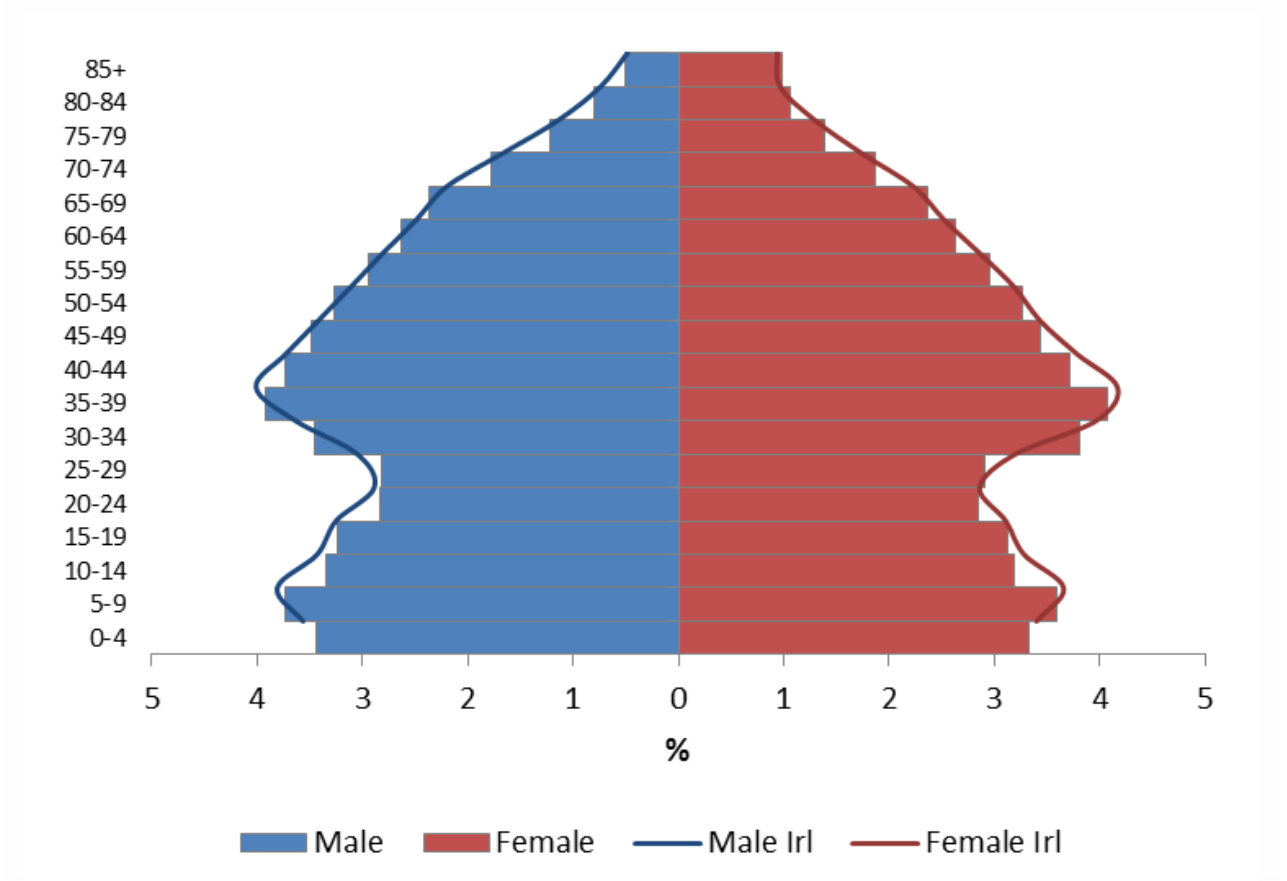
15,328
Holiday homes

40.8%
Private households built since 1991

Source: CSO SAPS 2016

The population pyramid for Cork & Kerry, mirrors that of Ireland, showing an ageing demographic profile and fewer of working age. Figure 1.1.

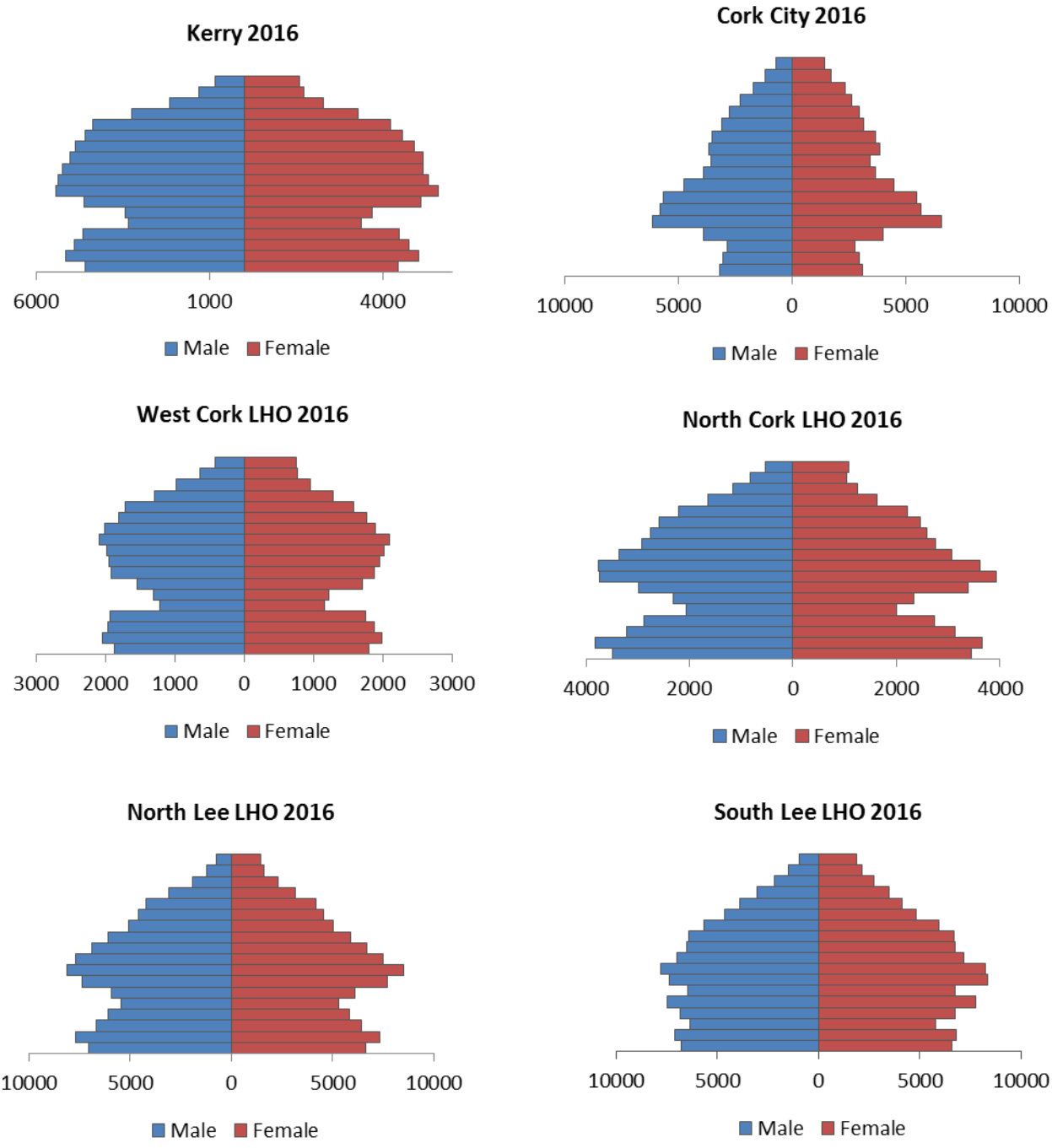
Figure 1.1 **Population by age cohort as % total population for Cork & Kerry compared with Ireland, 2016**



Source: CSO SAPS 2016

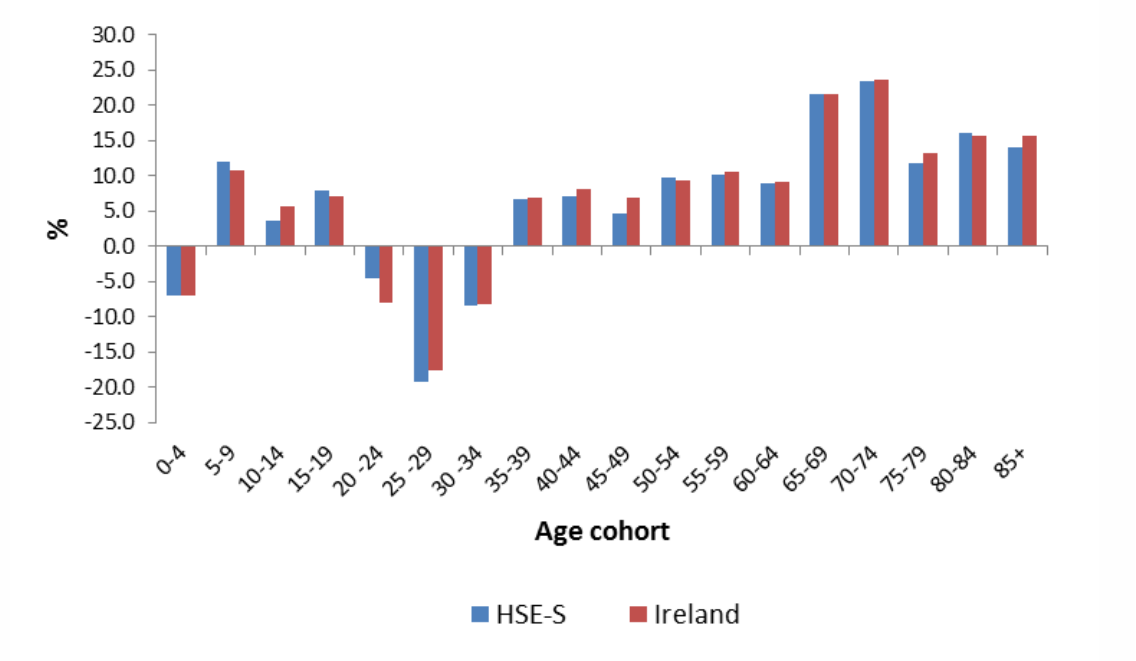
However, the pyramid for Kerry on its own shows a much older ageing pattern whereas Cork City completely reverses this picture. Looking in even more detail shows that West Cork while having a greater proportion of younger people (aged 0-19) there is a distinct narrowing of those of young working age and an overall pattern closer to that of Kerry. North Cork and North Lee are more reflective of the national picture but South Lee has a greater proportion of a younger working age cohort. These patterns reflect mobility based on employment opportunities and higher education facilities combined with age. Younger age cohorts are more mobile and more often move to large urban centres for employment and further education. The patterns in the pyramids are also reflective of geography – West Cork and Kerry are more remote and peripheral and have a greater relative proportion of older people. Figure 1.2.

Figure 1.2 **Population (total number) pyramids for Cork & Kerry 2016**



CSO SAPS 2016

Figure 1.3 **Percentage change in population by age cohort 2011-2016, HSE-S & Ireland**



CSO SAPS 2016

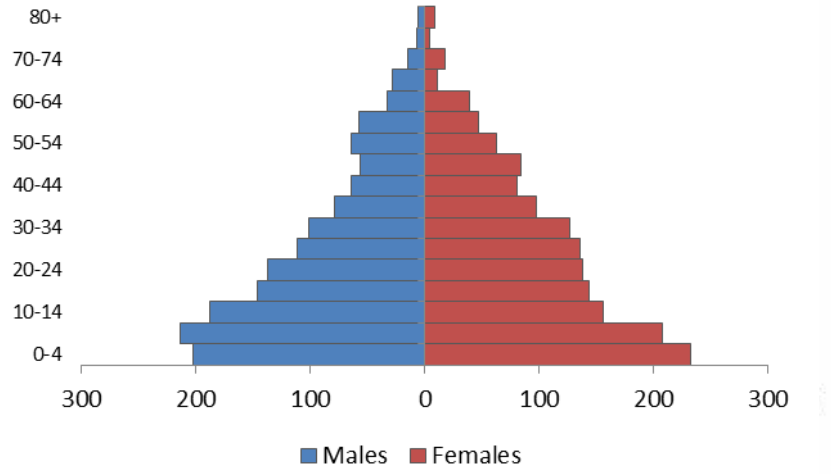
Figure 1.3 echoes the population pyramids and clearly shows our declining younger age cohorts and ageing population.

Nationality & Ethnicity

The nationality of our population is also varied. 87.8% are Irish with Polish being the next highest cohort at 3% (or 20,529 persons). UK nationals account for 2.6% and the remainder EU account for 2.8%. Nationals from elsewhere in the world account for 2%[2].

In 2016, there were 3,110 Irish travellers living in Cork & Kerry, an increase of 385 since 2011[2]. Irish Travellers however have a very different population pyramid to the rest of the population of Cork & Kerry. A high birth rate is evident with very few living to old age. Figure 1.4

Figure 1.4 **Irish Travellers Cork & Kerry 2016**



CSO SAPS 2016

Population projections

In addition to our population ageing, our population is going to increase. Since the last census the increase has been 3.9% (or 26,041 people)[2]. The most recent regional population projections indicate the region's population increasing to 733,000 by 2031 (M2F2 traditional scenario)[3] . Those aged 65 and over are projected to increase to 150,0003 (from 98,877 in 2016)[2] by 2031.

Dependency ratios

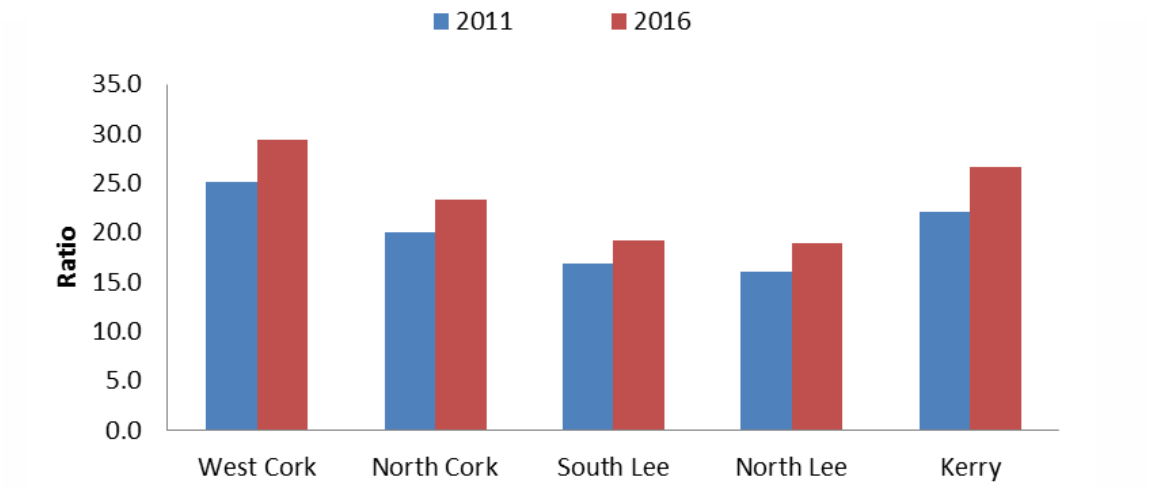
There is currently more than **one person** (under 15 or over 64) **dependent on every two workers** in Cork and Kerry in 2016[2].

Population projections would give us a total dependency ratio of 61.4 people dependent on every 100 workers by 2031, up from 53.7 in 2016.

The old age dependency ratio (persons aged 65+ as % of persons aged 15-64) are higher in West Cork and Kerry but all areas show an increase even since the last census in 2011 as evident in the graph. Figure 1.5

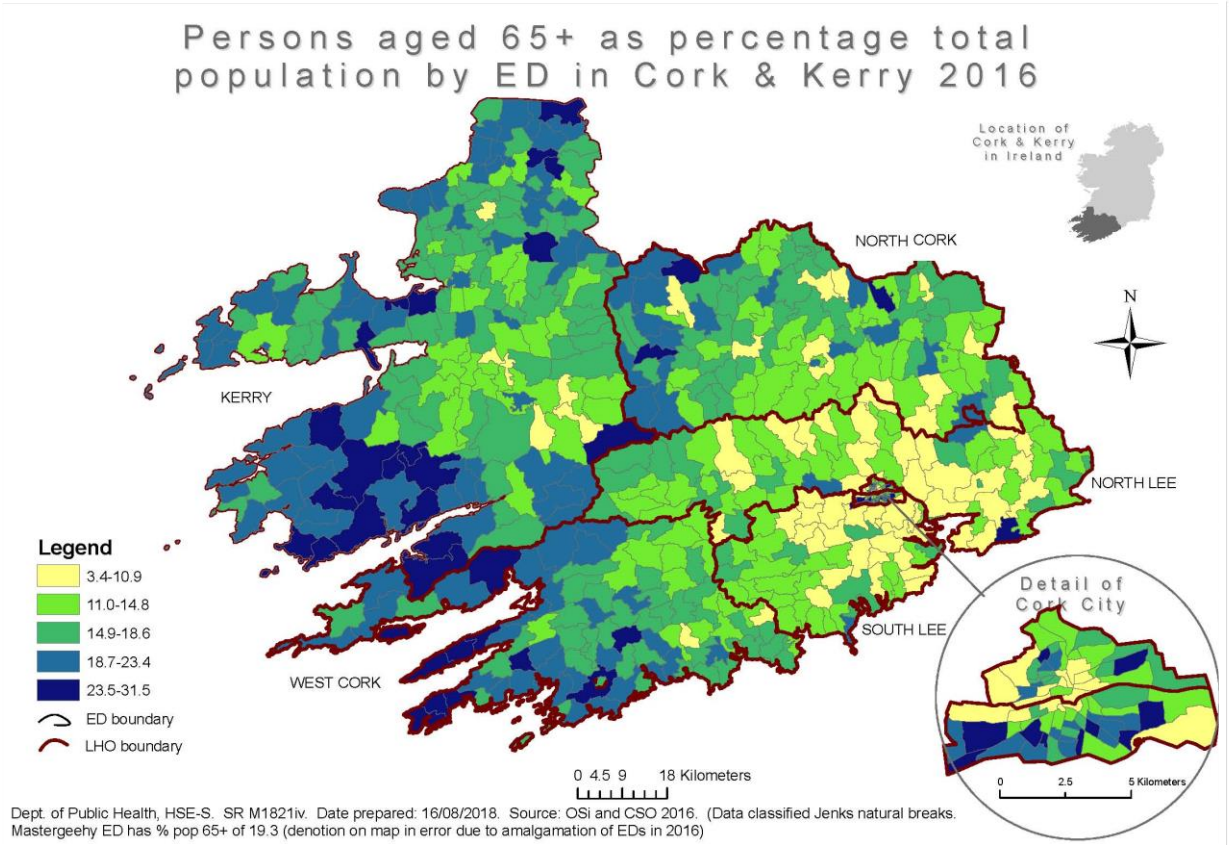
The old age dependency ratio in Cork & Kerry is 22 up from 18.8 in 2011[4]

Figure 1.5 **Old age dependency ratio by LHO, 2011-2016**



Source: CSO Census 2011 & 2016

Figure 1.6



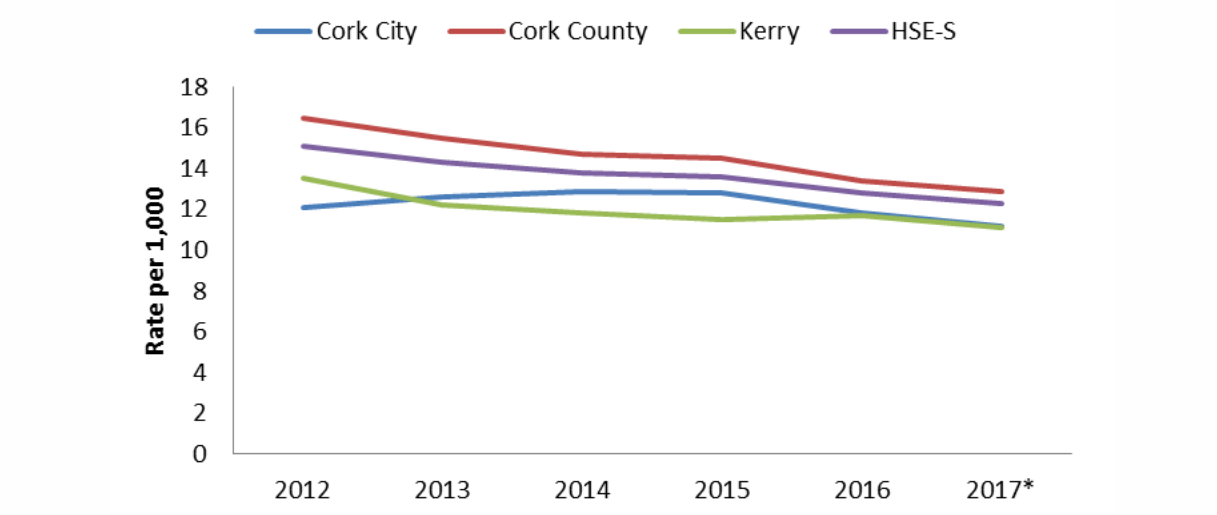
The map (Figure 1.6) clearly shows that remoter areas of Cork & Kerry have a higher percentage of older persons, who are more likely to need medical support and simultaneously have less ready access to it.

However, only **3%** of Irish Travellers are aged 65 and over in Cork & Kerry (and nationally)[2]. This is in stark contrast to the settled population. In Cork & Kerry **14.3%** (13.4% nationally)[2] of the settled population are aged 65 or over.

Births and life expectancy

Tied in with an ageing population is a decline in the birth rate over the last few years in particular (Figure 1.7); and an increase in life expectancy. There were **8,470** births registered in the region in 2017, of which 107 were to teenage mothers. These figures are both down from 2016 (8,766 and 111 respectively). The average age of mother at first maternity in 2017 was 31.4.[5,6]

Figure 1.7 **Births per 1,000 population Cork & Kerry, 2012-2017**



Source: CSO Vital Statistics Annual Reports 2012-2016 and Yearly Summary 2017

Life expectancy in Ireland at birth now stands at 79.9 for males and 83.6 for females, giving a total **life expectancy at birth of almost 82 years[7].** At age 65, you can expect to live another 21.1 years if you are female and 18.6 years if you are male[7].

Table 1.1

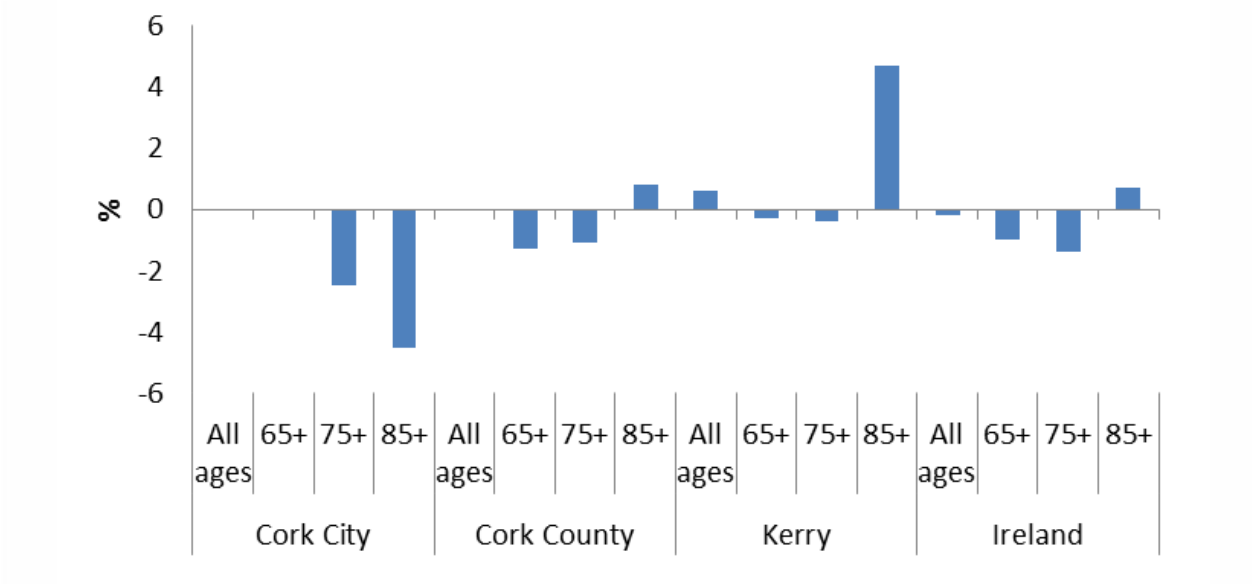
		2002	2006	2011
Male	Birth	75.2	76.5	77.9
	65 years	15.3	16.4	17.5
Female	Birth	80.5	81.6	82.7
	65 years	18.8	20	20.7

Table 1.1 above shows improving life expectancy for Cork and Kerry from 2002 through to 2011[8].

Living alone

The push through to older age cohorts is reflected in the increasing numbers of older people living alone. In all areas except Cork City, the percentage of older people living alone has increased since census 2011. This is particularly acute in Kerry where **47%** of persons aged 85 and over are living alone, an increase of **4.7%** since 2011 (Figure 1.8)[2].

Figure 1.8 **Change in persons living alone, older age cohorts as a percentage of total person in private households 2011-2016**



Source: CSO SAPS 2016

In Cork & Kerry:

27% **aged 65+ are living alone (24,414)**

35% **aged 75+ are living alone (12,551)**

45% **aged 85+ are living alone (3,498)**

Source: CSO SAPS 2016

Deaths and cause of death

In total there were **4,893 deaths** in Cork and Kerry in 2017 across all age cohorts. Of these, there are four main causes: cancer caused 1,428 deaths, diseases of the circulatory system caused 1,522 deaths, diseases of the respiratory system accounted for 618 deaths and external causes of injury and poisoning accounted for 234 deaths[27]. Other causes of death account for 1,091. Figure 1.9a. The main causes of death are comparable nationally. Figure 1.9b.

