

Do the findings really speak for themselves?
An examination of alcohol research/policy interface

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Abstract

In the context of ongoing public debate about the prevalence of alcohol-related problems in Ireland, the purpose of this study is to examine the interface between alcohol research and alcohol policy, with a view to determining how, and to what extent, the findings of research are incorporated into public policy in this sphere. The theoretical context of this debate is provided by the varying historical conceptualisations of alcohol problems and it is grounded in an empirical exploration of research into alcohol consumption and public policy in Ireland. Within this context, a ten year trends analysis of weekly alcohol consumption levels is presented, and the implications for alcohol policy are explored. The nature of the interface between alcohol policy and alcohol research is examined, and the question of what other determinants influence the formulation of alcohol policy is considered. An alternative, more successful, research/ policy interface in the form of the National Drugs Strategy is appraised and the question of whether alcohol should be included in this strategy is debated. In conclusion, this study of alcohol research and policy deduces that, where the site of direct 'interface' between public health research and governmental policy should stand, there is instead a gulf, and as yet no bridge seems to exist between evidenced-based policy ideals of health promotionists and the realities of formulating public policy. What link does exist between research and policy is a much more evolutionary one, where the research which best 'fits' the policy process in question is selected and where evidence-based research is only one of many, sometimes competing, determinants in the policy processes.

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Abbreviations

AA	Alcoholics Anonymous
ADS	Alcohol Dependence Syndrome
AMS	Academy of Medical Science
ANOVA	Analysis of Variance
BAC	Blood Alcohol Concentration
CAAP	Community Alcohol Awareness Programme
CLAN	College Lifestyle and Attitudinal National Survey
CORI	Conference of Religious of Ireland
CSSI	Cabinet Committee on Social Inclusion
DCRGA	Department of Community, Rural and Gaeltacht Affairs
DIGI	Drinks Industry Group of Ireland
DJELR	Department of Justice, Equality and Law Reform
DoHC	Department of Health and Children
DSU	Drugs Strategy Unit
DTSR	Department of Tourism, Sport and Recreation
EC	European Community
ECAS	European Comparative Alcohol Study
EU	European Union
EUROSTAT NUTS II	EUROSTAT Nomenclature of Territorial Units for Statistics with multiple level of codes level two
FÁS	Foras Áiseanna Saothair
HRB	Health Research Board
LDTF	Local Drugs Task Forces
LVA	Licensed Vintners Association
MD	Mean Difference
MEAS	Mature Enjoyment of Alcohol Society
MR	Mean Range
NAC for the YPFSF	National Assessment Committee for the Young Peoples Facilities and Services Fund
NACD	National Advisory Committee on Drugs
NAP	National Alcohol Report
NDS	National Drugs Strategy
NDST	National Drugs Strategy Team
NGO	Non-Governmental Organisation

NSMS	National Substance Misuse Strategy
NUI	National University of Ireland
NWAF	North West Alcohol Forum
P.HL	Per Hectolitre
PSU	Primary Sampling Unit
PTAA	Pioneer Total Abstinence Society
RBT	Random Breath Testing
RDTF	Regional Drugs Task Forces
RES	Research Evaluation Services
RSA	Road Safety Authority
SD	Standard Deviation
SE	Standard Error
SLÁN	Survey of Lifestyle and National Health
SMI	Strategic Management Initiative
STFA	Strategic Task Force on Alcohol
TD(s)	Teachta(i) Dala(i)
USA	United States of America
WHO	World Health Organisation

1 Introduction

‘[R]emember... a solution does not have to be elegant to be effective. For your elegant research to be effective on the long road of the policy formulation process, it must sometimes be used to fuel inelegant vehicles.’
(Secker, 1993: 120S)

The link between public health research and policy is not a linear one, and research is not the only determinant of policy. As researchers, if we are to have any prospect of seeing ‘elegant research’ utilised in policy, then a certain amount of adaptation is necessary in order to ensure that the research in question is incorporated into policy. The idea of evidence-based policy is that this will happen as a matter of course, based on the linear relationship that is assumed to exist between the two. However, the transformation of research into policy, while obvious in theory, often fails in practice. This occurs not only because research evidence is contested by stakeholders in the policy process, but because its use is affected by a process of selection that means it is the research which best ‘fits’ the policy model that is put into practice. (Stevens, 2007: 32). Thus, this study seeks to examine the nature of the interface between alcohol research and alcohol policy, and to understand the processes which affect the incorporation of research into policy. This chapter defines the basic research concepts of ‘public policy’ and ‘health promotion’ employed in this study and details the research procedure of the study.

1.1 What is public policy?

Health promotionists advocate an evidence-based model of public policy-making. The main premises of this model are documented in section 1.2.1 below. Section 1.2.2 presents the model of public policy the researcher feels to be most suited to explaining the complexities of the alcohol policy-making process, and it is this model which is used to provide the framework for understanding the alcohol policy process.

1.1.1 Evidence-based public policy

The traditional model of evidence-based policy interprets the policy making process as a linear model, with a direct link between evidence and policy, and strong emphasis on the need for research to be founded on a methodologically rigorous and objective base (Stevens, 2007: 3). The perspective is rational, empirical, rooted in the epidemiological traditions of public health, and readily intelligible to the ordinary citizen (Butler 2002a: 5). It finds concrete expression in programmes such as the Cochrane and Campbell Collaborations. However, actual instances of the direct use of evidence in policy are rare, even in health policy (Black, 2001). It is usually suggested that there are too many competing ideas and interests for policy to be directly based on research (ibid.; Leicester 1999) and that the policy process is 'rarely characterised by rational decisions made on the basis of the best information' (Young *et al.*, 2002: 218)

1.1.2 The evolutionary model of policy-making

The model which is employed by this researcher is the evolutionary model of policy making. It helps to explain how evidence can be used selectively to further the interests of powerful social groups, without relying on the theory that research fails to be made into policy solely through the deliberate connivance of policy makers. It sees social structure, in addition to political tactics, as important in supporting selection in the use of evidence. It uses an evolutionary approach to explain the pattern of selection. It starts from the assumption that evidence-based research develops an array of ideas that proceed to compete for attention in policy, as organisms arise and compete for survival. The ideas may be facts, findings or recommendations that have been produced by academics, journalists, think tanks, pressure groups or others. Some of these ideas fit the interests of powerful groups and some do not. Ideas that do fit will find powerful supporters. Others will not. Those ideas that fit will therefore have groups and individuals that can carry them into policy, as would a genetic adaptation be reproduced if it proves useful to an organism's survival. The ideas that do not fit will tend not to be picked up by people who have the power to translate them into policy. This evolutionary advantage leads to the survival of the ideas that fit. The major advantage of this analogy is that it illuminates the biased use of evidence without relying on policy makers to be

irrational, or on the ability of powerful social groups to coordinate a campaign to ignore unhelpful research (Steven's, 2007: 4).

1.2 What is health promotion/ public health theory?

The concept of health promotion originates from the World Health Organisation, founded in 1946, with the ethos that '[h]ealth is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity (WHO, 1946; cited in Butler, 2000a: 4) While health promotion has evolved gradually from the early ideals of the WHO, its advocates remain committed to providing processes which enable people to achieve this original definition of health. The clearest statement of what the aims of health promotion are, and of the means most likely to achieve these aims, is that contained in the 1986 *Ottawa Charter for Health Promotion*. This charter identifies five overlapping and interlining tasks which policy makers must undertake if health promotion is to become a reality:

1. Build healthy public policy – putting health on the agenda of all policy makers in all government sectors so as to ensure that health promotion ideals are achieved.
2. Create supportive environments – recognising that people and their environments are inter-dependent, thus people need to maintain healthy living and working environments in order to themselves be healthy.
3. Strengthen community action – local communities should participate fully in identifying and developing strategies for the promotion of health in their own areas.
4. Develop personal skills – enhancing people's knowledge of health and their decision making skills to assist them in optimising their own health.
5. Reorient health services – if health promotion is to become a reality, health professionals must be re-educated to take on the broad, holistic and activities implicit in the public health approach (Butler, 2002a: 4-5).

From an analytical perspective, health promotion two principal and potentially conflicting components:

1. Individualistic component – refers to individual behavioural choices or lifestyles and their impact on health

2. Structural component – refers to the impact of socio-economic and other environmental factors on the health of the wider population (*Ibid*).

The health promotion/public health ideal, therefore, is one of collaboration between health professionals and the populace (Butler 2002a: 209).

1.3 Research procedure

Each phase of this research will be divided into chapters. The following chapter, Chapter Two, will be a review of the historical concepts of alcohol consumption, and will provide the theoretical basis upon which the examination of the relationship between alcohol research and policy will be conducted.

Chapter Three will present the methodology utilised in this research and discuss the research design which was most relevant for each research objective. Data collection and analysis will be examined and the limitations, and ethical consideration, of the research will also be discussed.

Chapter Four will present a ten year trends analysis of weekly alcohol consumption levels. The analysis will be based on variables which remain consistently significant throughout the period in question, and the question of what are the implications of such consistent significance for alcohol policy is explored.

Chapter Five will investigate the alcohol research/ policy interface in Ireland and consider what current alcohol policy-making processes exist in this country. The chapter will examine what progress has been made in regards to implementing a national alcohol policy and what issues are delaying the progress.

Chapter Six will consider the success of an alternative cross-cutting research/ policy interface in the form of the National Drugs Strategy (NDS) and examine the case for including alcohol in this pre-existing policy process.

Chapter Seven will discuss the findings of this research by linking together the various strands of analysis in the previous chapters and attempt to draw conclusions from this research in line with the objectives purported at the onset of this dissertation (McGarry: 2004: 14).

2. Literature Review

‘The answers you get from literature depend on the questions you pose’.

-[Margaret Atwood](#)

2.1 Introduction

Atwood’s advice is worth considering when embarking on any review of literature, but is perhaps especially relevant when approaching the diverse and contentious field of alcohol studies. The health and social problems associated with the consumption of alcohol have long been causes of concern in sovereign societies. The aim of this thesis is to explore the interface between empirical research into alcohol consumption and public policy in this country, and the literature reviewed in the present chapter will provide a theoretical context for this debate. In particular, the literature review will examine how conceptualisations of alcohol problems have shifted across time, place and cultures- varying from predominately moralistic to more empirically-based models. Thus, the cultural effects of the moral perspective on alcohol consumption are documented in the rise of temperance and abstinence movements across Europe, culminating in the brief prohibition of alcohol in the United States of America. The disease concept of alcohol is discussed in relation to the emergence of Alcoholic Anonymous (AA) and its indirect effects on public policy. The history of the public health or health promotion approach to alcohol consumption is detailed and health promotion proposals for the reduction of alcohol-related problems are then examined thematically in order of documented effectiveness.

2.2 Temperate times: The moral perspective on alcohol consumption

‘There is no such thing as a moderate use of intoxicating drinks, or at least there are very few, if any, who will preserve in using them but moderately’.

-James Birmingham, biographer of Father Mathew (1840: 57).

The moral perspective on alcohol consumption has its roots in the Protestant theology of the individual worshipper (See Mehl, 1970). According to Järvinen (2002), under the moral perspective it is the individual concerned who is responsible both for

the problem drinking developing in the first place and for finding a solution to it. It is the individual who suffers most from destructive drinking habits, and it is up to that individual whether he or she wants to risk his or her own physical health and mental and social well-being by drinking. Since the cause of alcohol problems is deemed to lie ultimately in the individual, the outcome will depend upon that individual's will-power and motivation (2002: 6). Thus, the moral perspective was most widely adhered to in the nineteenth century, when Victorian religious mores directly coloured everyday life in England and Ireland. As Mathias (1958) comments, for nineteenth-century citizens, intemperance in drink was understood in terms of an individual moral failing and individual responsibility. The terminology used was linked with sin and temptation. Only the weakness of the individual was at fault and he or she could be redeemed by a moral crusade and repudiation of alcohol (Mathias, 1958: 108).

2.3 From temperance to abstinence: The Irish Temperance Movement

In his study of the early days of the Irish temperance movement, Bretherton (1992) notes that 'temperance appears to have been a Protestant monopoly'. Noel (1936) concurs with this assessment, noting that, when he met a Catholic in Drogheda in 1936 who was 'so zealous for the sobriety of the place', he immediately assumed the man was a Protestant. Butler and Jordan (2006: 880) suggest that, as a predominantly Catholic country, Ireland was not a 'temperance culture'¹. Nevertheless, as Stivers (2000: 32) points out, Ireland was at the forefront of the temperance movement in Europe during the early nineteenth century. In 1817 Skibbereen became the site of the first total abstinence society in Europe. By 1830 there were reportedly 25 temperance societies in Ireland. Membership entailed abstinence from spirits, but beer and wine were permitted. Total abstinence from alcohol was not the norm until the influence of the British Association for the Promotion of Temperance by Total Abstinence led some reformers to doubt the effectiveness of moderate alcohol. In 1836 the Dublin Total Abstinence Society was formed and other groups soon followed suit, shifting from advocating temperance to promoting total abstinence. One such group was the Cork Total Abstinence Society which was led by a Quaker called William Martin. Since Cork was predominantly Catholic, Martin and his associates realised that their work would flourish if they

¹ H. G. Levine (1992) defines temperance cultures as those societies which, in the nineteenth and early twentieth centuries, had large, enduring temperance movements (Levine 1992: 16). He argues that such temperance movements were confined to societies which were predominantly Protestant and also within which a large portion of the total alcohol consumption was in the form of distilled spirits (Butler, 2002b: 4).

could persuade a Catholic priest to lead the movement. They chose a Capuchin monk and moderate drinker by the name of Father Mathew (Stivers, 2000: 34).

Stivers (1976) writes that Father Mathew believed drunkenness was Ireland's greatest social problem, the cause of almost all crimes and the root of disorder at all levels of society. Not only was total abstinence supposed to reduce crime and political conflict (Stivers, 1976: 38-39), but also in Father Mathew's words:

The fewer passions that rule us the freer we are, and no man is so free as the man who places himself beyond and out of reach of temptation, for "those who court danger shall perish therein". (Mathew, 1890, 38).

Father Mathews also wished to curtail the availability of alcohol and lessen the influence of the drinks industry, in an attempt to, as quoted above, keep people 'out of reach of temptation'. In this belief he predated the alcohol control theories of health promotionists by more than a century. However, Father Mathew's beliefs had a theological element not present in health promotion theory. The underlying assumption of those who advocate total abstinence was that the selective and restrained use of alcohol was an unattainable objective for morally weak populace to achieve, moderation always led to excess (Stivers, 2000: 31). The conception of man underlying this tenet was the corrupted man who, after the Fall from Grace, was absolutely unable, without God's help, to control his passions and save himself from a life of sin and an eternity of damnation. Thus, only teetotalism, as the foundation upon which religion builds, could free an individual from the temptation of drunkenness (Ibid 37 - 38).

The temperance movement itself was decidedly Father Mathew's (Stanton, 1849: 343). He did all the work himself - administering the pledge, passing out temperance medals, blessing the people. To paraphrase McKenna (1924), the Irish temperance movement was not sufficiently organised to successfully function without Father Mathew's immediate presence. Father Mathew came to a parish and easily got people to commit to his pledge, but he left behind no machinery to bring his pledge-bearers to act on each other by mutual example, aid, exhortation or reproach (McKenna, 1924: 302-3). Thus, the complete association of Father Mathew with the temperance movement and the lack of structural organisation within the movement ensured that when Father Mathew died, the temperance movement in Ireland died with him.

Although the Father Mathew temperance did not survive its founder's death, its successor, founded in 1898 by the Catholic Church, is still a viable organisation today. This is due to the fact that the Pioneer Total Abstinence Association (PTAA) was established on different ideological tenets, more compatible with the traditional Roman Catholic view of alcohol as inherently good, and a gift from God – albeit a gift which should not be abused and which some people might voluntarily refuse for religious motives. As Butler and Jordan observe, although it is difficult to identify any consistently articulated perspective on alcoholism within the PTAA, the dominant view would appear to be one which is sceptical about conceptualising alcoholism as a disease and which emphasises the volitional nature of drinking (Butler and Jordan, 2007: 880). Nevertheless no matter what its form, it is hard to see any great relevance to the moral theory of alcohol consumption in modern neo-liberal society.

2.4 From abstinence to taboo: Prohibition in America

As Kyvig (1979: xi) writes, alcohol was banned in the United States of America at the end of World War I in a burst of civic idealism when the Eighteenth Amendment was adopted into the American Constitution in January 1920. Advocates of the reform persuaded an overwhelming majority of federal and state legislators to support the prohibition of alcohol, asserting that removing the temptation of the morally weak towards intemperance would reduce crime and corruption, solve social problems, reduce the tax burden created by prisons and poorhouses, and improve health and hygiene. Prohibition took the temperance movement's concept of the morally weak individual to its logical conclusion, that is the removal of temptation by declaring it anathema. However, Prohibition weakened societal control over alcohol consumption by removing it from the public sphere. Alcohol consumption and alcohol-related crimes increased during the 13 year period that Prohibition was in effect (Warburton 1932; Towne 1923). As Levine and Reinerman (2004) document, Prohibition proved an increasingly hard law to enforce, with mass violations occurring in every state and this, followed by the economic depression of the 1930s led to its repeal in 1933.

Beauchamp (1980) asserts that the widespread perception in America of Prohibition as a failure facilitated the redefinition of alcohol problem from an issue which affected the entire community, to a cause for concern for only a minority of drinkers. Thus, after the repeal of Prohibition, the need was to construct a definition or explanation of

alcohol problems that relegated alcohol as a substance to a relatively minor role (Beauchamp, 1980: 9). Levine (1978) suggests that the repeal of Prohibition was the catalyst for generating a more scientific definition of alcohol consumption. He argues that the concept of addiction was discovered only when the idea that individuals could lose control of their behaviour became socially established. Thus, only some people, for reasons yet unknown, become addicted to alcohol. Prohibition ushered in the 'diseasing of America' (Peele, 1989).

2.5 Alcoholism: The disease concept and Alcoholics Anonymous

Levine (1978) believes that the most important difference between temperance thought and the disease conception is the location of the source of addiction. The temperance movement found the source of addiction in the drug itself, alcohol was viewed as an inherently addicting substance, much as heroin is today. Post-Prohibition relocates the source of addiction to the individual body. Levine submits that, although that change represents a major development in thought about addiction, the post-Prohibition ideas are still well within the paradigm first established by the temperance movement. He asserts that insofar as alcoholism and temperance advocates share the concept of addiction, and recommend abstinence as the only solution for the afflicted individual, their differences remain solely intra-paradigmatic (Levine 1978: 2).

While Levine sees deep historical roots for the modern idea of alcohol addiction in the Temperance heritage, Beauchamp (1980) argues that the disease conception and Temperance movements had distinctive ideological differences, as the disease conception transfers the focus from the Temperance belief that all alcohol consumption is problematic and all consumers are susceptible to its influence, to the more medical diagnosis of a minority susceptibility to alcohol addiction, thus the substances itself was no longer the problem (Beauchamp 1980: 7-8). Nevertheless, there is an undoubted linkage between the two movements. Reinerman (2005) catalogues how the Temperance movement prepared the way for the disease conception. He conjectures that the moral enterprise of the temperance crusaders gave direction to the spreading concern over what role autonomous individuals played in controlling their own actions. Thus, alcohol was redefined from what even leading Puritan preachers had called "the good creature of God" into a "demon destroyer" held to be the direct cause of crime, violence and poverty, while drunks

were simultaneously reconceptualised as people stricken with a disease of the will which rendered them powerless (Reinarman, 2005: 310-11).

Butler (2002a) charts how the disease conception of alcohol was disseminated through the agency of AA. He relates how a number of American stakeholders came together after the repeal of Prohibition to promote the concept of alcoholism as a discrete disease of the will which affected a minority of drinkers (Butler 2002a: 20). AA was founded in Akron in 1935 on the basis of this concept. However, as Peele (1985) notes, while Alcoholics Anonymous proposed a biological explanation for alcoholism, its climate is that of nineteenth century revivalistic Protestantism, echoing Levine's assertion that its ideological origins lie in the Temperance movement. The twelve steps in the AA credo are heavily linked to religion, God is mentioned six times in the steps, and moral inventory and contrition play a large role in AA meetings (Peele, 1989: 44).

2.6 The disease concept and AA in Ireland

The disease concept of alcohol was first introduced into Ireland with the arrival of Alcoholics Anonymous, in 1946. At the time the country had a populace which was almost 95% Catholic (Butler and Jordan 2007: 880). Inglis (1998) describes the Catholic Church in Ireland at this time as having a 'moral monopoly' which extended into the societal and governmental spheres. Thus, as Butler and Jordan observe, even though Church influence on social policy was usually mediated indirectly and through a broad cultural consensus as to the moral rightness of the Catholic viewpoint, AA, and by association the disease conception, needed to avoid censorship from Catholic Church in order to prosper in Ireland (Butler and Jordan 2007: 880).

Butler and Jordan note that the origins of both AA and the disease conception generated much suspicion within the Irish Catholic Church during the 1940s. Firstly, both originated from the non-denominational Oxford Group; a movement aimed at recreating the spirit of primitive Christianity, and secondly the 12-Step programme of recovery outlined by AA was to all intents and purposes presented as a non-denominational and life-long spiritual fellowship. (Butler and Jordan, 2007: 880). Furthermore, as Ferriter (1999) details the mainstream and ideologically moderate Catholic temperance movement in Ireland, the Pioneer Total Abstinence Association

(PTAA) was still hugely popular in the 1940s and was much more ideologically compatible with Catholic teachings than AA (Ferriter, 1999: 120-125).

