Strategic Task Force on Alcohol

Second Report

September 2004

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DEPARTMENT
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CHILDREN
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SLÁINTE AGUS LEANAÍ

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Section 1: Introduction

The Minister for Health and Children established the Strategic Task Force on Alcohol (STFA) in January 2002, as recommended in the first report of the Commission on Liquor Licensing.

The brief of the Strategic Task Force on Alcohol is, inter alia, to recommend specific, evidence based, measures to Government to prevent and reduce alcohol related harm in Ireland.

(full STFA terms of reference in Annex 2)

1.1 Public health approach

The public health approach to alcohol policy has emerged over the last three decades because of the weight of evidence-based scientific research. This approach, endorsed by the World Health Organisation (WHO), recognises that alcohol contributes to a range of health, social and behavioural problems - in terms of its toxicity, its potential to create dependency and its negative impact on human behaviour. The overall level of alcohol consumption and the predominant pattern of drinking in the population, are predictive of the incidence and prevalence of alcohol problems in any given society. Therefore, alcohol policy must take into account the total drinking population when defining the scope of public health action as well as targeting high-risk groups and individual high-risk drinkers.

1.2 Strategic Task Force on Alcohol approach

The Strategic Task Force on Alcohol, under the aegis of the Department of Health and Children and chaired by the Chief Medical Officer, has endorsed the principles of a public health approach as the framework for developing recommendations to reduce alcohol harm in Ireland. The ten strategy areas of the WHO Charter on Alcohol and the European Alcohol Action Plan form the basis for the work of the Task Force.

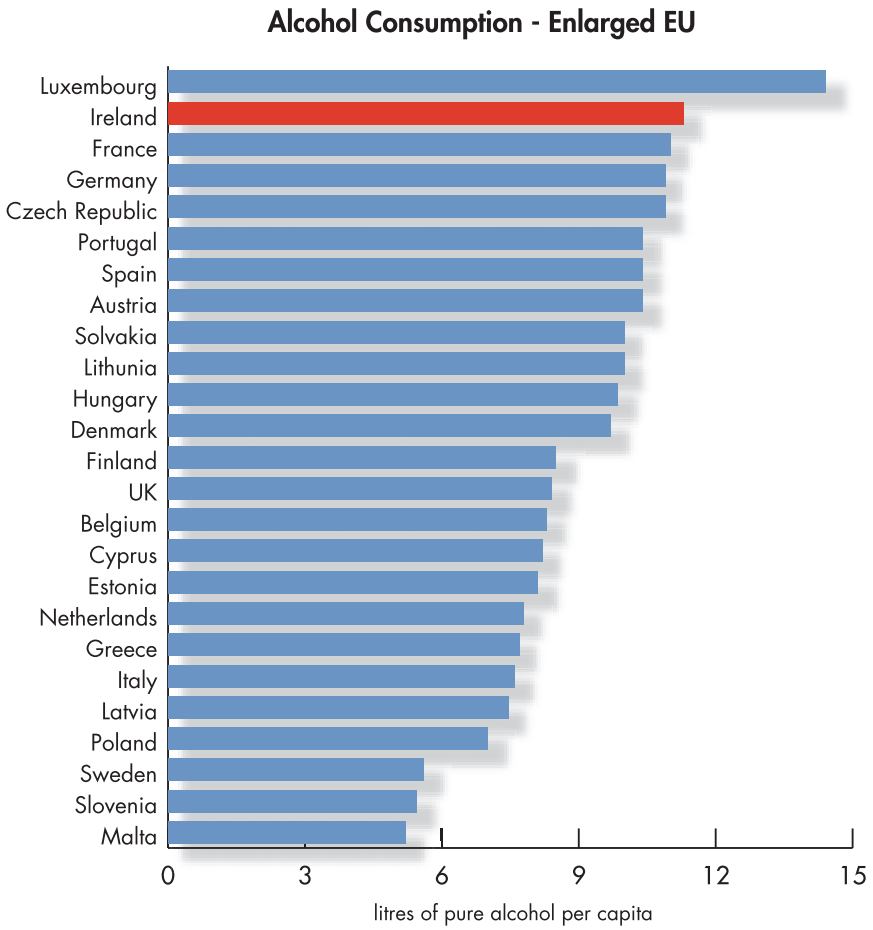
Since the publication of the Strategic Task Force Interim Report in May 2002, an international publication on alcohol policy was published in 2003 - *Alcohol: no ordinary commodity, research and public policy*.[1] This comprehensive global review of alcohol policy, sponsored by the World Health Organisation, has enriched the scientific research evidence and has proved informative and timely for the current work of the Strategic Task Force on Alcohol.

Section 2: Current trends in alcohol consumption

2.1 Alcohol consumption

Ireland continues to be amongst the highest consumers of alcohol in the world. In the new enlarged European Union, Ireland ranks second after Luxembourg for alcohol consumption in 2001 (the most recent available international data). The overall per capita consumption (per head of the total population) ranges from a low of 5.39 litres in Malta to a high of 14.4 in Luxembourg (Figure 1).

