How Local is Local? Assessing the Prospects for Local Alcohol Policy in Ireland

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Introduction

Dr Holder has presented models or case studies, from various parts of the world, of local alcohol policy initiatives based upon clear systemic ideas. While acknowledging that these initiatives can be politically controversial and generally not without their difficulties, he is cautiously optimistic about their capacity to reduce the incidence and prevalence of alcohol problems. He emphasises the distinction between *programmes* and *policies*: the former referring to specific strategies, usually of an educational or therapeutic nature, aimed vaguely at the general public or selectively at subgroups such as problem drinkers or young people, and the latter to theory-driven, broader strategies aimed at bringing about environmental or structural change through the use of law or regulation. His basic premise is that programmed activity is likely to have just a superficial impact on societal alcohol problems, and that serious and sustained improvement in this sphere can only come about through the development and implementation of policies which have a well-developed rationale and a general impact on communal drinking habits.

In responding to Holder's paper from an Irish perspective, I shall attempt to answer the following questions:

- How novel are his ideas about community alcohol policy in an Irish context?
- What are the cultural and institutional factors which either assist or militate against such policy initiatives in this country?
- What alcohol policy processes are currently in train in Ireland and what realistically can we expect of them?

Public and Policy Discourse on Alcohol Problems in Ireland

The disease concept of alcoholism - which suggests that alcoholism is a discrete, unitary disorder largely explicable in terms of the individual vulnerabilities of a minority of drinkers and only minimally attributable to alcohol per se - gained much ground in Ireland in the thirty years or so following the Second World War (Butler, 2002). The disease concept, which had its origins in the USA, was diffused internationally by the World Health Organisation, adopted incrementally by

the Irish Department of Health, and promoted most explicitly by a voluntary organisation known as the Irish National Council on Alcoholism (INCA). A central implication of this conceptualisation of alcohol problems was that there was neither justification nor necessity for the State as a whole to concern itself with alcohol control systems, such as those dealing with price or with public access to retail outlets, since it was assumed that there was no link between societal patterns of consumption and the incidence of this disease. Instead, it was considered that public sector responsibility in this sphere could validly be limited to the provision of treatment and rehabilitation programmes for alcoholism within the health sector, as well as public education about the disease of alcoholism.

From the mid-1970s, however, Irish researchers (particularly Dr Dermot Walsh of the Medico-Social Research Board) became aware of and were drawn into international research networks which were developing a public health perspective on alcohol, almost the polar opposite of the disease concept (Davies and Walsh, 1983). This public health perspective emphasised the diversity of the alcohol-related problems experienced by society, suggested that prevention of this spectrum of problems demanded a coordinated or intersectoral response from government, and argued for a central role for regulatory or control policies as part of this new systemic public health approach to alcohol. In short, the public health perspective switched the focus back from alcoholism to alcohol. In Ireland, the public health perspective on alcohol was the theoretical framework used in relation to alcohol problems in *The Psychiatric Services*: *Planning for the Future*, an important planning document on public mental health services which was published in 1984. It was the public health perspective which informed the policy process that culminated in the publication in 1996 of the *National Alcohol Policy*, and it was also this perspective which underpinned the publication in May 2002 of the interim report of *Strategic Task Force on Alcohol*.

It might, therefore, be concluded that Holder's ideas about alcohol policy are not particularly novel in an Irish context, that versions of them have circulating here for almost twenty years and that they have already made a significant impact. A conclusion of this kind would be unwarranted, however, for two main reasons. The first reason is that discourse based on the public health perspective on alcohol in Ireland appears to have been almost entirely confined to a small circle of professionals and policy makers; it has never been popularly publicised or promoted as was the disease concept and, although there are no social survey findings available on general awareness of it, impressionistically the public health perspective is not a 'governing image' (Room, 2001) as was the disease concept. The second, and perhaps the more important, reason for not seeing

Holder's ideas as familiar and influential in Ireland is that there has been virtually no implementation of the policy proposals which have been based upon this theoretical perspective (Butler, 2001). This is especially true of some of the aspirational ideas about bottom-up or community initiatives on the prevention of alcohol problems contained in the National Alcohol Policy.

The answer to the first question, concerning the novelty of Holder's ideas in an Irish policy context, is therefore that they are novel in the following important ways: they have not been widely publicised; they do not appear to be well-known beyond the confines of those few people with specialist interest in alcohol policy; and they have not significantly influenced the implementation of new policies.