Butler and Jordan (2007) document how AA became accepted in Ireland over a three decade period from 1946 to 1972. The movement's initial success was due to the work of Conor F. He succeeded in gaining permission from the medical director of St. Patrick's Hospital, Dr. Norman Moore, to hold Europe's first ever AA meeting on the premises on 19 November 1946. More latterly, the movement's success can be attributed to the efforts of Sackville O'C M., who joined in April 1947. He proved very skilled in his use of both print and broadcast media to promote AA and cultivated clerical approval by forging links with St Patrick's College, Maynooth. Over the course of several years Sackville succeeded in persuading Church leaders that the AA approach to spirituality was compatible with conventional Catholic religiosity, and by the mid 1970s AA no longer had to concern itself with straying into ideological conflict with the Catholic Church (Butler and Jordan, 2007: 882).

The organisational principles of AA specifically precluded it from involvement in outside debate Butler (2002a) stresses the importance of remembering this when considering the implications of the disease conception for health policy in Ireland. This effectively meant that AA in Ireland did not contribute to policy debate or act as a lobbyist in relation to any aspect of national alcohol policy. By implication however, because of its individualistic approach to etiology, AA called into question the value of control policies and favoured the provision of treatment facilities for individual alcoholics. By concentrated attention on a minority of 'diseased' drinkers AA contributed, albeit unintentionally, to a process of deflecting attention away from the wider context of drinking in Irish society (Butler, 2002: 28-29).

Butler and Jordan (2007) recount how governmental policy support for the notion that alcoholism was a disease developed incrementally between the 1940s and 1960s. This development was prompted mainly by the World Health Organisation's (WHO) decision to disseminate the concept internationally during the early 1950s and more tacitly by the Catholic Church's increasing acceptance of AA. It was not however until 1960 that an Irish governmental figure referred explicitly and positively to the disease concept of alcohol. In 1959 the government had published a bill which proposed to

liberalise the country's licensing laws². The Church opposed the legislative proposal and argued that increasing the public's access to alcohol would result in higher consumption and a higher prevalence of related problems (Butler and Jordan 2007: 883). As can be seen from the Dáil records, the Minister for Justice drew explicitly on a 1952 alcoholism subcommittee report of the WHO in defence of the proposed legislature (Dáil, 1959: 948-949). The report concluded that 'increased consumption has no causal significance in relation to the prevalence of alcoholism' (WHO, 1952). Butler (2002a) suggests that while it is difficult to know how convinced the Minister for Justice was of the scientific validity of the disease concept, it seems likely that he appreciated its political value in allowing him to ignore the advice of the bishops. As Butler (2002a) further suggests, it seems reasonable to infer that during the legislative process of inter-departmental consultation, the Department of Health had simply accepted the WHO endorsement of alcoholism as a disease and had transmitted these views to the Department of Justice (Butler, 2002: 32). Beauchamp (1980) argues that the disease concept gave scientific validity to social drinking, while simultaneously, as Butler (2002a: 32) says 'put[ting] a scientific gloss on drinking problems'. Butler (2002a) asserts that the Intoxicating Liquor Act 1960 was the first, and for a long time the only, instance of Irish legislative behaviour which ignored the advice of the Roman Catholic hierarchy. In enacting this relatively liberal licensing code the Government clearly felt that controlling the drinking habits of its citizens was no longer a necessity, given that alcohol as a substance was no longer deemed to be at fault (Butler, 2002: 33 -40).

2.7 A concept of alcohol control: The theories underpinning the public health perspective

The adoption of a health promotion/ public health theory of alcohol-control in the mid-1970s represented a radical u-turn on how alcohol was viewed by researchers, previously firm advocates of the disease concept. The perspective arose from the theory that effective public health strategies have the power prevent or alleviate population-wide alcohol-related problems (Edwards, 1997: S73), and first gained popularity with the publication of Bruun et al.'s *Alcohol control policies in public health perspective* in 1975. This WHO-sponsored monograph drew attention to the

² The major recommendations of the 1960 Liquor Act were that closing times on weekdays should be extended to 11.30pm and that pubs throughout the country should be allowed to open on Sundays between the hours of 12.30pm to 2.00pm and 5.00pm to 9.00pm (Butler, 2002a: 31).

preventable nature of alcohol problems and to the role of national governments and international agencies in the formulation of rational and effective alcohol policies. The authors argue that higher the average amount of alcohol consumed in a society, the greater the amount of problems experienced by that society (Babor et al., 2003: 5). *Alcohol control policies* emphatically concludes that:

Changes in 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 (p. 90)

Consequently Bruun et al. suggest that the most effective way to prevent alcohol problems is through policies that limit the availability of alcohol (Babor et al., 2003: 5).

In 1976 Edwards and Gross further diminished the authority the disease conception carried in the scientific community when they submitted their concept of alcohol dependence syndrome (ADS). This influential theory asserted that alcohol-related problems could occur without dependence, but that dependence was likely to carry with it many problems. Gigliottia and Bessa (2004) emphasise that ADS, unlike alcoholism, is not a static disease defined in absolute terms. Instead it is a disorder which becomes embedded in habit along an individual's lifetime and which depends on the interaction of biological and cultural factors to determine how the individual will relate to alcohol and in which the reasons why the individual started drinking are an important addition to those related to dependence (2004: 2). According to Edwards and Gross (1976: 1058), dependence is thus an "an altered relationship between the person and his/her way of drinking".

In December 1994 the sequel to Bruun et al.'s influential work was published. Entitled *Alcohol policy and the public good*, Edwards et al.'s report gave the public health perspective established by Bruun et al. a persuasive empirical underpinning and an unquestionable practical relevance to policy formation. In *Alcohol policy and the public good* Edwards et al. assign a broader view of what alcohol policy encompasses than Bruun et al.'s earlier work. Bruun et al. confine their definition of alcohol control policies to strategies employed by governments to influence alcohol availability, while Edwards et al. consider alcohol policy to enclose all public health responses which had been dictated in some measure by national and historical concerns (Babor et al. 2003: 7). Babor et al. (2003) assert that, when formulating

effective alcohol policy, one must bear in mind that alcohol has self-reinforcing potential, as this fact is of fundamental importance to understanding the dynamics of the relationship between a population and its drinking. Alcohol is not a run of the mill consumer substance, but a drug with dependence potential to which everyone who drinks is susceptible. Thus, the authors maintain that public health responses to the dangers of alcohol must be matched to the complexity of these dangers, in order to assist policy makers in responding better to the population-level harm caused by alcohol consumption. The context for those responses should be improved understanding of the nature of an agent that is far from being 'an ordinary kind of commodity' (Babor et al., 2003: 26 - 27).

Thus, the public health perspective of alcohol consumption encapsulates a diverse spectrum of theories related to problem alcohol use and how it may be curtailed. However, as Edwards (1997, S75) suggests that the primary test for a policy's worth is whether it can demonstrate empirically that it is effective in reducing the burden and costs of society's alcohol problems in relation to one or several alcohol-reduction targets.

2.8 The policies of alcohol control: research-based recommendations

Room (2001a) and Babor et al. (2003) recently undertook extensive reviews of the substantial international literature on the effectiveness of different alcohol policy measures. The Strategic Task Force on Alcohol's *Interim Report* in 2002, and *Second Report* in 2004 (DoHC 2002; 2004), reviewed these policies in terms of their applicability to Ireland (Appendix A). In evaluating the evidence in their *Interim Report*, the STFA grouped the different kinds of alcohol control measures into four categories, based on degrees of effectiveness. The policy measures with high effectiveness or moderately strong effectiveness are those which act to regulate the market availability of alcohol beverages and drinking-driving countermeasures (Table 2.1). Alcohol policy measures for which the research evidence is still limited but shows some effect are banning advertising, well developed community mobilisation approaches and other availability measures such as server training. The policy measure for which there is considerable evidence of non-effectiveness on drinking behaviour and reduction of alcohol-related problems is alcohol education in schools. Other measures listed as having little evidence of any effect on drinking behaviour and alcohol-related problems include voluntary codes of bar practice, regulating the

content of alcohol advertisements, the provision of alcohol-free activities as alternatives and warning labels on alcohol containers (DoHC 2002: 17). The policies reviewed in this section of the literature are those which were deemed to have at least some effect on alcohol consumption.

Table 2.1: Alcohol policy effectiveness

Policy measure	Proven High effectiveness	Proved effectiveness	Some effect	No effect
Regulate physical availability	<ul style="list-style-type: none"> - Minimum drinking age - Alcohol control enforcement - Server liability 	<ul style="list-style-type: none"> - Limit hours & days of sales - Government run retail stores 	<ul style="list-style-type: none"> - Server training and tavern mgt policies - Limit number of sale outlets 	<ul style="list-style-type: none"> - Voluntary code of bar practice
Drink-driving countermeasures	<ul style="list-style-type: none"> - Lower BAL - Random breath testing - Immediate license suspension 	<ul style="list-style-type: none"> - Zero BAL for young drivers 		
Taxation		<ul style="list-style-type: none"> - Increased taxes 		
Alcohol promotions			<ul style="list-style-type: none"> - Banning advertising 	<ul style="list-style-type: none"> - Advertising content regulations - Warning labels
Community action approach			Community mobilisation	
Education & persuasion				<ul style="list-style-type: none"> - Alcohol education in schools
Promoting Alternatives				Alcohol-free activities

Source: Interim Report of the Strategic Task Force on Alcohol, 2002.

2.8.1 Regulate Availability

Regulating the physical availability of alcohol is one of the most effective policy measures that influence alcohol consumption and related harm. The research to support this premise is robust in terms of the quality and strength of evidence and it's effectiveness across cultures³. Babor et al. (2003), Kortteinen (1989) and Brady (2000) have shown that a reduction in the physical availability of alcohol is associated with reductions in both alcohol consumption and alcohol-related

³ See Kortteinen 1989; Edwards 1995; and Babor et al. 2003

problems. Lessening the physical availability can occur effectively through restrictions on the hours and days of sale and the number and type of alcohol outlets (Babor et al. 2003, 117 – 133). Highly effective measure such as restricting access to alcohol and enforcing server liability can be achieved by establishing a National ID card scheme for the entire population in such a manner that cards must be used for proof of age purposes in connection with the sale of alcohol, failure to ask for an ID would result in a set fine for the server (DoHC 2002: 19).

2.8.2 Drink-driving countermeasures

Babor et al. (2003: 158-65) document how drink-driving countermeasures consistently produce long-term population-wide reductions in alcohol-related problem of between 5% and 30%. However, in order to be effective such measures must be vigorously enforced and given a high public profile so that they are perceived to be vigorously enforced (Edwards 1994: 202-281). Babor et al. (2003) stress that the punishment that seems to have the most consistent impact on reducing levels of drink-driving is licence disqualification⁴. Furthermore, the closer the proximity of punishment to the drink-driving event, the less likely offenders are to re-offend. One method of ensuring this is administrative licence suspension for drink-driving. Administrative suspension allows licensing authorities to suspend licences without a court hearing, quickly and closer in time to the actual offence (Babor et al., 2003: 163). It is permitted in 40 of the 50 states the USA, and the impact on drink-driving accidents in these states has been consistently positive, with an average reduction of 5% in alcohol-involved crashed and a reduction of 26% in fatal crashes connected to administrative licensing revocation (Ross 1992; McKnight and Voas 2001). Miller et al. (1998), in a study on novice drivers, concluded that the benefit-to-cost ratio was \$11 per dollar invested when violators received a six month licence suspension.

Henstridge et al. (1997) have shown that random breath testing (RBT) is the most effective way to enforce compliance with the legal blood alcohol concentration (BAC). RBT allows law enforcers to breathalyse any driver they wish, and makes compliance compulsory. An alternative method of strengthening BAC compliance is to use selective checkpoints, where only motorists who are judged by police to be over the BAC limit are asked to take a breath test. Henstridge et al. (1997), in a time-series

⁴ See Peck et al. 1985; Ross 1992; Siskind 1996; McKnight and Voas 2001.

analysis of accidents in four Australian states, found that RBT was twice as effective as selective checkpoints. For example, in Queensland, RBT resulted in a 35% reduction in fatal accidents, compared to 15% for selective checkpoints. Henstridge et al. (1997) estimated that every time the daily testing rate increased by 1000, it corresponded to a decline of 6% in all serious accidents and 19% in single-vehicle night-time accidents. Moreover, analyses revealed a measurable effect on the whole population 10 years later. Sherman (1990) has further shown that motorists' compliance with the legal BAC was periodically boosted by recent exposure to RBT operations, the presence of which was remembered and acted upon up to 18 months later (Babor et al., 2003: 161).

Although the average BAC level in European Union (EU) countries is 50% mg or lower. Ireland has a BAC level of 80% mg, reduced from 100% mg in the Road Traffic Act of 1994. Subsequent statistics from the Garda National Traffic Division show that level drink-driving offences dropped to approximately 5,000 offences in 1995. However, a steady increase has been reported since then, as public perception of BAC enforcement dropped. In 2000 approximately 10,500 detections for drink driving were made by the Gardaí. The vast majority (93%) of detections were over the BAC legal limit and 62% of those were over twice the limit (Garda National Traffic Division, 1995; cited in Friel et al., 1999). The National Safety Council (2002) has estimated that alcohol is associated with at least 30% of all road accidents and 40% of all fatal accidents. At the current legal limit of 80mg/100ml a driver is six times more likely to have a collision. (Friel et al., 1999). Figures from the National Roads Authority (2001) show that one-third of road deaths occur between the hours of 9pm to 4am, the time period most associated with drink-driving. Furthermore, this figure has remained more or less constant since 1997 (DoHC, 2002). Random breath testing was introduced to Ireland in July 2006 and the Road Safety Authority (RSA) published figures in July 2007 showing that the number of deaths on Ireland's roads has decreased by almost 100 since the introduction of RBT. The number of people injured in crashes has decreased by 700 over the same period (RSA, July 2007). Thus, evidence suggests that setting a reasonably low BAC, undertaking a highly frequent and visible enforcement of this BAC limit, threatening and actually suspending driver privileges and establishing certainty of punishment especially through randomised enforcement are the factors most likely to form a drink-driving counterstrategy with the greatest potential for success. (Babor et al., 2003: 163)

2.8.3 Alcohol taxation

In *The effects of price on alcohol consumption and alcohol related problems* Chaloupka et al. (2002) clearly illustrate that consumption decreases when alcohol prices increase. Their study documents that the consumption levels of frequent and heavy drinkers, children and young adults are all influenced by alcohol price. A report from the Academy of Medical Science (AMS, 2004) outlines how the decline in the relative cost of alcohol over the last 30 years in the UK has corresponded to an increase in alcohol consumption. Chaloupka et al. (2002) and Babor et al. (2003) detail how raising alcohol taxes can lead to a reduction in many alcohol related problems such as drinking and driving, alcohol-related violence and other crimes. The AMS (2004) have calculated that a 10% increase in alcohol taxes in the UK would reduce alcohol-related mortality by up to 37% (DoHC, 2004). However, Conniffe and McCoy (1993) have demonstrated that levels of alcohol consumption are very resistant to increases in price, and the price increase needs to be quite steep in order to be effective. Furthermore, they argue that there are large cross-over price effects from increasing the price of only certain types of alcohol. Thus, if spirits rise in price, another drink will be substituted by consumers unless its price has also rise. Yet if all prices are raised to prevent substitution occurring the overall drop in consumption is modest. The authors suggest that a 10% rise would produce only a four per cent fall in consumption, assuming other factors, including income, remained unchanged (Conniffe and McCoy, 1993: 3).

The *Strategic Task Force on Alcohol's Second Report* (SFTA; DoHC, 2004) shows that an increase in excise duty on alcohol in Ireland has a direct effect on consumption. In December 2001, excise duty on cider was increased from 44.48 per hectolitre (p.h.l) to 83.25 p.h.l to bring it into line with the with excise duty on beer. In December 2002, excise duties on spirits and alcopops were increased, from 27.61 p.h.l. and 19.87 p.h.l. respectively, to a uniform spirits-based rate of 39.25 p.h.l. Following the increase in excise duty, the alcohol sales figures for both cider and spirits significantly decreased, demonstrating that alcohol taxes can have an influence on alcohol consumption in Ireland. A comparison of alcohol sales figures for 2001 and 2002 shows that cider sales significantly decreased (-11.3%). A comparison of sales figures for 2002 and 2003 shows that following the tax increase on spirit products, spirit sales sharply decreased (-20.1%). However, the recovery of cider sales in 2003 demonstrates that the effect of increases in alcohol taxes can be short-lived. Therefore, to sustain a reduction in overall consumption and related

harm, it is necessary that taxes on alcohol products continue to increase (DoHC, 2004: 21-22). This finding is reinforced by Conniffe and McCoy (1993) who suggest that alcohol is income elastic but price inelastic. Thus, economic prosperity leads to an increase in alcohol consumption, and as suggested earlier, an extremely high increase in alcohol taxation is needed to curtail consumption levels. (DoHC, 2004: 30).

2.8.4 Control promotion of alcohol

The WHO published a report in 2003 demonstrating that alcohol marketing affects social norms about drinking throughout society. Duffy (1995) conducted a UK study testing six econometric models of potential linkages between alcohol advertising and expenditure on alcohol using quarterly 1963-1992 industry expenditures on television, radio and print advertising. He found small or statistically non-significant impacts on the sales of wine and spirits and negative results for beer. However, a US study comparing data from different states with different policies on non-broadcasting advertising showed that beer consumption was increased by outdoor price advertising (Ornstein and Hanssens, 1985).

A further body of research has focused on responses to advertising by young people. Babor et al. (2003: 183) argue that young people are influenced by exposure to repeated high-level alcohol promotions, which inculcate pro-drinking attitudes and increases the likelihood of heavier drinking. Synder and Blood (1992) document how teenage students rate alcohol as more beneficial and less risky after repeated exposure to magazine alcohol advertisements. Slater and Domenech (1995) and Slater et al., (1995) found that college students rated the benefits of beer more highly after viewing televised beer adverts. In Ireland, research by Dring and Hope (2001) showed that children were strongly attracted alcohol advertising and that young people believed that advertisements were targeted at their age group.

More recent research reports that alcohol sports sponsorship has an effect similar to alcohol advertising (DoHC, 2004: 31). The effectiveness of linking masculinity, alcohol and sports was demonstrated in an US study in which male teenagers consistently preferred televised beer advertisements with sport content, and correlations were found between liking these advertisements, levels of drinking and future drinking intentions (Slater et al. 1996: 1997). Sports sponsorship serves to

embed alcohol products into the everyday activities of the consumer, through title name, sports results, commentary and discussions of the sporting events, which in turn taps into and reinforces cultural identity (DoHC, 2004: 31).

2.8.5 Community mobilisation

The STFA (2002, 2004) document that there is a substantial body of scientific evidence from the USA, Australia, New Zealand, and Finland that a community policy approach, with several measures interlinked to work effectively together, can reduce alcohol problems. However, sustaining the gains beyond the initial project time scale remains a challenge. Community mobilisation is an approach that aims to increase public awareness of the particular alcohol problem in a community and to gain public support for policies directed at preventing or reducing the problem. However, when compared to community mobilisation initiatives for drugs, alcohol mobilisation projects are in some way artificial, they have to be created and sustained by government initiatives and do not attract the same level of community interest. In Ireland two different government-initiated community projects have been undertaken, one explored the effectiveness of a community alcohol awareness project and the second developed a community strategy response to the STFA 2002 Report (see Box 2.1) (DoHC, 2004: 32).

Box 2.1: Community mobilisation - Examples from Ireland

The North West Alcohol Forum (NWAFF)

The Alcohol Forum was set-up in response to the STFA Interim Report 2002. The community in the North West, led by the North Western Health Board, brought together representatives to form a multi-agency community initiative. The overall aim was to produce recommendations that would prevent and reduce alcohol related problems in the North West. The first task of the NWAFF was to identify and assemble information to inform the decision making process. A second task running parallel was to consult with key groups in the community who have first hand experience dealing with alcohol issues in the course of their work. The third task, based on information and consultation was to draw up a set of recommendations for the North West. The product of their work is the publication of the NWAFF Report, with recommendations for immediate action to prevent and reduce alcohol problems in the North West.

Community Alcohol Awareness Project (CAAP)

The South Western Area Health Board developed a pilot community initiative to explore the effectiveness of an alcohol awareness project with a local

community. The community chosen was a typical growing community within a commute of Dublin with a population of 3,200 people. A full-time community health co-ordinator was assigned from the Health Board and was based in the town centre. A number of interventions were implemented including training with front line staff, a free confidential help line, Responsible Serving of Alcohol (RSA) training for bar staff, media workshop with transition students, public debate, art competition for primary children, promotional materials with the LESS IS MORE campaign message, open evening for local clubs and groups and a slide presentation at a local fashion show. The evaluation reported that the training of the front line staff was seen as beneficial to the participants' work and also provided the opportunity to form links between disciplines working at the front line interface of alcohol problems. In the community there was a high level of awareness of the project's events and young adults in the community identified moderation as the message associated with the slogan LESS IS MORE. However the time-scale of the pilot project was very short (approx five months), and was insufficient for sustained change.

Source: Strategic Task Force on Alcohol Second Report (2004)

The community mobilisation approach in other countries have been successful in curtailing drinking and alcohol-related problems (Hingson et al. 1996, Holder et al. 200, Wagner et al. 2000) and in creating awareness and support for alcohol policies which reduce high-risk drinking (Homila, 1997), drink-driving (Honston et al. 1996; Voas et al. 1997) and underage drinking (Holder et al. 1997; Wagenaar et al. 1996). Babor et al. (2002, 200) suggest that while there is evidence of a link between education-orientated community projects and a reduction in alcohol-related problems, it is likely that, even with adequate resources, strategies that try to use only education to prevent alcohol-related harm are unlikely to deliver large or sustained benefits due to their inability to counteract other forces that pervade the environment.