Figure 1.9a **Principal Causes of Death All Ages Cork & Kerry 2017**

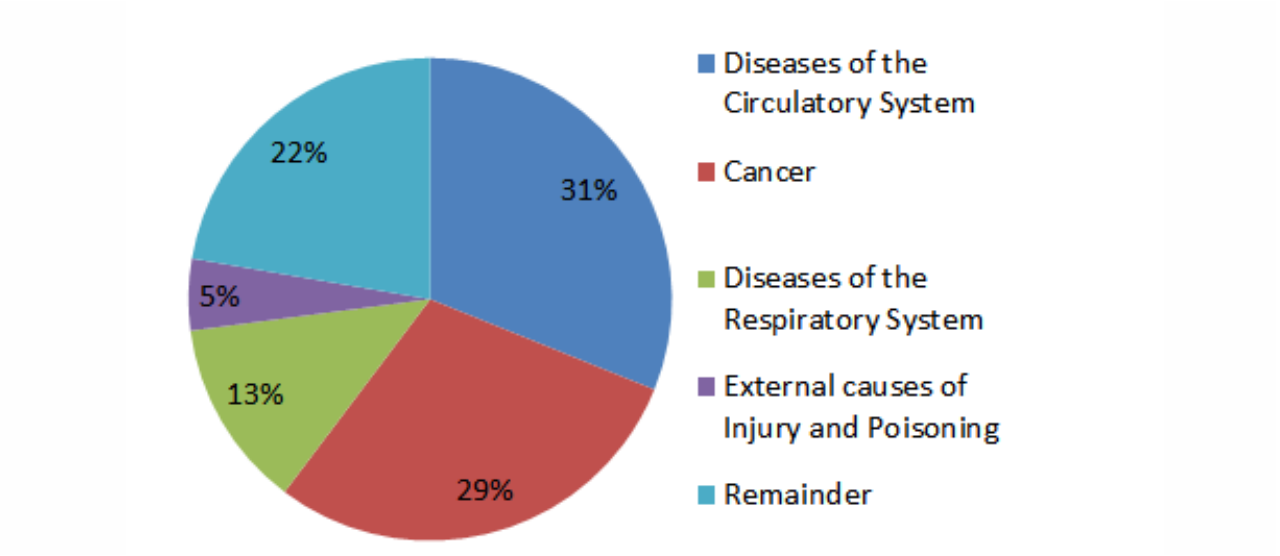
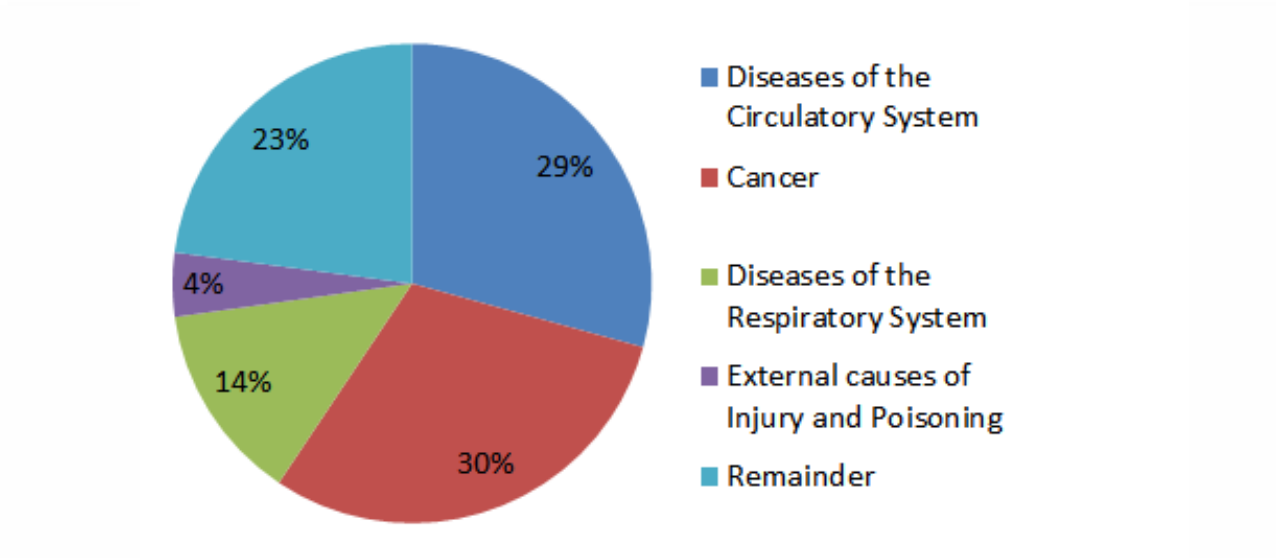


Figure 1.9b **Principal Causes of Death All Ages Ireland 2017**



There were 884 premature deaths, that is deaths occurring in those under the age of 65, in Cork and Kerry in 2017. Of these, cancers caused 360 deaths, diseases of the circulatory system caused 179 deaths, diseases of the respiratory system accounted for 35 deaths and external causes of injury and poisoning accounted for 154 deaths. Other causes accounted for 156 deaths. Figure 1.10a. As with all ages, the pattern mirrors that of Ireland. However, it is notable that cancers cause a greater proportion of premature deaths than across all ages, where diseases of the circulatory system and cancer are more equably attributable[27]. Figure 1.10b.

Figure 1.10a Principal Causes of Premature Death 0-64 Cork & Kerry 2017

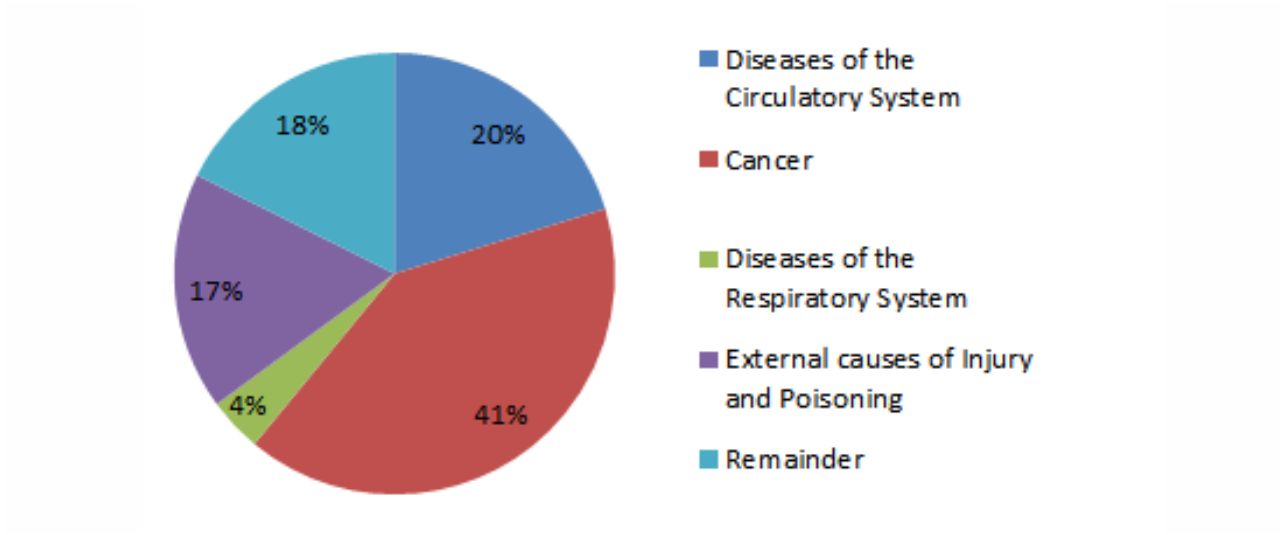
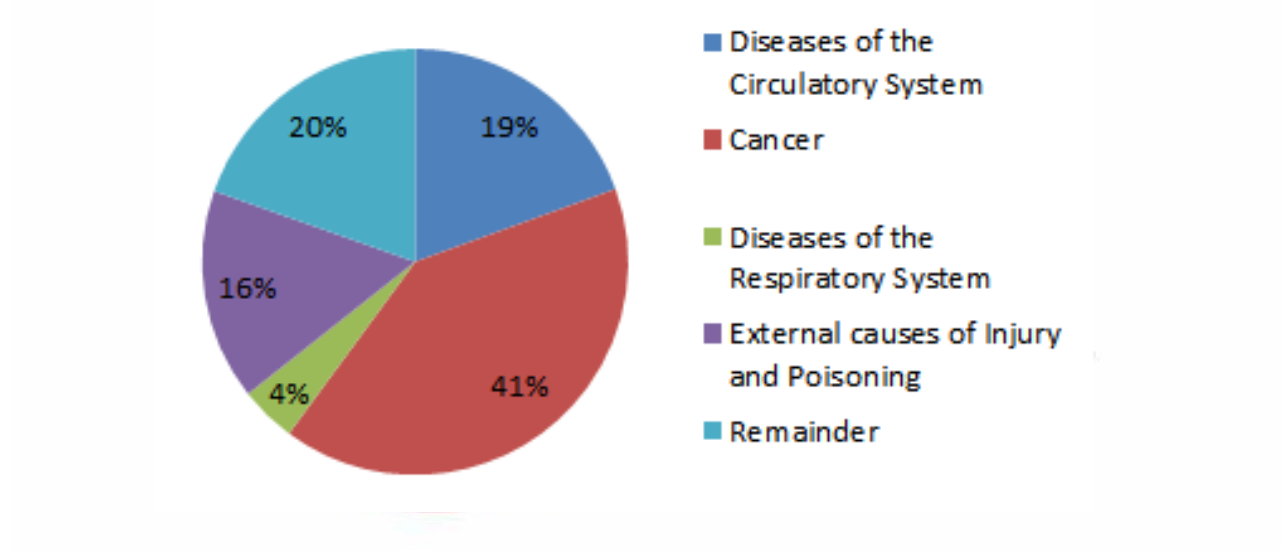


Figure 10b Principal Cause of Premature Death 0-64 Ireland 2017



Our population & alcohol

Seventy-five per cent of people in Ireland have consumed alcohol in the last 12 months[9]. This figure would mean that over half a million people (517,931) in Cork and Kerry have consumed alcohol in the last 12 months. Eighty four percent of those aged 25-34 are drinkers[9]. That would suggest there are **67,260** in the 25-34 age cohort who drink in Cork and Kerry. Nearly two-thirds (62%) of men and almost half (48%) of women who drink alcohol, do so at least once a week[9]. Thirty per cent of drinkers drink on multiple days each week.

In "terms of population average of standard drinks consumed daily, Irish women were one of the seven top alcohol drinkers in the world - consuming on an average of 3.1 drinks every day"[1].

Alcohol risk & drinking behaviours

The risk of alcohol harm rises with the amount of alcohol consumed. In 2016 we each drank 11.5 litres of alcohol[28] and we had the **fourth highest level** of alcohol consumption out of 36 OECD countries in 2012[15].

Low risk weekly guidelines for adults in Ireland are up to 11 standard drinks in a week for women, and up to 17 standard drinks in a week for men. A standard drink has about 10 grams of pure alcohol[15]. Figure 1.11

Figure 1.11 Low risk weekly guidance for adults in Ireland

The amount and frequency of alcohol consumption can define three different types of drinking behaviours[17].

Hazardous drinking[17] is defined as when a person drinks over the recommended weekly limit. It is also possible to drink hazardously by binge drinking, even if you stick within your weekly limit. Binge drinking is when you drink an excessive amount of alcohol in a short space of time - six or more standard drinks in a single session. Two-thirds of university students consume alcohol at a hazardous level[18]. At a local level, research by secondary school students for the BT Young Scientist of the Year in Kanturk in Cork found that **over one third (34.2%) of adolescents were hazardous drinkers,** of whom over two-thirds (68.2%) were under 18 (the legal age of consumption[19]. The same study found 47% of parents were hazardous drinkers.

In Ireland, 37% of drinkers binge drink on a typical drinking occasion[20]. This figure is as high as 50% for those aged under 35. Twenty two percent of drinkers binge drink at least once a week, and 39% do so at least once a month[20].

Echoing Roche *et al* and the relationship between harms from alcohol use and social determinants mentioned earlier, drinkers from more disadvantaged areas are more likely to bringe drink (43%) on a typical drinking occasion than those from more affluent areas (35%)[20].

Harmful drinking[17] is defined as when a person drinks over the recommended weekly amount and has experienced health problems directly related to alcohol. Health effects of harmful drinking include depression, acute pancreatitis, high blood pressure, cirrhosis, some types of cancer, such as mouth, liver, bowel and breast cancer, and heart disease. Sixteen percent of new cases were considered harmful in 2017[21].

Dependent drinking[17] is when alcohol is both physically and psychologically addictive and it is possible to become dependent on alcohol, where a person feels that they are unable to function without alcohol and the consumption of alcohol becomes an important - or sometimes the most important - factor in their life. **Three out of four of all cases were classified as alcohol dependent in 2017[21].** The proportion of cases classified as dependent increased from 58.8% in 2011 to 72% in 2017[21].

In Ireland, 15% of drinkers report that in the last 12 months they have had feelings of guilt of remorse after drinking[17]. 8% have failed to do what was expected of them because of drinking[17].

Inequity & alcohol harm

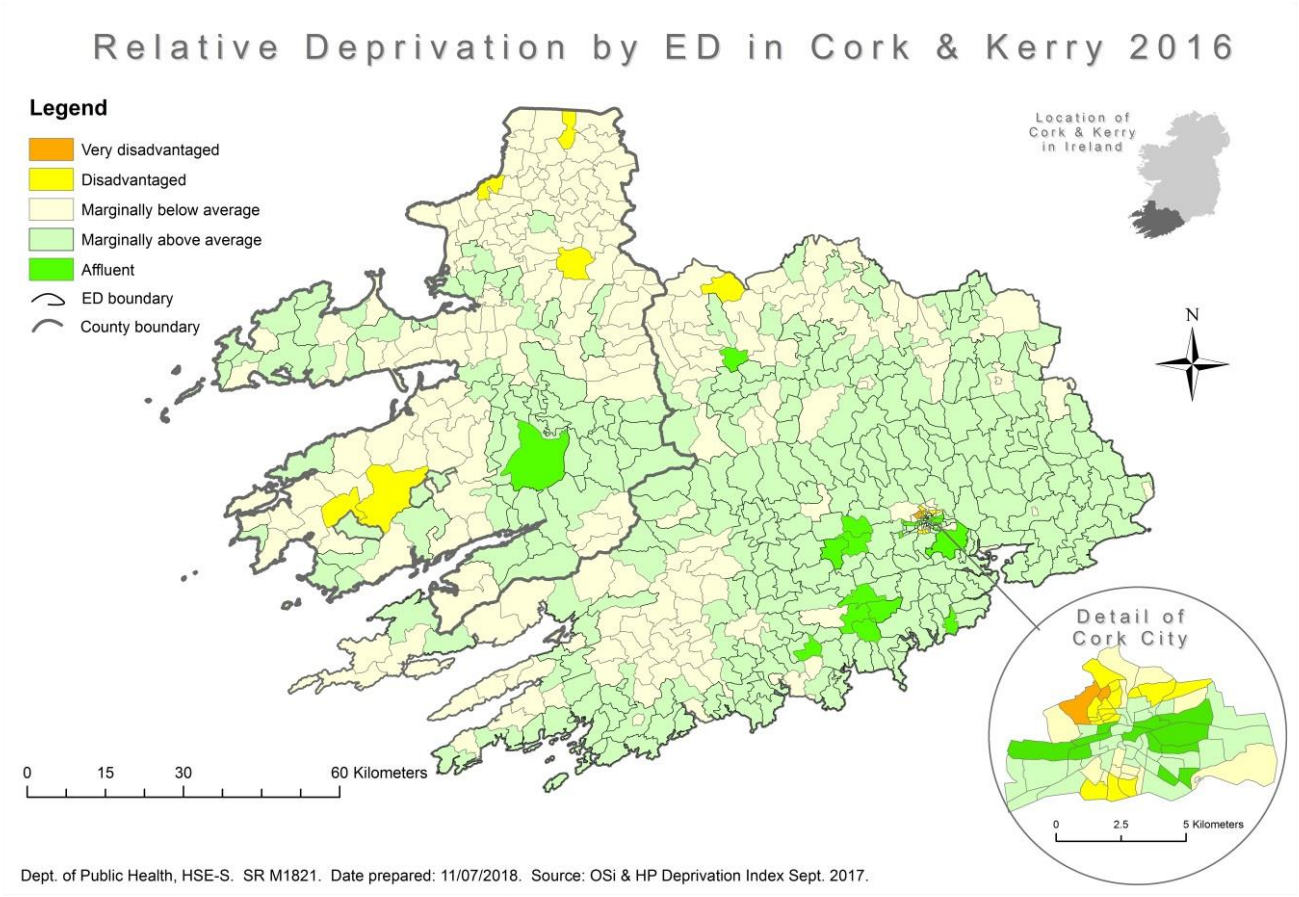
It is well established that social determinants result in inequities in health and well-being. Alcohol use and related harms are unevenly distributed across society. Roche *et al* (2015) observe that *"Social determinants can strongly influence inequities in alcohol consumption and related harms"*[10]. Social determinants can influence both alcohol use patterns and harms. Importantly, individuals with similar patterns of alcohol consumption may experience different levels of harm as a result of different education levels, employment status, income, areas of residence[10].

Further, the relationship between harms arising from alcohol use and social determinants is two-way. One exacerbates the other. *"Alcohol-related harms are therefore impacted by both consumption patterns and social determinants (with disadvantaged groups experiencing greater harms), while also acting as social determinants (e.g. poor health leading to loss of earnings and thus greater disadvantage)."* [10].

Smith and Foster (2014)[11] concur *"Lower socioeconomic status (SES) is associated with higher mortality for alcohol-attributable causes, despite lower socioeconomic groups often reporting lower levels of consumption."* In Cork & Kerry, the areas of greatest relative deprivation are, as expected, in parts of the north and south inner city and bigger urban centres but pockets of greater relative deprivation are also evident in the remoter rural areas.

Using multiple census based variables from population to social class to labour market situation, the HP Deprivation Index[12] has derived a relative deprivation index which shows how an area relates to all other areas at that point in time (currently 2016 census) as a way of assessing relative material deprivation or affluence.

The map below (Figure 1.12) uses the latest census data (2016) to show the levels of material deprivation at ED level for Cork & Kerry. It should be noted that there are no EDs in Cork & Kerry that are deemed 'extremely disadvantaged' and none that are 'very affluent' or 'extremely affluent'.

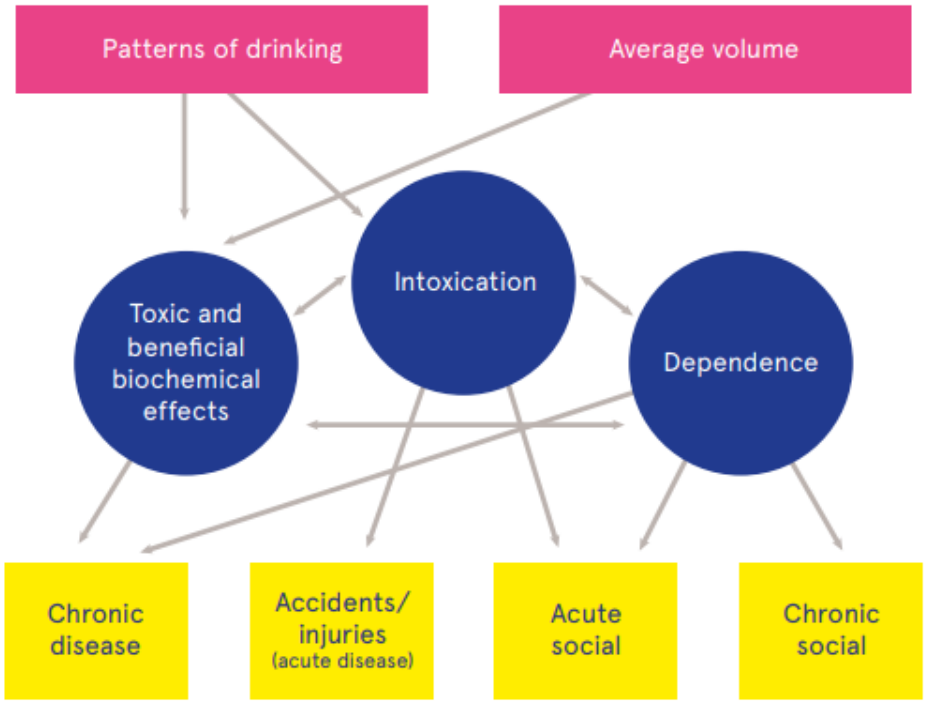


Alcohol harm

Alcohol consumption can cause harm – to individuals, their families, friends, work colleagues and wider society. "There are three main direct mechanisms by which consuming alcohol may cause harm to an individual. These are toxic effects on organs and tissues; intoxication, leading to impairment of physical coordination, consciousness, cognition, perception, and behaviour; and dependence, whereby the drinker's self-control over his or her drinking behaviour is impaired"[15].

These result in "four categories of negative alcohol outcomes – chronic disease consequences, chronic social consequences, acute health consequences and acute social consequences"[15]. The relationship between alcohol consumption, mechanisms of harm and alcohol related consequences is described in Figure 1.13[15].

Figure 1.13 **Alcohol consumption, mechanisms of harm and alcohol-related consequences[15]**



In 2018, Hope *et al*[13] reported that **51% of us in Ireland experienced harm due to strangers' drinking,** 44% experienced harm due to the negative consequences of known drinkers, 14% from co-workers' drinking, 42% experienced alcohol related domestic problems and 61% reported having known a heavy drinker in their life or someone who drinks a lot sometimes.

Table 1.2 below shows harms from strangers' drinking for men and women[13]. Table 1.3a shows psychological harms from known drinkers and Table 1.3b shows the tangible harms experienced from known drinkers by gender[13].

Table 1.2 **Harms from strangers' drinking reported in last 12 months, based on weighted sample (N=2005), by gender**

Harms from strangers	N	Any harm	Bothered by strangers' drinking	Kept awake at night	Harassed on street	Felt unsafe in public	Afraid when encountered on street	Called names/ insulted
Overall total	2005	**50.8**	26.5	26.0	22.5	18.8	15.8	9.2
Gender								
Men	981	**53.3**	26.3	27.9	23.6	15.5	12.2	10.9
Women	1024	**48.5***	26.7	24.3	21.3	22.0***	19.4***	7.6*

**p<.05; ***p<.001*

Table 1.3a **Psychological harms from known drinker in last 12 months, based on weighted sample (N=2005), by gender**

Psychological harms	N	Stressed or anxious	Harassed in private setting	Problems with friend/ neighbour	Family problems	Feel threatened at home	Feel depressed	Financial trouble
Overall total	2005	21.8	15.9	11.6	10.7	8.8	7.6	2.2
Gender								
Men	981	19.3	17.1	12.9	7.6	7.3	5.3	1.2
Women	1024	24.3**	14.7	10.3	13.7***	10.2*	9.9***	3.2**

*p<.0.5; **p<.01; ***p<.001

Table 1.3b **Tangible harms from known drinker in last 12 months, based on weighted sample (N=2005), by gender**

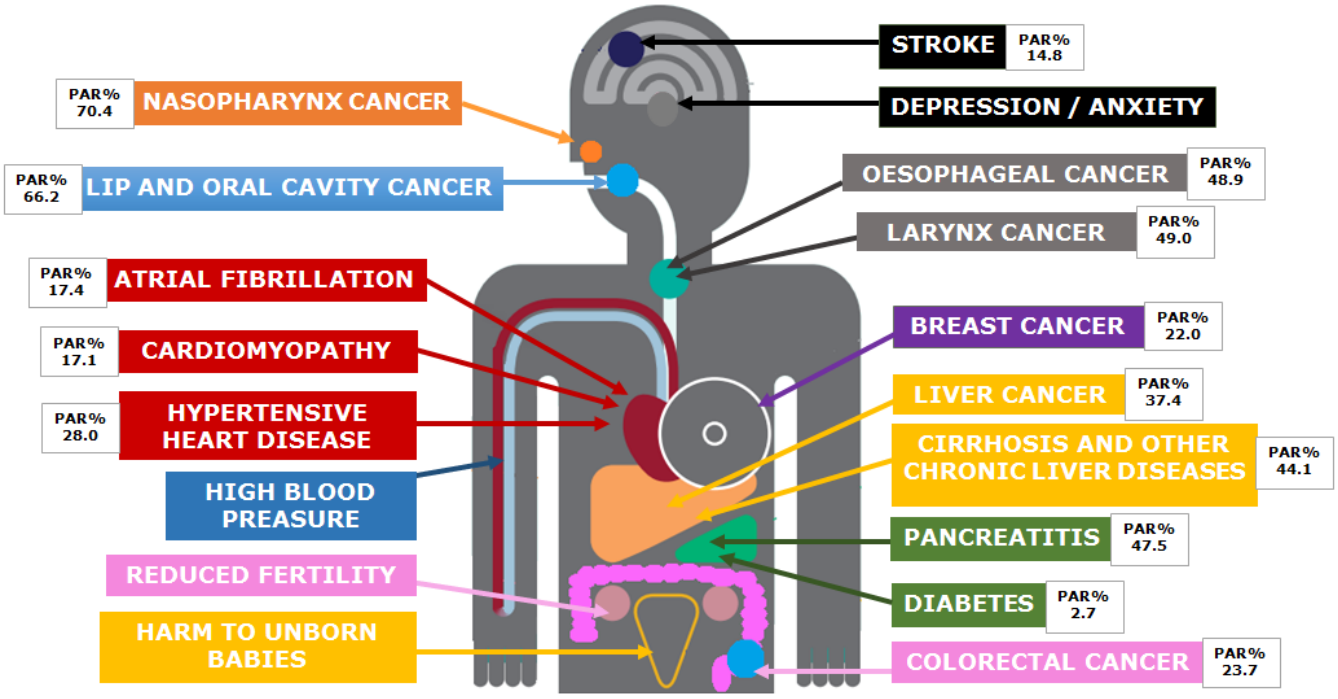
Tangible harms	N	Called names/ insulted	Ruined belongings	Passenger with drunk driver	Pushed/ shoved	Property damaged	Harmed physically	Traffic accident
Overall total	2005	16.4	6.8	5.3	5.2	3.6	1.3	0.2
Gender								
Men	981	16.0	8.2	7.4	5.8	3.0	1.4	0.1
Women	1024	16.7	5.6*	3.3***	4.6	4.3	1.2	0.3

*p<.05; ***p<.001

Approximately 900 new cancers and 500 cancer deaths are attributable to alcohol in Ireland[14] and alcohol is a major cause of premature mortality and a considerable contributory factor in health inequalities.