Cultural and Institutional Influences on Alcohol Policy in Ireland

What is immediately striking about the case studies presented by Holder is that they all are set in societies which Levine (1992) has categorised as having *temperance cultures* - 'the term temperance cultures is used here to refer to those societies which, in the nineteenth and early twentieth century centuries, had large, enduring temperance movements' (p.16). Levine identified nine such temperance cultures: 'the English-speaking cultures of the US, Canada, the UK, Australia, and New Zealand; and the northern Scandanavian or Nordic societies of Finland, Sweden, Norway, and Iceland' (p.16). He argues that temperance activity of this kind is confined to societies which were predominantly Protestant and also within which a large portion of the total alcohol consumed was in the form of distilled spirits, and he also suggests that the cultural and social influence of these religious-based movements extended beyond those who were formally aligned to them and also across time.

Ireland, with its large Roman Catholic majority, is not by this reckoning a temperance culture. It is not part of the Roman Catholic ethos to view alcohol as inherently evil or to suggest that all believing and practising Catholics are morally obliged to abstain. Historical studies of the legendary Father Mathew temperance campaign of the 1840s (for instance, Malcolm, 1986) highlight the ambivalence of the Catholic Hierarchy towards a campaign which was suspiciously Protestant in its ideological antipathy towards alcohol. These studies also throw interesting light on the relationship between Fr Mathew and the leading Irish parliamentarian of the day, Daniel O'ConneIl, as O'Connell sought to balance popular support for temperance against his own personal support from the drinks industry. Ultimately, O'Connell distanced himself from the Fr

Mathew movement, concluding that its opposition to alcohol was excessive and exaggerated. Due largely to his lack of organisational skills, Fr Mathew left no enduring temperance movement behind him, and it was not until the end of the nineteenth century that the Pioneer Total Abstinence Association was established as a more conventional temperance organisation, integrated bureaucratically into the mainstream of the Catholic Church in Ireland (Ferriter, 1999). The temperance ideals of the Pioneer Association were never of the fundamentalist kind characteristic of Protestant temperance organisations. It was never suggested, for instance, that all Irish Catholics should abstain from alcohol, nor indeed was it even expected that all Catholic clergymen should do so; instead, as the organisation's title indicates, it was assumed that those who voluntarily abstained from alcohol for spiritual motives would be a relatively small and hardy band of 'pioneers' within the larger institution of the Catholic Church.

The relevance of this historical material for present-day alcohol policy making is reasonably clear. Unlike those 'temperance societies' which have featured in Holder's case studies, Ireland is a country in which there has never been cultural support for legislative or other policy measures apparently based upon a fundamentalist rejection of alcohol. Since the 1960s, and coinciding with the general success of the alcoholism movement here, the relatively moderate Pioneer Total Abstinence Association has experienced both a decline in numbers and a lack of clarity as to its general mission in Irish society. The policy environment here is not generally supportive of initiatives which, however rational and evidence-based they may be, can be seen as prohibitionist, so that present-day politicians are unlikely to support such initiatives unless and until they have been explained, publicised and generally gained popular support.

Looking specifically at governmental structures, the main point to be made is that since 1922 Ireland has tended towards a centralised system of government with a relatively underdeveloped local governmental system (Daly, 1997). Health and social services, education, and policing all are all funded from central government and almost entirely based upon policy laid

down by central government, so that there is little scope for local alcohol policy initiatives such as those described by Holder. On the other hand, given the small size of the country - with a total population of about 4 millions at present - it could be argued that, by comparison with large urban areas in other countries or in the overall EU context, all policy here is local policy. It is also worth noting that our electoral system, PR-STV, ensures that the gap between national parliamentarians and the electorate is a narrow one, with TDs being compelled to stay close to the 'grassroots' if they wish to be re-elected. What this means for alcohol policy is that parliamentarians are

sensitive to but mainly responsive to public opinion; political support for alcohol policy initiatives is likely to come *in the wake* of popular support for such initiatives. Finally, the strength and the lobbying capacity of the drinks industry must be recognised. The drinks industry has the money and expertise to lobby government effectively, just as it has a strong record of supporting local community social and sporting events, and it is also not without significance that TDs have frequently used pubs as sites for the 'clinics' in which they maintain contact with their constituents.

The answer to the second question, therefore, is that Ireland is not culturally sympathetic to policy which appears to be based upon fundamentalist opposition to alcohol. The centralised nature of Irish governmental systems also appears to preclude local alcohol policy activity of the kind described by Holder. It is theoretically possible, given the relatively small scale of Irish society, to agree to and implement effective public health policies on alcohol on a national level, but only if or when public understanding of and popular support for this perspective has been created.

Current Irish Alcohol Policy Making

The third question which I will address concerns current alcohol policy making in Ireland. On the whole, the prospects for bringing about a,reduction in the prevalence of alcohol-related problems along the lines suggested by Holder do not seem particularly good. This is not because there is no policy making currently taking place here, but rather because there are at present two parallel policy processes, the dominant of which is ideologically at variance with that of Holder's.