2.9 Conclusion

The literature reviewed here has shown how alcohol has occupied a contentious place in society for centuries, and how our understanding of alcohol has evolved from a moralistic perspective to an evidence-based one. Furthermore, it shows how empirical research over the past forty years has generally discredited the notion of 'alcoholism' as a discrete disease primarily attributable to individual predisposition, and has replaced it with a public health model which links increases in population consumption with increases in the prevalence of a range of health and social problems. However, this research has also made it clear that policy measures which are effective from a public health perspective - in particular, price increases,

restrictions on public access to alcohol retail outlets, and limits to the advertising and promotion of alcohol - are precisely those measures least likely to be electorally popular; given the culture of consumer sovereignty⁵ in which we live. It would, therefore, be naive to suppose that the research / policy interface is uncomplicated, with policy makers rushing to implement 'evidence-based' policy in this sphere.

⁵ The doctrine of consumer sovereignty can be used in two neoliberal senses: one descriptive, the other normative. In its descriptive sense it simply signifies that the consumer is in fact the ultimate monarch: production in a market economy is ultimately oriented toward meeting the wants of consumers. Production is the means; consumption the end and market performance is responsive to consumer demands. In its normative sense the doctrine of consumer sovereignty asserts that the performance of an economy should be evaluated in terms of the degree to which it fulfils the wants of consumers. Different institutional systems, and even different market structures under a market system, fulfil these wants in different degree (Rothenberg, 1962: 269).

3 Methodology

The design of this study on the alcohol policy research interface originates from a within-nation comparative approach. The nature of the research design was exploratory and the data utilised was from secondary sources. The method of data collection was face-to-face interviews, postal surveys, database searches, peer-reviewed articles, media content and national and regional reports.

3.1 Research objectives

The aim of this study was to explore the interface between research on alcohol consumption and public policy in Ireland. Thus, the researcher wished to document trends in alcohol consumption in an increasingly affluent Ireland, in order to determine what factors are consistently related to high levels of alcohol consumption and, given this data, to discover whether an effective interface exists between what alcohol research recommends is done to reduce these levels and the measures actually introduced through alcohol policy.

Objective 1: To explore the nature of alcohol consumption in Ireland and determine what changes have occurred since the emergence of greater economic prosperity.

Objective 2: To examine the nature of the interface between alcohol research and alcohol policy.

Objective 3: To examine the National Drugs Strategy in terms of its strategic management structures and to determine whether alcohol can be effectively included.

Various sources of information were drawn upon to investigate the above objectives. Secondary analysis was performed on datasets generated by Eurobarometer and the Centre for Health Promotion Studies in National University of Ireland (NUI) Galway. Information was also obtained from published national and regional reports and peer reviewed literature on data relating to the alcohol-control measures and policy-making processes. Details of the data sources are referred to under each research question heading below (Friel and Conlon, 2004: 30)

3.2 Overall research design

Burns and Grove (1997:49) argue that research design is a blueprint for the conduct of a study that maximizes control over factors that could interfere with the study's desired outcome and Yin (2003: 19) suggests that it is the logic that links the data to be collected and the conclusions to be drawn to the initial questions of the study. Research design refers to the planning of scientific inquiry – designing a strategy to determine the answer to a set of objectives. Thus, it is highly useful to bring together a careful early inventory of resources, problems and the sources of the data which may be utilised to obtain the answers to the research objectives (Wiersma, 1991: 81). In other words, when designing research we need to ask: given this research objective, what type of evidence is needed to answer the questions it poses in a convincing way? (De Vaus, 2001:9).

Taking the above questions into consideration, an exploratory research design was employed by the researcher to investigate the topic under study and the research was designed around the research objectives outlined in section 3.1. Each objective was broken down into a set of questions in order to document and clarify the encased issues. This formula facilitated the formation of an approach which could best deal with the decision-making around research design and delivery (McGarry, 2004: 27).

3.3 Objective 1

To explore the nature of alcohol consumption in Ireland and determine what changes have occurred since the emergence of greater economic prosperity

3.3.1 Nature of the research enquiry

The researcher wished to undertake an analysis of the changing patterns of alcohol consumption in Ireland in order to ascertain whether Irish alcohol consumption levels have been affected by greater economic prosperity, and if this has been the case, to discover what demographical variables are most related to the increase in consumption, and what the implications of such an increase are for alcohol policy.

Objective 1 was broken down into a set of manageable questions that aimed to direct the nature of the research enquiry. The questions identified were as follows;

- What were levels of alcohol consumption in Ireland like before the economic boom of the mid-1990s?
- What were levels of alcohol consumption like after a few years of economic prosperity?
- What are levels of alcohol consumption like in twenty-first century Ireland, after a decade of economic prosperity?
- What factors are consistently significantly related to alcohol consumption levels throughout the period in question?

3.3.2 Research design for Objective 1

In order to answer the questions posed by Objective 1, secondary data analysis of at least three different quantitative datasets was required. Hyman (1972) defines secondary analysis as 'the extraction of knowledge on topics other than those which were the focus of the original surveys'. Johnson and Sabourin (2001) suggest that, in essence, secondary data analysis is a process that creates a whole which is greater than the sum of the parts, and furthermore, it can only be considered as such if it analyses the data from a different perspective than the original analysis, as it thus creates an opportunity both for further discovery and for a deeper understanding of the interpretations of the data (Dale et al., 1988).

There are several advantages to using secondary quantitative data analysis, and specifically to employing secondary analysis of national surveys, to answer the research questions listed above. They include:

- *Knowledge accumulation*: secondary analysis allows the reusing of a group of data and hypotheses in order to subject them to new interrogation.
- *External applicability of results*: the datasets have already been tested to ensure sample results can be generalised to the national population.
- *Coverage of population*: national studies have extensive resources to ensure adequate sampling and harmonisation of data collection.
- *Reliability and validity*: national surveys are vigorously tested to ensure the reliability and validity of the data.

- *Temporal within-nation comparisons*: undertaking secondary quantitative data analysis will allow statistical comparisons to be carried out between pre-Celtic Tiger, mid-Celtic Tiger and post-millennium alcohol consumption levels in the Irish populace (Valente, 2004: 11-12).

Thus, these issues are best explored through quantitative research conducted using existing datasets. The researcher selected the 1992 Eurobarometer 37.01 survey and the 1998 and 2002 Surveys of Lifestyle and National Health (SLÁN) as the most appropriate datasets on which to conduct the secondary analysis necessary to answer the questions posed by Objective 1.

3.3.3 Eurobarometer 37.01 procedures

The Eurobarometer 37.01 merges the responses to identical questions from the two waves of Eurobarometer surveys, *Eurobarometer 37.0: Awareness and importance of Maastricht and the future of the European Community, March-April 1992* and *Eurobarometer 37.1: Consumer goods and social security, April-May 1992*. These surveys queried respondents on standard Eurobarometer measures such as public awareness of, and attitudes towards, the Common Market and the European Community (EC), and also focused on alcohol and drug use. Demographic and other background information was also gathered on respondents.

Eurobarometer 37.0 and 37.1 covered the population of the respective nationalities, aged 15 years and over, in each of the EC Member States. The basic sample design applied to all member states was a multi-stage, random (probability) one. In each EC country a number of random sampling points were selected, with probability proportional to the population size and to population density. In the Republic of Ireland the electoral register was used to provide the sampling points. These primary sampling units (PSU) were selected from each of the administrative regions in every country according to the EUROSTAT NUTS II⁶ and according to the distribution of the national, resident population in terms of metropolitan, urban and rural areas. A starting address was drawn at random in each of the selected sampling points and further addresses were selected as every Nth address from initial address by standard random route procedures. In each household, the respondents were drawn at random. All interviews were conducted face-to-face in people's homes in the

⁶ EUROSTAT Nomenclature of Territorial Units for Statistics with multiple levels of codes, level 2.

appropriate national language. Up to two recalls were made to obtain an interview with the selected respondent and no more than one interview was conducted in each household. The firm responsible for carrying out the Irish Eurobarometer 37.0 and 37.1 surveys was Lansdowne Market Research and interviews were conducted between 21 March and 11 April 2004 and between 21 April and 12 May 2004 respectively. The total valid sample of interviews included in Eurobarometer 37.01 from the 37.0 and 37.1 datasets was N = 1001 (100%) for Eurobarometer 37.0 and N = 1000 (95.9%) in Eurobarometer 37.1. Data entry was carried out by INRA (EUROPE).

3.3.4 SLÁN procedures

The National Health and Lifestyle Survey was first undertaken in 1998 and repeated again in the summer of 2002. In both rounds a representative cross-section of the Irish adult population was surveyed, using a sample powerful enough to detect summary differences at a national level, according to socio-economic status and key lifestyle variables such as exercise, alcohol and drug intake and diet. Allowances were made for non-response and the likelihood of inability to participate.

The sampling procedure followed on both occasions was the same. A national postal sample was generated randomly from the Irish electoral register supplied by Precision Marketing Information (PMI) Ltd, a subsidiary of An Post. The sample thus generated was then distributed proportionately, based on health board population size and urban rural breakdowns so that each county of the Republic of Ireland was represented. Final selection was made at a district electoral division level. The self-completed questionnaires were posted from the National University of Ireland (NUI), Galway with freepost return envelopes enclosed. Following a reminder letter and further reminder questionnaires, all remaining non-respondents were contacted by telephone where possible, or by trained fieldworkers calling to the person's home to collect the questionnaires. A helpline to deal with general queries on questionnaire completion was set up in NUI, Galway and respondents were entered into a prize draw unless they stated otherwise. Excluding those not eligible (that is deceased or confirmed at the follow-up stage to be unavailable at that address), the total valid sample of questionnaires was 11,212 in 2002 and 12,722 in 1998. A national response of 6539 (62%) and 5992 (53.4%) was obtained respectively in 1998 and 2002. Data entry was carried out by RES Ltd.

3.3.5 General secondary analysis procedures

The objective in undertaking this ten year comparative analysis was to establish the patterns of alcohol consumed that emerged from all three surveys according to statistically significant demographic variables. Data for those who consumed at least one unit per week was used to define the alcohol-consuming populations, and was inputted as the dependent variable for all decadal consumption trends. Thus, respondents who consumed at least one unit of alcohol a week represented 58.9% (N = 1179), 52.9% (N = 3462) and 48.4% (N = 2899) respectively of the three sample populations. Analysis by age, gender, relationship status, homeownership, religiosity, location, employment status and type of alcohol drink consumed were performed against weekly alcohol intake and comparisons were made between the 1992, 1998 and 2002 alcohol consumption levels. Variables relating to income and binge drinking were only available in the 2002 datasets, and comparisons between the two variables were conducted for that year. The valid response rate, excluding missing values, was used for each question.

The age, gender and location analyses were performed to ascertain what demographical and geographical portion of the population consumed the most alcohol per week, and given this, what portion has seen the greatest increase since the onset of the Celtic Tiger. Furthermore, the researcher wished to discover whether these increases are consistent across several years of economic prosperity, or in other words, did an increase occur between 1998 and 2002 as well as between the pre-Celtic Tiger 1992 and the economically vibrant 1998? Analyses were performed on relationship status and religiosity to discover whether variables relating to lifestyle and personal circumstances affect the level of alcohol an individual drinks. Analyses were conducted on employment status and income to ascertain whether respondents' economic situation affects the amount of alcohol they drink. An analysis was also conducted on the changing trends in type of alcohol consumed during the ten year period.

3.3.6 Statistical methodology

Means comparison tables were used to compare the yearly levels of weekly alcohol consumption across the different statistically significant variables' subgroups. The number, mean and standard error of mean of the variable subgroups are reported.

The range of values within which the mean lies is reported for each subgroup, and if an overlap of values occurs across the years, then no significant increase/decrease in consumption has occurred. Similarly, if no overlap occurs across the years, then a significant increase/decrease has occurred. The formula for the mean range is:

$$(Mean - Standard Error of Mean) \text{ to } (Mean + Standard Error of Mean) = \\ \text{Range of values within which mean lies.}$$

Thus, reporting the mean in this fashion will ensure that any increase observed in consumption levels between the survey years is not due to random error within the sample and it will thus allow comparisons of weekly level of alcohol consumption to be made across time between the methodologically different Eurobarometer and SLÁN datasets. Independent t-tests were used to formally test for the presence of a significant relationship when the independent variable has less than three categories. Eta squared (η^2) was the measure of association used to determine the strength of the significance.

Welch's test was used to formally test for significance when the independent variable contained three or more subgroups. ANOVA tests could not be performed due to the presence of heterogeneity in all three samples, with the 1998 dataset reporting the most consistent level of heterogeneity. Welch's test employs a more robust measurement of variance based on least squared statistics and can thus be safely used to deal with heteroscedasticity in a sample with a moderate or large number of respondents. Tamhane 2 post-hoc tests were subsequently used to test significance between subgroups.

A chi squared (χ^2) test was used to formally test for significance between the categorical variables income level and frequency of binge-drinking episodes. To investigate the source of any difference in the chi squared test, standardised residuals are reported. Residuals were calculated by subtracting the value predicted by the regression equation for each case from the observed value of the dependent variable. Standardised residuals are the residual divided by an estimate divided by an estimate of its standard error. Standardised residuals have a mean of 0 and a standard deviation (SD) of 1 (Altman, 1991). The alpha level was set at .05 for all significance tests ($\alpha = 5\%$).

3.3.7 Definitions for analysing alcohol consumption

Measurement of consumption: In this study the quantity-frequency index was used to measure alcohol consumption. With this measure, respondents estimate how often they drink and how much they drink on a typical drinking occasion (Bloomfield et al., 2003: 97-98).

Binge-drinking: The SLÁN 2002 survey defined binge-drinking as consuming six or more drinks on one drinking occasion.

Abstainers: Abstention was defined as never drinking beyond sips or not drinking at all.

Current drinker: A person who consumed at least one unit of alcohol in an average week.

One unit of alcohol: One unit of alcohol equals 10ml pure ethanol.

3.3 Objective 2 and Objective 3

Objective 2: *To examine the nature of the interface between alcohol research and alcohol policy.*

Objective 3: *To examine the National Drugs Strategy in terms of its strategic management structures and to determine whether alcohol can be effectively included*

3.4.1 Nature of the research enquiry

The above research objectives have been formulated with the aim of providing mechanisms to investigate whether ‘the findings really talk for themselves’ in alcohol

research/policy interface process. To this end, the second and third objectives of this study are taken together to form one important methodological research inquiry which will undertake a literary exploration of alcohol and drugs research and policy-making in an Irish context. In order to simplify the research process both objectives were broken down into their component questions.

Objective 2 was broken down in the following set of research questions:

- What processes are involved in the development of public policy?
- What institutions are involved in the process of public policy making?
- Is policy-making an evidence-based process?
- Who are the main stakeholders in alcohol policy-making?
- What input do health promotionists have in the policy-making process?
- What policy-making processes currently exist in Ireland?
- Where do we stand in regards to the implementation of the National Alcohol Policy?
- Does an interface exist between alcohol research and alcohol policy?

Objective 3 is classified according to the following research questions:

- Why did the National Drugs Strategy (NDS) flourish where the National Alcohol Policy failed?
- What institutions compromise the NDS?
- What are the aims and objectives of the NDS?
- What strategic management structures are present in the NDS?
- Does an effective drugs policy/research interface exist in the NDS?
- Is it possible to include alcohol in the NDS?
- If so, should alcohol be included in the NDS?

3.4.2 Research design of Objective 2 and Objective 3

The nature of the research questions posed above is such that descriptive research is most evidently required to define the issues involved. The most appropriate method for this research is secondary research and thus necessitated the review and analysis of documents relating to public policy formation in general, and alcohol policy formation in particular, to the formation of health promotion research recommendations and to the creation, structuring and policy processes involved in the National Drugs Strategy (Mc Garry 2004: 29). Peer-reviewed literature, regional

and national policy documents and media articles were examined during this review process.

3.4.3 Sources of data and method of data collection

The relevant data was sourced from reviewed literature and previous research on:

- Public health alcohol-control recommendations
- Alcohol policy documents
- National Drugs Strategy publications

A systematic search of the relevant internet and library databases was carried out using the above topical key words to determine what literature was available. Journal articles were the major source of information and the journals most frequently used in this study were the Journal of Addiction, British Medical Journal, Journal of Substance Use and Journal of Studies on Alcohol. At the outset, sifting through the multitude of information helped to identify the specific issues relevant to this research and guided the formulation of the research questions as set out earlier, while later utilisation of these resources proved invaluable in providing answers to the research questions (McGarry, 2004: 34).

3.5 Limitations of the research

As with all research, conducting a secondary analysis of existing datasets has many limitations to be managed as precisely as possible. The availability of existing datasets with large samples is balanced by the compromise of a predetermined and fixed population sample with surrogate measures that only approximate the study concepts. However, (Young, 2000: 3) suggests that these limitations can be somewhat negated by ensuring thorough familiarity with the datasets, as this allows the researcher to select appropriate proxy measures for his or her study concepts and helps the researcher avoid the temptation to measure concepts not well represented in the data. Thus, the scope of research that could be carried out on alcohol consumption between the period 1992 and 2002 was limited to only a few variables, given that the datasets used to answer Objective 1 were not specifically designed to measure alcohol consumption levels against key demographic characteristics. Furthermore, questions were not uniform across the datasets and different measurements were used in some of the variable. Thus 'rural' was defined

as an area with 1,999 residents or less by the Eurobarometer survey and as an area with 1,500 residents or less by the SLAN surveys. Level of education and geographical region were coded very differently by EUROBAROMETER and SLAN, but the former proved to be insignificantly related to alcohol consumption and the latter proved impossible to recode in a manner homogenous enough to allow effective comparisons to be made. The researcher has noted where such differences in measurement have occurred in Chapter four. Producing answers to Objective 1 has been a considerable task, involving detailed work on individual datasets and the production of several hundred pages of output for analysis, in addition to the time involved in cleaning multiple datasets and becoming familiar with their characteristics. Some variables and data had to be extensively manipulated in order to produce relevant findings. Furthermore, results may have been influenced by methodological differences such as sampling frame, item wording, and method and timing of data collection (Jolly et al., 2006: 6). The foremost way in which results may have been influenced is through the different methods of data collection. Eurobarometer 37.01 reported a much higher response rate than either of the SLAN surveys, as the survey was administered through face-to-face interviews and not postal surveys. Similarly a greater level of acquiescent bias may be present in the Eurobarometer results because the researcher was physically present.

3.6 Ethical considerations

Concerns about secondary use of data generally focus on the potential for harm to the individual subjects of the research and the lack of informed consent. Consent applies not only to a particular researcher, but also for an identified purpose. To quote Kalman (1994), 'the requirements to seek an individual's consent to participate and to provide data for a specific purpose must take precedence.' Since researchers are generally not able to predict potential requests for secondary use of data that they are collecting, they are unable to fully inform subjects of the primary research about potential future uses of data. As this full disclosure of information is one of the requirements of informed consent, it follows that it is not possible to get informed consent for unanticipated uses of data. Several writers have proposed solutions for negating the anticipated risks of secondary use of research data. A number of the solutions focus on the requirements for confidentiality from the secondary researcher. Clubb et al. (1985: 62) recommend 'a form of licensing or swearing in as a condition for access to data with the possibility of legal sanctions and penalties for breaches of

confidentiality'. The British Sociological Association recommends that researchers consider obtaining consent that at least 'covers the possibility of secondary analysis' (cited in Law, 2005: 8). A number of approaches to the original consent form have been proposed. In some cases the original consent form includes provision for secondary research, with the requirement that the secondary study receives approval from an ethics review committee. At the very least, this raises the question of potential secondary use in the minds of both the researcher and the subject, and allows respondents the opportunity to object should they wish (Law, 2005: 8-9). Both the Eurobarometer and SLÁN surveys included such a provision and ethical approval for the secondary analysis conducted in this study was granted by Trinity College Dublin's Ethics Committee and by the Irish Social Sciences Data Archive, which granted the researcher access to the surveys. While this may not strictly meet the requirement for informed consent, it demonstrates a commitment by the secondary analyst to be 'bound by the same confidentiality and privacy restrictions as the primary analysts' (Szabo and Strang, 1997: 7).

3.7 Conclusion

The methodology detailed above was chosen as the most appropriate to deal with the exploratory nature of the research enquiry. The research design facilitated the collection of relevant data to make the connection between the stated research objectives and research outcomes. There were a number of limitations to this study, in the form of the preset structure of the secondary quantitative analysis, as explained above. However, it was possible by carefully following the research design to undertake an exploration of alcohol consumption in an increasingly economic prosperous Ireland, of which a descriptive analysis will be presented in the following chapter, and to thus provide context for an inquiry into the nature of alcohol research and policy in Ireland (McGarry, 2004: 37).

4 Analysis of alcohol consumption levels in Ireland, 1992-2002

4.1 Introduction

Previous chapters provided the theoretical context and methodological framework for this study into the interface between alcohol policy and research. This chapter seeks to provide an understanding of the many factors involved in what health promotion policy seeks to reduce, namely the increase in alcohol consumption in Ireland. It shall attempt to do so by examining the demographical variables which are consistently significantly related to weekly levels of alcohol consumption, beginning in the pre-Celtic Tiger Ireland of 1992 and comparing these figures against the more economically vibrant 1998 and 2002. In conclusion, the question of what societal groups show the greatest increase in consumption is considered, along with the implications of what such an increase means for alcohol policy.

4.2 General distributions

The 37.01 Eurobarometer Survey had 1877 respondents aged 18 year or over, while the total number of respondents aged 18 or over in the SLÁN surveys was N = 6370 (SLÁN 1998) and N = 5931 (SLÁN 2002). Respondents who consume at least one unit of alcohol a week represented 61.2% of the population in 1992 (N = 1149, SD = 4.76), 53.7% in 19978 (N = 3418, SD= 15.41) and 48.6% in 2002 (N = 2885, SD = 13.37) and are therefore well represented for the purpose of secondary analysis. One unit of alcohol is calculated as a half pint/glass of beer, lager, stout or cider, a single measure of spirits or a single glass of wine, sherry, port or premixed drinks. Weekly alcohol consumption is measured as the amount of units of alcohol a respondent typically imbibes in one week and it is this measurement of alcohol consumption which will be used as the dependent variable in all decadal trend analysis. Abstainers represented 38.8% of the overall sample populations in 1992, 16.7% in 1998 and 16.1% in 2002, with 47.6% of women (N = 454) and 29.7% of men (N =274) abstaining in 1992, 19.1% of women (N = 622) and 13.9% of men (N = 400) abstaining in 1998, and in 2002 17.1% of women (N = 581) and 14.7% of men (N = 349) abstained from alcohol consumption.