Fig 1.14 shows primary disease-specific alcohol-attributable deaths (in %) in 2016 in Ireland[1]:

Figure 1.14 Alcohol Misuse Damages Health



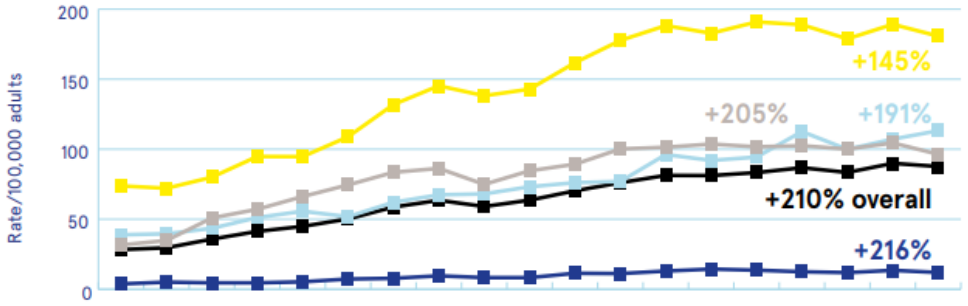
Adapted image[26]

PAR is the fraction of cases of a disease in a population that is attributable to a specific exposure, in this case alcohol. For example, PAR of 70% for cancer of the Nasopharynx would therefore tell us that 70% of all nasopharyngeal cancers would be attributable to consumption of alcohol*.

Alcoholic liver disease has increased significantly across all age cohorts since the mid-1990s, and in some ages by in excess of 200%. Figure 1.15a below plots the number of alcohol liver disease discharges from Irish hospitals between 1995 and 2013. The greatest percentage increase is seen in those aged 15-34 which has risen by 216% in the period.

* "Population attributable fraction (PAF) is an epidemiologic measure widely used to assess the public health impact of exposures in populations. PAF is defined as the fraction of all cases of a particular disease or other adverse condition in a population that is attributable to a specific exposure." (Population attributable Fraction; Mohammad Ali Mansournia, and Douglas G Altma; BMJ 2018; 360 doi: https://doi.org/10.1136/bmj.k757 (Published 22 February 2018)

Figure 1.15a Rate of alcoholic liver disease discharges per 100,000 adults, by age, 1995-2013



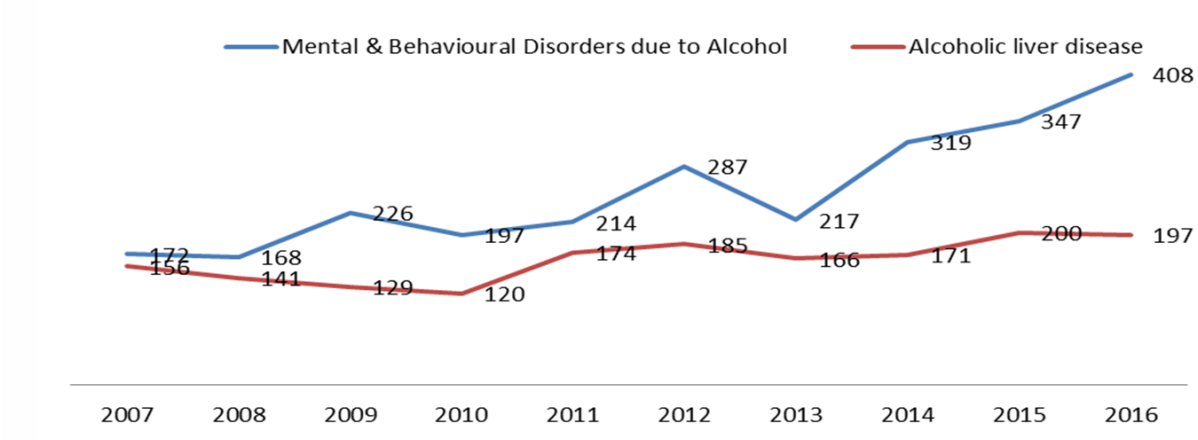
	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
15-34	3.8	5.1	4.6	4.6	5.3	7.3	7.8	9.6	8.3	8.3	11.4	11.2	13.0	14.4	13.6	12.5	11.9	13.5	12.0
35-49	31.6	34.8	50.9	57.1	66.2	74.5	83.5	86.3	74.9	84.6	89.3	100.2	101.4	103.7	101.7	102.5	100.1	104.5	96.4
50-64	73.8	72.1	80.0	94.8	94.7	108.9	131.9	145.3	138.2	142.9	161.8	177.7	188.3	182.8	190.9	188.9	178.8	189.2	180.8
65+	38.9	39.6	43.5	51.2	55.7	51.8	62.1	67.4	68.1	73.2	76.1	77.0	96.2	92.0	94.4	112.6	99.9	107.2	113.2
All	28.3	29.6	35.8	41.3	44.9	50.2	58.7	63.5	59.1	63.6	70.3	76.1	81.3	81.2	83.3	86.8	83.4	89.9	87.7

The economic costs are substantial, assessed by Hope et al as €862.75m as the total estimated cost of alcohol's harm to others (AH2O) and €1.5b on alcohol related hospital discharges (excluding emergency care, general practice, psychiatric care and alcohol treatment services) in 2012[13].

The estimated cost to the health system in 2012 of dealing with inpatients with either a wholly or partially alcohol-attributable condition was €1.5 billion, which accounted for 11.0% of all public healthcare expenditure that year[15].

The graph (Figure 1.15b) below shows the in-patient and day case numbers in public hospitals from 2007 to 2016 in Cork and Kerry for alcohol related illness^[27].

Figure 1.15b Total In-Patient & Day Case Numbers In Public Hospitals 2007-2016 In Cork & Kerry



Source: HIPE, PHIS, Personal Edition 2018, Department of Health

"Nationally the number of alcohol-related discharges increased from 9,420 in 1995 to 17,120 in 2013, an increase of 82%"[15] Table 1.4. There has also been an increase in the average length of stay "from 6 .0 days in 1995 to 10.1 days in 2013, which suggest that patients with alcohol-related diagnoses are becoming more complex in terms of their illness"[15].

^ Caution should be taken when looking at small numbers and also with regard to those with mental health problems as it is common for this cohort to experience alcohol misuse.

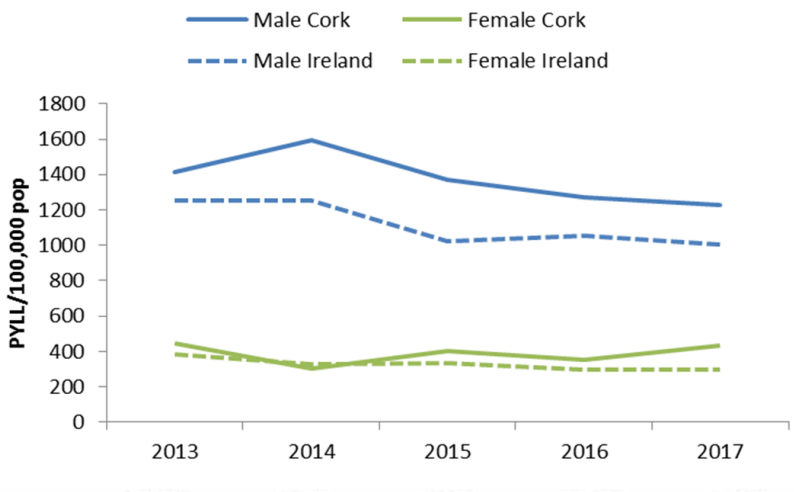
Table 1.4 **Number and length of stay of alcohol-related discharges, 1995–2013**

	All persons	Males	Females	Mean LOS
1995	9,420	7,124	2,296	5.97
1996	10,842	8,289	2,553	5.64
1997	11,445	8,727	2,718	5.98
1998	12,421	9,366	3,055	6.31
1999	13,860	10,579	3,281	6.00
2000	14,807	11,007	3,800	5.9
2001	16,219	12,109	4,110	6.14
2002	18,057	13,471	4,586	6.62
2003	18,035	13,378	4,657	6.51
2004	17,976	13,505	4,471	6.94
2005	15,088	10,971	4,117	7.86
2006	17,053	12,629	4,424	8.11
2007	18,024	13,344	4,680	8.04
2008	18,400	13,579	4,821	8.75
2009	18,109	13,254	4,855	8.64
2010	17,755	13,015	4,740	9.07
2011	17,078	12,457	4,621	9.35
2012	17,225	12,552	4,673	9.18
2013	17,120	12,398	4,722	10.1

Source: HRB Overview Series 10. Alcohol in Ireland: consumption, harm, cost and policy response 2016

Potential years of life lost (PYLL) is an estimate of the average additional years a person would have lived if he or she had not died prematurely. Many such years of life are lost due to alcohol consumption. The graph below shows the potential years of life lost (PYLL) in Cork for males and females. Males in Cork are losing a greater number of potential years of life than nationally. Females are closer to the national picture, although they also are losing more years than nationally, with 2017 showing a widening of this gap. Figure 1.16

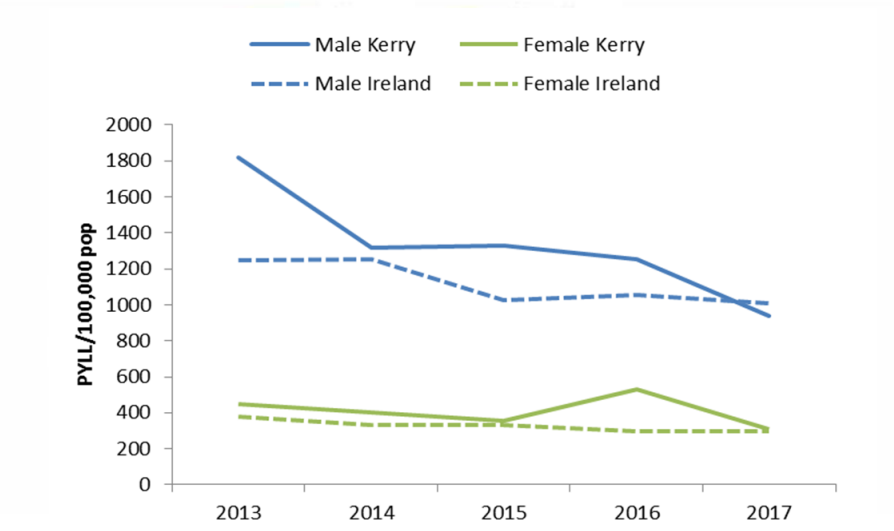
Figure 1.16 **Mortality All Ages for selected alcohol causes CORK - Potential years of life (PYLL) lost 2013-2017**



Source: PHIS, Personal Edition 2018, Department of Health

In Kerry, there has been a decline in the PYLL for males since 2013 to a point where YPLL for males in Kerry is now less than nationally. In 2017, females more broadly matched the national picture in Kerry[27]. Figure 1.17

Figure 1.17 **Mortality All Ages for selected alcohol causes CORK - Potential years of life (PYLL) lost 2013-2017**



Source: PHIS, Personal Edition 2018, Department of Health

Alcohol harm through the life course

Throughout all stages of life, alcohol use can impact negatively on our health and wellbeing. Risk and damaging behaviours impact differently as we age.

Beginning life

Alcohol can have a major impact on life, even as early as the point of conception. *"Alcohol use during pregnancy has been established as a risk factor for adverse pregnancy outcomes including stillbirth,*

spontaneous abortion, premature birth, intrauterine growth retardation and low birth weight[22]". Alcohol use during pregnancy is the direct cause of fetal alcohol syndrome[22]. **"Ireland has the worst rates in the world for drinking during pregnancy"**[23] does not make for good reading. Sixty per cent of Irish mothers drink during pregnancy[23].

During breastfeeding, alcohol consumption can have an effect on baby. Alcohol can pass from the bloodstream into breast milk and can affect the quality of baby's sleep[24].

Adolescence

Although most young people begin to drink alcohol in their teenage years, a small number begin drinking much earlier. The median age those with problem alcohol use first started drinking in Ireland was 16 in 2017, but the range was age 12-22[21]. The consequence of this becomes evident as the person grows to adulthood. The median age for 'first started drinking' in Ireland of those with problem alcohol use who have been previously treated is 15[21]. We have already noted that two-thirds of university students consume alcohol at a hazardous level[18] . This shows Irish young people are initiating hazardous drinking levels early in life.

Working age

People of working age are susceptible to alcohol related health conditions including cancers, neuropsychiatric conditions and other chronic disease including cardio-vascular disease and diabetes. In addition alcohol impairs judgment, ability to work or getting to work, and contributes to self-inflicted injury.

Incidence of treated problem alcohol use cases in those aged 15-64 is 111.6 per 100,000 in 2017, down from 151.5 per 100,000 in 201121. Prevalence is also down from 289.5 cases per 100,00 in 2011 to 234.4 cases per 100,000 in 2017[21].

Older people

Younger and older people are usually affected more. The amount of body fluids tends to decrease with age, so an older person will be more affected by the same amount of alcohol[24]. Alcohol can cause health problems like heart disease, cancer, strokes, liver problems and brain damage. Too much alcohol can also worsen existing health conditions, like diabetes, high blood pressure and osteoporosis. It can also worsen mental health difficulties and impact medications negatively. Figure 1.14. In Ireland, 10% of those over 65 are consuming alcohol on four or more days per week, higher than any other age group[25].

These and other aspects of alcohol use and its impact on the population of Cork & Kerry are explored in more detail in the following chapters.

Chapter 2

Alcohol and Harm in Cork and Kerry

2.1 Alcohol and pregnancy

"When a million babies are born every year with permanent brain injury from a known and preventable cause, the response ought to be immediate, determined, sustainable and effective".[1]

Background / Introduction

Prenatal alcohol exposure (drinking during pregnancy) is the cause of Foetal Alcohol Spectrum Disorders (FASD). When a pregnant woman drinks alcohol, so does her unborn baby. During pregnancy alcohol passes from the mother's bloodstream through the placenta and into the baby's bloodstream, where it can affect its development. This damage may not be detected at birth, but may later show up in the form of behavioural, social, learning and attention difficulties in childhood, adolescence and throughout adulthood.

Studies on alcohol consumption during pregnancy suggest the number of affected children in Ireland may be significant. In January 2017, the Lancet published a systematic review and meta-analysis of alcohol consumption in pregnancy, the risk of Foetal Alcohol Syndrome (FAS) and the prevalence of people with FAS in the population. It estimates that about 600 Irish babies with FAS are born each year and that over 40,000 Irish persons have FAS. For every 67 women who drink alcohol during pregnancy, one child is born with FAS. This is the best estimate currently available.

Foetal Alcohol Spectrum Disorders (FASD)	Foetal alcohol syndrome (FAS)
FASD causes problems with a baby's body, brain, behaviour and can cause problems throughout a person's life. For example: • hyperactivity and poor attention, • learning difficulties and a lower IQ, • difficulty controlling behaviour, • difficulty getting along with other people, • being smaller than expected, • problems with eating and sleeping, • emotional and mental health problems.	**FAS** is more serious and can happen when you drink heavily during your pregnancy. In addition to all the signs of FASD, your baby may: • be smaller than normal or underweight, • have damage to their brain and spinal cord, • have an abnormally small head or eyes, abnormally-shaped ears or facial features, • have problems with their heart and / or other organs.

Source: [11]

In general Foetal Alcohol Syndrome (FAS) results from drinking during pregnancy at levels that would be recognised as problematic outside of pregnancy. However, FAS is only one of the adverse outcomes that are caused by prenatal alcohol exposure. In the public health interest, the goal of an alcohol free pregnancy is to prevent cases of the full spectrum of Foetal Alcohol Spectrum Disorders (FASD). International evidence says that for every case of FAS there are at least 9 or 10 cases of FASD[4].

Although visible signs of abnormality may be present at birth, most children born with FAS are not recognised and diagnosed at birth. Children who are born with a Foetal Alcohol Spectrum Disorder are not recognisable as having an FASD until difficulties become evident at preschool or school. The baby looks normal and is of expected size and birth weight. It is not possible to assess neurodevelopmental outcome of the new-born other than in gross motor terms.

nternational studies, including surveillance surveys in a number of EU member states, have shown that active case ascertainment yields a prevalence of FASD in 1-7% of live births. Whether the live birth prevalence found is at the lower (1%) or upper (7%) percentage of live births is related to the population alcohol intake expressed in litres per head of population[5].

Relevance of issue to Cork and Kerry

The best estimate currently available suggests that 87 babies with FAS are born each year in Cork and Kerry and that over 5,800 persons with FAS live in Cork and Kerry[2]. Irish people are not immune to the harmful effects of alcohol. We all know someone, child or adult, who has Foetal Alcohol Spectrum Disorders' (FASD) invisible characteristics.

FASD Invisible characteristics include attention deficits, memory deficits, hyperactivity, difficulty with abstract concepts such as maths, time and money, poor problem-solving skills, difficulty learning from consequences of one actions, poor judgement, immature behaviour, poor impulse control and confused social skills. These invisible characteristics may or may not be associated with recognisable physical features associated with FASD.

Why do women continue to drink during pregnancy?

Mothers want the best for their baby. The majority of women change their drinking pattern in pregnancy or when planning pregnancy. Women, however, can receive conflicting advice. Differing advice on alcohol use in pregnancy is problematic. European Member States do not have standard guidance on alcohol use in pregnancy. Women need a consistent clear message that pregnancy needs to be alcohol free to prevent FASD. As we have already noted up to 40% of pregnancies are unplanned in Ireland[6], so some women may be drinking before realising they are pregnant.

Alcohol use by women is increasing in all socioeconomic groups (SEG), as is binge drinking especially among students and those of lower SEG[7]. Women who drink heavily are patients themselves and need help. The international evidence[8] shows that addiction services for women with alcohol exposed pregnancies or following the birth of a baby with FASD are more effective when they are: gender specific – for women only; include provision for child care; and prioritise pregnant women for timely service so as to support pregnancy risk reduction in the index pregnancy. Consideration might be given to screening for alcohol use in pregnancy and providing evidence based brief intervention to pregnant women as indicated. There is increasing international evidence[9,10] to show long lasting beneficial outcome from organised parent child assistance programmes with the potential for significant societal and economic benefits, in terms of reduced demand for services needed to respond to and deal with children and adults with FASD.

Pregnancy outcomes such as premature birth, birth weight, or miscarriage may not be affected by prenatal alcohol exposure. However, it is not these outcomes of pregnancy that is the main concern of prenatal alcohol exposure; it is the neurodevelopmental outcome for the child. This is the fundamental point to note.

What do we do about it?

The prevention of prenatal alcohol exposure in Ireland requires a response from both government and society. In Ireland, it is the social norm to drink, including when pregnant. This is a powerful societal factor leading to prenatal alcohol exposure. Irish society's focus on alcohol in social occasions puts undue pressure on women in pregnancy and contributes to feeling that by being pregnant and abstaining, women are 'missing out' on something. Women receive unequal focus on their alcohol use. In fact, the recent World Health Organisation Global Burden of Disease report[3] on alcohol source confirms that 74% of all alcohol consumed internationally is by men. Men consume nearly three times the alcohol than that consumed by women.

Ireland needs to bring about a change in societal expectation and habit so that abstaining from alcohol when trying to conceive, and when pregnant, becomes the new social norm. Only by the whole of society co-operating and committing to protecting pregnancy in practical ways can the population of Ireland strive and hope to bring this change about. We need to make the healthy choice an easier option for pregnant women such as ensuring alcohol free alternatives are readily available at social gatherings.

FASD impacts on the individual with the disorder but also on families, education, social care, health, society in general and even including the criminal justice system. International studies confirm that the actual country prevalence of FAS and FASD is directly related to the population consumption of alcohol. Society as a whole, by reducing per capita alcohol consumption, can join in the effort to prevent prenatal alcohol exposure in Ireland. FASD can have devastating lifelong neurodevelopment outcomes, through often unintended prenatal alcohol exposure. Cutting down on alcohol consumption supports healthy reproduction. This requires a whole of society and whole of government response.

Public Health Messages

Pregnancy needs to be alcohol free to prevent Foetal Alcohol Spectrum Disorders. **There is no safe amount and no safe time for alcohol during pregnancy.** The risk of Foetal Alcohol Spectrum Disorders (FASD) is a dose related effect. There is no low risk drinking of alcohol during pregnancy; there is only a reduced risk and even this risk is too high. Ideally a woman would abstain from alcohol when she is trying to conceive a baby. This provides the best chance for healthy foetal brain growth and development.

About 40% of pregnancies are not planned and women who may have had the occasional drink before they realised they were pregnant should not be worried. The brain continues to grow and develop throughout pregnancy. The adult brain can show signs towards recovery during alcohol free periods. This provides grounds for hope that the foetal brain can also recover during the alcohol-free remaining period of the pregnancy.

It remains very worthwhile therefore to stop drinking alcohol at any stage of pregnancy and cutting out alcohol completely after knowing you're pregnant. This is both the safest and healthiest approach for the unborn baby as no amount of alcohol has been shown to be safe to consume during pregnancy. Achieving an alcohol-free pregnancy does not happen without making a conscious decision to do so, and maintaining an alcohol-free pregnancy requires the support of others. With a bit of fore thought, family, friends and social networks can do much to help.

There is no single solution to tackling alcohol-related harm. We need a package of measures to limit the affordability (price), availability (place) and promotion of alcohol. Alcohol harm needs to be addressed through a comprehensive policy and action at a range of levels targeted at different sections of the population.

National and Local government, supported by public health teams, can influence harm by designing, implementing and lobbying for evidence-based policies for reduction of alcohol-related health harms.

See http://www.askaboutalcohol.ie/health/alcohol-and-pregnancy/tips-for-an-alcohol-free-pregnancy/

2.2 Alcohol, young people and children

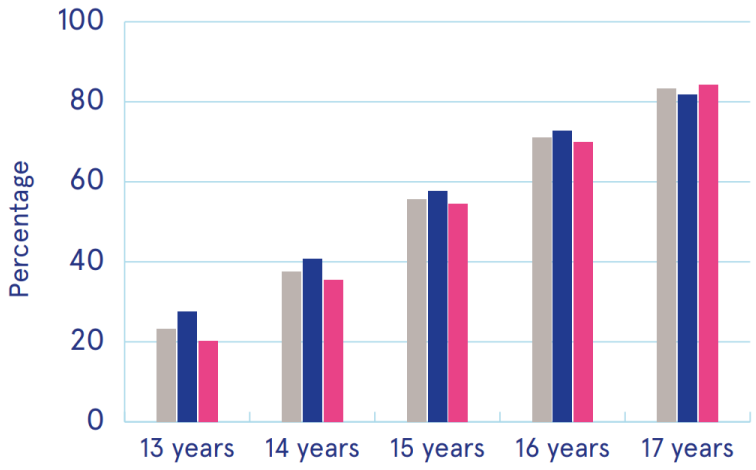
Introduction

Alcohol use in children and young people has deleterious effect on health as their bodies and brains are still developing. Despite this, the average age in Ireland that young people start to experiment with substances is 15[1]. Over the last decade, there has been a shift in emphasis in finding ways of engaging with young people in Ireland to address the issue of heavy drinking and addiction to alcohol. This is particularly the case as the teenage years have been identified as crucial in the development of lifestyle patterns.

A study in 15-16 year olds found that over 75% of students in Ireland have tried alcohol and just under 30% had their first encounter with alcohol under the age of 13[2]. More than 25% of 15-16 year olds reported having 5 or more drinks in one sitting in the last 30 days. This makes Ireland one of the countries with the highest levels of alcohol consumption and binge drinking in Europe in that age group.

In 2014, a study commissioned by the Health Research Board showed that 51% of 13–17 year olds reported that they had ever had an alcoholic drink[3]. Use of alcohol increased linearly by year of age. Boys aged between 13 and 16 were more likely than girls to have ever had an alcoholic drink (Figure 2.2.1).

Figure 2.2.1. The percentage of children who have had an alcoholic drink by age and gender, 2014



	13 years	14 years	15 years	16 years	17 years
All	23.2	37.6	55.7	71.1	83.3
Boys	27.6	40.7	57.7	72.7	81.9
Girls	20.3	35.5	54.5	70	84.3

Source: HRB Overview Series. Alcohol in Ireland: consumption, harm, cost and policy response, 2016

Suicide and Mental Health disorders

Suicide in Ireland is the leading cause of death in men aged 15-24 years of age which is the fourth highest in the European Union (EU). Ireland has the 7th highest rate of suicide in the 15-19 year age group in 2015[4]. A national study found that there are strong links between alcohol misuse and suicidal behaviours and that excessive drinking is strongly associated with poor mental health and well-being[5].

Harm to themselves or others

Children and young people are more prone to engaging in harmful behaviours when intoxicated largely due to the fact that they are more likely to push the boundaries of what is acceptable. In a national Irish survey of young people 15% of young adults admitted to being involved in a fight as a result of alcohol and 20% admitted to suffering an injury while intoxicated[6]. Ten percent had unprotected sexual intercourse while 5% had unwanted sexual advances.

Chronic alcohol related medical conditions, particularly alcoholic liver disease, are increasing in young people aged 15 to 34 years in Ireland. Hospital Inpatient Enquiry (HIPE) Data demonstrate that the rate of hospital discharges related to alcoholic liver disease increased by 247% for 15-34 year old between1995 and 2007[7].