The first policy process is the one alluded to above which, broadly speaking, is compatible with everything that Holder has described. It is a public health approach which emphasises alcohol rather than alcoholism; which sees a link between overall consumption levels and the prevalence of a range of alcohol-related problems; which sees a role for all sectors of government rather than just the health and educational sectors; which values bottom-up or community initiatives; and which favours control measures in relation to price, accessibility and advertising / promotion of alcohol. This point of view was presented most emphatically in recent times in the Interim Report of the **Strategic Task Force on Alcohol** (based in the Department of Health and Children) in May 2002.

The second ongoing policy process is that of the **Commission on Liquor Licensing** (based in the

Department of Justice, Equality and Law Reform and established following the enactment of the Intoxicating Liquor Act, 2000) which has produced two interim reports since its establishment in late 2000. The Commission's first term of reference enjoins it to " make recommendations for a Liquor Licensing system geared to meeting the needs of consumers, in a competitive market environment, while taking due account of the social, health and economic interests of a modern society". Despite the references to social and health interests, it is clear from a reading of its two interim reports that philosophically the Commission is driven by a fundamental commitment to neoliberal economic theory. Within this framework alcohol is seen as a normal commodity, the sale and supply of which should be arranged in line with economic ideas about consumer sovereignty and competition and with the minimum of regulation. While there is opposition within the Commission to greater deregulation of the retail drinks trade, this opposition comes from existing retailers - anxious to protect monopolies which they currently enjoy - rather than from public health interests. Social and health concerns are addressed naively within the Commission and on a programmed basis: the implication is that drink problems are largely confined to young people, and there is a touching but unsubstantiated belief in the preventive value of school-based educational programmes. The overall thrust of the Commission's recommendations to date is towards greater liberalisation - if not total deregulation - of the retail drinks trade, and the public health perspective appears to have made no impact on this process. The suggestion, for instance, that alcohol should be available for sale at garage forecourts is one which is discussed in the second interim report of the Commission on Liquor Licensing. From a public health point of view this drink-driving connection is one that seems obviously undesirable, but the Commission concludes that it will merely keep it under review.

If the two alcohol policy processes are compared and seen as being ideologically and institutionally in competition with one another, it appears as though the proponents of the neoliberal view are easily defeating their public health adversaries. The National Alcohol Policy of 1996 has been largely ignored, and it is hard to see how the recent Strategic Task Force on Alcohol can be any more successful.

The answer to the third question, therefore, is that Ireland currently has two ongoing policy processes, one driven by a public health concern with reducing alcohol-related damage and the other by a neoliberal concern with liberalising the retailing of drinks. The latter is clearly in the driving seat.

A Way Forward

I shall finish by making two suggestions which might go some way towards realising the ambitions outlined in Holder's paper. While I understand that Ireland is not a temperance culture in the sense discussed above, neither is it a society in which people are blind to the problems caused by alcohol. It seems to me that one of the important missing ingredients in this mix is the use of media and public relations to hammer home clearly and regularly that there is a connection between levels or patterns of consumption and the prevalence of drink-related problems in this country. Both at national and local level, media can be used to argue that if we make alcohol more accessible and if we keep it relatively cheap, people will almost certainly drink more; and if people drink more, we can expect more problems. The public interest, in this case, would be served best by regulation and control rather than by rampant competition and consumer sovereignty. This is not unique in public policy terms: we all know that Dublin cannot thrive as a city if we allow unfettered access to motorists, for instance. Just as with traffic, public support for alcohol control policies must be built and maintained through the use of media and promotion.

My second point refers to the ludicrous situation whereby we have two parallel and competing policy processes in the alcohol sphere. It is not as though our public policy and administrative systems are so underdeveloped or naïve as to make this inevitable; throughout the 1990s the concept of the Strategic Management Initiative (SMI) was devised and put into effect here, containing within it specific ideas for the management of complex policy issues that transcend any single sector of government. Alcohol policy is an obvious "cross-cutting" domain, and it would seem only sensible that structures should be set in place for a single and integrated policy as has been done so successfully in relation to illicit drugs. Indeed, the most straightforward way forward might be to add alcohol onto the policy brief of the National Drug Strategy Team and all the other components of the national drug strategy.

Which of these should come first, the development of popular support for alcohol control systems or the establishment of alcohol policy structures at governmental level? If political leaders wait for popular sentiment to develop on this issue, then the structures may be a long time in coming. Perhaps both should be tackled simultaneously, although this would demand unusual political courage and leadership.

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