The population distribution for Census 1991, Census 1996 and Census 2002 are presented for comparative purposes in Table 4.1. The distribution of the Eurobarometer population was similar to that of the 2002 Census. People aged between 15 and 24 were under represented and women aged 25-44 were over-represented in both SLÁN surveys, with the 2002 survey reporting the greatest difference in 15-24 year olds against the census numbers. Women aged 65 and over were also slightly over-represented in the 2002 SLÁN survey.

Table 4.1: Population distribution of Eurobarometer 37.01 1992, SLÁN 1998, SLÁN 2002, Census 1991, Census 1996 and Census 2002

Age group	CENSUS 91		EURO 92		CENSUS 96		SLÁN 98		CENSUS 02		SLÁN 02	
	M	F	M	F	M	F	M	F	M	F	M	F
18-24	17.4	15.9	18.6	16.4	17.2	15.8	17.9	16.1	15.9	15.3	10.6	10.1
25-34	20.9	20.7	20.9	20.8	20.3	19.9	18.8	23.1	21.3	20.9	14.1	18.4
35-44	20.0	19.0	19.5	19.1	19.5	19.0	22.0	23.9	19.3	19.1	24.1	28.0
45-54	15.0	13.9	16.1	15.5	10.3	15.7	15.6	11.6	16.7	16.2	19.7	17.5
55-64	11.8	11.5	10.5	12.5	11.7	11.1	16.3	9.4	13.8	11.8	12.3	9.3
65 +	14.9	18.9	14.3	15.8	14.6	18.5	15.4	15.9	13.0	16.7	19.2	16.8
Total	100	100	100	100	100	100	100	100	100	100	100	100

4.3 Are we a land divided: Do age, gender and location have an impact on consumption levels?

4.3.1 Age as a factor in alcohol consumption

Table 4.2 details the average level of alcohol consumed by the different age groups on a weekly basis. Overall, between 1992 and 2002 there was a significant increase in alcohol consumption, the mean range (M.R.) of values within which average weekly consumption figures lie rose from an average of between 6.87–7.15 units in 1992, to 13.44–13.9 units in 2002. Within the ten year period the greatest significant increase in consumption occurred between 1992 and 1998, with the amount of alcohol imbibed on a weekly basis nearly doubling from its 1992 levels to a mean range of 12.12–14.64 units in 1998.

There was a significant increase in mean consumption across all age groups between 1992 and 1998, with the greatest increase evident in those aged 15-24 years. The amount of alcohol drunk by this age group on a weekly basis more than doubled from a mean range of 7.84–8.48 units of alcohol per week in 1992 to 18.07–19.41 units of alcohol per week in 1998. The smallest increase in weekly alcohol intake occurred in those age 65 years and over, with a mean consumption of between 4.9–5.8 units in 1992 and between 9.85–11.09 units in 1998. However, this age was the only one to witness a significant, albeit small, increase in consumption levels between 1998 and 2002 (M.R. = 11.59–12.97). All other age groups in 2002 reported consuming a relatively similar amount of alcohol to the levels reported in 1998, with the exception of the 15-24 age group, which report a significant, although small, decrease in weekly consumption to a mean range of 16.31-17.97 units.

Table 4.2: Levels of alcohol consumption per week from 1992-2002 by age group

Age group	EURO 1992			SLÁN 1998			SLÁN 2002		
	N	Mean	S.E.M	N	Mean	S.E.M	N	Mean	S.E.M
18-24 yrs	250	8.16	.32	777	18.74	.67	391	17.14	.83
25-34 yrs	289	6.99	.27	808	14.12	.54	539	14.26	.64
35-44 yrs	247	7.08	.30	867	12.82	.45	837	11.98	.39
45-54 yrs	156	6.69	.36	424	12.96	.71	581	13.75	.54
55-64 yrs	100	6.47	.47	247	14.06	.89	252	13.75	.82
65 + yrs	107	5.22	.36	295	10.47	.62	285	12.28	.69
Total	1149	7.01	.14	3418	14.38	.26	2885	13.65	.25

Age proved to be a significant indicator of level of alcohol consumption. In 1992 [Welch (5, 445.43) = 7.57 $p < .001$], in 1998 [Welch (5, 1165.5) = 17.63, $p < .001$], in 2002 [Welch (5, 1044.05) = 7.66, $p < .001$]. Tamhane 2 post-hoc tests (Table 4.3) indicate that the most consistent significant differences arose between the weekly alcohol intake of those aged 18-24 years and 45-54 years, and of those aged 18-24 years and over 65 years. The greatest differences in weekly consumption arose between the 18-24 age group and the over 65 age group, with the mean differences between the groups rising significantly from a mean range of 2.23–3.17 units in 1992, to 7.35–9.19 units in 1998 and then decreasing significantly to 3.78–5.94 units in 2002.

Table 4.3: Significant differences between age groups in weekly consumption levels

Significant age groups		EURO 1992		SLÁN 1998		SLÁN 2002	
		M. D.	S.E.M	M.D.	S.E.M	M.D.	S.E.M
18-24 yrs	25-34	-----	-----	4.62*	.86	-----	-----
	35-44	-----	-----	5.92*	.81	5.16*	.92
	45-54	1.46	.49	5.76*	.98	3.40*	.99
	55-64	-----	-----	4.68*	1.12	-----	-----
	65 +	2.70*	.47	8.27*	.92	4.86*	1.08
25-34 yrs	35-44	-----	-----	-----	-----	2.28*	.75
65 + yrs	25-34	-1.76*	.46	-3.65*	.83	-----	-----
	35-44	-1.85*	.47	-2.35*	.77	-----	-----
	55-64	-----	-----	-3.59*	1.09	-----	-----

* The mean difference (M.D.) is significant at the .05 level.

4.3.2 The gender divide: Who drinks more?

The average weekly levels of alcohol consumed by men and women in each year are detailed in Table 4.4. Men imbibed the greatest amount of alcohol in all three years, with a mean consumption of 3.08 more units of alcohol per week than women in 1992, 7.22 units more in 1998, and 8.43 more in 2002. Male respondents' weekly consumption more than doubled over the ten years, from a mean range of 8.15–8.55 units in 1992 to 17.25–18.05 units in 1998 and then remaining relatively similar at a mean range of 17.67– 8.55 units in 2002. The level of alcohol consumed by women also rose significantly, nearly doubling from a mean of 5.11–5.43 units per week in 1992, to 10.3–10.73 units in 1998, and then dropping somewhat to a mean of 9.46–9.9 units in 2002.

Gender proved to be consistently significantly related to levels of weekly alcohol consumption. In 1992: [$t(1135.83) = 12.0, p < .001, \eta^2 = .11$], in 1998: [$t(3292.97) = 14.51, p < .001, \eta^2 = .06$] and in 2002: [$t(1985.74) = 17.20, p < .001, \eta^2 = .13$].

Table 4.4: Breakdown of weekly alcohol consumption by gender

Gender	EURO 1992			SLÁN 1998			SLÁN 2002		
	N	Mean	S.E.M	N	Mean	S.E.M	N	Mean	S.E.M
Male	649	8.35	.20	1868	17.65	.40	1353	18.11	.44
Female	500	5.27	.16	1550	10.43	.30	1531	9.68	.22
Total	1149	7.01	.14	3418	14.38	.26	2884	13.63	.25

4.3.3 If men drink more, what age group of men drinks the most?

Respondents' weekly levels of alcohol intake are broken down by age group and gender in Table 4.5., Men aged 18–24 years consistently drank the most alcohol in each of the survey years with an increase in consumption visible in each survey year, the greatest increase occurring between 1992 and 1998, with only a slight increase evident between 1998 and 2002. Thus, male respondents aged 18–24 years drank an average of 9.06–9.98 units of alcohol per week in 1992, 21.14–23.24 units in 1998 and 22.34–25.6 units per week in 2002. Men in the 25–34 age group reported the second highest level of alcohol intake across the ten years, with a significant increase in consumption evident between 1992 (M.R. = 8.53–9.37) and 1998 (M.R. = 17.83– 9.61), and levels remaining fairly stationary between 1998 and 2002 (M.R. = 18.86–21.36). Within their gender, men aged 55 years and older consumed the least amount of alcohol per week, with a mean range of 6.38–7.14 units in 1992, 13.49–14.93 units in 1998 and 15.36–16.92 units in 2002. However, men aged 55 and over witnessed the second highest rate of increase in consumption over the ten years, second only to men age 18-24.

Female respondents aged 18–24 years recorded the highest alcohol intake within their gender, with a considerable increase in consumption apparent between 1992 (M.R. = 6.23–7.03) and 1998 (M.R. = 13.44–14.94), and a slight decrease in consumption between 1998 and 2002 (M.R. = 11.39–12.51). It is worth noting that the weekly consumption levels of men and women aged 18-24 was above the recommended weekly limit 1998, with the same being true for men in 2002⁷. Over the ten year period women aged 55 years and older consistently reported the lowest

⁷ The medically recommended weekly alcohol intake is 14 units of alcohol for women and 21 units for men.

level of weekly alcohol consumption, consuming an average of 3.38–4.02 units per week in 1992, 7.47–8.69 units in 1998, 7.97–8.49 units in 2002.

Table 4.5: Weekly levels of alcohol consumption based on age and gender

Age groups by gender		EURO 1992			SLÁN 1998			SLÁN 2002		
		N	Mean	S.E.M	N	Mean	S.E.M	N	Mean	S.E.M
18-24 yrs	Male	132	9.52	.46	409	22.19	1.05	169	23.97	1.63
	Female	118	6.63	.40	368	14.19	.75	222	11.95	.56
Total		250	8.16	.32	777	18.74	.67	391	17.14	.83
25-34 yrs	Male	147	8.95	.42	386	18.72	.89	222	20.11	1.25
	Female	142	4.96	.26	422	9.92	.57	317	10.17	.53
Total		289	6.99	.28	808	14.12	.54	539	14.26	.64
35-44 yrs	Male	130	8.85	.46	448	16.55	.69	355	15.97	.73
	Female	117	5.11	.30	419	8.84	.51	482	9.04	.36
Total		247	7.08	.30	867	12.82	.45	837	11.98	.39
45-54 yrs	Male	96	7.56	.50	269	15.63	1.01	298	17.87	.86
	Female	60	5.30	.47	155	8.34	.68	283	9.04	.52
Total		156	6.69	.37	424	12.96	.71	581	13.75	.54
55 + yrs	Male	144	6.76	.38	356	14.21	.72	309	16.14	.78
	Female	63	3.70	.32	186	8.08	.61	227	8.49	.52
Total		207	5.83	.30	542	12.11	.54	536	12.90	.53

4.3.4 The urban/ rural divide: does it apply to alcohol consumption?

Table 4.6 represents the average level of alcohol consumed by urban and rural⁸ respondents. There is little difference between the two groups in each survey year, with those living in urban areas consistently consuming slightly more alcohol than their rural counterparts. Both groups consumed the greatest amount of alcohol in 1998 (Urban M.R. = 14.54–15.34; Rural M.R. = 13.17–13.93), with both urban and rural respondents consuming nearly twice as much as in 1992 (Urban M.R. = 7.14–7.54; Rural M.R. = 6.31–6.69) Consumption figures in 2002 for both urban and rural

⁸ It should be noted when examining the data in section 4.7 that the 1992 Eurobarometer survey defined a rural area as somewhere with 1,999 or less inhabitants, while the SLÁN surveys used the CSO definition of an area with 1,500 inhabitants or less.

dwellers were only slightly less than 1998 (Urban M.R. = 13.97–14.64; Rural M.R. = 12.59–13.27). The similar consumption levels reported by both groups in each year suggest that location has very little impact on weekly alcohol intake, an assumption which is born out by significance tests. While location proved to be a significant indicator of levels of alcohol consumption in all three years [1992: $t(1049.63) = -2.99$, $p = .003$; 1998: $t(3053.41) = -2.518$, $p = .012$; 2002: $t(2723.36) = -2.26$, $p = .008$], the variance explained in each year was less than 1%.

Table 4.6: Level of alcohol consumption in urban/ rural areas

Location	EURO 1992			SLÁN 1998			SLÁN 2002		
	N	Mean	S.E.	N	Mean	S.E.	N	Mean	S.E.
Urban	459	7.34	.20	1388	14.94	.40	1393	14.27	.37
Rural	720	6.50	.19	1345	13.55	.38	1353	12.93	.34
Total	1149	7.01	.14	2733	14.31	.27	2746	13.61	.25

4.4 Can personal affiliations explain levels of alcohol consumption?

4.4.1 Alcohol in land of saints and scholars: Is religion a factor in weekly alcohol intake?

As is apparent from Table 4.7 there is an inverse relationship between religiosity and weekly level of alcohol consumption. In both 1992 and 2002, those who professed to be unreligious or to not belong to a religion drank more alcohol than those who belonged to a religion. The weekly consumption levels of both religious and irreligious respondents rose significantly over the ten years between 1992 and 2002. Irreligious respondents had an average weekly alcohol intake of 8.22–8.76 units in 1992, increasing to 15.98–17.58 units in 2002. The consumption levels for those respondents who belonged to a religion rose from an average of between 6.14 and 6.44 units of alcohol per week in 1992, to between 12.91 and 13.43 units in 2002.

Table 4.7: Average levels of alcohol consumption for religious and non-religious respondents

EURO 1992				SLÁN 2002			
Are you religious	N	Mean	S.E.M	Do you belong to a religion	N	Mean	S.E.M
Yes	772	6.29	.15	Yes	2513	13.17	.26
No	377	8.49	.27	No	353	16.78	.80
Total	1149	7.01	.14	Total	2866	13.63	.25

4.4.2 Are the differences in religious and non-religious consumption levels age-related?

As can be seen from Table 4.8, the differences between non-religious and religious alcohol consumption extended across the age groups, with non-religious respondents of all ages drinking slightly more than their religious counterparts. Non-religious respondents aged 18-24 drank the greatest amount of alcohol in both of the survey years. Furthermore, this group witnessed the greatest increase in consumption between 1992 (M.R. = 8.62–9.66) and 2002 (M.R. = 18.58–23.08). Religious respondents aged 35-44 years saw the least increase in consumption levels, from an average weekly intake of 6.08–6.76 units of alcohol in 1992, to 11.19–11.99 units of alcohol in 2002. Non-religious respondents aged 45 years and over drank the least amount of alcohol in 1992 (M.R. = 5.48–5.98), while in 2002 religious respondents aged 35-44 had the lowest weekly alcohol intake.

Religiosity proved to be significantly related to weekly levels of alcohol consumption on both 1992 and 2002. In 1992 [$t(617.42) = -6.97, p < .001$] and in 2002 [$t(427.39) = -4.27, p < .001$]. Religiosity explained 7.3% of variance in weekly alcohol in 1992 and 4.2% in 2002.

Table 4.8: Male/ Female alcohol consumption classified by religiosity

Religiosity by age group		EURO 1992			SLÁN 2002		
		N	Mean	S.E.M	N	Mean	S.E.M
Religious	18-24	145	7.44	.40	323	16.11	.83
	25-34	184	6.13	.28	464	13.66	.68
	35-44	162	6.42	.34	731	11.59	.40
	45 +	281	5.73	.25	995	13.16	.40
Total		772	6.29	.15	2513	13.71	.26
Not Religious	18-24	105	9.14	.52	66	20.83	2.25
	25-34	105	8.50	.56	72	17.89	1.82
	35-44	85	8.33	.57	103	14.85	1.43
	45 +	82	7.82	.56	112	15.45	1.22
Total		377	8.49	.28	353	16.78	.80

4.4.3 Young, free and single: Are consumption levels related to relationship status?

Table 4.9 gives a breakdown of alcohol consumption by relationship status. In all three survey years, respondents who were not in a long-term relationship consumed a greater amount of alcohol. In 1992, those not in a serious relationship ($M = 7.77$) consumed an average of 1.3 units more alcohol per week than those in a committed relationship ($M = 6.47$). In 1998, married/cohabiting respondents ($M = 12.18$) consumed an average of 4.56 fewer units of alcohol per week than their unattached counterparts ($M = 16.74$), and in 2002 they consumed an average of 4.27 less units per week (Not cohabiting: $M = 11.98$; Married/cohabiting: $M = 16.25$).

Consumption levels for both groups increased greatly between 1992 and 1998, and remained relatively stationary between 1998 and 2002. The mean range for unmarried respondents rose significantly from a weekly average of 7.54–8.00 units of alcohol to 16.32–17.16 units between 1992 and 1998, with levels remaining fairly static in 2002, at an average range of 15.78–16.72 units of alcohol. Weekly consumption levels for married/cohabiting respondents also increased significantly between 1992 and 1998, from a mean range of 6.4–6.64 units of alcohol in 1992 to 11.87–12.49 units in 1998, and as was the case with unmarried respondents, 2002 consumption levels were similar to those reported in 1998, at an average of 11.71–12.25 units of alcohol.

Table 4.9: Breakdown of alcohol consumption by relationship status

Relationship Status	EURO 1992			SLÁN 1998			SLÁN 2002		
	N	Mean	S.E.M	N	Mean	S.E.M	N	Mean	S.E.M
Married/ Cohabiting	672	6.47	.17	1787	12.18	.31	1738	11.98	.27
Not Married/ Cohabiting	507	7.77	.23	1624	16.74	.42	1133	16.25	.47
Total	1149	7.01	.14	3411	14.35	.26	2871	13.66	.25

Whether a respondent was in a long-term relationship or not was significantly related to weekly consumption levels in every survey year. In 1992 [$t(997.52) = -4.46, p < .001$], in 1998 [$t(3032.82) = -8.68, p < .001$], in 2002 [$t(1840.11) = -7.85, p < .001$]. However the variables proved to be only weakly correlated, with the amount of variance explained relatively similar for all three years, in 1992 and 1998 [$\eta^2 = .02$], and in 2002 [$\eta^2 = .03$].

4.5 Employment and income: Do they influence consumption levels?

4.5.1 Is employment status related to alcohol intake?

Respondents who gave details on both their employment status and alcohol consumption levels represented 52.3% (1992: $N = 982$, $SD = 4.85$), 46.3% (1998: $N = 2952$, $SD = 15.28$) and 43.2% (2002: $N = 2561$, $SD = 13.28$) respectively of the three samples. Table 4.10 details the decadal trends in alcohol consumption for homemaking, unemployed, retired and employed respondents. Consumption levels increased significantly in the ten year span, commencing at a weekly average of 6.82–7.12 units of alcohol in 1992, and nearly doubling to an average of 13.93–14.49 units in 1998, with 2002 witnessing a minor reduction to 13.26–13.78 units of alcohol per week. Unemployed people consistently drank the most alcohol in each of the survey years, with an average weekly alcohol intake of 8.51–9.51 units in 1992, 14.27–16.03 units in 1998, and 15.66–17.86 units in 2002. Employed people reported the greatest significant increase in consumption between 1992 ($M.R. = 7.31$ – 7.87) and 1998 ($M.R. = 14.92$ – 15.62), with a notable, albeit slight reduction

occurring in 2002 (M.R. = 13.52–14.16). Retired people were the only group to report a consistently significant increase in consumption levels across the ten years, consuming an average of 6.31–7.05 units of alcohol per week in 1992, rising to 11.01–12.65 units in 1998 and increasing slightly but significantly to 12.68–14.2 units of alcohol in 2002. Homemakers reported the lowest level of alcohol intake in every year surveyed, although their consumption levels did increase greatly between 1992 (M.R. = 4.45–4.85) and 1998 (M.R. = 8.77–9.99), while figures remained fairly static for 2002 (M.R. = 8.82–10.02).

Table 4.10: Levels of alcohol consumption categorised by employment status

Employment status	EURO 1992			SLÁN 1998			SLÁN 2002		
	N	Mean	S.E.M	N	Mean	S.E.M	N	Mean	S.E.M
Homemaker	220	4.65	.20	381	9.38	.61	286	9.42	.60
Unemployed	125	9.01	.50	315	15.15	.88	196	16.76	1.10
Retired	156	6.68	.37	248	11.83	.82	265	13.44	.76
Employed	481	7.59	.28	2952	15.27	.35	1814	13.84	.32
Total	982	6.97	.15	2952	14.21	.28	2561	13.53	.26

Employment status proved to be a significant indicator of level of alcohol consumption. In 1992 [Welch (3, 354.38) = 43.36, $p < .001$], in 1998 [Welch (3, 661.02) = 26.14, $p < .001$] and in 2002 [Welch (3, 498.82) = 18.42, $p < .001$]. Tamhane 2 post-hoc tests (Table 4.11) indicate that the most consistent significant differences arose between homemakers and unemployed respondents, and between homemakers and employed respondents. The greatest significant difference in consumption levels arose between homemakers and unemployed people, with unemployed respondents drinking an average of 3.81–4.89 more units of alcohol a week in 1992, 4.70–6.84 units more in 1998 and 6.09–8.59 units more in 2002. In 1992 employed respondents imbibed an average of 2.64–3.24 more units than homemakers; in 1998 the difference increased to between 5.2 and 6.6 more units, and in 2002 it fell slightly to a difference of 3.75–5.09 more units. 1998 was the only year in which a significant difference occurred in the average weekly alcohol intake of retired and employed respondents, with employed respondents consuming an average of 2.56–4.34 more units of alcohol per week than retired respondents.