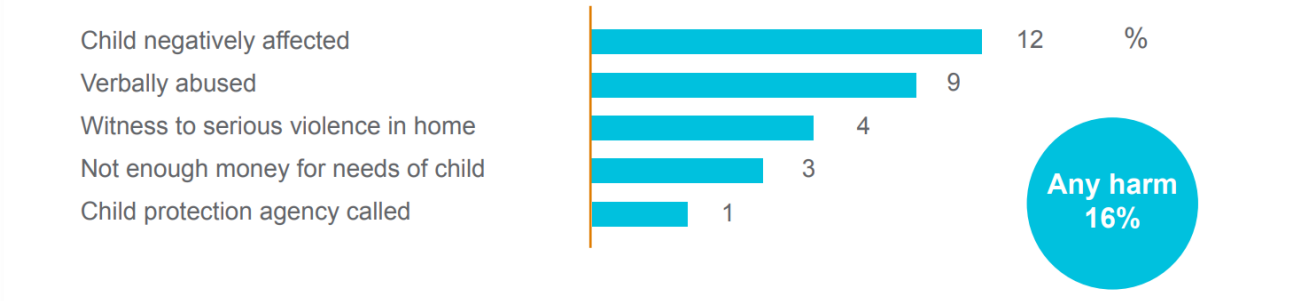
Parental misuse of alcohol and Adverse childhood experiences

The recent launch by Alcohol Action Ireland of the 'Silent Voices' campaign aims to highlight the harmful effect alcohol has on children by giving a voice to those who were cared for in households where alcohol was abused. In Ireland, it is estimated that between 1 in 6 or 7 children are impacted by alcohol related harms caused by others which leads to a life conditioned by others.[19]

Recent insights into the damaging effects of alcohol on children were published in conjunction with Trinity College Dublin[8]. One in six guardians of children reported that the child/children had experienced harm because of someone else's drinking. The most common forms of harm are shown in Figure 2.2.2.

The children who were most at risk were those whose carers were in the youngest age group (18-29 years) living in homes with the lowest household income. Carers that were separated were more likely to report harm to a child due to alcohol compared to a carer that was married (29% vs. 11-19%)[8].

Figure 2.2.2. Harms to children from other's drinking



Source: The untold story: Harms experienced in the Irish population due to others' drinking 2018

Young adults were also shown to experience harm from other's drinking as can be seen in Figure 2.2.3. The 18-29 year age group experienced more harm than any other age group across all measured harms.

Figure 2.2.3. Tangible harms from known drinker in last 12 months, based on weighted sample (N=2005), by socio-demographics

Tangible harms	N	Called names/ insulted	Ruined belongings	Passenger with drunk driver	Pushed/ shoved	Property damaged	Harmed physically	Traffic accident
Overall total	2005	16.4	6.8	5.3	5.2	3.6	1.3	0.2
Gender								
Men	981	16.0	8.2	7.4	5.8	3.0	1.4	0.1
Women	1024	16.7	5.6*	3.3***	4.6	4.3	1.2	0.3
Age groups								
18-29 yrs	437	33.2	20.6	10.3	15.1	8.7	3.2	0.2
30-44 yrs	630	17.1	5.1	4.3	3.8	3.3	1.0	0.3
45-60 yrs	517	11.2	2.5	3.9	2.5	2.3	1.4	0.2
60+ yrs	421	4.0***	0.5***	2.6***	0.5***	0.5***	0.0***	0.0

*p<.05; ***p<.001

Source: The untold story: Harms experienced in the Irish population due to others' drinking, 2018

Cork and Kerry

Two previous surveys were undertaken by the Department of Public Health in Cork and Kerry in 1996 and 2004 by Dr Tim Jackson[14, 15]. The survey was a multi-staged, quota-controlled household survey with random starting points surveying 15-44 year olds. In total there were 1,512 respondents distributed equally amongst Cork City, Cork County and Kerry. A booster sample of 900 participants aged between 15 and 24 from socially deprived areas was used to increase statistical robustness. The study found that 47% of boys and 32% of girls were current drinkers. The proportion of this age group that reported having been drunk (87%) had increased by 15% since the 1996 study. More recently a task force has been set up in order to address alcohol misuse in the Cork and Kerry region with publication of the Cork and Kerry Alcohol Strategy in 2016[16].

What can be done about it?

Education on its own has not been shown to impact meaningfully on long term use of alcohol17, 18. Therefore the World Health Organisation (WHO) strategy of a multidisciplinary approach must be focused on. This depends on a number of factors, including but not exclusively, continuing to legislate effectively and enforce current legislation, strengthening the current knowledge of the morbidity and mortality in regions and development of robust national information systems. The WHO has a strong emphasis on preventative strategies.

This report identifies deficits in knowledge we currently have in the Cork and Kerry region in terms of attitudes and drinking patterns of young people. As a department we must discuss possible opportunities to collaborate with alcohol and addiction services in Cork and Kerry to see how we can engage more in this area.

Public Health Messages

To understand the public health message it is necessary to first have an understanding of what motivates young people to consume alcohol and to continue to do so in a harmful way. Studies have shown that availability of alcohol[9] whether that be in the community, school or at home and having friends who drink alcohol[10, 11] impact on the likelihood of a young person trying alcohol. The home environment is also highly influential on a young person's likelihood of drinking alcohol12 with adolescents brought up in a house with one or more parents who abuse alcohol more likely to end up involved in substance misuse[13]. Therefore it can be surmised that tackling alcohol misuse in children and young people must be multifactorial in approach.

The 2018 introduction of the Public Health (Alcohol) Act goes some way towards targeting alcohol misuse across the sectors in Irish society. Reducing visibility of alcohol will aid in denormalising alcohol as a common purchase in supermarkets and corner shops. Increasing the price with minimum unit pricing will help in particular with young people as it will make previously cheap bottles of alcohol unaffordable for school going children. Restrictions on advertising alcohol particularly at sporting events will impact exposure to alcohol to young people all over the country

In order to communicate public health messages to reduce alcohol consumption and its negative societal and health impacts for young people we must;

- engage with youth societies and organisations
- use social media platforms
- develop online tools with easy to access and easy to understand information about alcohol
- work with parents on how best to engage with their children about alcohol

Resources to access more information on alcohol, young people and children

http://www.askaboutalcohol.ie/
https://www.corkdrugandalcohol.ie
http://alcoholireland.ie/
http://alcoholireland.ie/campaigns/aha/

2.3 Alcohol and Sexually Transmitted Infections (STIs)

Background

Sexually transmitted infections (STIs) are notifiable under the Infectious Disease regulations (1981). They are becoming an increasing problem not just in Ireland but worldwide. Due to the nature of the infections and the mode of transmissions, they are a topic that people don't really want to talk about.

In recent years, as the number of notifications has continued to rise, an increasing amount of research has been published reporting the prevalence and risk factors for STIs in Ireland.

The coexistence of alcohol use and sexual behaviour has the potential to increase harms associated with each of these separately. The WHO commissioned a project to study the factors associated with sexual risk behaviour among alcohol users in diverse cultural settings.[18] The project was conducted in eight countries since alcohol use and sexual behaviour are both culture-sensitive phenomena. However, the results showed overlapping themes that highlight some commonalities across cultures.

Along with more or less representative pictures of alcohol use and sexual risk behaviours in the studied regions/countries, the following key issues emerged in the review of the literature: the prevalence of certain myths and notions about "masculinity"; a lack of clear and firm alcohol-related policies; increasing HIV prevalence and a need to augment prevention efforts; the interwovenness of alcohol use, sexual risk behaviours and STI/HIV/AIDS; the effect of modernization and the media on the youth, which manifests in early drinking, early sexual activity and increasing vulnerability to risk behaviours; and a paucity of research data on alcohol and sexual risk behaviours.

Although some alcohol use and sexual behaviour patterns operated "separately" or independently of one another, a number of patterns of interaction between alcohol use and sexual risk taking were identified, with some of these patterns manifesting a specific individual behavioural scheme, some a cultural scheme and some a cross-cultural scheme.

Key patterns of interaction between alcohol use and sexual behaviour related to the following issues:

- The construction of maleness in terms of alcohol use
- A denial and neglect of risk as a way of coping with life
- The use of alcohol-serving venues as contact places for sexual encounters
- The use of alcohol at/during (first) sexual encounters
- The promotion of alcohol use in pornographic material

Binge drinking and sex

Research is increasingly linking alcohol use with risky sexual behaviours (such as multiple sexual partners, unprotected sex, casual sex and paid for sex) which can lead to STIs and unwanted pregnancies[3,4,5,6,7,8,9,10]. Research has demonstrated that those who consume alcohol more regularly and those who consume heavy amounts of alcohol, reported having had more sexual partners, more unprotected sex, more regretted sexual encounters, more terminated pregnancies and more STIs.[4,10]

Young People, alcohol and STIs

A change in the public perception of alcohol use means that individuals who are now in their thirties, have grown up with what has become a more tolerant attitude towards increased use of alcohol. They have grown up in a culture where hazardous drinking from an early age has become acceptable, if not the norm[10].

In relation to attitudes towards sexual health, it has been reported that university students that had a pattern of hazardous drinking, reported higher incidents of unprotected sex, unintended sex and one night stands[11]. It has also been reported that "alcohol use and drunkenness… at younger ages was predictive of early sexual initiation among girls and boys"[12], and that sexual initiation was associated with alcohol use among girls and boys, with only 77% of girls and 72% of boys reporting having used a condom.[13]

From an Irish perspective, there is concern regarding the increase in diagnosis of STI in Ireland and particularly the increase in those aged 20 years or under[14]. This increase in STI diagnosis coupled with an increasingly concerning attitude to alcohol, highlights the need for Public Health action in an attempt to reduce both alcohol consumption and STI diagnosis.

Binge drinking and STIs

The consumption of alcohol in Ireland in 2016 had increased by 4.8% from 2015. The Healthy Ireland Survey 2015 reported that Irish people underestimate the amount of alcohol they consume by approx. 60%, and that of the alcohol that is consumed, 75% is attributed to binge drinking[15].

Fox *et al* (2015) reported that 64% of children aged 13 to 17 years of age reported having consumed alcohol previously, and of that 64%, 50% reported drinking on a monthly basis or even more frequent basis. Long and Mongan (2014) carried out a National Alcohol Diary Survey in 2013. The results indicated that 64% of men and 51% of women began drinking alcohol before they reached 18 years of age and that 18 to 24 year olds have the highest incidence (75%) of harmful drinking.

Relevance of issue to Cork and Kerry

In HSE South - Cork and Kerry, from 2014 to 2018 (all data from CIDR, 2018 provisional data), the five most common STIs notified to the Department of Public Health were Chlamydia, Gonorrhoea, Herpes Simplex (Genital), HIV and Syphilis. Although data indicating the correlation between Alcohol and STIs weren't available, we present some of the notifications to the department in recent years.

A total of 6,122 notifications were received for these STIs. Chlamydia accounts for the highest notifications of STIs (71%), followed by Herpes Simplex (Genital) (12%), Gonorrhoea (11%), HIV (just over 3%) and Syphilis (just under 3%). Gonorrhoea, Syphilis and HIV were more common in males than females (75%, 85% and 76% respectively), and females accounted for more notifications of Chlamydia and Herpes Simplex (Genital) (57% and 78% respectively).

15-24 yr. age group had the highest number of notifications (52%) followed by the 23-34yr age group (34%). These figures support research from Alcohol Rehab Guide (2018) which stated that 18-25 year olds had the highest incidence of STIs[1].

Figure 2.3.1

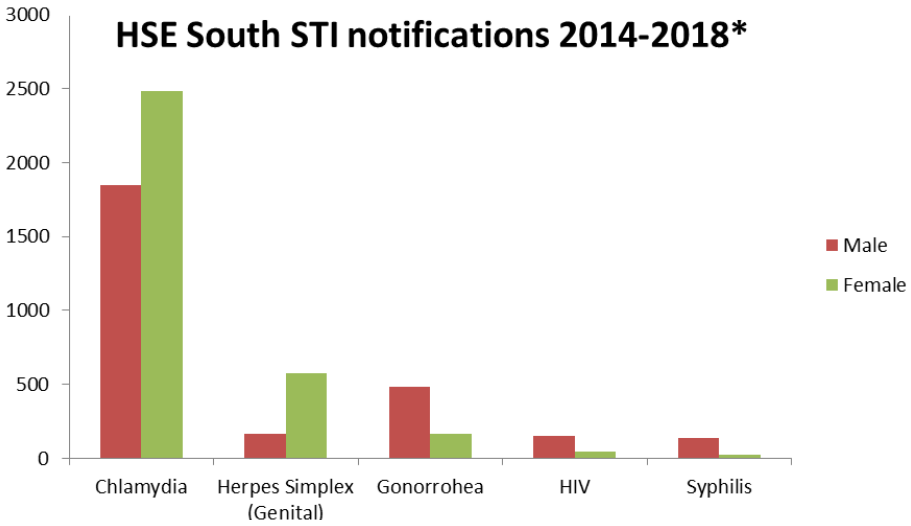
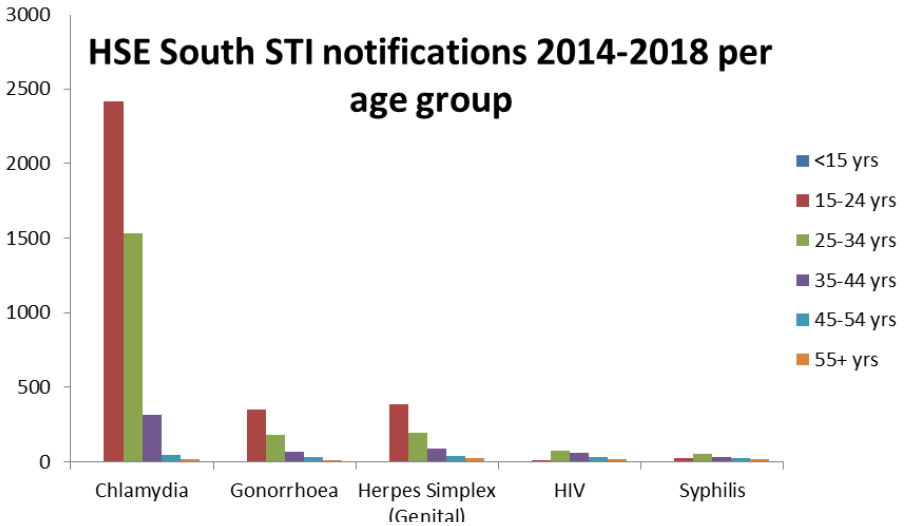


Figure 2.3.2



Source: Computerised Infectious Diseases Reporting (CIDR) 2019

What do we do about it?

In order to prevent STIs occurring in the first place, other areas need to be addressed, namely, education of the at risk populations and development of intervention programmes to help address alcohol reduction for those attending STI clinics[3,4,5,6,7,8,9,12,13].

"The Department of Education require that all schools have a policy regarding the teaching of Relationships and Sexuality Education (RSE) and that RSE is taught from junior infants to 6th year. Although RSE is a mandatory programme, it is not taught in all schools, or in all classes in all schools."[19]

A lot of work has been carried out by the Sexual Health and Crisis Pregnancy Programme and many other volunteer groups, STI clinics, and student health services in universities to highlight STIs and how to prevent them. Unfortunately the prevention message does not seem to be having the desired effect on the numbers of STIs notified. Further studies could be carried out to try to identify why the message is not effective….

- Is it not reaching the targeted audience?
- Is it reaching the targeted audience but not being heeded?
- Is there more of an acceptance of STI developing and the sense that they are no longer as dangerous as they used to be?

Public Health Messages

STIs are preventable. Diagnosis of an STI can be cured in some instances; however, some STIs and their effects remain with you for life[1]. Unfortunately they are known to increase the risk of serious complications later in life, such as cancer, HIV, pelvic inflammatory disease, infertility, birth complications, ectopic pregnancy and even stillbirth[2].

The link between alcohol consumption, sexual behaviour and STI/HIV is complex. Research indicates that there is a link between alcohol consumption and sexual risk taking which can lead to STI's.18 Notably there has been an increase in the diagnosis of STI's in Ireland, particularly in those aged 20 years or under. This is a Public Health concern that needs highlighting and addressing[18].

Effective preventive action like preventive media messages, campaigns and regulations will help raise awareness of risk. There is a need for more alcohol health risk education programmes with a focus on sexual risk prevention.

Relationships and Sexuality Education (RSE) in school curriculum to focus on risk taking behaviours and health harm including the compounding effect of mixing risky behaviours such as alcohol & sex.

2.4 Alcohol & Cancer

Background

Alcohol causes cancer of the mouth, pharynx, larynx, oesophagus, liver, bowel and female breast and there exists a dose response relationship in this causative pathway meaning that the more we drink the greater our risk of alcohol-related cancer.

Ingested alcohol is primarily absorbed from the small intestine into the liver and metabolized by two major groups of enzymes namely alcohol dehydrogenases (ADHs) and aldehyde dehydrogenases (ALDHs). Acetaldehyde, a by-product of metabolism has been classified as carcinogenic to humans (IARC Group 1) and recognized as an important determinant of upper aerodigestive tract cancer[1].

Alcohol is a major risk factor for oesophageal squamous cell carcinoma (OSCC), the most prevalent histological subtype of oesophageal cancer (OC) worldwide2. Up to 50-75% of cases of esophageal cancer in both men and women are attributable to the consumption of alcohol.[3]

The link between alcohol and breast cancer is well established but public awareness of this remains low. Moderate alcohol consumption has been linked to an approximate 30-50% increased risk in breast cancer.[4] Research indicates that alcohol use is related to certain types of breast cancer, and more strongly related to hormone-receptor-positive breast cancer than hormone-receptor-negative breast cancer. Consumption of just one standard drink per day is associated with a 9% increase in the risk of developing breast cancer, compared to non-drinkers, while consuming 3 to 6 standard drinks per day increases the risk of breast cancer to 41%.

It is well recognized that one cause of chronic liver disease and hepatocellular carcinoma (HCC) is alcohol consumption[5]. Recent studies suggest that the most common cause of HCC is alcohol. It has also recently been shown that a significant relationship between alcohol intake, metabolic changes, and hepatitis virus infection does exist. Other causes of HCC include Hepatitis B & C infection, cirrhosis, exposure to some toxins, diabetes, obesity etc.

Relevance to Cork & Kerry

Below are some the key facts and presentations regarding alcohol and cancer.

- 900 people are diagnosed with alcohol-related cancers and around 500 people die from these diseases every year, according to the National Cancer Control Programme (NCCP).
- The NCCP research found that, between 2001 and 2010, 6.7% of male cancer deaths and 4.6% of female cancer deaths in Ireland were attributable to alcohol – 2,823 men and 1,700 women.

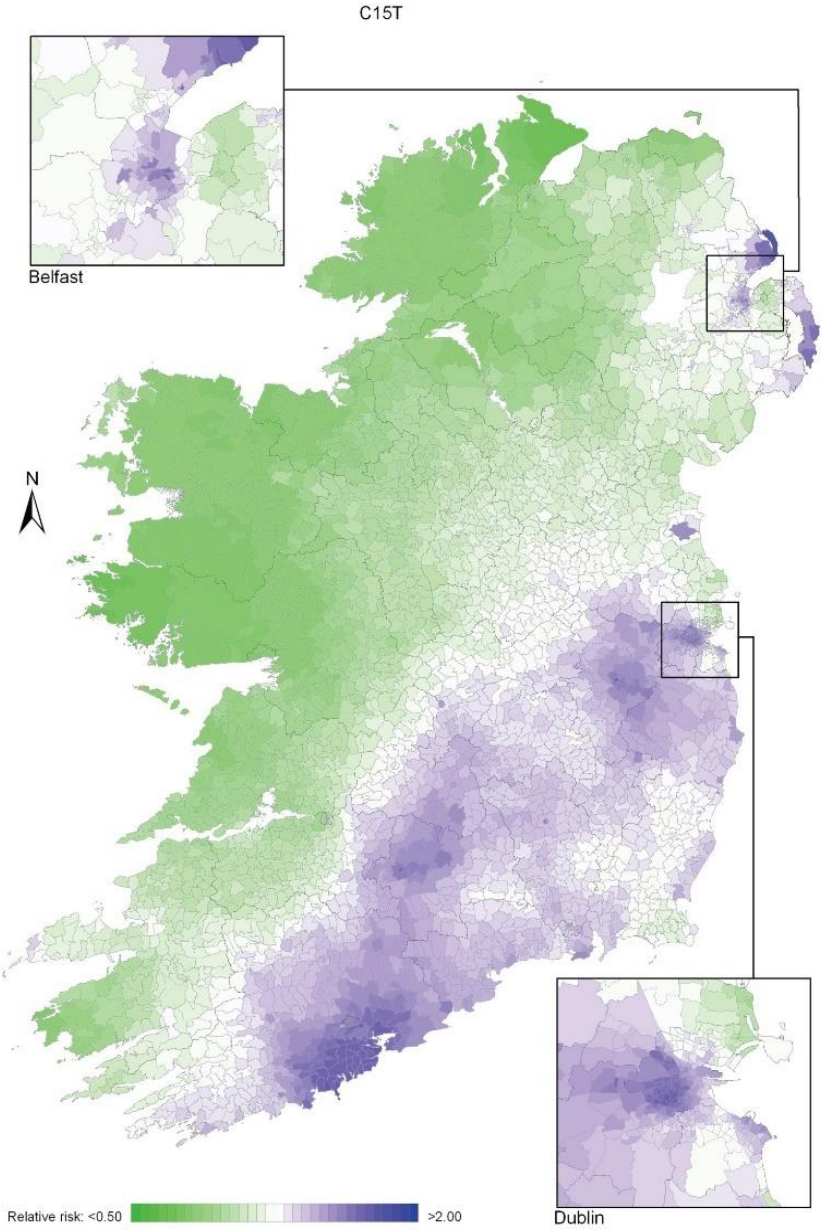
- Among Irish men, the majority (63.6%) of alcohol-related cancer deaths were in the upper-aero digestive tract, while among Irish women, four in ten (40.9%) alcohol-related cancer deaths were due to breast cancer.

Data from NCRI was used to illustrate the burden of disease in Ireland and where available, illustrates risk as it relates to Cork and Kerry[6].

Oesophageal cancer

Ireland had the second highest incidence rates for oesophageal cancer amongst European countries after the UK.[6] The average number of new cases diagnosed each year was 182 in women and 301 in men. During 1995-2007, the number of new cases diagnosed increased by approximately 2% per annum. For both sexes combined there was a large area of higher relative risk extending south of a line from west Cork to Dublin (Figure 2.4.1). The risk of developing oesophageal cancer up to the age of 74 was 1 in 258 for women and 1 in 105 for men.

Figure 2.4.1 Oesophageal cancer, smoothed relative risks: both sexes (2005-2007)



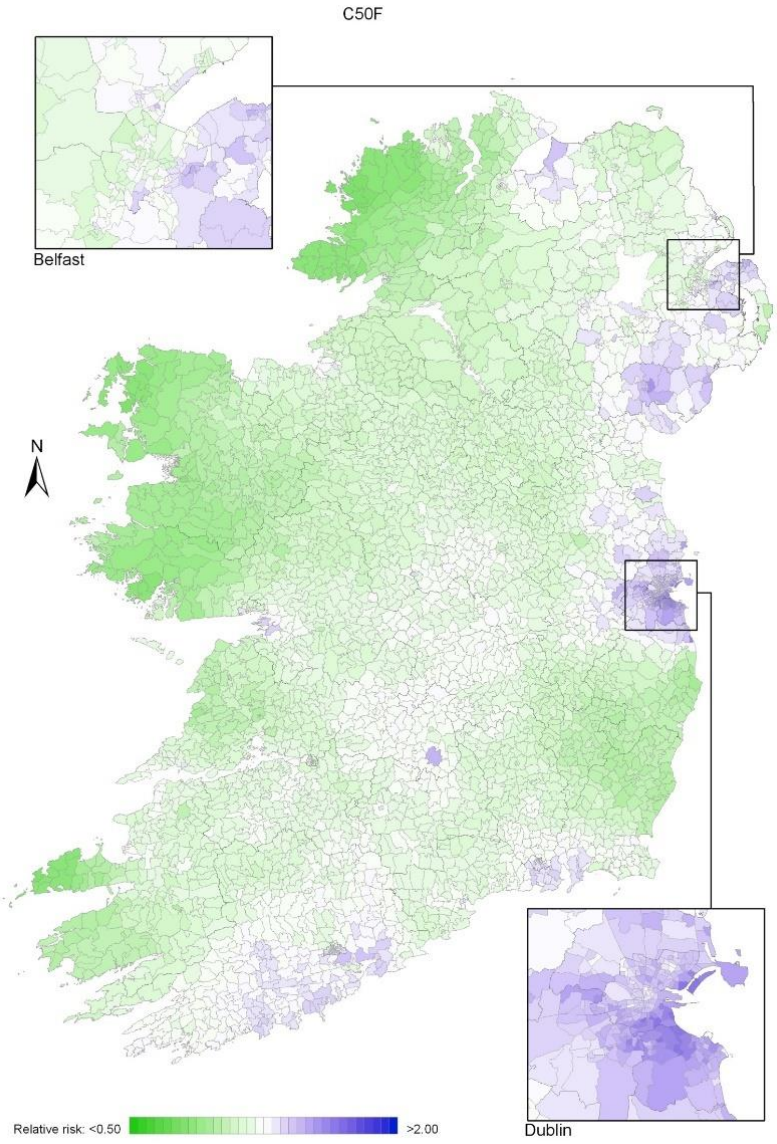
Source: [6]

Breast cancer

The average number of new cases diagnosed each year was 2,965 in women and 20 in men. Breast cancer was the most common cancer in women in Ireland, accounting for 29% of all malignant neoplasms, excluding non-melanoma skin cancer. This was within median levels of rates in 21 EU countries where data was available to NCRI.