Table 4.11: Significant differences in alcohol consumption levels by employment status

Significant groups		EURO 1992		SLÁN 1998		SLÁN 2002	
		M. D.	S.E.M	M.D.	S.E.M	M.D.	S.E.M
Homemaker	Unemployed	-4.35*	.54	-5.77*	1.07	-7.34*	1.25
	Retired	-2.03*	.43	-----	-----	-4.01*	.97
	Employed	-2.94*	.30	-5.90*	.70	-4.42*	.67
Retired	Unemployed	-2.30	.63	-3.32*	1.20	-----	-----
	Employed	-----	-----	-3.45*	.89	-----	-----

* The mean difference (M.D.) is significant at the .05 level

4.5.2 Does how much you earn affect how much you drink?

Respondents' income details were only available for 2002, so no decadal comparisons are possible. A total of 2,618 (43.6%) gave information regarding their weekly salaries and average weekly alcohol intake. No significant relationship was found to exist between weekly alcohol intake and income. However, a variable measuring binge-drinking was incorporated into the 2002 SLÁN survey, and significance was found to exist between frequency of binge-drinking, measured as the consumption of six or more drinks in one sitting, and income [$N = 3710$; $\chi^2(18) = 41.27$, $p = .001$]. The relationship between income and frequency of binge-drinking proved to be fairly strong [Cramer's $V = .06$, $p < .001$]. From examining the standardised residuals in Table 4.12, one can see considerable departures from the expected frequency in several of the income bands. Those earning €189 or less per week were slightly over represented in the 'two or more times a week' category, and under-represented in the 'one to three times a month' category. Respondents who earned €190–€319 per week were notably over-represented in the 'less than once a month category' and under-represented in the 'two or more times a week category' and the 'once a week' category. Respondents on a weekly salary of €450–€639 were over-represented in the 'once a week category', while those earning €640–€949 were notably under-represented in the 'once a week' category and over-represented in the 'one to three times month category' and the 'less the once a month' category. Respondents earning a weekly salary of €950–€1269 were over-represented in the 'one to three times a month' category and notably under-represented in the 'less than one a month' category, while those earning €1270 or above were overrepresented in the 'more than twice a week' category and slightly under-represented in the 'once a week' category. Therefore, it can be postulated that the most frequent binge-drinkers

were those who earned the least and those who earned the most, while respondents earning €640–€1269 binge-drank infrequently and those on a weekly salary of €320–€449 binge-drink the least frequently.

Table 4.12 Household net weekly income* how often respondent drinks six drinks or more

Household net weekly income		REGULARITY OF DRINKING 6 DRINKS OR MORE				Total
		2+TIMES A WK	ONCE A WEEK	1-3 TIMES A MONTH	< MONTHLY	
Under 190	Count	78	87	65	180	410
	Column %	12.8%	10.0%	9.3%	11.8%	11.1%
	Std. residual	1.3	-.9	-1.4	.8	
190 - 319	Count	79	121	106	288	594
	Column %	13.0%	14.0%	15.2%	18.8%	16.0%
	Std. residual	-1.9	-1.5	-.5	2.7	
320 - 449	Count	94	151	103	246	594
	Column %	15.5%	17.4%	14.8%	16.1%	16.0%
	Std. residual	-.4	1.0	-.8	.0	
450 - 640	Count	121	209	137	319	786
	Column %	19.9%	24.1%	19.7%	20.8%	21.2%
	Std. residual	-.7	1.8	-.9	-.3	
640 - 949	Count	105	145	140	241	631
	Column %	17.3%	16.7%	20.1%	15.7%	17.0%
	Std. residual	.1	-.2	2.0	-1.2	
950 - 1269	Count	71	92	86	136	385
	Column %	11.7%	10.6%	12.4%	8.9%	10.4%
	Std. residual	1.0	.2	1.6	-1.8	
1270 or more	Count	60	61	59	121	301
	Column %	9.9%	7.0	8.5%	7.9%	8.1%
	Std. residual	1.5	-1.1	.3	-.3	
Total	Count	608	866	696	1531	3071
	Column %	100.0%	100.0	100.0%	100.0%	100.0%

4.6 The nation's favourite drink: changing trends in alcohol consumption

Figure 4.1 graphs the level of consumption from 1992 to 2002 according to type of alcoholic drink. In 1992, 64% (N = 1202) of respondents consumed either wine, beer, spirits, or a combination of the three, in 1998, 79% (N = 5032) did so, and in 2002 the figure was 78.2% (N = 4641). Beer was the most commonly consumed alcoholic beverage in Ireland, with most respondents naming it their alcohol beverage of choice in each year surveyed. In 1992 the combination of 'beer and spirits' was the second most common choice, with this changing to 'wine and beer' in 1998 and finally wine alone in 2002. Indeed, levels of wine consumption underwent the biggest increase over the ten years, from 7.3% in 1992, to 12.9% in 1998 and 23.5% in 2002. Respondents who reported drinking "Beer & Spirits" decreased greatly over the same period, from 28.6% of the population in 1992, to 8.5% in 1998, and 8.4% in 2002.

Figure 4.1: Alcohol consumption patterns 1992 - 2002

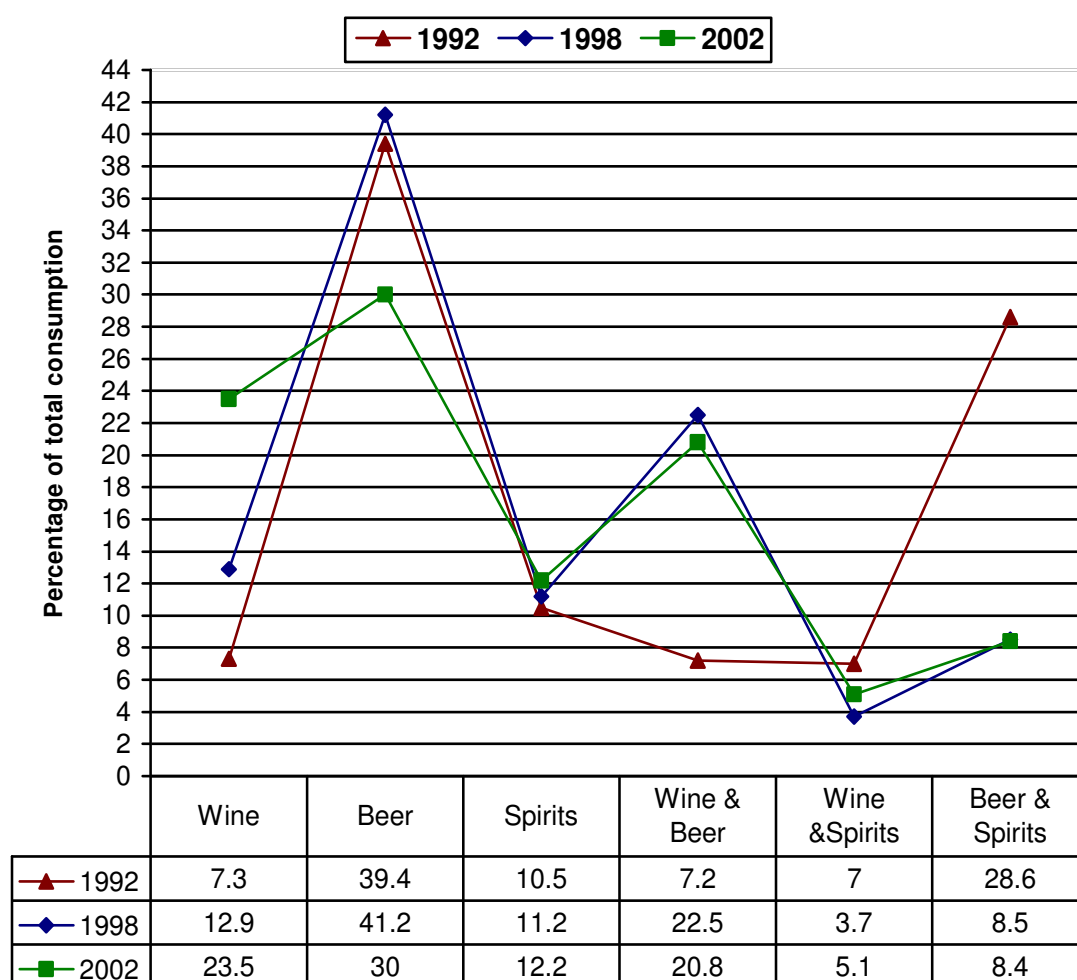


Table 4.13 details the weekly amount of alcohol consumed based on the type of alcohol drank. In 1992 respondents who drank 'beer & spirits' consumed the most units of alcohol (M.R. = 7.86 – 8.42). In 1998 (M = 16.77 – 17.61) and 2002 (M = 16.95 – 17.93), respondents who said they drank only beer had the highest weekly alcohol intake. The amount of alcohol imbibed by beer drinkers in 1998 and 2002 also showed the greatest significant increase from 1992 levels (M.R. = 7.69 – 8.21). Wine drinkers reported the lowest levels of weekly alcohol intake in each of the survey years, consuming between 3.01 and 3.51 units alcohol per week in 1992, between 8.24 and 9.24 units in 1992, and between 9.29 and 9.93 units per week in 2002.

Table 4.13 Levels of alcohol consumption by alcohol type

Type of alcohol	EURO 1992			SLÁN 1998			SLÁN 2002		
	N	Mean	S.E.M	N	Mean	S.E.M	N	Mean	S.E.M
Wine	69	3.26	.25	387	8.74	.50	694	9.61	.32
Beer	459	7.91	.22	1686	17.19	.42	1030	17.44	.49
Spirits	113	5.65	.31	373	10.19	.56	358	11.85	.53
Wine & Beer	84	6.80	.47	494	12.78	.63	403	13.51	.71
Wine & Spirits	75	4.84	.41	110	9.97	1.03	128	9.42	.98
Beer & Spirits	332	8.14	.28	274	14.65	.94	218	14.10	.93
Total	1132	7.05	.14	3324	14.32	.26	2831	13.63	.25

In each of the survey years a significant relationship exists between type of alcohol imbibed and the amount of units of alcohol a respondent consumed on a weekly basis. In 1992 [Welch (5, 289.85) = 45.46, $p < .001$], in 1998 [Welch (5, 705.97) = 42.73, $p < .001$] and in 2002 [Welch (5, 712.95) = 39.44, $p < .001$]. Tamhane 2 post-hoc tests were conducted to determine between which groups significant difference arose (Table 4.14).

In each survey year wine-drinking respondents showed the greatest amount of significant difference in their consumption levels compared to respondents who drank other types of alcohol. In 1992 the levels of alcohol consumed by wine drinkers was significant against all other alcohol types, while in 1998 a significance difference in mean consumption was present for beer, 'wine & beer' and 'beer & spirits', and in 2002 significant difference in means was evident against all alcohol types except

‘wine and spirits’. Furthermore, the mean difference was consistently negative across the ten years, indicating that wine-drinkers imbibed considerably less on a weekly basis than their counterparts.

Conversely, beer drinkers consumed significantly more alcohol per week than spirits and ‘wine & spirits’ drinkers in each year surveyed, with the mean difference between their weekly consumption levels increasing greatly between 1992 and 1998. In 2002 the difference between the average weekly alcohol intake of beer drinkers and spirits drinkers remained similar to 1998 levels, but the difference between the average weekly intake of beer drinkers against ‘wine & spirits’ drinkers dropped considerably from 1998 levels. The greatest overall increase in difference between weekly consumption levels arose between beer and spirits drinkers. The average amount of alcohol consumed by beer drinkers was 1.55–2.33 units more per week than spirits drinkers in 1992, but in 1998 beer drinkers imbibed an average of 6.31–7.69 more units of alcohol, with the differences in average consumption remaining high in 2002 (M .R. = 7.25 –8.41) A large increase in weekly alcohol intake was also witnessed between respondents who drank wine against those who drank beer, with the differences in average weekly consumption between these groups increasing significantly between 1992 (M.R. = 3.98–4.68) and 1998 (M.R. = 7.82–8.91), and remaining relatively similar between 1998 and 2002 (M.R. = 7.25–8.41).

Table 4.14 Significant differences between types of alcohol consumed on a weekly basis

Significant groups		EURO 1992		SLÁN 1998		SLÁN 2002	
		M. D.	S.E.M	M.D.	S.E.M	M.D.	S.E.M
Wine	Beer	-4.33*	.35	-8.46*	.64	-7.83*	.58
	Spirits	-2.39*	.41	-----	-----	-2.42*	.62
	Wine & Beer	-3.54*	.54	-4.05*	.80	-3.90*	.78
	Wine & Spirits	-1.58*	.49	-----	-----	-----	-----
	Beer & Spirits	-4.89*	.38	-5.92*	1.06	-4.90*	.98
Beer	Spirits	1.94*	.39	7.00*	.69	7.83*	.58
	Wine & Beer	-----	-----	4.41*	.76	2.42*	.62
	Wine & Spirits	2.75*	.47	7.22*	1.11	3.90*	.78
	Beer & Spirits	-----	-----	-----	-----	4.90*	.98
Spirits	Wine & Beer	-----	-----	-2.59*	.84	-----	-----
	Beer & Spirits	-2.48*	.42	-4.46*	1.09	-----	-----
Wine & Spirits	Wine & Beer	-1.96*	.63	-4.68*	1.37	-4.09*	1.21
	Beer & Spirits	-3.30*	.50	-4.68*	1.40	-4.67*	1.35

* The mean difference (M.D.) is significant at the .05 level

4.7 Conclusion

The trends documented in this chapter indicate that alcohol consumption in Ireland in the twenty-first century is greatly increased on what it was at before the Celtic Tiger, with the average amount of alcohol consumption by respondents rising consistently over the 10 year period. The factors which seem to have the greatest effect on weekly consumption are age and gender, with young men drinking the most alcohol per week in each of the survey years. Religiosity also had a moderate effect on weekly alcohol intake, with irreligious respondents recording a significantly higher weekly alcohol intake than religious respondents. A respondent's employment situation also had a considerable significant effect on his or her weekly alcohol intake, with unemployed respondents recording the highest level of alcohol consumption and those in employment the lowest. Income was a significant predictor of the frequency of binge-drinking, with which a respondent binge-drank, with the most common binge-drinkers being those in the lowest and highest income brackets. Also, the type of alcohol consumed was a significant factor in how much alcohol a respondent drank on a weekly basis, with wine-drinkers recording the lowest overall consumption levels and beer drinkers recording the highest.

There are several conclusions to be drawn from this analysis. Firstly, Irish people drink considerably more alcohol during times of increased economic prosperity and, given that each survey year reported a higher mean consumption, it can be concluded that consumption levels are increasing the longer economic prosperity is maintained. This conclusion is further corroborated by the finding that those earning the most money are nearly as likely to binge-drink as those earning the least. Thus, as Conniffe and McCoy (1993: 2) suggested, alcohol consumption is income elastic; people consume more alcohol when the economy is good and as the economy continues to grow so will alcohol consumption levels. The third conclusion to be drawn from this analysis is that, within the alcohol consuming population, young men are drinking the greatest amount of alcohol every week; men aged between 18-24 years are the highest consumers, and men aged 25-34 are not far behind them.

The question thus remains, given these conclusions, what can be done to minimise their consumption levels? The implications for alcohol policy are far-reaching; in order to reduce alcohol consumption levels, government would have to strictly

regulate the national economy to minimise economic growth and increase the price of all types of alcohol by a credible amount in order to affect consumption levels, given that alcohol has been conclusively proven to be price inelastic and large cross-over effects occur when the price of just one or two alcoholic drinks are increased (Conniffe and McCoy, 1993). Further public health policies, such as introducing a 0% BAC for young drivers and reducing the availability of alcohol, would most likely reduce young men's weekly alcohol intake. However, it is deeply doubtful that any of these measures will be seriously countenanced, at the least until a new social partnership agreement is created in 2016, if ever, given that we live in a country which advocates a model of public governance based on consensual social partnership and which relies on a neo-liberal economy to ensure economic prosperity.

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5. Alcohol research/ policy interface

5.1 Introduction

‘One of the gravest errors which can be made by the novice policy analyst is to assume that policy making is in any way a rational process’.

- Tim Stockwell (1993: 53S)

In light of the previous discussion on increasing levels of alcohol consumption in Ireland it is commonsensical to examine the alcohol policy-making process in Ireland. There is a consistent common belief among researchers that policy is rational and evidence-based, and rooted in a firm historical process. However it is worth remembering that, until recently, it has been rare for any society to focus alcohol's effects on health as a criterion of state policy, whereas mechanisms for engaging in alcohol consumption have been in existence for a considerable time. For intoxicating commodities such as alcoholic beverages there is an obvious conflict in modern societies between the doctrine of consumer sovereignty and health promotion. The solution to this cultural dilemma has been to place the burden of managing the conflict, and the blame for failure, on the individual (Room, 1997: S8 – S10). Bruun et al. (1975) have documented how, in the case of other commodities which potentially threaten public health or order, international agreements exist by which nations control exports and support each other's market controls. No such agreements exist for alcohol. The ethic of free trade of alcohol at the international level is a reflection of the doctrine of consumer sovereignty and national corporatism in modern industrial societies (Room, 1997: s10) and has been reflected in Irish governmental policy since the advent of social partnership in 1987 and the adoption of Strategic Management Initiatives in 1994. Research evidence is not the sole determinant of policy, and researchers need to understand what these other determinants are in order to increase the likelihood that their research recommendations are implemented (Stevens, 2007: 32). In other words, researchers need to understand the politics of the policy making process, know which ministers are involved in policy formulation and be aware of what stakeholders are affected by it. Such knowledge would allow researchers to present their findings in a way that makes them seem more compatible with whatever other determinants are influencing policy-makers,

thus raising the probability that their recommendations are implemented (Ryder, 1997: 1270).

5.2 Social partnership

Murphy (2002) documents how, since 1987, the process of governance in Ireland has included a model of social partnership based on three-yearly economic and social agreements between the government and three pillars – employers, trade unions and farmers. Since 1987, the social partnership agreements have been focused on fostering international competitiveness, macro-economic stability, tax reductions and employment creation. As Butler (2002a, 12) comments, much of the credit for the unprecedented economic growth during this period is given to this conscious and explicit utilisation of a partnership model of public governance in which sectional interests and local groupings work together to achieve common social and economic gains. In 1996 the Community and Voluntary Pillar was also included in the national social partnership process. This fourth pillar has defined itself as primarily concerned with social inclusion, equality and poverty (Murphy 2002: 80) and since its inclusion social issues have been targeted as strategic objectives.

Twenty years of social partnership in Ireland has resulted in the seven National Partnership Agreements listed below (Box 5.1). Within this space of time social partnership has become institutionalised as a model of economic planning. There exists an identifiable cross-party consensus that it represents the most viable and appropriate approach to formulating economic and social policy in Ireland (O'Donnell and Thomas 1998: 169). However, it must be noted that these agreements represent a major shift in power from elected representatives to full-time officials in the civil service and in the organisations of the major partnership interests. They were, as Ó Cinnéide phrases it, 'signed, sealed and delivered as a *fait accompli* to the nominal legislators of the country' (Ó Cinnéide, 1998: 47).

Box 5.1: National Partnership Agreements 1987 - 2006

1987 Programme for National Recovery
1990 Programmes for Economic and Social Progress
1994 Programme for Competitiveness and Work
1997 Programme for Inclusion, Competitiveness and Employment
2000 Programme for Prosperity and Fairness
2003 Programme for Sustaining Progress
2006 Towards 2016 ⁹

Source: Social Partnership Unit

As Murphy (2002, 84) asserts, prerequisite for entry into social partnership is a shared understanding of the aims of partnership. This involves accepting an ideological backdrop that underpins the status quo and its related inequality. Thus, by its very nature the social partnership process denies the possibility of conflictual dialogue (Murphy 2002, 85). Furthermore, the dominant economic model is rarely if ever challenged in national policy-making arena. Indeed, dominant ideologies are reinforced and competitiveness is put forward as the bedrock on which all other policies must be assessed. Social partnership as a system of public policy-making creates a 'smothering consensualism' in politics, legislative power is concentrated in the hands of an unaccountable few and contentious issues, such as alcohol policy, are not discussed with due merit and considerations (Ó Cinnéide, 1998:42). When prevailing neo-liberal ideologies are challenged it is often in the guise of arguments about sustainability or regional balance (CORI, 1999), rather than concern to transform the inherent inequalities they produce. Those who do seek to initiate debate or challenge the consensus, within or on the fringes of social partnership, find that they are rebuked verbally or in writing for going outside the rules of the game. Thus, social partnership's 'smothering' emphasis on consensus and finding 'pragmatic common ground' means there is little, if any discussion about difficult public health issues (Murphy, 2002: 84-85).

⁹ This most recent social partnership agreement covers a ten year period and encompasses a wide range of policy areas. The goal of the agreement is to achieve a dynamic, internationalised and participatory society and economy, founded on a commitment to social justice and economic development that is both environmentally sustainable and internationally competitive (Citizens' Information, 2007).

5.3 Strategic management initiative

The theory of Strategic Management Initiative (SMI) consists of a wide range of measures introduced in 1994 to bring about improvement in the delivery of public services (Department of An Taoiseach, 2007). Butler (2002a) details how SMI was heavily influenced by public management developments in New Zealand and Australia. He suggests SMI was largely based on the view that achievement of important public policy objectives frequently demanded a level of intersectional collaboration which did not routinely exist in Ireland's fragmented and 'departmentalist' centralised governmental system (Butler 2002a: 11). In May, 1996 the SMI Co-ordinating Group of Secretaries issued a report entitled *Delivering Better Government* which formed the basis for the programme of change. This report has come to embody what SMI represents in Ireland. The report identified the main areas for change as:

- Delivering quality service to customers and clients;
- Reducing "red tape";
- Delegation of authority and accountability;
- Improved "human resources management";
- Improved financial management and ensuring value for money;
- Use of information technology;
- Improved co-ordination between Departments.

Therefore, as Butler (2002a, 11) comments, an important aim of SMI was to establish structures and processes to manage 'cross-cutting' issues, with explicit reference being made for the first time in Ireland to an organisational-networks style of policy formulation and implementation (See Byrne et al., 1999). SMI has provided a statutory mandate for Department level strategy, 'business' level planning within departments and complements and assists the processes of social partnership (Murray, 2001: 15).

5.4 Alcohol policy-making: Who are the main stakeholders?

Stakeholder analysis is a technique to identify and assess the importance and interests of key people, groups, or institutions that significantly influence policy making processes or are influenced by policy. The method can be used flexibly to investigate and analyse a whole range of stakeholder interests, characteristics, relative power, and circumstances. Primary stakeholders are those directly affected

by policy, while the effects experienced by secondary stakeholders are more circuitous. Table 5.1, entitled 'alcohol policy stakeholders', gives a simplified overview of those involved in, and effected by, alcohol policy. The table is intended to merely act as an aid in understanding the complexities of the stakeholder interests in alcohol policy, given that the rankings used are based on the researcher's own observations and as such no primary research has been conducted as to their validity. For the sake of clarity, only one main stakeholder group has been included per policy interest.

Table 5.1: Alcohol policy stakeholders

Stakeholder group	Nature of interest in policy decision	Potential impact on policy	Relative importance of interest	Importance of group	Influence (power) of group
Primary stakeholders					
Drinks Industry Group Ireland (DIGI) and Mature Enjoyment of Alcohol Society (MEAS)	Security of income	High	High	Low	High
Epidemiologists/ Relevant NGOs.	Reduction of alcohol-related problems in society	Low	Medium	High	Low
Gardaí	Policing of alcohol-related crime and disorder	Medium	Medium	Medium	Medium
Alcohol-dependant people	Recovery from dependence and removal of avenues of dependence	Low	Low	Medium	Low
Secondary stakeholders					
Department of Health and Children	Health effects of alcohol-related problems	High	High	High	High
Department of Justice, Equality and Law Reform	Alcohol-related crime and public disorder	High	High	High	High
Department of Enterprise Trade and Employment	Deregulation of the alcohol market	High	Medium	Low	High

Source: Based on an example in Grimble, R (1998)

5.5 Interpreting the evidence: Recommendations for alcohol policy from two different viewpoints

Although it is understandable that governments should legislate based on what they deem politically viable and appropriate rather than on what a group of scientists suggests they should do, such action makes evidence-based alcohol policy something of a parody. Consider the example of Britain, where two reports were published in March 2004: one by the Academy of Medical Sciences, the other by the prime minister's strategy unit. The academy's report concluded that to control alcohol problems one needed to control alcohol; that is, reduce the average level of consumption in the population (Marmot 2004: 906). The academy reached this conclusion on the basis that a strong correlation exists between average consumption, the prevalence of heavy drinking, and associated harm. It found the evidence for introducing alcohol education initiatives unconvincing and therefore called for raising the price and limiting availability of alcohol (AMS, 2004).

The prime minister's strategy unit, with access to the same evidence, concluded that controlling average consumption, through the mechanism of raising the price and limiting access, would have unwanted side effects and was not a viable option (Marmot 2004: 907). They therefore called for education, more policing, improved treatment, and for the alcohol industry to enter into voluntary agreements to behave reasonably (Prime Minister's Strategy Unit, 2004). The academy working group would undoubtedly agree that all of these actions were necessary, but they took the view, based on evidence, that such actions would not effectively ensure a reduction of alcohol-related problems and should therefore only be considered as a means of complementing measures to control overall level of consumption.

Two reports, same evidence, and yet such different conclusions. As scientists, steeped in the public health approach, those who prepared the academy's report no doubt came to the issue with the sole aim of reducing alcohol-related harm in British society. The prime minister's strategy unit had a different set of aims and it is reasonable to surmise that it found the prospects of raising the tax on alcohol and regulating the availability of alcohol unattractive. Introducing these measures would affect business growth and mean halting neo-liberal governmental trends, with regards to the relaxation of restrictions on the availability of alcohol. Thus, the policy implications of the scientific research may well have influenced their view of the evidence, as governments often balance a number of interests when forming

policies. Scientific evidence which shows direct correlations between exposure to alcohol and risk of developing alcohol-related problem is only one consideration (Marmot, 2004: 907). Others include analysis of costs and benefits, risk analysis, and appreciation of the degree to which policies fit with public values (Royal Commission on Environmental Pollution, 1998). Thus, what the science shows and its policy implications are two distinct issues for policy makers, and should therefore be considered as such by health promotion policy advocates.

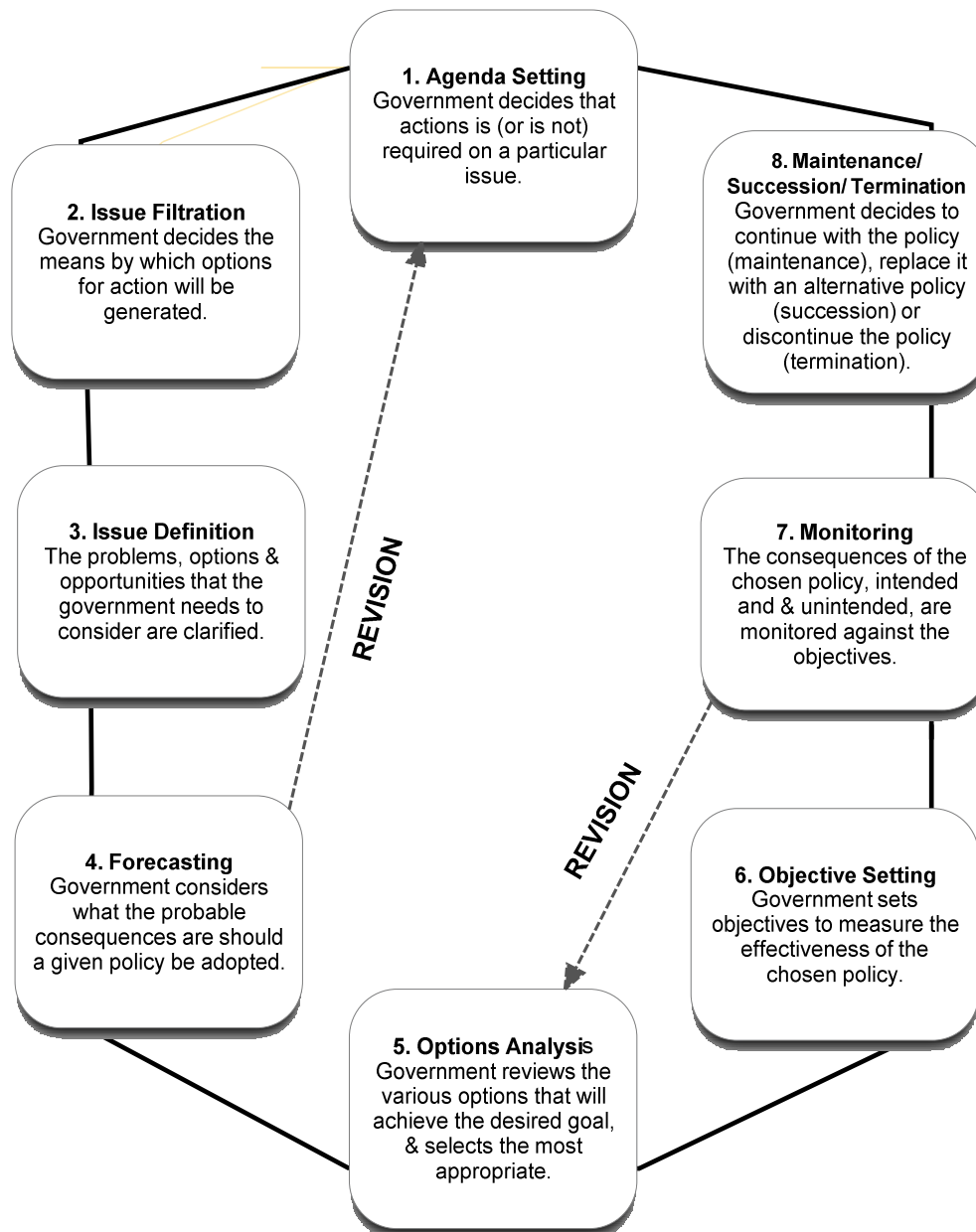
5.6 Understanding the process of policy development

Ryder (1996) suggests that by understanding policy development as a process, policy advocates can match their strategies to the stages of the process, and thus raise the probability that the advocated policy will be adopted. Policy development can be best understood as a political activity (Ryder 1996: 1265) and while it may not be rational in the scientific sense understood by researchers, it is coherent, understandable and reasonably predictable if you are aware of some factors (Secker 1993: 116S). Firstly, government ministers do not make policy; they endorse one of a limited range of options put to them in summary form by advisers, and thus prefer proposal which have clear short-term benefits. Secondly, ministers work in a restrictive environment comprised of unions, parliamentary factions, laws, cabinet decisions, party platform and industry pressure groups. Thirdly, governmental processes function in terms of trade-offs and deals. Ministers may support a certain lobby group on one issue in return for that group's support on a totally unrelated issue. Lastly and perhaps most importantly, ministers do not think in terms of what the ideal position could be, but in terms of what the present situation is and how a proposed policy would change it – the cost, difficulties and benefits of that change are considered and weighed against the perceived public reaction to it, for ultimately, as ministers their jobs depend upon successful re-election (Secker 1993: 116S – 117S).

Hogwood and Gunn (1984) propose a model of policy development which envisions government policy as an eight-stage process (Figure 5.1). Ryder (1996: 1266) advises that these processes may be non-linear and more than one stage may be in operation at the same time. By viewing the policy process as a series of stages, researchers can match their strategy to the stage of the policy's development. This raises the probability that the recommendations researchers' advocate will be

selected by those involved in the policy-making process as 'fitting' their interests, and thus be adopted as policy (Stevens, 2007: 26).

Figure 5.1: Policy process stages



The above analysis of the policy process suggests three fruitful approaches researchers could pursue to achieve effective alcohol policy. First, researchers can alliances with others holding similar aims (Ryder 1996: 1269). In Australia, public health lobbyists allied with the Winemakers' Federation to successfully advocate the adoption of standard drink labelling on beverage containers in December 1995 (Stockwell, 1993). Secondly, researchers can provide evidence to be used as

'ammunition' in the battle to achieve health promotional policy. The use of research evidence in the standard drink labelling campaign in Australia is a clear example of this practice. It is also important that such 'ammunition' is in a form other allies can utilise, for example, that data be presented in a form that is understandable to those unfamiliar with statistics. Thirdly, battles are best fought on grounds of one's own choosing, and where the oppositions 'ammunition' is less effective. The banning of smoking in Western Australian betting shops (Secker 1993) is a good example of this. Arguing the case from a public health perspective was seen as an unwinnable approach; therefore Secker conducted his research and couched his arguments in terms of the detrimental affects to businesses (Ryder 1996: 1270).

5.7 Current Irish alcohol policy making processes

Ireland currently has two parallel policy processes. The first policy process is the public health approach. As previously discussed literature has shown, this approach sees a link between overall consumption levels and the prevalence of a range of alcohol-related problems, and envisions a role for all sectors of government rather than just the health and educational sectors. It values bottom-up or community initiatives (Butler 2002c:6) and favours control measures of the sort detailed comprehensively in chapter two.

The second policy process is based on the work of the Commission on Liquor Licensing, which was stationed in the Department of Justice, Equality and Law Reform from 2000–2003, following the enactment of the Intoxicating Liquor Act, 2000. The Commission's first term of reference enjoined it to "make recommendations for a Liquor Licensing system geared to meeting the need of consumers in a competitive market environment, while taking due account of the social, health and economic interests of a modern society' and it has produced two interim reports and one final report since its establishment. Despite the references to social and health interests quoted above, it is clear from a reading of its three reports that, philosophically, the Commission is driven by a fundamental commitment to neo-liberal 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 was opposition within the Commission to greater deregulation of the retail drinks trade, this opposition came from existing retailers - anxious to

protect monopolies which they currently enjoyed - rather than from public health interests. Social and health concerns were addressed naively within the Commission and on a programmed basis in its reports: the implication inferred is that drink problems are largely confined to young people. The Commission displayed a touching but unsubstantiated belief in the preventive value of school-based educational programmes. The overall thrust of the Commission's recommendations was 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 was discussed in the second interim report and the final 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 concluded that the government should merely keep it under review (Butler 2002b: 6-7).

The enactment of the Intoxicating Liquor Act 2003 can be viewed as a compromise between the two policy processes. This Act curtailed the practice of late opening Thursdays, thus realising one of the public health approach's recommendations, but it was enacted by the Commission due to strong anecdotal evidence that late opening was producing adverse effects on workplaces and educational establishments. The legislation was therefore based on protecting economic interests rather than on reducing alcohol-related problems at a societal level, whilst the broad philosophy of this legislation was very similar to that of the Licensing Act 2003 in England and Wales, in that it is largely about combating drunkenness and disorderly conduct rather than about addressing alcohol issues through the use of control measures (Butler 2003: 295).

If the two alcohol policy processes are compared in the context of 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 (NAP) of 1996 has been largely ignored by policy-makers, a fate which the Strategic Task Force on Alcohol's more recent reports seem destined to share, given the lack of governmental interest in them to date (Butler 2002b: 7).

5.8 The National Alcohol Policy: Where do we stand?

National Alcohol Policy in Ireland was published in 1996 and was 'directed at reducing the prevalence of alcohol-related problems and thereby promoting the health of the community' (DoHC, 1996: 59). It provided an extensive overview of alcohol use in Ireland, examined various strategies to reduce consumption and set out a detailed and comprehensive cross-cutting plan of action in order to implement effective public health policies. It is worth noting that the National Alcohol Policy report was published concurrently with the Rabbitte Report but, whereas the Rabbitte Report had a considerable effect on drug policy making, the NAP failed to advance significant implementation of a different style of public policy on alcohol (Butler 2007: 15). Where then has it failed where the Rabbitte Report succeeded?

Butler (2001c: 5) suggest that, unlike the disease concept of alcoholism which has wide popular appeal, the health promotional approach to alcohol seems to have little to endear it to anybody outside of the public health community. From a philosophical point of view, it smacks of old-fashioned paternalism, with the State appearing to be in the position of telling citizens how they should conduct themselves with regard to their drinking habits. The public health perspective has little appeal for those problem drinkers who have become accustomed to thinking of themselves as suffering from a respectable disease, since it appears to suggest that drinking problem are attributable to drinking habits as much as genetics. Quite obviously the public health approach is disliked by the drinks industry since it attributes blame to the industry's product and recommends tighter control and regulation of the industry and its product. Politicians, if they were to take the public health perspective seriously, would be required to enact laws based on some of the measures listed in Chapter two in order to stabilise, if not actually reduce, alcohol consumption levels.

Thus, as Butler (2007:15) asserts, the answer to the question posed above seems quite straightforward: the political system did not adopt the public health strategies recommended in the 1996 National Alcohol Policy report because to do so would have entailed open conflict with the drinks industry, discord in the social partnership process, possible job losses and loss of revenue, as well as serious risk of electoral unpopularity. In short, political leaders and senior public sector managers decided that the economic and political tensions inherent in the adoption of such as public health approach outweighed its scientific merit. Furthermore, it should be noted that English policy makers followed a similar line when they unveiled the Alcohol Harm

Reduction Strategy for England in 2004. Policy-makers in England decided against implementing an alcohol strategy based on alcohol-control measures in favour of one which dealt with alcohol as a free-market commodity. Thus, the strategy endorsed the implementation of structures which would 'provide the [alcohol] industry with further opportunities to work in partnership with the government to reduce alcohol-related harm' and eschewed proposals on excise taxes because 'evidence suggested that using price as a key lever risked major unintended side-effects' (Prime Minister's Strategy Unit, 2004: 23)

5.9 Conclusion

This chapter has generally demonstrated that public policy making is a complex policy process, involving competing interest groups and value perspectives, rather than a rational or evidence-based activity. It has also shown that the wider policy climate of 'social partnership', which has dominated public policy making in Ireland for the past twenty years, is essentially based upon consensus, pragmatic identification of the middle ground and discouragement of overt ideological conflict. It is clear that this culture of consensus is not one in which the radical differences between public health and neo-liberal models of alcohol policy can readily be acknowledged, publicly debated or unequivocally resolved. And finally, this chapter has shown that despite the explicit commitment to 'cross-cutting' management, commonly referred to as 'joined-up government', contained in the new managerialism of the SMI, no attempts have been made to create the policy structures - such as those established under the rubric of the National Drugs Strategy - which would be necessary for the creation of an integrated and evidence-based national alcohol strategy. Indeed, the most obvious way to create such policy structures would be to include alcohol onto the policy brief of the National Drug Strategy (Butler 2002c: 8). What the lack of such structures implies is that for empirical researchers, and especially for epidemiologists, the relatively simple task of data gathering is likely to become frustrating in the absence of any clarity about the nature of the research/policy interface. The challenge thus remains how to implement an effective alcohol policy based on public health research.

6 Cross-cutting policy making at work: A review of the National Drugs Strategy

6.1 Introduction

The *National Alcohol Policy- Ireland* and the *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs* were both published in the autumn of 1996. Yet, where the former has sunk without a trace, the latter has set down seemingly immovable roots. The difficulties inherent in formulating effective alcohol policy have been discussed in previous chapters, it is suffice to say that successive policy reports on alcohol and alcohol-related problems, however scientifically valid and socially laudable they may have been, have not been implemented nor have any permanent management structures been established to undertake their implementation (Joint Committee, 2006: 21). This evidently has not been the fate of drugs policy in Ireland, as will shortly be shown. Thus, this chapter will examine the implementation of the National Alcohol Policy's favoured sibling, the National Drugs Strategy, a parallel health policy process built on strategic management foundations into which alcohol could be effectively incorporated should the ideological conflict between the health promotion and criminal justice paradigms ever be resolved.

6.2 Background to the National Drugs Strategy

What was the context to drugs-related problems in Ireland, that the National Drugs Strategy flourished where the National Alcohol Policy failed? As is the case for alcohol, public sector management of illicit drugs is a complex business, involving a wide range of sectoral interests. Since the late-1960's, when illicit drugs first became problematic in Ireland, various attempts have been made to create a co-ordinated policy response. By the mid-1990s the criminal justice system was struggling to cope with a high volume of drug-related crime, the healthcare system with a range of difficulties directly or indirectly associated with drug use; and many statutory authorities were finding it difficult to organise coherent and comprehensive responses to the drugs problem in their areas (Joint Committee, 2006: 22). Discontent with disjointed governmental efforts to co-ordinate an effective drugs

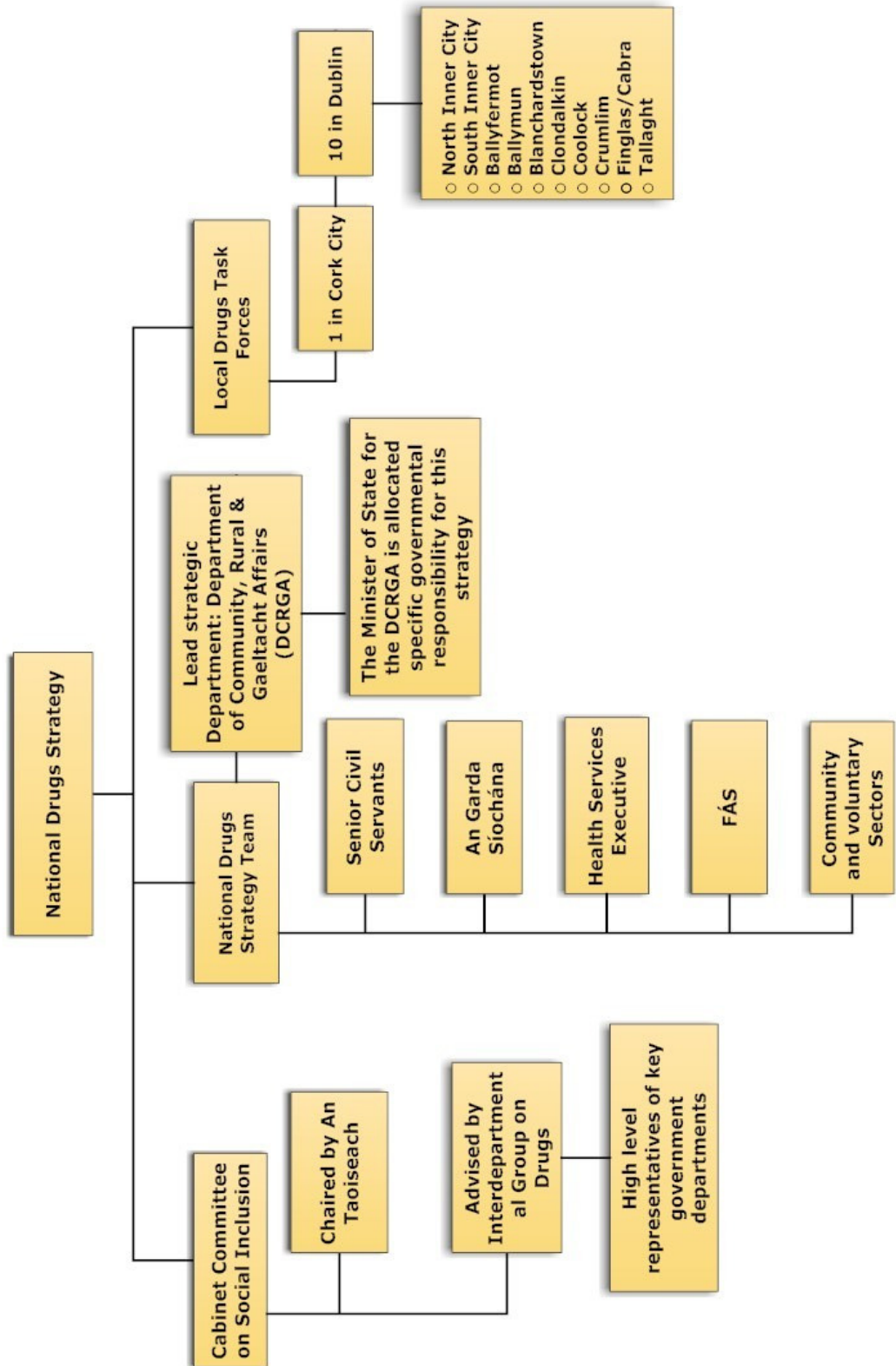
policy reached its zenith in June 1996 with the murder of Veronica Guerin, an investigative journalist who had written extensively on the drugs-crime nexus in Dublin. Her death reinforced popular fears that the government had lost control of the illicit drugs market in Ireland, and acted as a catalyst for convening an inter-departmental committee comprised of Ministers of State and chaired by the Minister of State to the Government Pat Rabbitte. Within three months the committee published the influential *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs*, which became known colloquially as the Rabbitte Report (Butler, 2007: 4). In drafting their recommendations for the creation of new structures aimed at the management of drug issues (Appendix B), the Ministers of State drew explicitly on ideas which had just been formulated in the context of wider approaches to Irish public sector reform under the banner of the Strategic Management Initiative (Joint Committee, 2006: 22).