In the period 1995-2001, the areas of higher risk were in the major urban areas of east Belfast (including North Down), Dublin, Cork and Derry, and also in Limavady, Down, Ards and Castlereagh. Figure 2.4.2

Figure 2.4.2 Breast cancer, smoothed relative risks: females 1995-2007



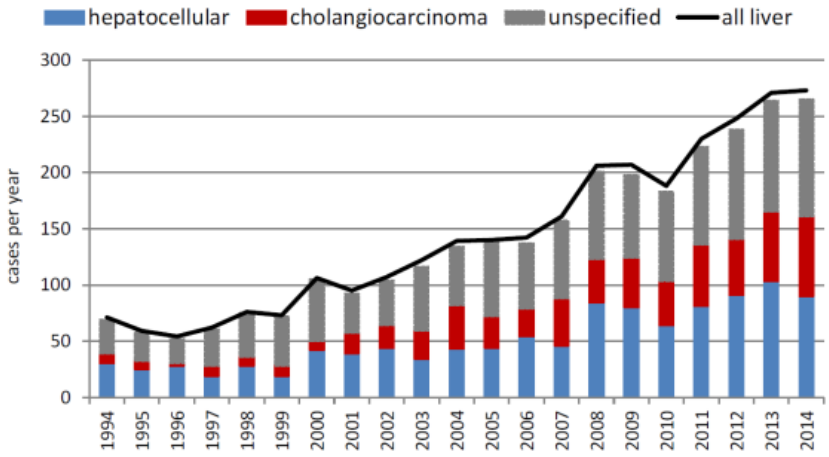
Source: [6]

In 2013, in Ireland, 12% of breast cancers were caused by alcohol - that's 353 cases a year.

Primary Liver Cancer

In December 2016, a report was published by the National Cancer Registry Ireland (NCRI) showing that the number of patients with 'primary liver cancer' had increased by over 300 per cent in the 21-year period from 1994 to 2014. Figure 2.4.3.

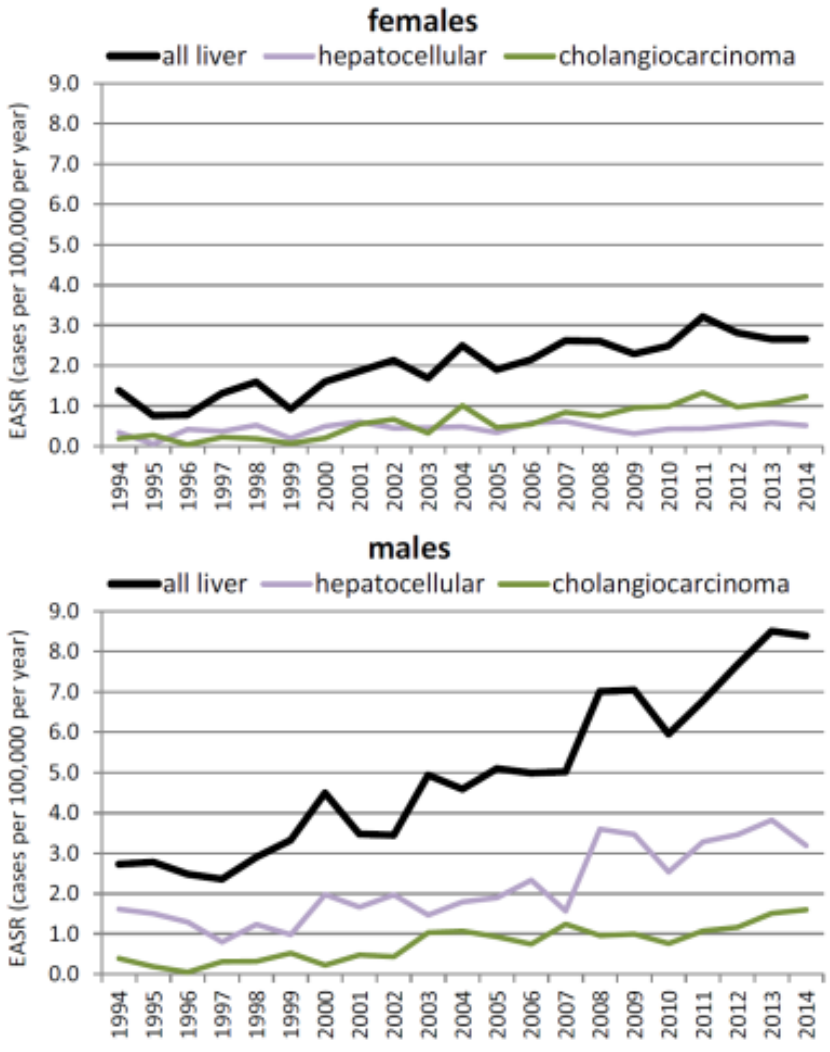
Figure 2.4.3 Number of cases of liver cancer diagnosed per year 1994-2014



Source: [8]

The report suggested that the increase in alcohol consumption observed in Ireland in recent decades is likely to have had a strong influence on the increase observed in HCC incidence, particularly in men. Figure 2.4.4

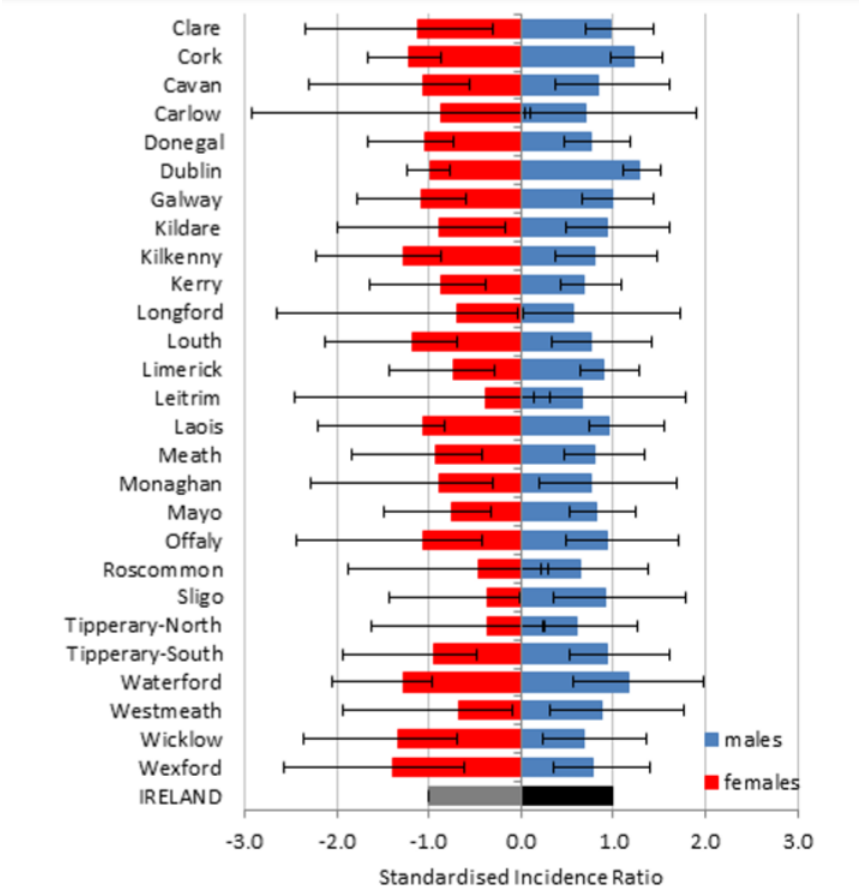
Figure 2.4.4 Trends in the incidence of liver cancer subtypes in females and males between 1994 and 2014



Source: [8]

The standardised incidence ratios at county level (Figure 2.4.5) demonstrated that Cork & Kerry had incidence rations within national averages.

Figure 2.4.5 Incidence of liver cancer: variation by county, 2004-2013



** Female SIRs shown on negative axis for illustration purposes only, values ranged from 0.36 to 1.40 (male values ranged from 0.57 to 1.29)*

Source: [8]

What do we do about it?

The NCCP stated that over half of alcohol related cancers in Ireland are preventable by adhering to low-risk weekly guidelines for alcohol consumption. There exists a worrying lack of awareness about the cancer producing risk of alcohol. Therefore designing a public and health professional information campaign is needed to highlight the risk of alcohol on cancer[7].

Public Health Messages

Alcohol causes cancer of the mouth, pharynx, larynx, oesophagus, liver, bowel and female breast and there is a dose response relationship in this causative pathway meaning that the more we drink the greater our risk of alcohol-related cancer. There is no safe level of drinking for health.

As the risk of cancer increases in line with alcohol consumption, the only way to reduce the risk of an alcohol-related cancer is to reduce alcohol consumption or avoid it completely.

The risk of cancer of the mouth, pharynx, larynx and oesophagus from alcohol consumption in combination with smoking tobacco is far greater than either drinking alcohol or smoking alone and is said to be multiplicative- implying that one risk substantially increases the risk from the other if it's concurrent.

Screening and early identification of patients with problem alcohol drinking using validated tools like AUDIT-C is undoubtedly cost-effective and will save lives.

Consumption of just one standard drink per day is associated with a 9% increase in the risk of developing breast cancer, compared to non-drinkers, while consuming 3 to 6 standard drinks per day increases the risk of breast cancer to 41%.

The cancer risks from alcohol are the same, regardless of the type of alcoholic beverage consumed (e.g. wine, beer or spirits). It has been established that ethanol, and not any other ingredients of alcoholic beverages, is the ingredient that mainly causes cancer, with acetaldehyde (a toxic chemical produced when our bodies break down alcohol) likely to be the most important biological carcinogen.

2.5 Alcohol, involvement in suicide and self-harm

Background

Alcohol is one of the most important risk factors associated with self-harm acts and deaths by suicide. Among people who die by suicide in Ireland, the proportion of those dependent on alcohol ranges from 51% to 85%[1, 2]. Based on data from the National Self-Harm Registry Ireland (NSHRI), alcohol is involved in one-third of all self-harm presentations to hospital Emergency Departments[3]. One in every three self-harm presentations to hospital Emergency Departments in Ireland involves alcohol, with 34% of men and 29% of women presenting with alcohol related self-harm. Alcohol related self-harm is also prevalent among Irish adolescents.

Figure 2.5.1 Alcohol involvement in self harm[3]

Alcohol related self-harm has important implications for treatment, with more alcohol-related presentations outside of usual working hours and on weekends. Alcohol involvement in self-harm poses challenges for the management and assessment of self-harm patients in Emergency Departments. Individuals with alcohol on board are more likely to leave the emergency department without being seen by a clinician[3]. Co-morbidity and dual diagnosis add complexity, and alcohol intoxication may lead to delayed assessment following a self-harm act as well as challenges in encouraging people to engage in treatment[4].

Alcohol contributes to increasing rates of self-harm and is involved in peaks at specific times in the year. These peaks would not exist if alcohol would not be involved. Over the past decade, the NSHRI has identified that the highest number of self-harm presentations to hospital occurred on public holidays, in particular St Patrick's Day and New Year's Day. Alcohol was independently associated with increased presentations on these days, with self-harm presentations having a 24% increased risk of involving alcohol. Alcohol was involved in 43% of all self-harm presentations on public holidays compared to 38% on all other days. In particular, this association was most pronounced during the Christmas period[3].

Case Study

A recent study[4], based on residents of Cork City and County, sought to identify factors associated with alcohol consumption in cases of suicide and nonfatal self-harm presentations. Suicide cases in Cork, from September 2008 to June 2012 were identified through the Suicide Support and Information System. Emergency department presentations of self-harm for Cork City and County residents in the years 2007–2013 were obtained from the National Self-Harm Registry Ireland. Alcohol consumption was detected in the toxicology of 44% out of 307 suicide cases. And in 21% out of 8,145 self-harm presentations. Only younger age (<25 years) was significantly associated with having consumed alcohol among suicides. The results showed that factors associated with having consumed alcohol in a self-harm presentation included male gender, older age (+55 years), overdose as a method, not being admitted to a psychiatric ward, and presenting out-of-hours.

What do we do about it?

The findings in relation to alcohol consumption and self-harm underline the need for increased awareness of the dual relationship between alcohol misuse and self-harm among clinical staff. Services to provide adequate care for individuals with issues relating to co-existing alcohol misuse and self-harm should be available including expertise in assessing dual diagnosis, in line with the NICE guidelines for self-harm (NICE, 2011). The findings also emphasise the importance of having 24/7 access to mental health services for individuals presenting with self-harm. Alcohol consumption commonly precedes suicidal behaviour, and several factors differentiated alcohol-related suicidal acts. Self-harm cases, in particular, differ in profile when alcohol is consumed and may require a tailored clinical approach to minimize risk of further nonfatal or fatal self-harm.

Public Health Messages

Public health activities have an important role in addressing alcohol related self-harm, and general population campaigns to reduce alcohol consumption may be effective in reducing suicidal behaviour associated with alcohol. A review of population-level interventions to reduce alcohol-related harm concluded that there is a pattern of support for regulatory or statutory enforcement interventions[6]. Alcohol policies and suicide in general supported the protective effect of restrictive alcohol policies on reducing suicide. Furthermore, it has been estimated that reducing Irish adolescents' heavy drinking could reduce their rate of self-harm by 17%[5].

The recently accepted Public Health Alcohol Act will contribute to reducing suicide and self-harm in Ireland, and will complement objective 3.2 of Connecting for Life - Ireland's National Strategy to Reduce Suicide, 2015-2020 - which is to support the Substance Misuse Strategy to address the high rate of alcohol and drug misuse.

The National Self-Harm Registry Ireland Annual report 2017 and cited papers are available on www.nsrf.ie

2.6 Alcohol and Driving as a Public Health Problem

Background

In 2017 and 2018, 305 people lost their lives on Irish roads[1]. One of the main contributory factors to road deaths in Ireland is alcohol. Consumption of alcohol is a significant contributory factor in 2 in 5 fatal collisions on Irish roads, as well as in many other collisions which result in major injuries[2]. The risk of a serious or fatal collision increases as the quantity of the driver's alcohol consumption increases. Comprehensive international research has shown that higher blood alcohol concentration (BAC, i.e. the amount of alcohol in the blood) leads to impaired vision and motor skills, slower reaction times, and reduced ability to drive safely[3]. After drinking alcohol, drivers are more focused on steering and operating the vehicle, and less aware of what is happening around them. They are less likely to see other road users, particularly pedestrians and cyclists[2].

Although driving after alcohol consumption is a problem affecting all groups within our society, younger drivers are more likely to be involved in fatal collisions after drinking alcohol. Irish men under 35 are particularly likely to drive when over the alcohol limit[2,4].

BAC is usually checked using a breath test, but blood tests and urine tests can also be used. The legal limit for drink driving is measured in the blood (50mg alcohol per 100ml blood), breath (22 mcg alcohol per 100ml breath), or urine (27mg alcohol per 100ml urine). Lower legal limits apply to learner and novice drivers than fully qualified drivers[5].

Research findings

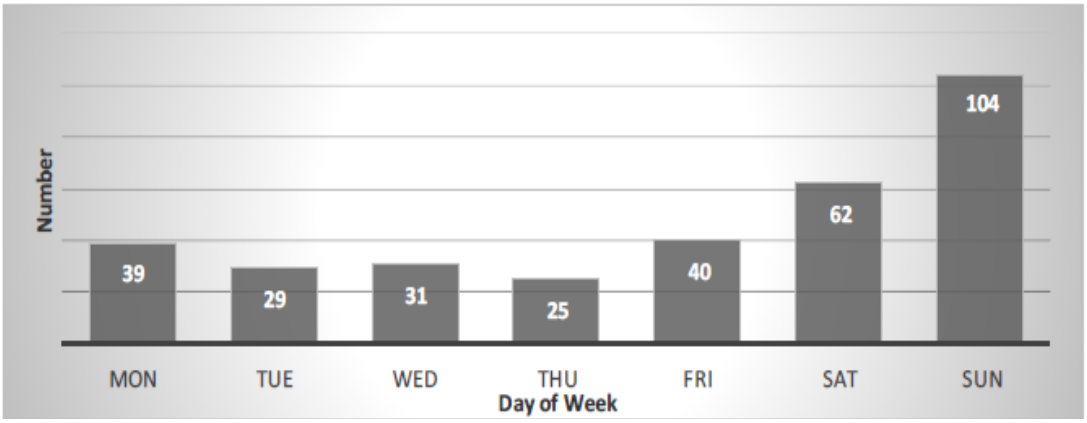
A report from the Road Safety Authority (RSA) revealed that between 2008 and 2012, alcohol was a major contributory factor in fatal road traffic collisions[2]. During this 5-year period, 947 people were killed in 867 collisions, and alcohol was a contributory factor in:

- 38% of all driver deaths
- 30% of all motorcyclist deaths
- 47% of all pedestrian deaths
- 42% of all passenger deaths

Alcohol-related fatal collisions in Ireland are most common late at night and early in the morning and are more likely to occur on the weekend than on other days of the week (Figure 2.6.1). About 1 in 5 fatal alcohol-related collisions (19%) occur in urban areas and the majority (81%) occur in more rural settings. The main reason for fatal collision is loss of control of the vehicle (66%) or crossing over to the wrong side of the road (14%), again suggesting a loss of control of the vehicle. Other reasons include a failure to observe or stop/yield, improper overtaking and other dangerous behaviour[2].

In some cases of alcohol-related collisions, culpability lies with somebody other than the driver. The same RSA report highlighted that, of 330 single vehicle collisions involving alcohol in Ireland between 2008 and 2012, 24% were caused by a pedestrian consuming alcohol prior to the collision, 9% were caused by a motorcyclist consuming alcohol, and 1% were caused by a cyclist consuming alcohol[2]. Pedestrian fatalities involving alcohol were more likely to occur on rural roads. Nonetheless, the majority of collisions (67%) were due to alcohol consumption among drivers.

Figure 2.6.1 All alcohol-related fatal collisions in Ireland, 2008-2012, by day of the week.



Source: Road Safety Authority. Fatal collisions 2008-2012. Alcohol as a factor

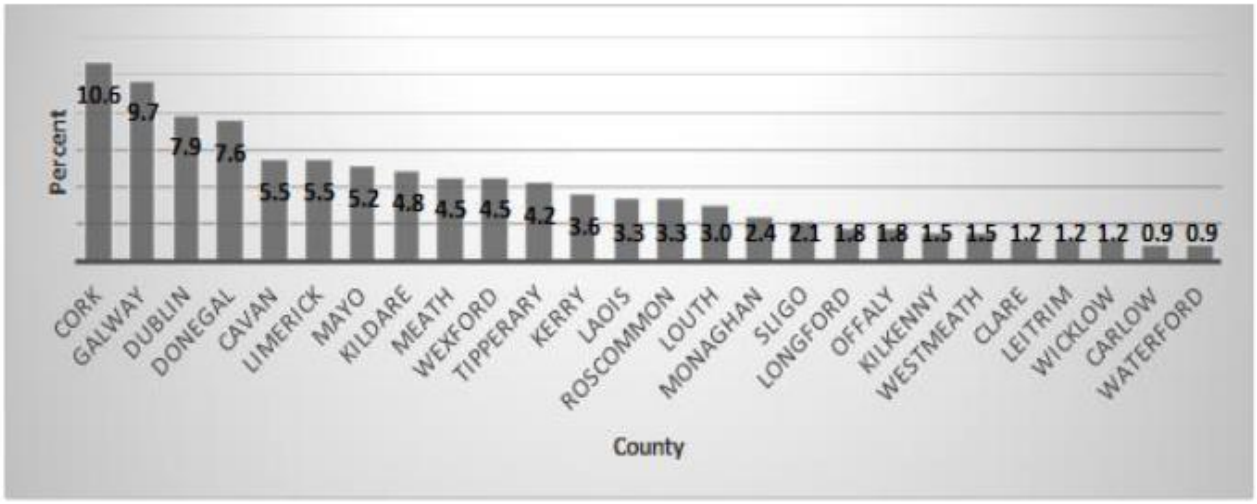
In recent years, barometer surveys have been conducted to explore the behaviours and attitudes of motorists within the general population regarding alcohol. In 2017, 10% of Irish drivers admitted driving a vehicle after consuming alcohol in the last year. They were more likely to do so if they were male (14%), aged under 24 (16%) or lived outside of Dublin (13%)[4].

Those who had consumed alcohol before driving were more likely to have lenient attitudes to drink driving, suggesting repeat offenders within the population. However, some changes in attitudes have evolved over time. In 2014, 62% of Irish motorists claimed to never consume alcohol before driving6. In 2017, this had increased to 73% of motorists[4].

Relevance of issue to Cork and Kerry

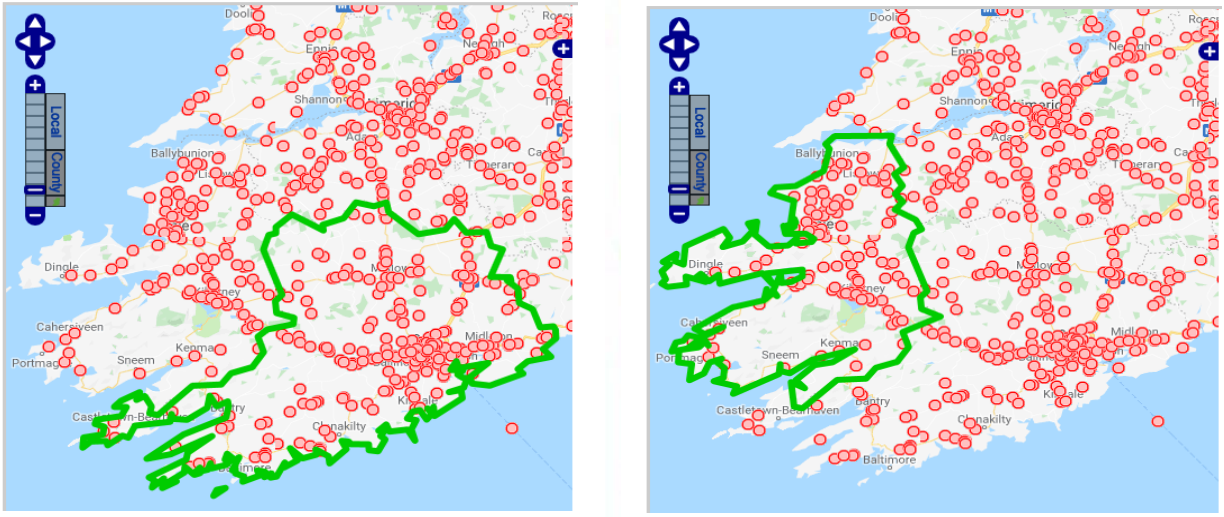
Road traffic collisions have devastating consequences for families across all of Ireland, including Cork and Kerry. It is a matter of concern that from 2008-2012, Cork was the top county in Ireland where alcohol was a contributory factor in fatal road traffic collisions (11% of total) (Figure 2.6.2)[2]. Of the 26 counties in the Republic of Ireland, Kerry ranked at number 12. Between 2005 and 2014, there were 353 fatal collisions in Cork and Kerry altogether (Figure 3), and a further 753 serious collisions across the two counties[7]. In 2018, Cork (and Dublin) had the highest number of all road fatalities in Ireland[1].

Figure 2.6.2 Alcohol-related fatal road traffic collisions by county, 2008-2012



Source: Road Safety Authority. Fatal collisions 2008-2012. Alcohol as a factor

Figure 2.6.3 Location of fatal road traffic collisions across Cork and Kerry respectively, 2005-2014.

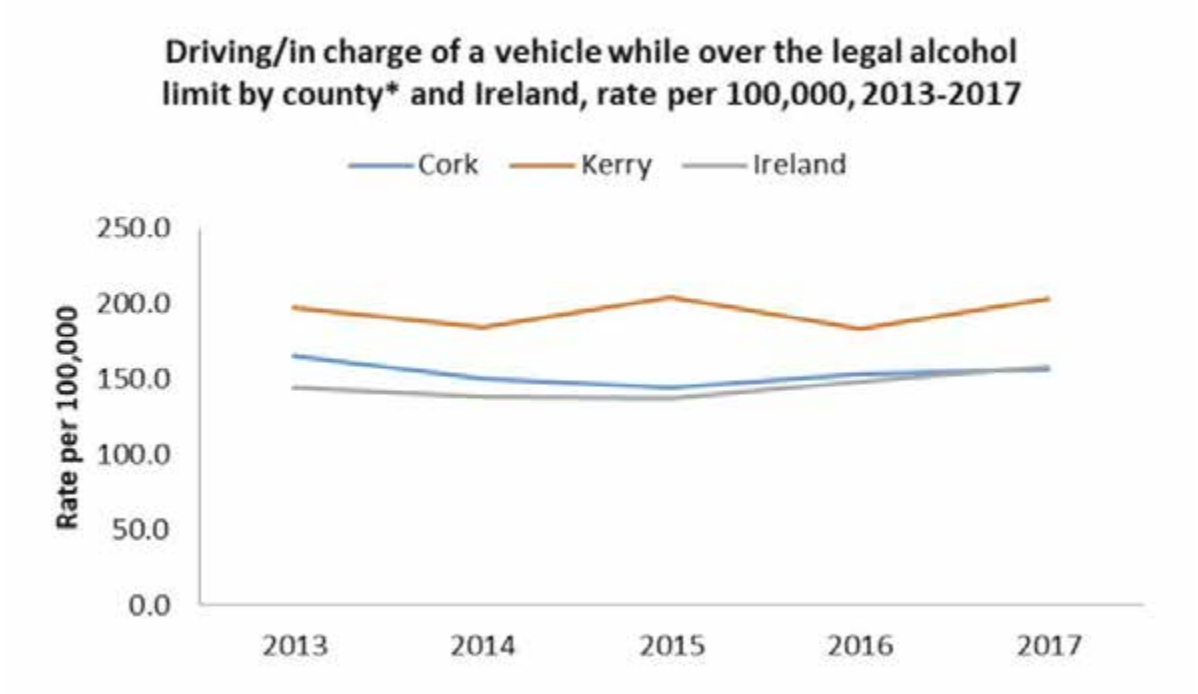


Source: Road Safety Authority. Collision statistics

What do we do about it?

Data from the Central Statistics Office (CSO) indicates the number of individuals driving or in charge of a vehicle while over the legal alcohol limit by county. This rate is calculated based on recent recorded crime offences. During 2013-2017, both Cork and Kerry were above the national average for rates of drink driving. Kerry had a particularly high rate during this timeframe (Figure 2.6.4)[8].

Figure 2.6.4 Rates of recorded crime offences for driving/in charge of a vehicle while over the legal alcohol limit, 2013-2017.