6.3 Recommendations of the Rabbitte Report

The content of the Rabbitte Report can be divided into two main interrelated themes. One of these was the acknowledgement that problem drug use could not be explained satisfactorily in individual terms but must be considered in relation to wider structural and environmental factors (Butler, 2007: 7) of 'social disadvantage/exclusion characterised in high levels of unemployment, poor housing conditions, low educational attainment, lack of recreational facilities etc' (Dept. of An Taoiseach 1996: 4). The second theme to emerge from the Rabbitte Report was the need to create policy structures which would concurrently recognise and respond to the complexity of drug-related problems and which would effectively co-ordinate the actions of the various stakeholders in this sphere (Butler, 2007: 7). Drawing on the SMI philosophy of establishing 'cross-cutting' structures, Rabbitte proposed a 'matrix of structural arrangements for delivery of services' (Dept. of An Taoiseach, 1996: 21) consisting of three layers involving Cabinet, a National Drugs Strategy Team (NDST) and eleven Local Drugs Task Forces (LDTFs) to integrate policy and practice in problem areas. As can be seen from Figure 6.1¹⁰, the proposed framework combined top-down features such as a Cabinet Committee with bottom-up structures in the shape of LDTFs (Butler, 2007:9).

¹⁰ Figure 6.1: *The National Drugs Strategy Structure* shows the structural mechanisms which were implemented. These differed nominally from those originally proposed in the Rabbitte Report. Rabbitte had recommended a Cabinet Drugs Committee, while the final designation was Cabinet Committee on Social Inclusion (Butler, 2007: 10).

Figure 6.1: Structure of the National Drugs Strategy



6.4 National Drugs Strategy Review

Illicit drugs policy-making structures in Ireland have evolved with relatively minor changes over the eleven years since their establishment. Nevertheless, a comprehensive review of the National Drugs Strategy was initiated by the Department of Tourism, Sport and Recreation (DTSR) in April 2000¹¹. In early 2001 the Review Team published its findings (DTSR, 2001) and the Government approved the National Drugs Strategy 2001-2008 (2001). *Table 6.1: Outline of structural mechanisms to deliver the National Drugs Policy 2001-2008* shows the updated structure of the Strategy, and it is this structure which be examined in relation to its cross-cutting mechanisms.

Table 6.1: Outline of structural mechanisms to deliver the National Drugs Policy 2001-2008

NATIONAL LEVEL	Direction & Co-Ordination	Cabinet Committee on Social Inclusion	<i>Oireachtas Committee on Drugs</i>		
		<ul style="list-style-type: none"> Minister of State for Local Development at DoTSR, with responsibility for National Drugs Strategy. DoTSR 	IDG	NDST	YPFSS National Assessment Committee
REGIONAL/ LOCAL LEVEL	Policy & Implementation (Key Government Departments/ Agencies/ Programmes)	DoTSR	Dept. of Health & Children	Revenue Commissioners Customs & Excise Service	Dept. of Justice, Equality & Law Reform
		Department of Education & Science	Department of Environment and Local Government	DSCFA <ul style="list-style-type: none"> Community Development Programme 	<ul style="list-style-type: none"> An Garda Síochána Irish Prisons Service Probation & Welfare Services Courts
REGIONAL/ LOCAL LEVEL	Co-Ordination	<i>Regional Drugs Task Forces</i>	Local Drugs Task Forces	YPFSS Development Groups	
	Implementation	Regional Health Boards		Community and Voluntary Sectors	

KEY: Existing Structure New Structure proposed in National Drugs Strategy 2001 - 2008

Source: Moran and Pike (2001: 10)

¹¹ The Department of Tourism, Sport and Recreation was originally designated as the lead department for the National Drugs Strategy, but following the reordering of central government departments in 2002, the Department of CRGA was assigned this task (Butler, 2007: 10).

6.5 National Drugs Strategy: Structures

Table 6.1 details the current overall structure of the NDS. A more descriptive analysis of these structures is conducted below, from the original structures such as the Cabinet Committee on Social Inclusion, the Local Drugs Task Forces, the National Assessment Committee for the Young Peoples Facilities and Services Fund and the National Drugs Strategy Team, to the later additions of the Regional Drugs Task Forces, the National Advisory Committee on Drugs and the Drugs Strategy Unit.

6.5.1 Cabinet Committee on Social Inclusion

The Cabinet Committee on Social Inclusion (CCSI) was established to give political leadership to the new action on drugs (McGarry 2004: 65). It is chaired by the Taoiseach and comprises the Tánaiste and the Ministers for Health, the Environment, Education and Justice and the Minister of State to the Government. The CCSI has responsibility for reviewing all trends in the sphere of drug-related problem, and assesses the progress of the NDS efforts to curb the supply and demand of drugs. It also resolves any policy or organisational issues which may inhibit effective developments in the response to the drugs problem (Dept. of Community Rural and Gaeltacht Affairs (DCRGA), 2004: 2).

6.5.2 National Drugs Strategy Team

The National Drugs Strategy Team (NDST) reports to the Cabinet Committee on Social Inclusion. The NDST is cross-departmental, comprising experienced personnel from the relevant areas in the main departments involved and their agencies. The Strategy Team also includes members with a background in the voluntary and community sector dealing with drugs. The structure of the NDST is heavily influenced by the principles of SMI (Dept. of An Taoiseach, 1996).

The National Drugs Strategy Team was set up on two levels:

- *The Policy Team:* An inter-Departmental Group which reviews the progress of the NDS implementation and addresses any policy issues that may arise. This

group is comprised of Assistant Secretaries from the Departments represented on the Cabinet Committee.

- *The Operational Team:* The National Drugs Strategy Team (NDST) comprises representatives from the same Departments as those represented on the Cabinet Committee. In addition it contains a representative from An Garda Síochána, the Eastern Health Board, FÁS and two persons with extensive experience in voluntary/community work in the drugs sector (Dept. of An Taoiseach, 1997).

The mandate of the NDST is to implement the Government's Strategy in relation to drugs and in particular to ensure that their problems and priorities of the fourteen LDTF and ten RDTF areas are constantly monitored by central government (McGarry: 2004: 202).

6.5.3 The Local Drugs Task Forces and Regional Drugs Task Forces

The Local Drugs Task Forces were set up in 1997 to provide a strategic, locally based response by the statutory, voluntary and community sectors to the drugs problem in the worst affected areas and 'to develop and implement a drugs strategy for their areas which coordinates all relevant programmes and addresses any gaps in services' (DTSR, 1999: 9).

The LDTFs serve a three-fold purpose:

- To ensure effective co-ordination of drug programmes and services at local level
- To involve communities in the development and delivery of locally based strategies to reduce the demand for drugs;
- To focus actions on tackling the problem in the communities where it is at its most severe (Moran et al., 2001).

The LDTFs each have a chairperson and employ a coordinator who helps prepare local action plans which include a range of measures in relation to treatment, rehabilitation, education, prevention and curbing local supply. In addition, the

LDTFs provide a mechanism for the coordination of services in the areas in which they operate and allow local communities and voluntary organizations to participate in the planning, design and delivery of those services. (DTSR, 2001: 47).

The RDTFs work in a partnership manner similar to the LDTFs and are made up of nominees from state agencies, members of the community and voluntary sector and elected public representatives. Each RDTF has a voluntary chairperson and an interim co-ordinator. By Dec 2003 RDTFs had been established in the 10 Health Board regions throughout the country.

6.5.4 National Advisory Committee on Drugs

The National Advisory Committee on Drugs (NACD) was established in July 2000 on a non-statutory basis for three years. In July 2004 the Government extended the mandate of the NACD until the end of 2008. The NACD has responsibility for research and information on drug misuse in Ireland. The Committee is comprised of a Director, a Research Officer and two other administrative and support staff. It has an annual budget of E1.27m and operates under the aegis of the Department of Community, Rural and Gaeltacht Affairs (DCRGA, 2004: 4). The function of the Committee can be synthesised as follows:

- To advise the Cabinet Committee on Social Inclusion and through it, the Government, in relation to the issue of problem drug use in Ireland.
- To review current information sets and research capacity in relation to the issue of problem drug use in Ireland and to make recommendations, as appropriate, on how deficits should be addressed, including how to maximise the use of information available from the community and voluntary sectors;

6.5.5 National Assessment Committee (NAC) for the Young Peoples Facilities and Services Fund (YPFSF)

The YPFSF is a Programme operated by the DCRGA that targets those young people most at risk from substance misuse in disadvantaged areas in order to 'attract' them away from the potential dangers of substance misuse. The YPFSF Committee is made up of representatives from Government Departments; outside agencies; the National Drug Strategy Team; Youth Services and the voluntary and community sectors. The YPFSF operates in the 14 Local Drug Taskforce Areas and 4 other urban areas: Carlow, Galway, Limerick and Waterford (DCRGA, 2005: 5).

6.5.6 Drugs Strategy Unit

The Drugs Strategy Unit (DSU) is located in the DCRGA and is also represented on the NDST and the NACD as well as a number of other relevant Committees.

The DSU mandate is as follows:

- To co-ordinate the overall implementation of the NDS;
- To advise and support the Minister of State with responsibility for the NDS;
- To drive the implementation of the NDS – particularly through the IDG;
- To monitor and report on the implementation of the various NDS actions and highlight gaps and issues arising to the IDG and the CCSI;
- To operate and manage the YPFSF and deal with emerging operational and policy issues in conjunction with the NAC;
- To be financially accountable for the work of the LDTFs, the YPFSF, the NACD and the NDST;
- To chair the British-Irish Council Sectoral Group on the Misuse of Drugs
- To represent Ireland at EU National Drugs Co-ordinators meetings (*Ibid.*)

6.6 National Drugs Strategy 2001-2008: Aims and objectives

Having overviewed the structural functioning of the NDS, it is time to examine the aims and objectives that it has set itself to achieve. The National Drugs Strategy has sought to strengthen its strategy by:

- Recognising that the best prospects for communities affected by the drugs problem, in the longer term, rest with a Social Inclusion strategy which delivers much improved living standards to areas of disadvantage throughout the country.
- Requiring all state agencies involved in delivering the National Drugs Strategy to specify annual targets in terms of outputs and desired outcomes for their respective programmes and initiatives (National Drugs Strategy, 2001: 8).

6.7 National Drugs Strategy: Pillars and key indicators

In order to measure the progress of the delivery of its drugs policy, the National Drugs Strategy 2001-2008 specified objectives and key performance indicators (KPIs) for each of the five pillars which comprise a part of the drug problem reduction stratagem - supply reduction, prevention, treatment, research and rehabilitation, and although 'evaluation' was not designated as one of the pillars, KPIs relating to the establishment of an framework for implementing and evaluating the Strategy were also specified. (DCRGA, 2004: 25 – 37). The success of the NDS objectives are measured by how many KPIs are achieved.

6.8 How 'joined-up' is the National Drugs Strategy?

It is evident that Ireland's National Drugs Strategy is an impressive monument to the principles of Strategic Management Initiative, with its 'pillars', key performance indicators, multi-layered and cross-cutting structures and general appearance of effective and efficient managements. However, whether one should accept that this strategy has been largely successful in attaining its goals of delivering 'joined-up'

and effective responses to the problems of illicit drug use is considerably less clear. Given, that 'evidenced-based research' is one of the pillars of the National Drugs Strategy, how does research inform policy? The answer to this question seems to be that it doesn't, or rather, as Stevens (2007) suggested, the research recommendations are selectively accepted, based on how they 'fit' into policy. The competing processes of health promotion policy and criminal justice/ legal policy that act as a barrier to implementing an effective alcohol policy also exist within the National Drugs Strategy, albeit in a different way. In the area of alcohol, economic interests prevent research recommendations being taken up. In the National Drugs Strategy, public fears, media portrayal of drugs and the illegal nature of illicit drug consumption have stopped research proposals from being implemented. Thus a conflicting value system exists in government; health promotion drugs policy, as advocated by the Minister of State in the DCRGA, views drug users as pathological and in need of therapy, while from the criminal justice perspective they are viewed as immoral rule-breakers deserving of exemplary criminal justice sanctions (Butler, 2007: 12). The broad thrust of Irish drugs policy since the establishment of the NDS has become increasingly 'tender', as exemplified by the expansion of methadone needle-exchange programs, whilst criminal justice has remained resolutely 'tough', as evidenced by the Criminal Justice Act of 1999, which provided for mandatory minimum sentences of 10 years for persons convicted of being in possession of drugs with a street value of £10,000 (€12,700) or more (Butler, 2007: 12).

These diverging policies have directly affected the National Drugs Strategy during the tenures of the previous Minister for Justice, Michael McDowell and Minister of State for the DCRGA, Noel Ahern. Minister McDowell displayed systematic resistance to the introduction of harm reduction strategies into the prison system, despite it having been advocated as part of the NDS by Minister of State Ahern. In September 2004 McDowell declared that 'there can be no question of any acceptance of any use of drugs in prisons, and all office holders in Government are bound by that cornerstone of Government policy.' Instead he proposed to achieve 'drug-free prisons' by introducing mandatory drug-testing, increasing measures to prevent drug usage, addiction counselling and treatment, and a implementing a genuine system of rehabilitation (20 Sept 2004, source Irish Times 22 Sept. 2004: 4). In response Ahern asserted that the NDS 'provides that the same types and level of drug treatment services be provided to addicts within the prison system as are available in the general community' (Ahern, 21 Sept 2004: *Ibid*). When public health advocates made specific suggestions that this meant drug-using prisoners

should be provided with needle exchange facilities in line with international best practice models, Minister McDowell denounced this suggestion as 'moral fuzziness' (Irish Times, September 29, 2004).

Thus, as documented above, the creation of strategic management structures does not seem to have resolved the traditional ideological and institutional conflict as to how the state should manage illicit drug users (Butler, 2007: 13). These tensions were brought sharply into focus in late 2005 by the resignation of Fergus McCabe from the NDST over the proposed 'mainstreaming' of the LDTFs funding¹². McCabe had been the community sector representative on the NDST since its inception and his resignation embodied the community sector's increasing lack of belief that the government's is committed to the principle of community involvement in the NDS (*Ibid*: 14).

6.9 Should alcohol be included in the National Drugs Strategy?

While the National Drugs Strategy is clearly no panacea for what appear to be intractable ideological problems, it has succeeded in creating a practical, integrated policy framework for reducing the harm associated with illicit drugs. In these circumstances, it would appear that the only viable options are either to create another policy process, a National Alcohol Strategy, comparable to and parallel with the National Drugs Strategy, and likely containing within it the same diverging health policy perspectives; or alternatively, extend the existing drugs strategy to include alcohol. The arguments in favour of the latter option seem undeniable. The process of putting together an entirely new alcohol strategy would undoubtedly be a lengthy and contentious political and administrative affair, which might ultimately come to nothing. On the other hand, the process of adding alcohol to the agenda of the existing National Drugs Strategy could proceed with relative speed, and would mean that the knowledge and experience gained over the past decade in managing illicit drug problems could now be applied in the sphere of alcohol-related problems. There would, also, be economies of scale to be derived from having a single policy structure for alcohol and illicit drugs, and the five-pillar model of the National Drugs Strategy would appear to offer an effective framework for a comprehensive policy

¹² 'Mainstreaming' refers to the process of transferring funding responsibility back to the appropriate central government department or agency. Prior to this, the LDTFs had been receiving dedicated funding negotiated through the NDST (Butler, 2007: 14).

approach to alcohol issues (House of the Oireachtas, 2006: 25). Thus, the arguments for the implementation of a national alcohol policy, either incorporated into the NDS or laid down on similar lines, seem compelling. However, in equal measure, the difficulties of establishing such a policy in opposition to the broader neo-liberal economic policies of government seem daunting.

6.10 Conclusion

The underlying ideological issues, which have so resolutely stymied the implementation of an alcohol policy founded on alcohol research, are still unresolved in the case of drugs policy. The structures upon which the National Drugs Strategy is built are less steady than they seem, and the policy process is by no means as rational or 'evidence-based' as is implied. (Butler, 2007: 15). Research is only one of the determinants of what informs policy and if research findings, such as recommending the implementation of harm reduction principles in prison, are not compatible with other policy considerations, such as the illegality of drugs, then they are not incorporated into policy. These criticisms are not meant to detract from what the National Drug Strategy has achieved. It has ushered in a more normalised and routinised style of drug policy making, something which can only truly be appreciated when one compares it to the somewhat erratic methods by which alcohol policy is decided. Furthermore, one can say that Irish drugs policy is further along the path to being able to pinpoint where research can have an impact on policy. And until such a time as that point can be found, the National Drugs Strategy is the most effective health promotion policy which exists in Ireland.

7. Discussion and conclusions

The following discussion will focus on the outcomes of the three objectives of the study drawing them together in the overall context of this research.

Objective 1: To explore the nature of alcohol consumption in Ireland and determine what changes have occurred since the emergence of greater economic prosperity.

Objective 2: To examine the nature of the interface between alcohol research and alcohol policy formation in Ireland.

Objective 3: To examine the National Drugs Strategy in terms of its strategic management structures and to determine whether alcohol can be effectively included.

7.1 Alcohol consumption in twenty-first century Ireland

The consumption of drink and the influence of alcohol in Irish society appear to have been rapidly increasing since the early 1990s. In Ireland, the past decade has been characterised by unprecedented economic growth and prosperity. This has coincided with an unequalled increase in alcohol consumption, and drinking patterns that have become highly problematic (Mongan, 2007: 8). According to the WHO (2004), Ireland has one of the highest levels of alcohol consumption in the EU. In 2001 Irish people consumed the third highest amount of pure alcohol in Europe at 14.45 litres per person, with only the Czech Republic at 16.21 litres and Luxembourg at 15.54 litres consuming more per capita. In world rankings, Ireland came fourth, with Uganda consuming the most alcohol at 19.47 per person (WHO, 2004: 12). Moreover, abstinence rates have decreased considerably since 1992, especially among women. Differentials in alcohol consumption were broadly maintained between the various sub-groups compared in Chapter 4, but the most important fact to emerge from this analysis is that all Irish people who reported consuming alcohol drank considerably more in 2002 than in 1992. Indeed, they continue to do so, as according to the 2004 ECAS study (Ramstedt and Hope, 2005), Irish drinkers have the highest percentage of weekly binge drinkers with 48% of men and 16% of women reporting binge drinking at least once weekly. For Irish men, 58 of every 100 drinking events

end up in binge drinking, while for Irish women the corresponding figure is 30 (Mongan, 2007: 12). This phenomenon of increased prosperity leading to increased consumption was predicted by Conniffe and McCoy (1993) at the onset of the Celtic Tiger, where they suggested that alcohol consumption in Ireland is income elastic. Thus, if policy makers wish to implement effective measures to reduce the level of alcohol consumed in Ireland, they need to factor individuals' increased level of disposable income into the equation.

7.2 Alcohol research – does it influence alcohol policy?

Current alcohol research locates itself firmly within the health promotion perspective. Advocates wish to see the implementation of 'an effective national alcohol policy with a strong public health basis using evidence-based strategies to reduce the harms caused by problematic alcohol use' (Mongan, 2007: 49). The belief is that a firm research base is a prerequisite for alcohol policies and actions and therefore the scientific community needs to be involved in developing scientifically sound alcohol data in order to provide socially relevant and feasible bases for alcohol policy decisions (Anderson and Baumberg, 2006: 404). A recent example of such research would be the European Union report *Alcohol in Europe – a public health perspective*, published in 2006 (Anderson and Baumberg 2006) and combined all existing health promotion evidence in order to demonstrate which health promotion policy options work and which do not. This report is essentially a Europe-wide version of the Strategic Task Force on alcohol's interim and progress reports, with a strong emphasis on introducing control policies which have been proven to work, for example recommendation V.1 for drink and driving suggests that a 'maximum blood alcohol limit of 0.5 g/L should be introduced throughout Europe, countries with existing lower levels should not increase them' (Anderson and Baumberg, 2006: 63). A recent example of how such research is employed by members of the scientific community can be seen the suggestion of professor of child and adolescent psychiatry David Schaffer, at the 2007 world congress of the International Association for Suicide Prevention in Killarney, that raising the minimum drinking age would achieve a quick and significant reduction in suicide rates among young people. Speaking about the US experience of raising the drinking age, Professor Schaffer said the most notable result was the reduction in the number of accidents and furthermore the new restriction also coincided with 7% reduction in the number of

suicides. He also noted that lowering the age seemed to have a long term effect on alcohol use (The Irish Times, 31 August 2007).

If introduced, the above public health policy proposals would undoubtedly be very effective in reducing alcohol-related problems in Ireland, after all research has proven it to be the case. However, the above examples also act as illustrations of how linear a process researchers view policy-making to be, with a direct and traceable link between evidenced-based research and policy formulation. Neither proposal has enough popular or media support to be worth the political risk of going head to head with the Licensed Vintners' Association (LVA) and the Drinks Industry Group of Ireland (DIGI), and neither proposal has even been considered in *Towards 2016*. Furthermore, neither proposal has been phrased by its advocates in a way which would make the economic and short term benefits clear to government ministers. Researchers wish to see an effective public-health orientated national alcohol policy introduced into Ireland, but the mechanisms have yet to be developed to effectively incorporate research findings into the political sphere.

In *Alcohol in Europe – a public health perspective* the authors do comment on the need for there be a much better match between the need for alcohol policy research as perceived by decision-makers and planners on the one hand, and the research priorities set by the research community on the other (Anderson and Baumberg, 2006: 404). Furthermore, they suggest that, to be useful, research evidence has to be communicated simply and given meaning by making it relevant to current issues. Thus, public health advocates have begun to see the necessity of presenting research in a manner which makes it appealing to policy-makers. The next step perhaps is accepting that, as the present neo-liberal governmental system stands, alcohol research does not create policy; policy-makers select research on the basis of its applicability to the economically-compatible policy they wish to implement. Thus, contrary to the advice of Anderson and Baumberg, public health advocates should not put some distance between themselves and either the government or the alcohol industry (2006: 404). In order to successfully participate in policy making in Ireland, researchers need to, in the words of Andrew Secker (1993: 116S) 'maintain regular, close contact with ministers, policy advisors and policy formulators' and 'know what power struggles and tensions exist between factions and pressure groups that affect ministers'. Unless researchers know how the other actors in the policy process operate, their ability to counter their strategies will be limited, as

translating research into policy is not the logical, linear process of popular belief, but rather more akin to navigating a labyrinth with the proverbial ball of yarn.

7.3 Alcohol policy – a recurring vanishing act?

The main question to be asked in regards to governmental alcohol policy is: where did it go? Over the last eleven years we have had a comprehensive National Alcohol Policy in 1996, two STFA reports detailing the policies needed to reduce alcohol consumption and alcohol-related harm in 2002 and 2004, a Joint Committee report which thoroughly investigated the feasibility of including alcohol in the National Substance Misuse Strategy and a European report which condensed current health promotion research findings into effective alcohol control strategies in 2006. And yet, no coherent alcohol policy exists in Ireland despite the recommendations of the numerous research reports listed above.

Why then has so little been done? Fundamentally, the ideological gap between health promotion advocates and policy-makers is too wide. It could be more accurately described as a gulf. Policy makers still believe that, as Senator Brady succinctly phrase it, 'alcohol itself is not a problem'. Mr Brady expressed the above sentiment during the May 2003 Seanad Éireann debate on alcohol and tobacco consumption, indeed he went on to say that 'as a nation, we enjoy a drink – but irresponsible and abusive consumption is [problematic]'. (Seanad Éireann, 2003). This statement accurately reflects the continued popularity, at a governmental level no less, of the disease concept's ethos of alcohol-the-substance as harmless and of a minority of consumers being susceptible to alcohol addiction. Government policy still prefers focusing on correcting consumer behaviour rather than on regulating the availability of the alcohol as consumer sovereignty is a tenet of our current economic system, and deregulation is much more economically and publicly acceptable than tighter regulation. The Department of Health and Children (DoHC) detail on their website how alcohol-related injuries cost the health service millions every year and alcohol-related road accidents continue to claim lives. Moreover, public order offences, most of which involved alcohol, are on the rise and underage drinking in Ireland is among the highest in Europe (DoHC, 2007). And after cataloguing the extent of alcohol-related problems, what measures do they say have been implemented in to combat these problems?

In response, the Government has developed a range of strategies to educate the public about the dangers of alcohol abuse and to reverse the trend towards excessive alcohol consumption in this country (Ibid).

Educational measures have been shown by public health researchers to have little impact on reducing alcohol intake levels and alcohol-related harm. Yet, as documented above, alcohol policy-makers continue to propose policy measures aimed at altering popular attitudes to alcohol, either by educating them to be aware of the dangers of over-consumption or alternatively, by “importing” a different societal attitude to alcohol. An example of the latter can be seen in the former Minister for Justice’s proposal to introduce ‘café-bars’ in 2005, in an attempt to replicate a Mediterranean approach to alcohol consumption in our society. Public health advocates were vehemently against the proposed policy and cited international research as evidence to show that an increase in the number of retail outlets invariably led to increased consumption. However, the stance of health promotionists seemed to have little effect on Minister McDowell’s plans. Indeed, his proposal received that backing of the Minister for Health, regardless of the fact that such an endorsement was out of line with her Department’s position on alcohol as a public health issue. The policy motion ultimately failed because of a Fianna Fáil backbenchers’ revolt over the issue (Irish Examiner, 13 June 2005).

The new Minister for Justice, Brian Lenihan seems to be edging justice policy slightly more into line with public health research. Although with no clear point of interface between the Minister’s policy plans and health promotion research, it may just be a case of research happening to be in line with policy. The Minister is considering the introduction of measures to restrict the ‘visibility’ of alcohol’, most likely in the form of restrictions on off-license opening times and has stated publicly that ‘drink has become far too easily accessible. We have to look at the point of sale’. However, a certain sense of “deja-vu all over again” permeates Mr. Lenihan’s proposals. Before implementing any changes, the Justice Minister intends to establish a new commission with a remit to independently examine the State’s licensing laws for pubs and off-licences and to consider how best to tackle the harmful effects of alcohol abuse. The Commission on Liquor Licensing, which operated under the auspices of Mr. Lenihan’s Department, produced three reports on his very subject between 2001 and 2003. Furthermore, during Mr McDowell’s tenure as Minister for Justice, the Irish Liquor Licensing Code was completely redrafted and modernised, but never implemented. Even if, as Mr Lenihan argues, the proposed commission will have a wider social remit than its predecessor, it seems excessively repetitive considering

that *Alcohol in Europe - a public health perspective* was published in 2006 and the second report of the STFA, containing alcohol-control recommendations specific to Ireland, was published just over three years ago. The need for another commission to consider what has already been considered and to compile a report that has been written several times over is questionable. Thus, the question remains as to whether the proposed commission will leave a more lasting mark than any of its predecessors.

7.4 The National Drugs Strategy – a template for alcohol policy?

The National Drugs Strategy is the National Alcohol Policy's more fortunate sibling. Both policy reports were published within weeks of each other, yet the former has become a testament to 'joined-up' government, while the latter has disappeared like the magician's proverbial vanishing act. This disparity in fortune can primarily be explained by differing legal status of alcohol, the key distinction being the illegality of drugs. The stakeholders in the drugs industry are not in a position to protest against tighter illicit drugs control measures, they do not employ legitimate lobby groups to prevent the implementation of unfavourable policy and they do not sit at the social partnership table and decide the economic and political future of the country. Furthermore, alcohol and drugs occupy different place in the public consciousness. The majority of Irish citizens regard drugs in an extremely negative fashion and illicit drugs consumption has acutely negative connotations, a viewpoint which is reinforced by uniformly negative media portrayals of the dangers of illegal drug-taking. Public and media attitudes to alcohol are much more complex. In general, alcohol as a product is regarded benignly, with much emphasis put on the traditional 'craic' and atmosphere inherent in Irish pubs. Thus, Minister McDowell's plans to deregulate the alcohol licensing industry by introducing café-bars received much public and media support because such market competition generated by café-bars would force publicans to reduce their sale prices. Contrarily, the adverse consequences of over-consumption of alcohol, such as drink-driving and alcohol-related public order offences and hospital admissions, are vilified by both the public and the media, with much emphasis placed on the need to curtail the number of such incidents and punish those who are involved in them. A recent example of this was a feature on the increase in random acts of violence in Ireland on *The Late Late Show* of 14 September 2007. Many of those with experience of these acts cited over-consumption of alcohol as being a factor in the incident, and public opinion was

centred on the need for increased police presence to combat such incidents and for punishment of those involved in such acts. Public health research has shown that alcohol-control measures are the most means by which to reduced incidents of alcohol-related harm such as the random acts of violence detailed on *The Late Late Show*, but until such measures cease to be regarded as detrimental to policy stakeholders and public enjoyment of 'a good night out'¹³, a National Alcohol Policy founded on health promotion research will most likely not be introduced into Ireland.

The National Drugs Strategy has undoubtedly been successful in normalising and harmonising illicit drugs policy-making (Butler, 2007: 15). However, it too has suffered from ideological tensions which originate from the differences between health promotion research and political policy-making. Contrary to the case of alcohol, the tensions between drugs research and drugs policy lie with the facilitating nature of harm reduction strategies and the censorious political and public attitude to illicit drugs. While it is unclear where the point of interface between drugs research and policy-making actually occurs, some degree of rationality has been introduced into illicit drugs policy-making because of the establishment of a cross-cutting National Drugs Strategy, and as such it acts as the most effective template from which to build a National Alcohol Policy. It would create a clearer forum for public health research findings to be applied, as well as being the most time- and cost effective means of creating a 'joined-up' alcohol strategy. Indeed, recent events have indicated that the time may be ripe for the next act in the magician's repertoire, the reappearance of a National Alcohol Policy. The new Minister for Drugs Strategy, Pat Carey, has indicated a move toward a joint drugs and alcohol policy and has met with Minister for Health, Mary Harney, to devise a joint awareness strategy. Under the present proposals the Department of Health would continue in its role as lead department in regards to alcohol consumption policy. Representatives from the drugs unit, in the Department of Community, Rural and Gaeltacht Affairs, are currently sitting on a working group with a remit to devise the next alcohol strategy. However, contrary to what research has indicated is the best course of actions, Minister Carey favours implementing parallel policies with separate strategies for alcohol and illicit drugs. The Minister does not believe that incorporating alcohol into the National Drugs Strategy is the best course of action because alcohol is a 'legal' drug (European Anti-Poverty Network Ireland, 13 August 2007). Thus, it remains to be seen whether this new venture will have more success than the previous attempts,

¹³ 'Don't let too much drink spoil a good night out' was the theme of a 2003-2005 poster campaign in Wave 3 of the Scottish Executive's Alcohol Misuse Campaign (Scottish Executive, 2006: 1)

given that setting up a separate cross-cutting structure for formulating alcohol policy will involve creating an entirely new strategy to concentrate solely on alcohol policy. This will undoubtedly be a lengthy and contentious political and public affair, given that those with a vested interest in alcohol sales have considerable political clout and legitimacy, and could ultimately come to nothing, yet again (Joint Committee, 2006: 26).

7.5 The search for an alcohol research/ policy interface

Public policy making is a complex process and involves competing interest groups and ideologies rather than logical or evidence-based activity. High-level political commitment to applying alcohol research recommendations to alcohol policy is lacking. Indeed no consistent political commitment to the application of health promotion concepts to alcohol policy seems to exist. Rather, the case seems to be that politicians selectively support particular initiatives when these initiatives have popular support (Butler, 2002a: 223). Thus, the introduction of penalty points for driving over the legal Irish BAC limit received political support because of its media-generated image as effective way to reduce road deaths. However, this is not an unusual occurrence in the policy-making process, research is not the sole determinant of policy and it displays a certain amount of naivety in regards to how the policy-process works that researchers would consider that it would have such a definitive effect on policy, the findings do not 'speak for themselves' in terms of the logic of translating them directly into policy. At no point in the history of the Irish State has the government had a clear mandate for the implementation of strict alcohol control policies, and given the economically vibrant neo-liberal culture in which we reside, it seems unlikely to develop one in the near future.

Ultimately, this study of alcohol research and policy deduces that, where the site of 'interface' between public health research and governmental policy should stand, there is instead a gulf, and as yet no bridge seems to exist between the ambitious rhetoric of health promotionists and the realities of human behaviour and governmental public policy. As things currently stand in regards to alcohol, health promotion is 'not a realistic proposition, but merely a pious aspiration' (Butler, 2002a: 225). The first step to bridging this gulf would seem to involve acknowledging how wide the gulf actually is. Until such a time as this occurs, we remain locked into the

Sisyphean¹⁴ task of conducting research which has little effect on policy and creating policy which has no discernible basis in research.

¹⁴ Sisyphus was the Greek king condemned to Tartarus for transgressing against Zeus. He attempted to trick his way back to the world of the living several times and, as punishment, the gods placed him under a compulsion to roll a colossal rock up a steep hill, but before he reached the top of the hill, the rock always escaped him and he had to begin again. Thus, a sisyphean task is one which can never be achieved, but must be repeatedly attempted (Simon, 2007).

Appendix A: SFTA Interim Report 2002 – Summary of recommendations

Strategy Areas	Recommendations
R1 Regulate availability	<ul style="list-style-type: none"> 1.1 Increase taxes 1.2 Establish National ID card that can be used for alcohol purchase 1.3 Restrict greater availability – any new license must meet specific criteria 1.4 Provide for Health Boards to intervene in licensing system
R2 Reduce drink driving	<ul style="list-style-type: none"> 2.1 Introduce random breath testing 2.2 Lower BAC to .50 mg% 2.3 Lower BAC to zero for provisional drivers
R3 Limit harm in drinking environment	<ul style="list-style-type: none"> 3.1 Target hot spots – map locations 3.2 Enforce law that prohibits serving to intoxicated person 3.3 Restrict alcohol sales promotions that encourage high risk drinking 3.4 Mandate RSA programme for license renewal
R4 Protect children and reduce pressure on adolescents to drink	<ul style="list-style-type: none"> 4.1 Reduce exposure of children to alcohol marketing (placement, content, sponsorship) and compliance with codes and regulations 4.2 Encourage sports organisations to promote alcohol-free environments for children 4.3 Restrict children from pubs at certain times.
R5 Provide information, education and services	<ul style="list-style-type: none"> 5.1 Raise awareness of importance of public health alcohol policy. 5.2 Develop delivery of SPHE, in and out of school setting. 5.3 Expand alcohol policy development for out of school setting. 5.4 Discourage high risk drinking. 5.5 Expand services for those experiencing alcohol related problems.
R6 Research and monitor data	<ul style="list-style-type: none"> 6.1 Put in place systematic data collection. 6.2 Continue with appropriate research.

Appendix B: Rabbitte Report – Summary of conclusions

Structures

It is recommended that:

- there be structures for the effective, co-ordinated delivery of the drugs services at national, regional and local level.
- a **Cabinet Drugs Committee**, chaired by the Taoiseach and comprising the Ministers for Health, the Environment, Education and Justice and the Minister of State to the Government, be established, to give political leadership in the fight against drugs, to review all trends in the drugs problem, to assess progress in the strategy to deal with the supply of and demand for drugs and to resolve any policy or organisational problems which may inhibit an effective response to the drugs problem.
- A **National Drugs Strategy Team**, reporting to the Cabinet Drugs committee and comprising experienced personnel from relevant Departments and their agencies, be established as a cross-departmental team of the type envisaged in the Strategic Management Initiative in the Public Service. The Strategy Team will also include members with a background in the voluntary and community sectors dealing with drugs. While accountability for individual programmes will remain with the relevant Ministers, the Strategy Team will be mandated to implement the Government's strategy in relation to drugs, in particular to maintain a close liaison with the eleven areas identified in this report as having the most acute drugs, particularly heroin, problem and to ensure that their problems and priorities are continually monitored at central Government level.
- a **Local Drugs Task Force** be established in each of the eleven areas identified in this report as having the most acute drugs problem and, therefore, requiring priority action. Each Task Force will comprise representatives of all relevant agencies, including the Health Board, the Gardaí, the Probation and Welfare Service, the relevant Local Authority, the local Youth Service and voluntary Drugs Agencies, together with community representatives and a chairperson proposed by the local Partnership Board and a co-ordinator provided by the relevant Health Board.
- each Local Drugs Task Force will be mandated to prepare a development plan, which will build on existing or planned services in the area, while also taking account of the local Partnership and LES programmes. Funding, over and above what is already in place, may be allocated by the Government to the Task Forces to support the implementation of the development plans, following their assessment by the National Drugs Strategy Team, based on criteria to be finalised in due course.
- The National Co-ordinating Committee on Drug Misuse is establishing **Regional Co-ordinating Committees** in each Health Board area. These will provide a valuable forum for joint planning between the various agencies and the voluntary/community sector. In view of the proposed establishment of the National Drugs Strategy Team, the National Co-ordinating Committee should be discontinued when the Regional Committees have been established.

Information/Research

It is recommended that:

- the Regional Health Boards proceed with the planned establishment of information databases as quickly as possible, but in such a way as to enable effective exchange of information between each Health Board region.
- an early-warning system be developed to alert the appropriate authorities to new types of drugs coming onto the market.
- the information available to community/voluntary organisations and all relevant professionals be fully reflected in the compilation and dissemination of data.
- the scientific and research community be assisted to contribute to the fight against illegal drugs.
- the further development of expertise in addiction studies in third level institutions be encouraged.

Treatment

It is recommended that:

- the overall strategy of the Health Boards be to:
 - eliminate the current treatment waiting lists; and
 - organise locally-based treatment access/outreach services, so that those who have not yet presented for treatment can be encouraged to do so.
- the Health Boards continue to expand their range of services, paying particular attention to the needs of young drug misusers.
- treatment waiting lists in Eastern Health Board region be eliminated during 1997.
- as locally-based treatment centres provide the best response to the needs of drug misusers, the Eastern Health Board consult fully with, and involve communities, to gain support for and confidence in their plans for such centres.
- further mobile clinics be developed.
- the GP/Pharmacist methadone prescription/dispensing scheme continue to be expanded, evaluated and strictly regulated.

- a telephone helpline be established in the Dublin area to provide information/advice to people in crisis situations.

Rehabilitation

It is recommended that:

- more emphasis be placed on providing options for stabilised drug misusers by way of occupational and social skills training (the Soilse and Saol projects serve as appropriate models in this regard)
- priority status be given to all Community Employment (CE) applications offering work experience/training for recovering addicts that are integrated with other support services.
- priority status be given to all CE applications offering work experience/training for former addicts who are employment ready.
- FAS and LES work closely and establish links with the sponsors of CE projects providing opportunities for former drug addicts who are employment ready, with a view to providing every assistance to the participants to progress to mainstream employment.

Education/Prevention

It is recommended that:

- in expanding its anti-drugs programme into primary schools during the current school year, the Department of Education pilot this programme in a number of primary schools, including a number of schools in the “priority” areas, following which the programme should be disseminated immediately to all primary schools in the “priority” areas.
- to accompany its introduction of the anti-drugs programme to primary schools, the Department of Education involve the Education partners and the community and voluntary sectors in the delivery of education programmes in schools and consult them in regard to the review of the programmes.
- in-service training be provided, as a matter of priority, for teachers in schools in the “priority” areas, so as to ensure their effective involvement with the schools anti-drugs programme.
- specific training be provided for home/school liaison teachers, so that, in programmes with parents, the schools anti-drugs programme can be explained and parental support elicited.

- the “On My Own Two Feet” project be extended, on a phased basis, to all second-level schools in the “priority” areas.
- particular emphasis be placed on early childhood intervention and, within this, ensuring that:
 - * priority is given to schools in the “priority” areas when the “Early Start” programme is being further expanded;
 - * the advice of the Education Research Centre is sought in relation to the inclusion of the level of drug misuse in the school catchment area as a criterion in any future expansion of the “Breaking the Cycle” initiative; and
 - * there is co-ordinated development of each of these initiatives.
- as a priority, a range of Departments and their supporting agencies develop programmes aimed specifically at addressing the deficit in parenting skills, which has become apparent in modern society and which exacerbates the problem of substance misuse and anti-social behaviour in general.
- home/school liaison teachers be appointed, on a phased basis, in each school in the “priority” areas which does not currently have the services of such a teacher.
- family support services be strengthened through the Health Boards and voluntary agencies, having regard to the recommendations of the Commission on the Family.
- to deal with the specific problem of severely disruptive pupils and their effect on learning in the school, teacher counsellors be appointed to schools in the “priority” areas, as and when the scheme is expanded.
- an examination be made of ways in which the Department of Social Welfare’s Community Development Programme might be used to assist the communities in the “priority” areas cope with and prevent problems which arise from drug abuse in their areas.
- enhanced truancy measures be put in place, including an obligation on schools to report, within the terms of the school attendance legislation, on any pre-Junior Certificate students whom they believe have left the school, and that special programmes be devised to deal with the needs of such early school leavers.
- information campaigns be more realistic and targeted, specifically they should:
 - * be developed in consultation with the community/voluntary sectors;
 - * use positive role models;
 - * use former addicts, to get the message across in a graphic manner; and
 - * be delivered in a style which is easily understood by the target audience.

- the Youthreach programme be expanded in the “priority” areas.

Estate Management

It is recommended that:

- an Estate Improvement Programme be introduced by the Department of the Environment to assist local authorities in tackling the problems of severely run-down urban housing estates and flat complexes and that a sum of £3 million be provided for such a programme over the period 1997/1998.
- the relevant local authorities and Partnership companies work particularly closely with the local communities in the management of housing estates and flat complexes in the “priority” areas.

Sport

It is recommended that:

- the relevant Local Authorities take the initiative in maximising the use of existing sports and recreation facilities in the “priority” areas and in developing sports and recreation activities in those areas, within the framework of the national sports strategy which is being developed.

Community Policing

It is recommended that:

- a comprehensive community policing strategy be developed in the “priority” areas, involving a re-deployment of Garda personnel to these areas.

Allocation of Funding/Resources

It is recommended that:

- more emphasis be placed by Departments on targeting all relevant programmes, including those financed from the National Lottery, at the “priority” areas.

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