*based on Garda Divisions, which approximate county boundaries but are not an exact match Source: [13]

Random breath testing was introduced in Ireland in 2006. The RSA reports that random breath testing has significantly improved road safety and saved 92 lives in its first year of operation alone. Following its introduction, the number of drivers who tested positive for alcohol at checkpoints decreased from 4 out of every 200 in 2006, to 1 out of every 200 in 2009[5].

Lower drink driving limits have improved road safety in Ireland, but alcohol-related driving remains a significant concern. In 2014, about 284,000 drivers are estimated to have engaged in drink driving, and of them, almost 40% had consumed two or more drinks[5,6].

New legislation was passed in 2018 to introduce stricter laws for drink driving, including **automatic disqualification**. Drivers who are detected by a member of An Garda Síochána with between 50-80 mg alcohol per 100 ml blood will be disqualified from holding a driving licence for a period of 3 months and receive a fine of €200[8]. This new measure has widespread public support; 91% of Irish adults support drivers being automatically disqualified from driving if they are caught driving over the legal alcohol limit[9].

Public Health Messages

There is no safe level of drink driving. Even one drink can increase the risk of a fatal road traffic collision[10]. Above the legal alcohol limit (50mg alcohol per 100ml blood), drivers are more likely to speed and to have problems judging distances. Motorcyclists have reduced ability to drive in a straight line. Passengers should never get into a car with anyone who has been drinking, and if possible they should stop them from driving.

Even below the legal limit, drivers are twice as likely to be involved in a collision[11]. With just a small amount of alcohol (20mg-50mg per 100ml blood) in your body, the ability to judge the distance and speed of oncoming vehicles is impaired. Drivers are also likely to take greater risks such as dangerous overtaking or driving too close to other cars.

It takes time for alcohol to leave the body, and nobody should drive after a big night out. It takes one hour for the effects of half a pint (or a small glass of wine) to wear off[12]. That means after 3 full pints, 3 large glasses of wine or 3 double measures of spirits motorists should wait 6 hours before driving. A person who has been drinking all night and only had a few hours of sleep will still be over the legal alcohol limit in the morning.

Pedestrians and other road users are at risk of serious or fatal collisions after excessive alcohol consumption. Pedestrians are at greatest risk in the hours of darkness, especially on weekend nights, and on rural roads. High-visibility clothing should always be worn if walking home after a night out.

The consequences of drink driving are devastating both for drivers and the victims. If convicted of driving over the alcohol limit, it can result in disqualification from driving and a heavy fine or jail sentence.

Chapter 3

Alcohol Policy and Health

Alcohol Policy and Health

The harmful effects of alcohol amongst individuals and communities can be reduced by effective actions targeted at protecting populations. The WHO through its efforts over the years have coordinated action at Member State level by bringing together the best evidence and technical support to nations to enable them to fulfil their responsibilities in formulating legislation and national policies and legislation.

Below is an excerpt from a WHO document nearly three decades ago titled 'The Development of Alcohol Policies in Federal Countries' that summarises the link between legal controls and levels of consumption that lead to harm[4].

> For the past fifteen years, the World Health Organization has strongly promoted a public health perspective in alcohol policy development. In 1975 an international group of alcohol researchers affiliated with the WHO/European Office critically reviewed the evidence regarding the relationship between legal controls on alcohol availability, mean levels of consumption and indices of alcohol-related problems (Bruun et al., 1975). To quote from their report:
>
> "... our main argument is well substantiated: changes in the overall consumption of alcoholic beverages have a bearing on the health of the people in any society. Alcohol control measures can be used to limit consumption: thus, control of alcohol availability becomes a public health issue" (pp. 12-13).

To reduce the level of alcohol-related harm means reducing consumption

Two decades later, given the growing burden of disease attributable to alcohol, the WHO published its strategy 'Global strategy to reduce the harmful use of alcohol'. It recognised that alcohol is one of the factors in the line of causation for not just non-communicable diseases, but also that the emerging evidence demonstrated that harmful use of alcohol contributes to the health burden caused by communicable diseases such as TB and HIV/ AIDS[5]. This report explores the link between Alcohol and STIs.

The WHO strategy grouped its recommendations of policy options and interventions for national action into 10 target areas as follows:

(a) leadership, awareness and commitment
(b) health services' response
(c) community action
(d) drink-driving policies and countermeasures
(e) availability of alcohol
(f) marketing of alcoholic beverages
(g) pricing policies
(h) reducing the negative consequences of drinking and alcohol intoxication
(i) reducing the public health impact of illicit alcohol and informally produced alcohol
(j) monitoring and surveillance.

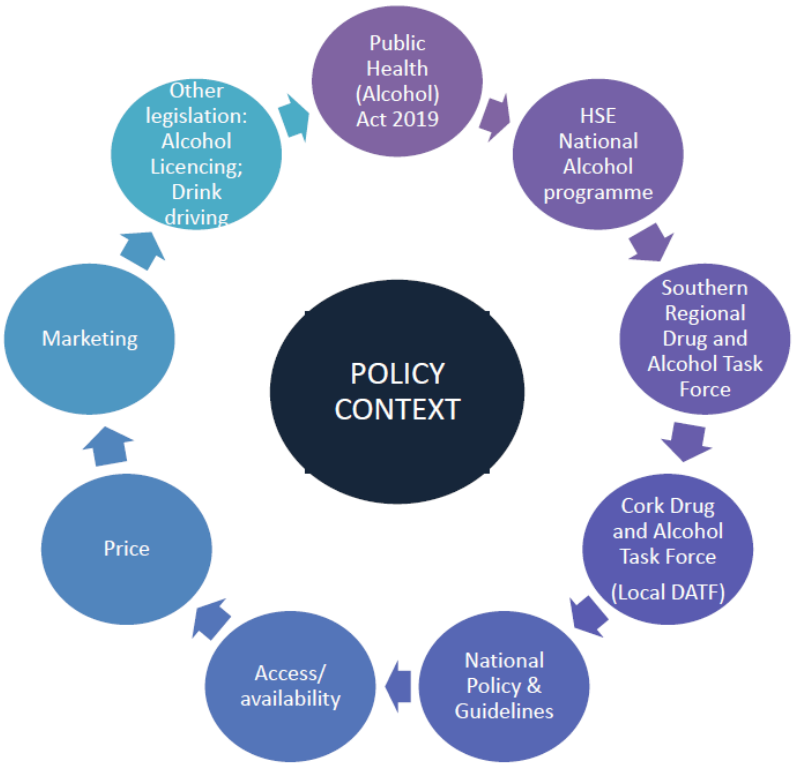
The 10 target areas are supportive and complementary to each other. In the following section of the report we examine the current national policy context and the history of Irish policy activity using this global strategic perspective.

Ireland's alcohol policy

The National Policy Context

The policy context of alcohol in Ireland has in recent years been dominated by the debate around the Public Health (Alcohol) Bill, now signed into statute as the Public Health (Alcohol) Act 2018. There are certain key aspects within the new act that set the scene for significant changes in the policy context in Ireland. They address several of the policy options and interventions in the 10 global strategic target areas we considered earlier.

Figure 3.1 **The National Policy Context**



The Public Health Alcohol Act 2018

The Public Health (Alcohol) Act is a key enabler for change in Ireland and to improve the health of people of Ireland.

The Bill was passed by both houses of the Oireachtas and signed into law in October 2018. Ireland has signalled to its people and the world through enactment of the Public Health (Alcohol) Act 2018 its commitment to prioritise the health of the nation over other interests.

"This is the first time in the history of our State that we have endeavoured to use public health legislation to address issues in respect of alcohol. It is, therefore, a ground-breaking measure."

Minister Simon Harris, Minister of State for Health, Ireland

The journey to achieving this key milestone in Irish history hasn't been easy and the table (Table 3.1) summarises the policy & legislative pathway that paved the way for the Public Health (Alcohol) Act 2018.

The table below is taken from the HRB Overview series 10 titled Alcohol in Ireland: consumption, harm, cost and policy response. It presents the Alcohol Policy activity in Ireland, 1990-2015 and is an adaptation from Hope and Butler 2010. Since the publication of this HRB series, the Public Health (Alcohol) Bill has become an Act in October 2018[6].

Table 3.1 The National Policy Context

1990	Minister for Health requested the development of a National Alcohol Policy
1994	BAC for drivers reduced to 0.80 mg
1994 to 2001	No increase in alcohol taxes
1996	National Alcohol Policy published by government
2000	Intoxicating Liquor Act, 2000 • Longer opening hours • Free movement of licences allowed • Lifting of restrictions for granting of certain licences • Temporary closure for selling to minors
2002	Tax increase on cider (December 2001 Budget) Strategic Task Force on Alcohol Interim Report
2003	Tax increase on spirits (December 2002 Budget) Intoxicating Liquor Act, 2003 • Revert to earlier pub closing time on Thursday nights • Temporary closure for serving drunken customers • Ban on happy hours • Ban on children in pubs after 9pm (extended to 10pm subsequently) Proposed legislation to restrict alcohol marketing

2004	Strategic Task Force on Alcohol – Second Report
2005	Alcohol marketing legislation shelved in favour of industry self-regulation
2006	Mandatory alcohol testing (similar to random breath testing) Below cost selling of alcohol allowed (Abolition of Groceries Order)
2008	Report of the Government Alcohol Advisory Group Intoxicating Liquor Act 2008 • Earlier closing time for off-licences • Regulation to restrict promotions changed to industry self-regulation Tax increase on wine (December 2007 Budget)
2010	Tax decrease on all drinks (December 2009 Budget) Road traffic bill • Reduction in BAC to 20 mg per 100 ml for learner, novice and professional drivers • Reduction in BAC to 50 mg per 100 ml for other drivers • Mandatory testing of drivers involved in collisions
2013	Tax increase on all drinks (December 2012 Budget)
2014	Public Health (Alcohol) Bill announced • The introduction of minimum pricing • Regulation of the marketing and advertising of alcohol • Health labelling of alcohol products • Enforcement powers to be given to Environmental Health Officers in relation to sale, supply and consumption of alcohol products
2015	Public Health (Alcohol) Bill 2015 published
2018	Bill entitled an Act, the Public Health (Alcohol) Act 2018

Price, availability and marketing are key sections within the Public Health Alcohol Act and acknowledges that no single measure is sufficient to moderate alcohol consumption. The legislation regulates the supply of alcohol by controlling price, availability and marketing; factors considered the cornerstones for reducing alcohol-related harm. They directly address four of the ten target areas in the global strategy including leadership, availability, marketing and pricing.

Figure 3.2 describes the time line of changes being introduced as a result of the Public Health (Alcohol) Act 2018.

Access

The steps (reforms) to reduce access include a range of measures to facilitate the separation of alcohol from everyday products; prohibition of price-based promotions and introduction of regulations on the labelling of alcohol products.

Stores will have to confine the sale of alcohol to a single area in the premises which is separated, through which alcohol products are not visible, and to which customers do not have to pass through to buy ordinary grocery products. This will help reduce exposure of children to alcohol products in stores, and will have an impact similar to tobacco legislation in helping to de-normalise access to these products. Point of sale advertising of alcohol products will also be confined to the designated display area or the inside of the storage cabinet. There will be new prohibition of price-based promotions such as reduced price and free offers and tougher restrictions on targeted promotions such as 'happy-hour'. Labels on alcohol products will need to include the number of grams of alcohol per container, calorific content and health warnings in relation to consuming alcohol in pregnancy. It will also need to include a link to a public health website, with information on the dangers of alcohol.

Price

Minimum unit pricing (MUP) is the price below which alcohol cannot legally be sold in Ireland. It is based on the amount of alcohol in a product, measured in grammes. One standard drink in Ireland contains 10 grammes of alcohol and the MUP would apply per standard drink. The act allows for a minimum price per gram of alcohol of €0.10, making the minimum price for a standard unit of one Euro.

Strong and cheap drinks are the alcohol products usually favoured by heavy drinkers, who generally seek to get as much alcohol as they can for as little money as they can. Young people with the least disposable income and have the highest prevalence of binge drinking are also the ones who would favour the strong and cheap drinks. They are the two groups who are most at risk of alcohol-related illnesses and death and MUP has shown to influence their patterns of drinking. MUP is therefore particularly important for public health policy, protecting the most vulnerable in our society.

Marketing

A range of restrictions have been introduced with the aim of reducing exposure of children to marketing of alcohol products. At present, they are bombarded with positive images of alcohol through marketing of brands and products – in effect, the alcohol industry is a child's primary educator on alcohol. The act includes restrictions on the content of advertising; place and timing of advertising during events, publications, broadcast television or radio, in cinemas etc. There will be a ban on advertising alcohol products within 200 meters of schools, crèches, public playgrounds or on public transport.

Fig 3.2 **Time line of changes - Public Health (Alcohol) Act 2018**

FROM

Nov 12th 2019

- Alcohol advertising in or on public service vehicles, at public transport stops or stations and within 200 metres of a school, a crèche or a local authority playground will be prohibited.
- Alcohol advertising in a cinema will be prohibited except around films with an 18 classification or in a licensed premise in a cinema.
- Children's clothing that promotes alcohol will also be prohibited.

FROM

Nov 12th 2020

In mixed retail outlets alcohol products and advertising are confined to one of the following: an area separated by a 1.2 metre high barrier, or units in which alcohol products are not visible up to 1.5 metres height, or up to three units that can be a maximum of 1 metre wide by 2.2 metres high.

In addition alcohol products can be contained but not be visible in a unit behind the counter.

FROM

Nov 12th 2021

- A prohibition on alcohol advertising on a sports area during a sporting event, at events aimed at children or at events in which the majority of participants or competitors are children.
- Alcohol sponsorship of events aimed at children, events which the majority of participants or competitors are children and events involving driving or racing motor vehicles is prohibited.

Source: [7]

National Strategies and Plans

The goals of the Government's alcohol policy are to

- reduce alcohol consumption in Ireland to 9.1 litres per person per annum (the OECD average) by 2020,
- address the high level of alcohol consumption (currently 11 litres) to protect and preserve public health.

Healthy Ireland & the HSE National Alcohol Programme

Healthy Ireland in the Health Services National Implementation Plan 2015-2017[1] has identified 6 national policy priority programmes to address chronic disease prevention and management. The HSE National Alcohol Programme is one of the six priority policy programmes of the Healthy Ireland Strategic framework in Ireland. Figure 3.3.

Figure 3.3 HSE National Priority Programmes

HSE National Alcohol Programme has responsibility for leading, developing, planning and overseeing an Action Plan, in line with the Report of the National Substance Misuse Steering Group (2012). It has five key priorities as follows:

- Raise awareness of the harm caused by alcohol
- Build capacity within services to address excessive consumption through early intervention alcohol screening
- Brief advice and effective services for alcohol dependency
- Enforce new legislation and regulations and
- Support evidence based community action[2].

Specific actions 90-95 included;

- Releasing key frontline staff for training in brief intervention so that they have the skills and confidence to recognise and address alcohol misuse
- Staff to "make every contact count" by screening, intervening and referring service users to specialist support as appropriate as a routine part of the delivery of care across all services. Record alcohol consumption patterns and interventions delivered.

- Display communications campaign materials and resources in all HSE settings to reinforce positive health messages.
- Continue the development of linkages with community drugs and alcohol services
- Record baseline, interventions and outcomes to demonstrate effectiveness of interventions
- Continue work in the area of sexual health promotion and improvement relating to the role of alcohol and sexual risk-taking.[1]

Reducing Harm, Supporting Recovery

Reducing Harm, Support Recovery - a health-led response to drug and alcohol use in Ireland 2017-2025[3] is the Governments strategy to reduce the harm caused by Drug and Alcohol and their misuse up to 2025. It aims to provide a whole of government response to problem substance misuse with a series of specific actions that identify partnership working across sectors that involve a number of stakeholders. The Healthy Ireland Framework sets the basis for this strategy.

Partnership working across statutory, community and voluntary sectors, Drug and Alcohol Task Forces and inter-agency action at local level to support evidence based approaches to problem drug and alcohol use are seen as important in the success of this strategy which will have a health-led approach.

Fig 3.4 **Reducing Harm, Supporting Recovery**

Vision

"A healthier and safer Ireland where public health and safety is protected and the harms caused to individuals, families and communities by substance misuse are reduced and every person affected by substance use is empowered to improve their health and wellbeing and quality of life."

Strategic Goals

1. Promote and protect health and wellbeing.
2. Minimise the harms caused by the use and misuse of substances and promote rehabilitation and recovery.
3. Address the harms of drug markets and reduce access to drugs for harmful use.
4. Support participation of individuals, families and communities.
5. Develop sound and comprehensive evidence-informed policies and actions."[3]

Other strategies

Other national strategies supporting the vision of the National Alcohol Policy include the Connecting for Life strategy- the nation's suicide prevention strategy, and the Better Outcomes, Brighter Futures Strategy- the national policy framework for children & young people in Ireland.

Alcohol Licencing laws

There exists growing concerns about the widespread availability of alcohol in communities. A recognition of the link between the licencing of alcohol and its consumption as highlighted at the start of this chapter has focussed minds about the need for stricter enforcement of Licencing laws and regulations to reduce the negative consequences of drinking and alcohol intoxication- another of the global target areas.

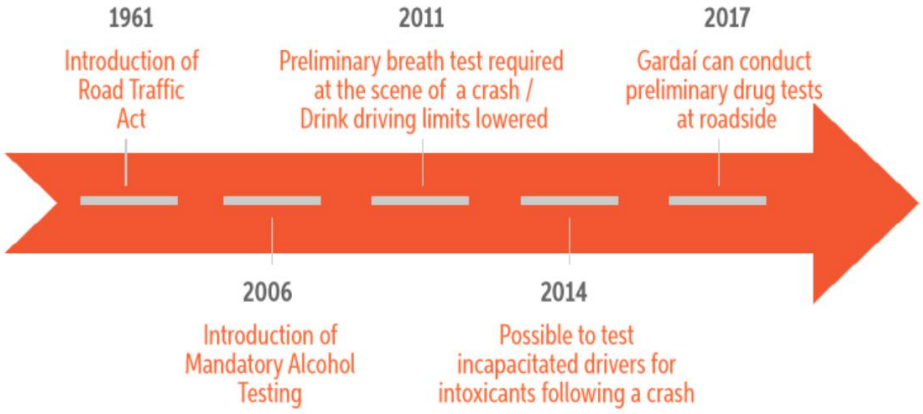
A central concern of licensing law has always been the sometimes-problematic impact that the consumption of alcohol can have on individuals and communities. For this reason the licensing statutes generally include a right for community members to object to the grant of a new licence or a renewal of a licence.

Drink driving legislation

The main legislation dealing with road safety is the Road Traffic Act 1961. This law has been updated and modernised regularly over the years (Fig 3.5) and following the introduction of the Road Traffic Act 2006 the Gardai have wide powers to reduce and eliminate the offence of drink driving. Chapter 2 describes the health harm from mixing drinking and driving.

For more details and to be on the right side of the law, read: https://www.drinkdriversdestroylives.ie /history-of-drink-driving-legislation/

Fig 3.5



Source: [8]

Regional and Local Drug and Alcohol Task Forces

The Regional and Local drug and Alcohol task forces bring all stakeholders within a region and at county level together to coordinate action in line with the national strategic direction. The next chapter describes the work of the Southern Regional and Cork Drug and Alcohol Task Forces. The work of the task forces supports community capacity building to tackle alcohol related issues affecting communities – Community Action on Alcohol.

Community Action on Alcohol

Community Action on Alcohol is one of the ten interventions recommended in the Global Alcohol Strategy to prevent and reduce alcohol harm. Here in Ireland, the Alcohol Forum initiated a Pilot Community Action on Alcohol Project in 2015, funded by the HSE and with a governance group based in the Department of Health.

The project aimed to build the capacity of communities, through Local and Regional Drug and Alcohol Task Forces to identify alcohol issues and develop Local Alcohol Action Plans. Building on the success of the pilot project, the National Community Action on Alcohol Programme was developed and the work continues to expand to new areas.

Read about the joint initiativesbetween the Southern Regional Drug & Alcohol Taskforce and Cork Local Drug & Alcohol Taskforce that was initiated in 2017 in the subsequent chapter.

Chapter 4

Local Approach to Alcohol & Interventions in Cork & Kerry

Local Approach to Alcohol and Interventions in Cork and Kerry

The primary drug in 80% of drug related problems addressed by the HSE in the Cork Kerry region relate to Alcohol. [1]

Addressing alcohol harm in Cork & Kerry involves a partnership approach by a wide variety of statutory, voluntary and community services and organisations. This chapter provides a synopsis of the local approaches, interventions and some services provided by the Health Service Executive South in collaboration with its partners in reducing alcohol harms across the life course for the population of Cork and Kerry.

HSE Alcohol Services in Cork and Kerry

Alcohol Treatment Services in Cork and Kerry provided through the HSE include Arbour House (outpatient), St Finbarrs Hospital, which is a Tier 3 specialist treatment centre working with clients, families and professionals in Cork. There are three other HSE Clinics also delivering similar services in the region – Heron House in Blackpool (Cork City), Edward Court and Brandon House in Tralee. These services work with both adults and young people under the age of 18 and facilitate an inclusive framework approach that has established long standing working relationships with both statutory and voluntary agencies throughout the region. This enables working from a co-constructed client centred perspective.

Service provision to clients, families & professionals are as follows;

- Initial consultations
- Initial assessments
- Comprehensive assessment
- Medical assessments & treatment
- Psychological assessment & treatment
- Case management
- Outpatient substance free treatment in the form of individual and group programs
- Harm Reduction programs
- Viral screening and referral to treatment for these
- Dual Diagnosis Programme
- Family support

- Strengthening Families Programs
- Community based Brief Intervention Programs
- Referral to inpatient detox and treatment
- Community Detoxification
- Aftercare
- Information sessions
- Research

Services are delivered to over **2000** people annually across Cork and Kerry.

Regional and Local Drug and Alcohol Task Forces (RDATFs and LDATFs) - An area-based partnership approach in addressing substance misuse in the region

Regional and Local Drug and Alcohol Task Forces (RDATFs and LDATFs) comprise of representatives from a wide range of agencies such as the HSE, Gardaí, Probation Services, Education & Training Boards, Local Authorities, Youth Services, Public Representatives and the Voluntary and Community sector. They play a pivotal role in addressing local needs with targeted action plans that address the actions outlined in "Reducing Harm, Supporting Recovery: a health led response to drug and alcohol use in Ireland – 2017-2025"[14].

SRDATF
southern regional drug & alcohol task force

Southern Regional Drug & Alcohol Task Force (SRDATF)

The SRDATF works at community level across Cork and Kerry partnering with local communities and state and voluntary agencies in taking a coordinated targeted and intervention based approach to those working with people who are misusing or at risk of misusing drugs and alcohol.

The Southern Regional Drug & Alcohol Task Force was established in 2003 with the role to develop and implement actions outlined in "Reducing Harm, Supporting Recovery: a health led response to drug and alcohol use in Ireland – 2017-2025"[14] in Cork and Kerry. It funds and supports 22 services that provide a variety of interventions to those experiencing difficulties with drug and alcohol use. Support is also provided to family members. They provide a mechanism which enables local communities to work closely with statutory and voluntary agencies in developing and implementing that strategy.

The aim of the SRDATF is to:

- Provide appropriate treatment and aftercare for those who are dependent on drugs & alcohol;
- Have appropriate mechanisms in place at national and local level, aimed at reducing the supply of illicit drugs
- Ensure that an appropriate level of accurate and timely information is available to inform the response to the problem
- Support and develop measures aimed at reducing the harm to those actively using drugs & alcohol and
- Support families and communities affected by drugs & alcohol. [2]

"The use of substances, particularly alcohol, has significantly impacted the communities we live in. The harms associated with the use of substances are widespread. It can be seen in our communities, our hospitals, GP surgeries, Garda stations, prisons, homeless, mental health and drug & alcohol services. The hidden harms of substance use are experienced by many, often silently, in their own homes throughout Co. Cork & Kerry.

Through our work with a variety of sectors we strive towards providing hope to those that can often feel forgotten or marginalized. We have responsibility in delivery services in a timely and accessible manner to people when they are at their most vulnerable."

Kate Gibney, Co-ordinator Southern Regional Drug & Alcohol Task Force

CLDATF
Cork Local Drug & Alcohol Task Force
https://www.srdatf.ie

Cork Local Drug & Alcohol Task Force (CLDATF)

The CLDTF was established in 1996 and as of 2014 is also responsible for reducing the harm associated with alcohol thus becoming the Cork Local Drug & Alcohol Task Force (CLDATF). It funds twenty one projects across Cork City providing the following services:

- information and awareness raising
- assessment
- care planning
- case management
- brief interventions
- holistic therapies

- advocacy
- onward referral
- community-based counselling
- pre and post treatment support[3]

https://www.corkdrugandalcohol.ie/

Cork & Kerry Alcohol Strategy 2016-2018 Time for Change

Vision Statement

Motivating the communities in Cork & Kerry to stop the damage caused by alcohol

Mission Statement

Building capacity in local communities through an advocacy, research & evidence based approach to change our relationship with alcohol[4]

https://www.corkdrugandalcohol.ie/wp-content/uploads/2016/01/2016-Cork-Kerry-Alcohol-Strategy-2016-2018.pdf

"In Ireland our attitude towards alcohol is one often filled with ambivalence. It is a subject that we have neglected with a great cost to our citizens.

It's time for change.

We must change how we consider its impact on our society. We must change our attitudes and behaviours towards alcohol. We must change by reducing the quantities of alcohol we consume."

David Lane (Coordinator of Drug & Alcohol Services HSE & Chairperson, Cork and Kerry Alcohol Strategy Group)[4]

The Cork and Kerry Alcohol strategy provides a comprehensive literature review of alcohol and its influences at the global, national and local level. It details clear regional priorities and objectives to address alcohol harm reduction, advocacy, education and capacity building within local communities in Cork and Kerry. Key objectives include:

Overarching Pillar Objectives

- Support the implementation of minimum unit pricing
- Support the reduction in the availability of alcohol in local communities
- Actively advocate for policy change & implementation to restrict the marketing of alcoholic products on a local, regional & national level
- Inclusion of alcohol in the new national substance misuse strategy.

Education & Prevention Pillar

- Actively promote a general awareness of alcohol harms
- Deliver evidence-based education and prevention programmes across Cork & Kerry.

Supply, Access & Availability Pillar

- To educate communities in the law regarding sale & supply of alcohol. What constitutes a valid objection to the renewal of an intoxicating liquor license or application for an exemption? How to make an objection?
- To review and challenge the current environment in which alcohol is available.

Screening, Treatment & Rehabilitation Pillar

- To inform local communities of drug and alcohol services
- To build the capacity of communities to implement screening and interventions in their area.
- To improve access to drug and alcohol services for local communities especially in rural areas.

Research Pillar

- Conduct research that will inform up to date practice in relation to evidenced based harm reduction.

Monitoring & Evaluation Pillar

- Continually monitor and evaluate the implementation of actions agreed within the Local Alcohol Action Plan.
- Continually monitor and evaluate the impact of our agreed actions.[4]

Current Alcohol-related services in Cork & Kerry

There is a strong network of community/voluntary organisations and services that address the needs of communities affected by drug and alcohol harm in Cork and Kerry. Many of these services are a combination of efforts to address needs at the local community level by communities themselves, services provided and supported by the HSE as well as partnerships following collaborations between the local task forces and various service providers including the HSE, Gardaí, prison, probation, education and youth services.

Community Drug & Alcohol Workers

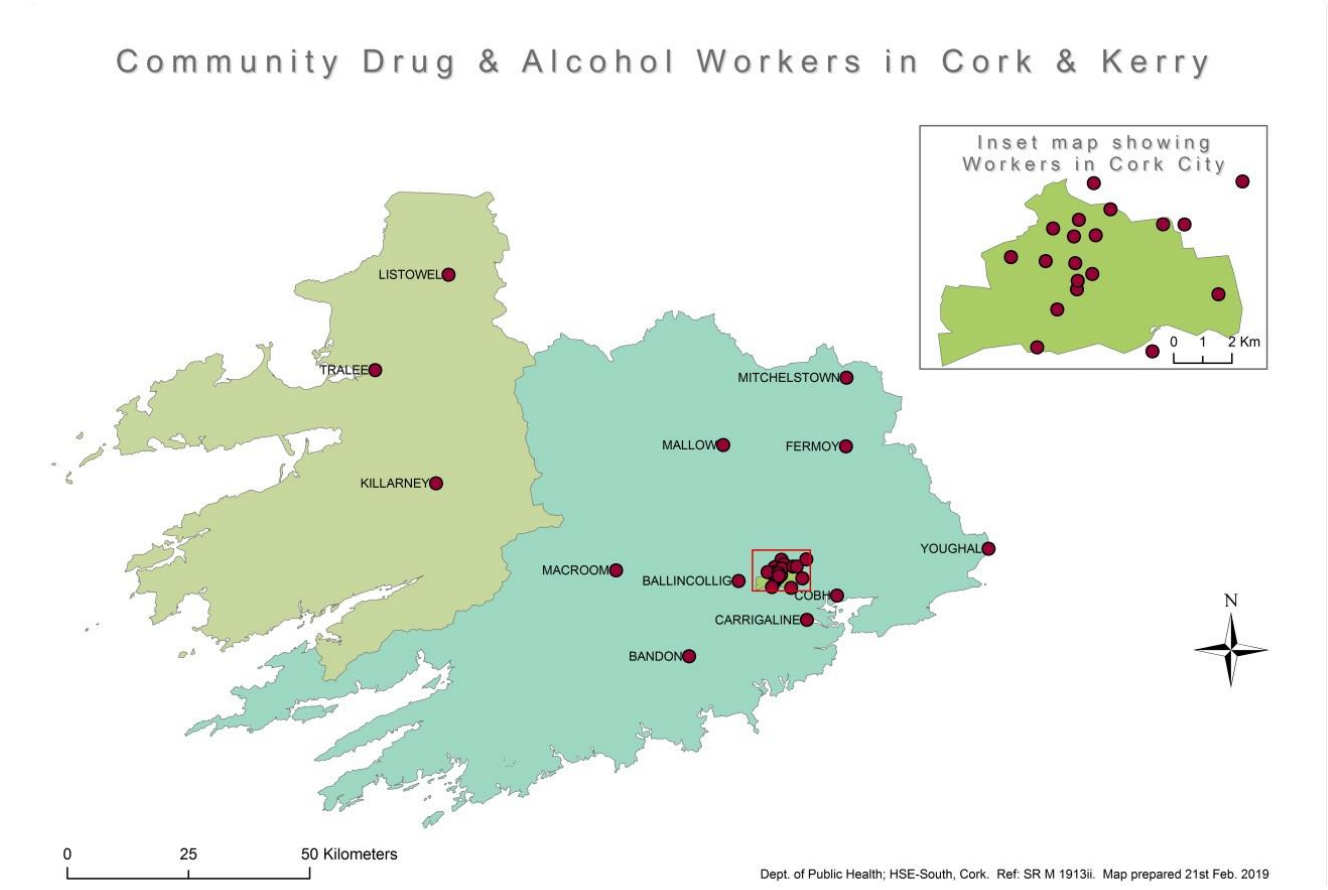
Community drug and alcohol workers provide education, intervention and information services across Cork & Kerry. Community Drug and Alcohol Projects (CD&APs) are located throughout Cork and Kerry (17 locations in Cork City and 9 locations in Counties Cork and Kerry). See figure 4.1. They use evidence-based interventions within the case management model to support individuals and families involved in substance use across Cork and Kerry. Most of the staff in frontline CD&APs have qualifications in addiction or incorporating addiction work. Several have additional qualifications in Social Care, Psychology, Psychotherapy or Counselling.

Contemporary approaches such as early treatment and rehabilitation intervention models are prioritised which have had critical implications for frontline work, its management and service user outcomes. Drug and alcohol services now require an increasingly higher level of multi-disciplinary ways of working which can implement strong, seamless and service user-friendly alliances throughout the sector, particularly within health, social and medical services. In order to carry out their work efficiently, frontline CD&APs are increasingly working with a range of professionals in the medical, health and social services including GPs, Consultant Psychiatrists, Mental Health workers, Public Health Nurses, Addiction Counsellors, Social Workers and others.

Services provided include:

- Assessment
- Care planning
- Case management
- Brief interventions
- Holistic therapies
- Advocacy
- Onward referral
- Community-based counselling
- Pre and post treatment support

Figure 4.1 **Map of Community Drug & Alcohol Workers across Cork & Kerry**



Community Outreach Drug/Alcohol Awareness Project (CODAAP) Cork City Partnership

The CODAAP project addresses a shortfall in education, awareness and prevention and capacity building around drugs and alcohol in Cork City.

The project aims to:

- Promote awareness of drug and alcohol related issues and to signpost information so that families, communities and professionals are aware of the wide range of statutory, voluntary and community services and supports available; and are empowered to access pathways to relevant supports and services appropriate to their needs.
- Increase and resource access to formal and informal education, training and other substance misuse prevention activities, resources and interventions.
- Facilitate communities and communities of interest to engage with policy and decision making processes on substance related issues, and to identify / respond to emerging needs, through strategic development, capacity building and networking.

"The Project is uniquely placed to identify and respond to the complexities of social exclusion and substance misuse, particularly alcohol, through citywide community engagement and mobilisation. We have been delighted to lead a community action on alcohol programme in one of the key pilot sites in Cork City."

Jackie Daly, Community Development / Drug & Alcohol Worker, CODAAP.

"The project continues to be a key advocate for family support in the city. We are very pleased to see the role of family support and family members recognised in the National Drugs Strategy as key in rehabilitation and recovery, and look forward to participating in local level implementation of the strategy."

Mella Magee, Community Development / Drug & Alcohol Worker, CODAAP.

Community Counselling Services are available to families, students, migrants and those with a dual diagnosis (for people who have both an addiction and a mental health difficulty).

Dual Diagnosis Treatment Programs, Tier 3 Specialist Non-Residential Treatment Services

Clinical Teams offers a range of evidence informed treatment interventions for service users with dual diagnosis (addiction and mental health) who contract a shared care plan with Mental Health Teams, GP, and Addiction Team for the duration of the treatment episode including:

- **Detox Program**, (A Structured Group Detox Program in 3 phases over 24 weeks with focus on emotion regulation skills practice while reducing use of alcohol, (drugs, meds & gambling). Weekly group sessions teach **Mindfulness Based Behavioural Skills, Social Networking, Diarying** of reduction & application of skills. Case Management sessions facilitate skillful management of both mental health diagnosis and addiction. Exclusions: Active Psychosis/ current suicidality. Annual capacity 60 per annum.

- **U & ME-A Program,** (Understanding & Managing Emotion & Addiction), is structured 52 week Group Addiction Treatment over 3 phases for dual diagnosed participants. This **"U & ME-A"** application of Dialectical Behaviour Therapy **(DBT)** is a skills contained therapeutic program crafted by our team since 2015 to facilitate optimum recovery outcomes for a range of complex dual diagnoses. Weekly group sessions teach **Mindfulness, Distress Tolerance, Emotion Regulation & Interpersonal Effectiveness,** with Social Networking, diarying of reduction & application of skills. Case Management sessions facilitate skillful management of both mental health diagnosis & addiction. Exclusions: Active Psychosis, current self-harm/suicidality, EUPD/BPD Diagnosis (for which Full DBT treatment with Mental Health Teams is recommended). Annual Capacity 40 per annum. **Many clients have graduated from the programme over the last four years and plans to replicate this program in Kerry have begun.**

- **Abstinence Program** (a structured application of the **Minnesota Model,** delivering a Group Program in 3 phases over 52 weeks. Participation in 12 Step Fellowship Meetings, weekly group session and Case Management meetings are requirements. Exclusions: Active Psychosis, current self- harm/suicidality & particular prescribed medications. Capacity approx. 40 per annum.

- **Addiction Recovery & Managing Anxiety Program,** is a structured Group Skills Program for dual diagnosis over 10 weeks. Exclusion: Active Psychosis, current self- harm/suicidality, sober enough to participate.

- **Relapse Prevention Program,** is a Structured Skills Group Program for dual diagnosis over 15 weeks. Exclusion: Active Psychosis, current self- harm/suicidality & active substance use.

"It is really difficult to live with the 'double' troubles of both mental health and addictions challenges! You have 'double' struggles and often feel very misunderstood by family, friends and professionals.
Treatment models for co-occurring mental health and substance use disorders ('Dual Diagnosis') have been associated with addressing recovery in mental health andsubstance disorders separately, often with negative outcomes for Service Users and frustration for Service Providers.

The increasing visibility of Dual Diagnosis is highlighted in Irish policies. Yet, specific difficulties remain in accessing effective treatments.
In 2013, our Clinical Teams in Cork recognised that our biggest challenge in service delivery was effectively meeting the complex needs of our Dual Diagnosed population. We researched to improve our skills and local practices, so to deliver better outcomes for Service Users. We partnered with local Mental Health Teams and acquired enhanced therapeutic skills that have informed our range of treatment offerings since 2015,sharing care plans with GP's and Mental Health Teams.

It's been exciting for Staff and for Service Users to implement a range of treatment programs building 'effective' recovery skills that directly effect changes in both managing mental health diagnoses and addictions.

Our Service Users have been voting with their feet, opting into group programs like never before! And they stay.

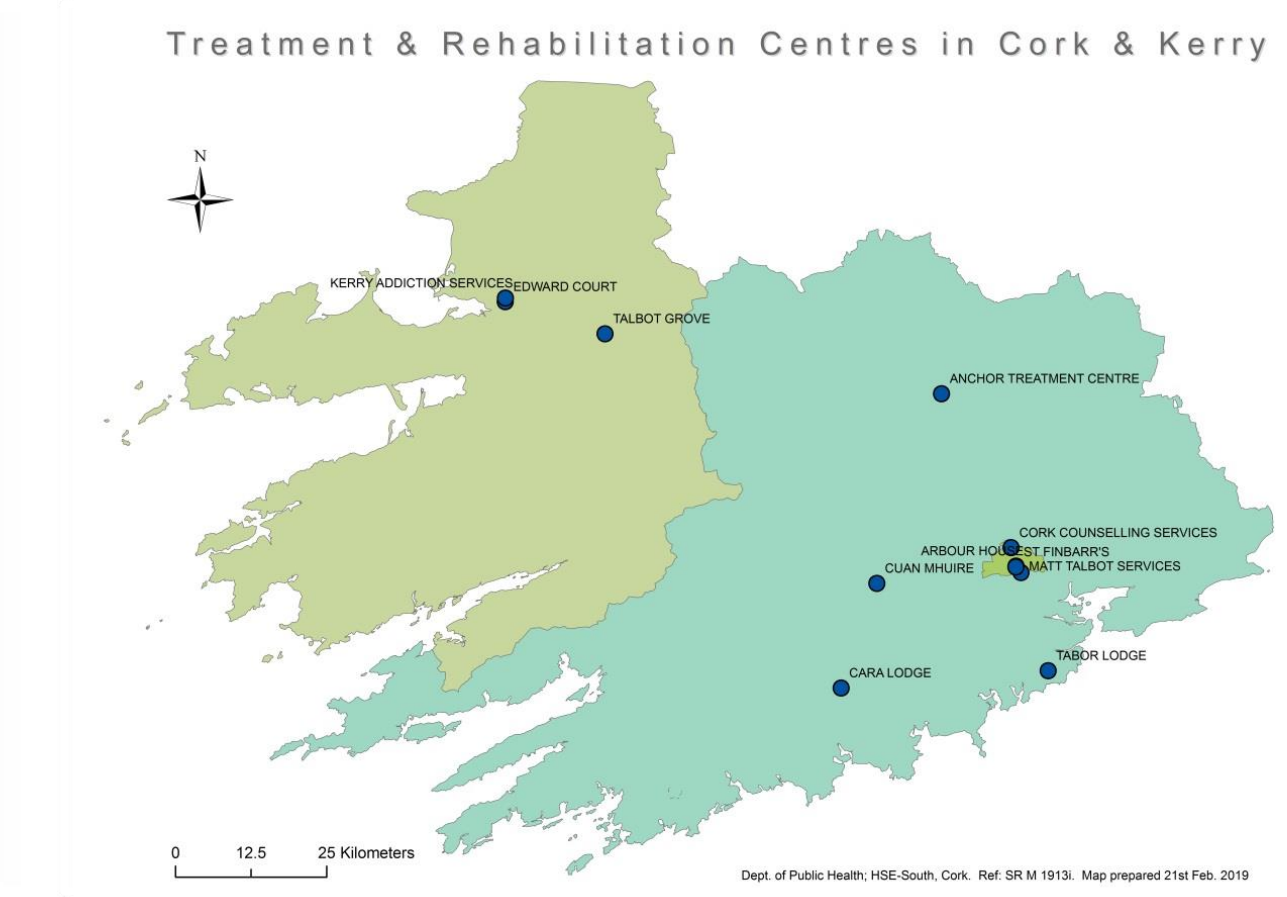
Most importantly, they are achieving improved outcomes.
Service Users and Staff are happy to spread the word."

David Wyse, Senior Addiction Counsellor, Cork, Kerry Community Healthcare Addiction Service, Arbour House Cork.

Specialist drug and alcohol treatment services

Across both counties provide residential treatment for people with both drug and alcohol problems. See Figure 4.2 for location of all drug and alcohol treatment services across the region.

Figure 4.2 **Map of Treatment & Rehabilitation Centres across Cork & Kerry**



Tabor Group Addiction Treatment & Rehabilitation Services, Cork

Tabor Group is a leading provider of residential addiction treatment services in Ireland. Providing support and care to hundreds of clients each year suffering from addictions to alcohol, substances, gambling and food.

Facilities include:

- Tabor Lodge, Residential Addiction Treatment Centre
- Renewal, Extended Residential Treatment Centre for Women
- Fellowship House, Extended Residential Treatment Centre for Men

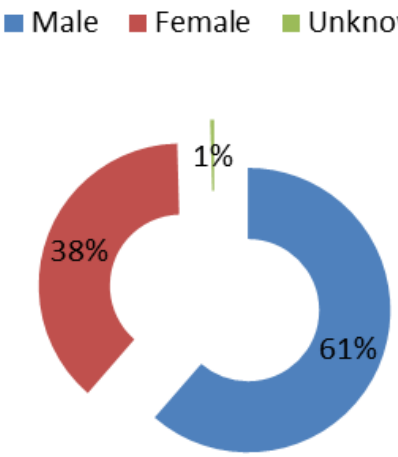
In addition to residential facilities, Tabor Group provide a continuing care programme to people who have completed treatment to assist with their recovery, and offer counselling to families whose loved ones are struggling with an addiction. [5]

*"Tabor Group is a residential treatment service.
It provides the most intensive intervention available for the treatment of addiction.
It caters for the most severe cases and the addictions most resistant to treatment.
Alcohol is, by far, the leading reason clients refer to Tabor Lodge:
148 of the 208 admissions to Tabor Lodge in 2018 stated that alcohol
was the main drug of addiction. This represents 67% of the total.
Alcohol addiction affects the full age range: 42% of those admitted
were aged 18 to 34 years with the remaining 58% from aged 35 to 'over 65'.
Alcohol addiction impacts children directly:
in over 33% of admissions there is a child living with the client."*

Mick Devine, Clinical Director, Tabor Group, Tabor Lodge

During 2016, the Health Research Board, Treated Drug Misuse Database[6] recorded **1,411*** people in treatment in Cork & Kerry where Alcohol was identified as the main problem drug. **691** of these were new to treatment in 2016. (49% of presentations). The Gender split is 61% male and 38% female in treatment. See Figure 4.3

Figure 4.3 Gender Split on those attending for Alcohol Treatment in Cork & Kerry 2016

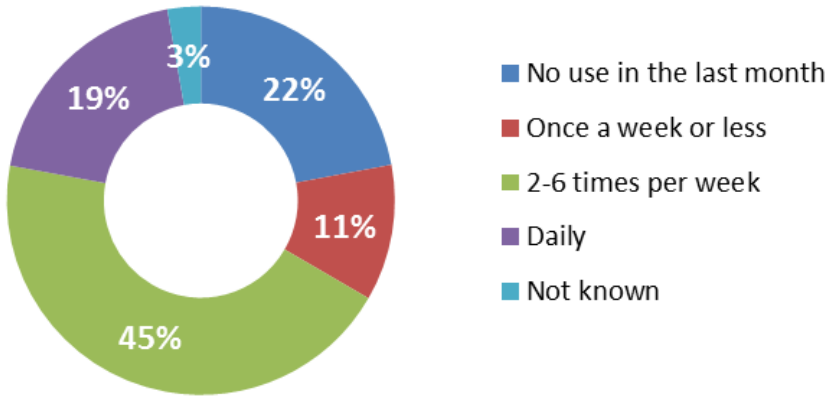


Source: HRB, National Drug Treatment Reporting System (data accessed Feb/March 2019)[6]

* The latest figure for Cork and Kerry in 2017 is 1242 persons in treatment where alcohol is the main drug.

Among those in treatment for alcohol use in the region in 2016, 19% (n=273) were daily drinkers with 45% (n= 628) consuming alcohol 2-6 times per week. See Figure 4.4

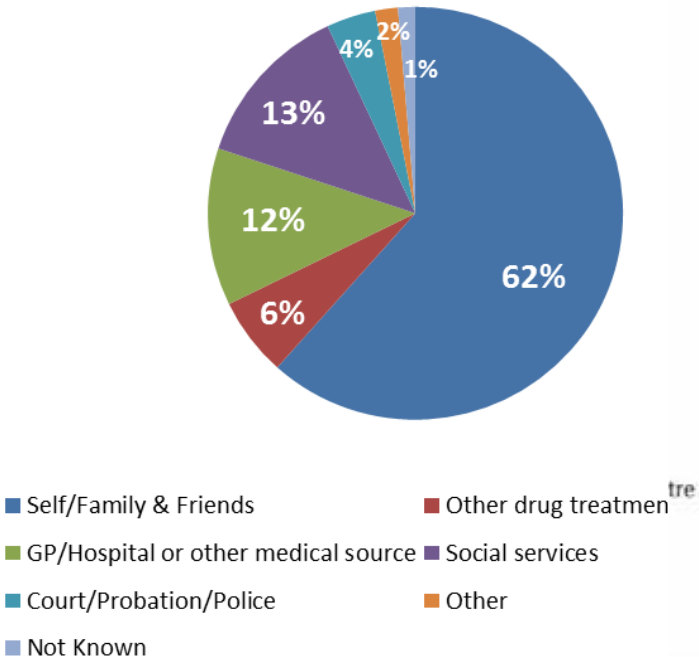
Figure 4.4 Frequency of Alcohol Use in those in Treatment in Cork & Kerry 2016



Source: HRB, National Drug Treatment Reporting System (data accessed Feb/March 2019)[6]

62% (n=869) of referrals into alcohol treatment were self/family and friends, 13% (n=183) from Social Services, 12% (n=112) from GP's/Hospitals/other medical services, 6% (n=87) from other drug treatment centres and 4% (n=54) through the criminal justice system. See Figure 4.5

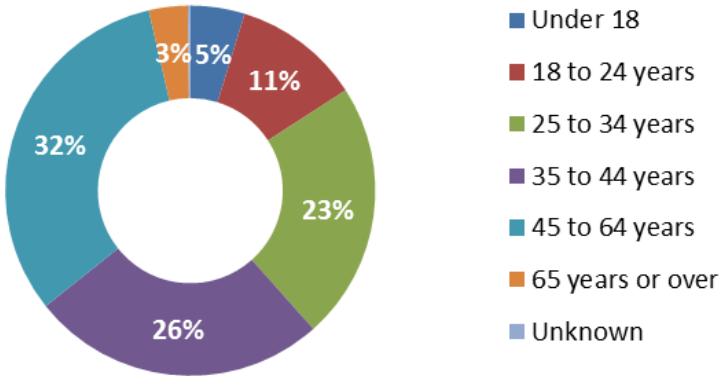
Figure 4.5 Referrals into Alcohol Treatment in Cork & Kerry 2016



Source: HRB, National Drug Treatment Reporting System (data accessed Feb/March 2019)[6]

The age range for those in treatment reporting alcohol as their primary drug in Cork & Kerry in 2016 varies, however the majority 81% are aged 25 to 64 years (n=1136). Only 3% (n=48) are aged 65 plus and 11% (n=157) are aged 18-24 years with 5% (n=67) under eighteen years of age. Figure 4.6.

Figure 4.6 **Age range of those in Alcohol Treatment in Cork & Kerry 2016**

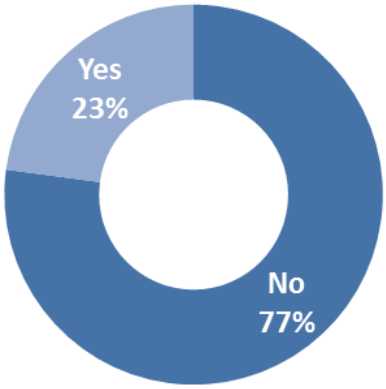


Source: HRB, National Drug Treatment Reporting System (data accessed Feb/March 2019)[6]

39% (n=411) had completed their Leaving Certificate, 29% (n=29%) had completed their Junior Certificate, 13% (n=182) had completed third level education, 11% (n=159) had completed primary education and 1% (n=15) never went to school. 47% (659) of people in Cork and Kerry in treatment for alcohol addiction in 2016 were unemployed, 28% (n=393) were in regular employment, 15% (n=216) were either retired, unable to work or at home, 7% (n=94) were students.

For all cases (n=1411) in treatment in the region, alcohol was the primary drug and for the majority of these 77% (n=1088) they were not using other drugs, however 23% (n=323) reported polydrug use with alcohol. See Figure 4.7

Figure 4.7 **Polydrug Use**



Source: HRB, National Drug Treatment Reporting System (data accessed Feb/March 2019)[6]

After Care Services and Link Workers are available to vulnerable groups such as those utilising homeless services and those in early recovery. There are a variety of **drug and alcohol support services and support groups** available to all ages, genders and their families including supporting prisoners and former prisoners, youth homelessness, migrants and those from the travelling community.

Post Release Project, Cork Prison

The Post Release Project was established in 2001. It was established under the auspices of Cork Prison Education Unit and funded through Drug & Alcohol Task Force as a direct response to a gap in service provision to prisoners preparing to be released. A recurring problem was identified whereby a significant number of prisoners were slipping back into old patterns of alcohol/substance misuse and were failing to negotiate a positive resettlement.

The project provides a comprehensive and integrated approached with voluntary and statutory services to meet the needs of prisoners released from Cork Prison. It operates within a model of flexibility and responsiveness to the needs of prisoners as they present. Many prisoners are leaving custody with complex needs e.g. poor mental health, addictions, homelessness and often a combination of all of these, often leading to a crisis management release. Those with very high support needs are often excluded from services due to their previous pattern of behaviour, poor mental health and not been compliant with medication and chaotic use of substances.

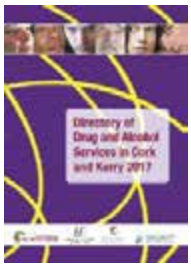
The main areas of service provisions of the project are:

- Preparation and assistance of homeless prisoners under the case management model and in conjunction with the City Council, Dept. of Social Protection and Voluntary Homeless Sector.
- The delivery of a comprehensive release programme to support the reintegration of prisoners by liaising with voluntary/statutory agencies on their behalf – welfare payments, medical cards, birth certificates, housing applications, referrals to community addiction services.
- Support in accessing residential treatment and financial support if required for aftercare residential care.
- Increasing their employability by providing them access to safe pass training prior to release, meeting their educational needs through accessing day or night course and providing financial support to enable them participate in community educational programmes.

'The first 24 - 48 hours of release are an extremely significant time in a prisoner's release. This is the time that will make a real difference in a prisoner's resettlement once supports are put in place for them in their communities. There are a wide variety of drug and alcohol support services and support groups available to both prisoners and their families, including youth housing projects, migrants and those from the travelling community, to ensure that they have a positive reintegration back into their families and communities'.

Frances Russell, Project Worker, Post Release Services, Cork Prison

For full listing of local Directory of Drug and Alcohol Services in Cork and Kerry see the Directory of Drug and Alcohol Services in Cork & Kerry



This directory is also available in seven languages including Arabic, Chinese, French, Lithuanian, Polish, Russian, Spanish and English. Go to *www.corkcitypartnership.ie*[7]

Addressing the alcohol harm needs of vulnerable communities

Within Cork and Kerry particular communities of interest such as older people, young people, those with a dual diagnosis of mental illness and alcohol, minority ethnic populations/communi ties/groups', those within the prison services and the homeless are more vulnerable to alcohol harms. Working in partnership, additional supports are provided to safeguard the alcohol harm needs of vulnerable communities across Cork and Kerry and target the specific needs of those who experience social isolation and present with complex problems.

Case Management & Person-Centered Care

In 2010, the National Drug Rehabilitation Framework (NDRF) developed a framework to help services integrate and co-ordinate their approaches to a more integrated care pathway for drug and alcohol service delivery.

> *"Case management is a process of co-ordinating the care of a service user through a shared care plan and resolving any gaps and blocks that arise."* [8]

Those who are affected by drug and alcohol misuse and homelessness often have difficulties in other areas of their lives that a system of assessment and, subsequently, case-management can identify and address systematically. Across all services and partner agencies, the overarching approach is to work with people who need the help that collectively we can provide.

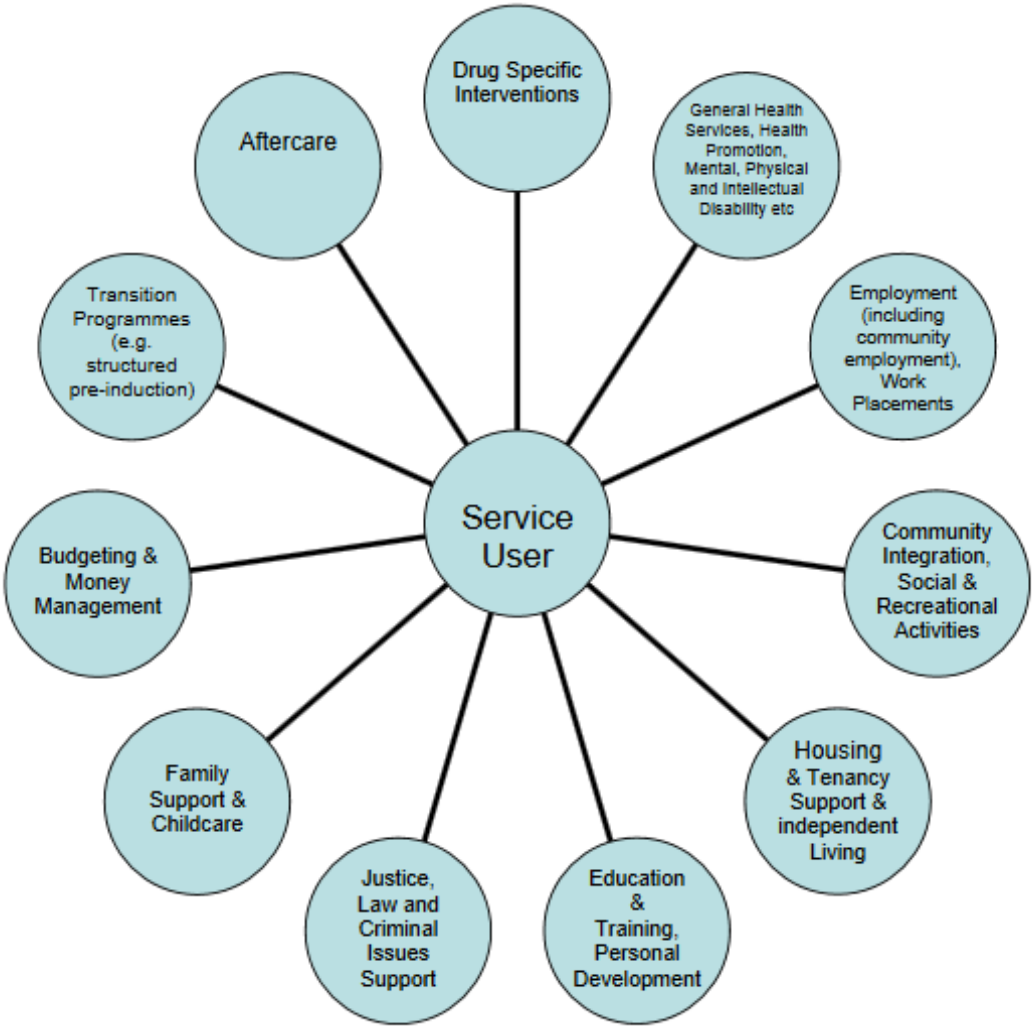
Recently, referral pathways have been established between Acute Hospital Emergency and Liaison Psychiatry Depts. and Cork Drug and Alcohol services. This integrated approach to caring for vulnerable people who need a range of services has resulted in timely and appropriate intervention.

"It is our intention that appropriate communication, with service user consent, between services continues to develop to help people receive the care that they want and need. From our recent experience there is great will in the region for this to happen."

Dr Eoin Coughlan (HSE Rehabilitation, Link and Training Manager Cork & Kerry)

Case Management is about services working in partnership with each other where the service user is at the center thus avoiding a situation where a vulnerable service user could "fall between the cracks" in the system. A key worker is assigned to work closely with the service user and assist them in their care plan to recovery. This integrated model of rehabilitation requires a number of key services and supports working together. See Figure 4.8

Figure 4.8 Supports required for an effective integrated model of rehabilitation[8]



Cork & Kerry – is the first region nationally to have successfully integrated addiction, prison and homeless services.

In 2011, the HSE Drug and Alcohol Services in Cork and Kerry appointed a Co-ordinator to support local implementation if the National Drug Rehabilitation Framework (NDRF). This resulted in agencies working in partnership and developing a formalised case management approach across addiction & homelessness services (including Cork Prison) in Cork and Kerry.[9]

"HSE and HSE-funded drug and alcohol services in the Cork/Kerry region have been working within the process of the Case-Management Framework since 2013. In 2014, the homeless services joined with the drug and alcohol services in the Cork/Kerry region to undertake the Case-management system and integrate this into their work with persons accessing the homeless services. This now amounts to 70 separate services working within the Case-Management Framework across both sectors and including the prison." [9]

This inter-agency partnership approach in the Cork and Kerry region was the **first** to occur nationally between addiction and homeless services. It has resulted in

- Integrated and co-ordinated care across sectors and organisations
- Reduced assessment waiting times in HSE clinics
- Reduced duplication across regional services
- More effective and efficient use of resources[10]

Young People & Adolescents

Young people and adolescents are vulnerable to short-term harm when they drink alcohol as they are more risk adverse engaging in anti-social behaviour, resulting in accidents and injuries and alcohol poisoning. Equally they are more vulnerable to longer-term alcohol harm with poor mental health, depression, memory problems, poor concentration and liver damage due to alcohol dependence.[11]

Parents are a significant influencer on young people's attitudes towards alcohol. The HSE has produced a helpful guide aimed at parents, guardians and others who care for children to understand the risks related to alcohol and drug use in teenagers with practical advice on how to tackle issues that may arise.

Figure 4.9 **Six step guide to protecting your child from alcohol and other drugs.**

Alcohol and drugs – a parent's guide[12]

Arbour House Child and Adolescent Service in Cork runs a young adult's adolescent programme for Alcohol addiction.

According to Dave Baumann, Senior Addiction Counsellor;

93 referrals were made to the service from January to October 2018

65% males 35% female

All 93 reported alcohol as being their first introduction to substance use.

35% reported their first use of alcohol as being spirits.

Vodka was the main substance of choice.

19% reported drinking to the point of blackout with very little recollection of what happened to them so a lot of anxiety in terms of remembering and this brings all kinds of worries for them as you can imagine when one finds oneself in that situation.

Service users have no concept of what a unit of alcohol is and therefore are very ill informed as to dangers in terms of accidental overdosing and levels of intoxication.

We work with children and adolescents ranging up to 18yrs of age. We also work with service users that are over the age of 18 up to 21yrs of age.

We provide support and counselling to children of parents with addiction/problem drinking and the siblings of adolescents that may have been impacted by the adolescents drinking.

"Focused educational programs that are not just one off modules need to be implemented in early school life. Programs could be developed as part of the existing student personal development programs that are already in our national schools and these kinds of programs can exist whereby they follow the student right through from early national school onto secondary school.

Parents need to be mindful of the learning that they are giving their children by virtue of their conversations, attitudes towards and behaviours surrounding their own drinking styles. Don't let the issue become the elephant in the room, check in with your kids around their actual knowledge and understanding of alcohol and its affects. Go online research it together.

"Frightening them" is often one of the strategies that I hear parents attempting to introduce to prevent or divert their adolescents away from drinking, but our experience tells us that this type of intervention is fairly limited as you are competing with the knowledge base and influence of their peers. Informed conversations tend to be more useful and this kind of dialogue is helpful in terms of the continuance of open discussion.

Talk to your adolescents about staying safe in the context of drinking environments if you're going to drink don't drink alone and make sure you have a safety plan.

To our adolescents I would say do not be afraid to speak to someone about it and if you feel that you can't speak to your parents/guardians directly speak to a teacher, friend, friends parent, club leader, uncle, aunty, granny etc., or use your phone and call us remember you don't need consent from adults to contact helplines or helping organisations."

Dave Baumann, Senior Addiction Counsellor, Child and Adolescent Addiction Team, Cork Kerry Community Healthcare, Health Service Executive, St. Finbarrs Hospital Cork.

Service provided by Arbour House Child and Adolescent Service;

- Initial consult to adolescents and their families together or independently
- Initial consult to adolescents only
- Initial consult to families
- Initial assessment and care planning
- Comprehensive assessment and care planning
- Direct provision of services that respond to the care plan in a manner that is aligned to the service user's readiness to address the presenting issue/concerns.
- A combination of psycho-education, skills development and therapy/counselling form the basis of the service provided.

It's a free service and attendance is voluntary and although confidential some exceptions to confidentiality do exist. We are happy to discuss the exceptions to confidentiality with you so don't be afraid to contact us.

Referrals to the service are made by various routes i.e. Self, Family Schools, Youth Reach, general community based adolescent services etc. Probation and Welfare, Local and Regional Drug and Alcohol Task Force Projects, Social Work and Residential Child Care services, Mental Health services (CAMHS), Other addiction treatment services, Medical services i.e. GP's, hospital and A&E services.

Lack of Parental/Guardian consent is not an exclusion factor to accessing services.

For more information contact Arbour House, Child and Adolescent Service on 021- 4968933

One of the team will be happy to discuss your concerns confidentially and guide you to the most relevant service.

REACT Alcohol Programme

REACT (Responding to Excessive Alcohol Consumption in Third-level) is a multi-component programme that seeks to reduce hazardous drinking and associated harms among college students in Ireland. The programme has been established in the context of the considerable physical, mental and social effects arising from hazardous drinking among third-level students, as well as the risk of reputational damage to third-level institutions. A key aspect of the programme is providing accreditation and an award to institutions that successfully implement the programme to recognise their efforts in this area and to incentivise participation.

REACT is co-funded by the Health Service Executive (HSE) and the philanthropic organisation Tomar Trust, and is a joint initiative between the Health Matters project at University College Cork (UCC), the Union of Students in Ireland (USI) and the Irish Student Health Association (ISHA). It was developed in 2015, with programme implementation commencing in 2016. Based on research on international best practice of actions, the programme consists of a suite of both mandatory and optional action points, which participating third-level institutions (universities/institutes of technology/colleges) are required to implement. These include setting up a dedicated Steering Committee to oversee and drive the programme in each institution and securing high-level commitment to the programme.

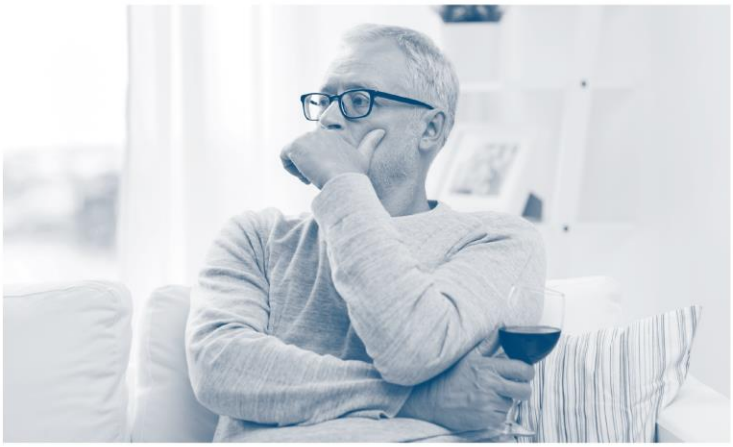
Development of the **REACT** programme was informed by a three-step process, comprising a literature review, a knowledge exchange forum and expert consultation. The final suite of measures consists of eight mandatory action points and 18 optional action points.

Currently, approximately 15 third-level institutions have agreed to take part in the programme, with some of these institutions at a more advanced stage of

implementation while others are still at the inception stage. Evaluation of the programme is also underway and seeks to look at both implementation and outcomes of the programme used a mixed methods approach (both qualitative and quantitative data). The **REACT** programme represents an important milestone in efforts to tackle the ongoing issue of hazardous drinking among college students in Ireland and will provide important learning for similar measures of this kind going forward.

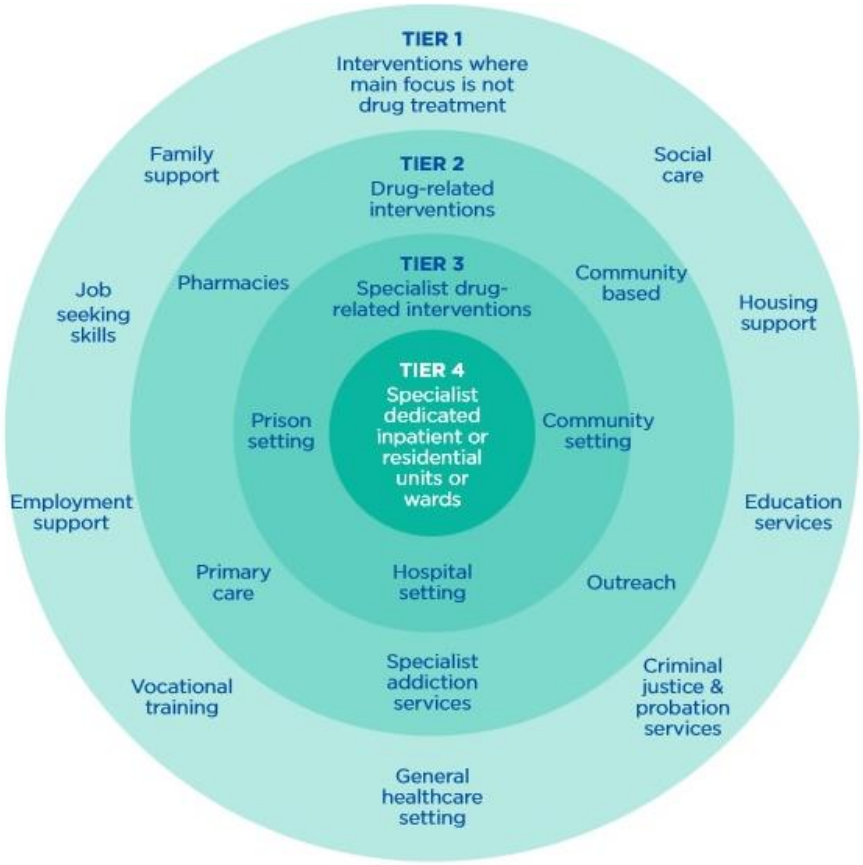
Susan Calnan, PhD Research Candidate,
REACT Project, School of Public Health, University College Cork (UCC)

Working Age Adults & Older People



Addiction services in the HSE are referred to by way of the Four Tier Model of Care (see Figure 4.10). This model is based on a four tier person-centred approach that focusses on tailored support to the individual based on their location and level of need.

Figure 4.10 The Four Tier Model of Care[13]



Tier 1 interventions include the provision of information, advice and referral, social reintegration and rehabilitation support following treatment.

Tier 2 interventions are provided by a pharmacy or delivered through a community setting by various agencies.

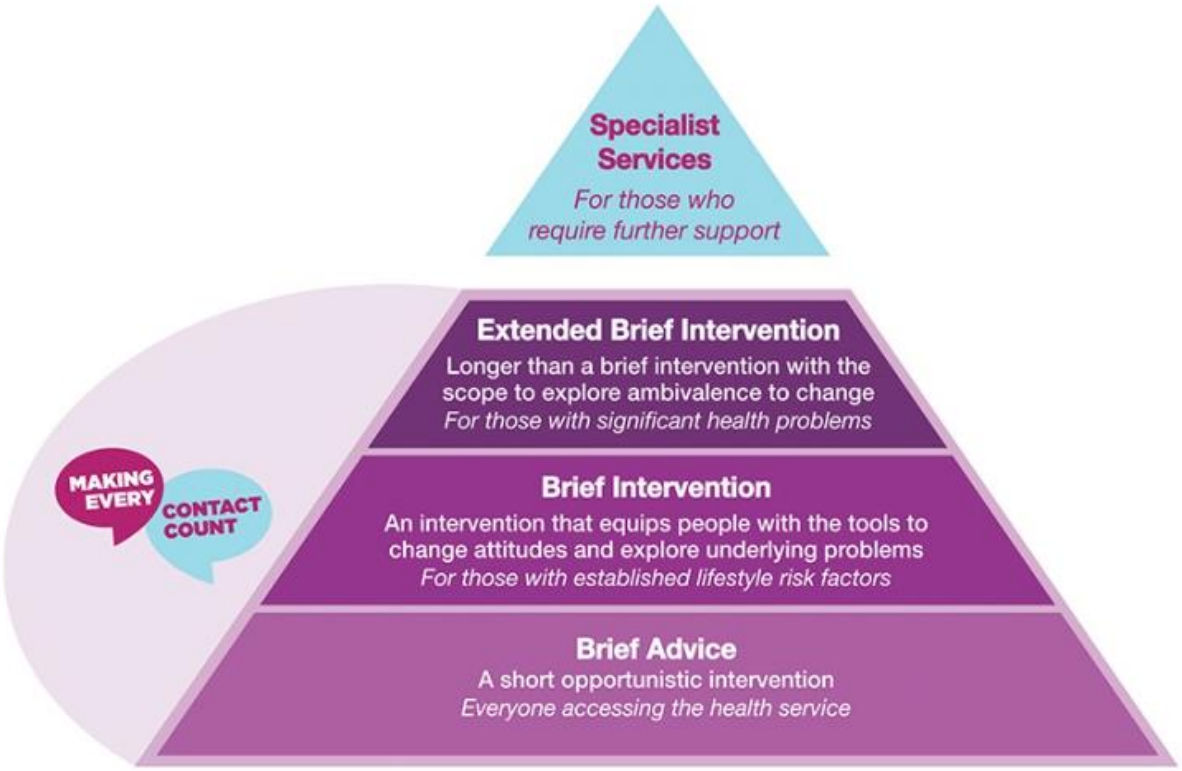
Tier 3 interventions are mainly delivered in specialised treatment and rehabilitation services.

Tier 4 interventions are provided by specialised and dedicated inpatient or residential units or wards, which include inpatient detoxification or assisted withdrawal and/or stabilisation.[14]

Treatment and interventions services for working age adults and older people

Brief intervention screening models are a way to identify people whose alcohol use is at risk to their health and encourage them to reduce their consumption or refer them for specialised supports.

Figure 4.11 HSE Make Every Contact Count [MECC][15]



MECC was established in the HSE in 2016 to support the implementation of Healthy Ireland in the Health Service. Its aim is to support people make healthy lifestyle choices around tobacco use, **alcohol** and drug use, unhealthy eating and physical activity. During routine consultations with trained MECC health care professionals, patients are asked about their lifestyle behaviours related to chronic disease to address their risk factors and are provided with brief advice, brief intervention and/or an extended brief intervention and specialist service referral.

Specifically in the case of Alcohol, the HSE has an agreed national model for training in Screening and Brief Intervention for alcohol and substance use called SAOR (Support, Ask and Assess, Offer Assistance and Referral).[16 17 18]

SAOR
BRIEF INTERVENTION

The SAOR model was first introduced in 2009 by James O'Shea and Paul Goff and initially addressed problem alcohol use in the Emergency Department & Acute Care Settings. **SAOR II** was launched in 2018 and builds on the learning from this model of brief intervention, further delivering this training across a wider range of services to include training workers in a diverse range of settings including acute care settings, mental health services, child and family services, community-based drugs services, homeless agencies, primary care services, third-level colleges, criminal justice, youth and sporting organisations and working with a variety of health and social care workers. [16] [17]

The SAOR Model is a screening, assessment, intervention and referral process that has its foundations in relationship building, creating a therapeutic relationship with the client that is supportive, friendly and person-centered. "The support aspect of the intervention is achieved by ensuring openness, empathy and supporting self-efficacy – all of which are pivotal in the delivery of a meaningful Screening and Brief Intervention (SBI)."[16]

Motivational interviewing techniques are the foundations of the SAOR Model and good relationship building to facilitate an appropriate referral. There are a number of tools to facilitate the SAOR process. The full suite of SAOR II tests can be accessed at: *https://www.hse.ie/eng/about/who/primarycare/socialinclusion/homelessness-and-addiction/alcohol-and-substance-use-saor/*[18]

The most commonly used tools is the is the Alcohol Use Disorders Identification Test (AUDIT) 18 (Figure 4.12)

Figure 4.12 **The Alcohol Use Disorders Identification Test (AUDIT) to identify those whose alcohol puts them at risk.[18]**

SAOR II

AUDIT – C

Questions	Scoring System					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	Weekly 2 - 3 times per week	4+ times per week	
How many standard drinks do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
How often have you had six or more standard drinks on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring

A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

SCORE

HSE Drug & Alcohol Helpline & Websites

The HSE has a confidential **Drug & Alcohol Helpline (1800 459 459)** and an email support service **helpline@hse.ie** which provides support, information, guidance and referral to anyone with a question or concern related to drug and alcohol use and/or HIV and sexual health. The service is non-judgemental and offers space to talk about your situation, to explore some options and to consider your needs.

Drug & Alcohol Helpline (1800 459 459)

http://www.drugs.ie/phone, http://drugs.ie/

Askaboutalcohol.ie is the official HSE website for accurate information on Alcohol.
http://www.askaboutalcohol.ie/

Conclusions

As can be seen from this report, there is a need for more awareness raising campaigns highlighting the harm that can be caused by alcohol misuse. Within a culture where alcohol seems a part of everyday life, the concept that this can cause harm needs to be thoughtfully introduced to different audiences based on our understanding of behaviours and attitudes to drinking in various age groups and cohorts. The Public Health (Alcohol) Act 2018 goes some way towards enabling an environment where the harmful effects of alcohol misuse can be conveyed across the sectors in Irish society.

Reducing visibility of alcohol will aid in denormalising alcohol as a common purchase item in supermarkets and corner shops. Increasing the price with minimum unit pricing will help in particular with young people as it will make previously cheap bottles of alcohol unaffordable for school going children. Restrictions on advertising alcohol particularly at sporting events will impact exposure to alcohol to young people all over the country.

Alcohol harm is evident across the life-course and has impacts across individuals, families and communities. There is no silver bullet solution but what we do know is that a "public health-led" system response that is person centered is the best way forward. Working in partnership across agencies and a cross-sectoral approach is key to success. In Cork and Kerry, every effort is being made to work collaboratively to reduce alcohol harm across the region.

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Abbreviations

ADH	Alcohol Dehydrogenase
ALDH	Aldehyde Dehydrogenase
AH2O	Alcohol's Harm to Others
AUDIT	Alcohol Use Disorders Identification Test
BAC	Blood Alcohol Concentration
BPD	Borderline Personality Disorder
CAMHS	Children and Adolescent Mental Health Services
CD&AP	Community Drug and Alcohol Projects
CIDR	Computerised Infectious Disease Reporting
CLDATF	Cork Local Drug and Alcohol Task Force
CODAAP	Community Outreach Drug/Alcohol Awareness Project
CSO	Central Statistics Office
DALYs	Daily Adjusted Life Years
DBT	Dialectical Behaviour Therapy
DPH	Department of Public Health
ED	Electoral Division
EUPD	Emotionally Unstable Personality Disorder
FAS	Foetal Alcohol Syndrome
FASD	Foetal Alcohol Spectrum Disorder
GBD	Global Burden of Disease
HCC	Hepatocellular Carcinoma
HI	Healthy Ireland
HIPE	Hospital Inpatient Enquiry
HRB	Health Research Board
HSE	Health Service Executive
IARC	International Agency for Research on Cancer
LDATFs	Local Drug and Alcohol Task Forces
LHO	Local Health Office
LOS	Length of Stay
M2F2	Moderate Migration and Fertility projection scenario
MECC	Make Every Contact Count (HSE)
MUP	Minimum Unit Pricing
NAP	National Alcohol Policy
NCCP	National Cancer Control Programme

NCRI	National Cancer Registry Ireland
NDRF	National Drug Rehabilitation Programme
NICE	National Institute for Health and Care Excellence
NSHRI	National Self-Harm Registry Ireland
OC	Oesophageal Cancer
OECD	Organisation for Economic Co-operation and Development
OSCC	Oesophageal Squamous Cell Carcinoma
PAF	Population Attributable Fraction
PAR%	Population Attributable Risk
PHIS	Public Health Information System
PYLL	Potential Years of Life Lost
RDATFs	Regional Drug and Alcohol Task Forces
RSA	Road Safety Authority
RSE	Relationships and Sexuality Education
SAOR	Support, Ask and Assess, Offer assistance and Referral
SBI	Screening and Brief Intervention
SEG	Socioeconomic Groups
SES	Socioeconomic Status
SRDATF	Southern Regional Drug and Alcohol Task Force
STI	Sexually Transmitted Infection
U&ME-A	Understanding and Managing Emotion and Addiction programme
WHO	World Health Organisation

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