Figure 1: Alcohol consumption per capita in the countries of the enlarged European Union, 2001

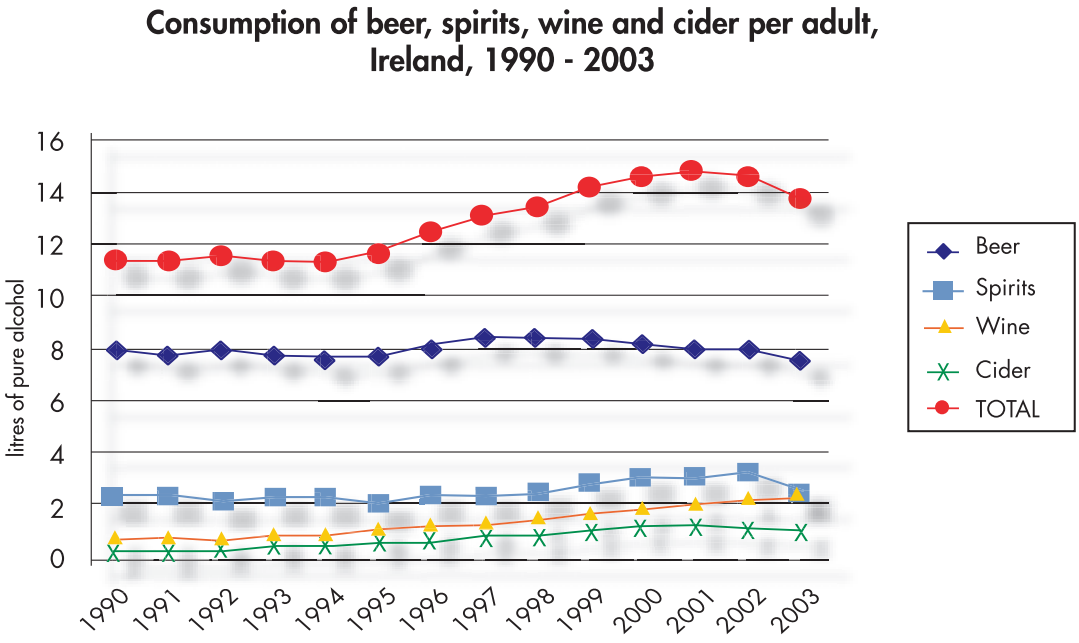


Source: WHO, Health for All Database, 2001

Alcohol consumption **per capita** is used for international comparisons. To establish a more accurate figure for the consumption rate in Ireland, given that alcohol is mainly consumed by adults, those under 15 years (representing 21% of the population) are excluded from the **per adult** consumption rate. Therefore, the alcohol consumption rate per adult is always higher than the per capita rate and is a more accurate reflection of the consumption rate in the country.

Alcohol consumption in Ireland peaked in 2001 at 14.4 litres of pure alcohol per adult, aged 15 years and over (Figure 2). In 2003, alcohol consumption in Ireland showed a decline for the first time in over sixteen years. The overall decrease in 2003 (-6%) was mainly due to a large drop in spirit sales and to a lesser extent a drop in beer sales during the year. One of the main reasons for this decline was an increase in excise duty on spirits (see Section 4.1 for more details). In 2003, alcohol consumption per adult was 13.5 litres of pure alcohol.

Figure 2: Alcohol consumption per adult (aged 15 and over), Ireland 1990-2003



Source: Revenue Commissioners and CSO Annual Reports

While beer continues to be the most popular alcoholic drink in Ireland, the market share of the different types of alcoholic beverages has changed over the last three decades. In 1972, the market share for beer was 65%, by 1992 that had increased to 70% but more recently has dropped to 54% (Table 1).

Table 1. Consumption of alcohol by beverage category in litres of pure alcohol and as percentage of total consumption

	1972	1982	1992	2002
Alcohol consumption per adult	7.72	8.77	11.35	14.34
Consumption of beer	5.05	5.66	7.93	7.71
Consumption of spirits	2.22	2.36	2.18	3.17
Consumption of wine	0.35	0.61	0.83	2.27
Consumption of cider	0.10	0.15	0.41	1.19
Percent of beer	**65**	**64**	**70**	**54**
Percent of spirits	**29**	**27**	**19**	**22**
Percent of wine	**5**	**7**	**7**	**16**
Percent of cider	**1**	**2**	**4**	**8**

Source: Revenue Commissioners and Central Statistics Office, Annual Reports

The growth of wine and cider consumption has been very strong with an almost three-fold increase in consumption and a doubling of the market share between 1992-2002, from 7% to 16% for wine and from 4% to 8% for cider. These changes suggest that the Irish drinking population continue to consume and increase their consumption of traditional drinks, while also adding wine to their drinking habits.

2.2 Drinking Patterns

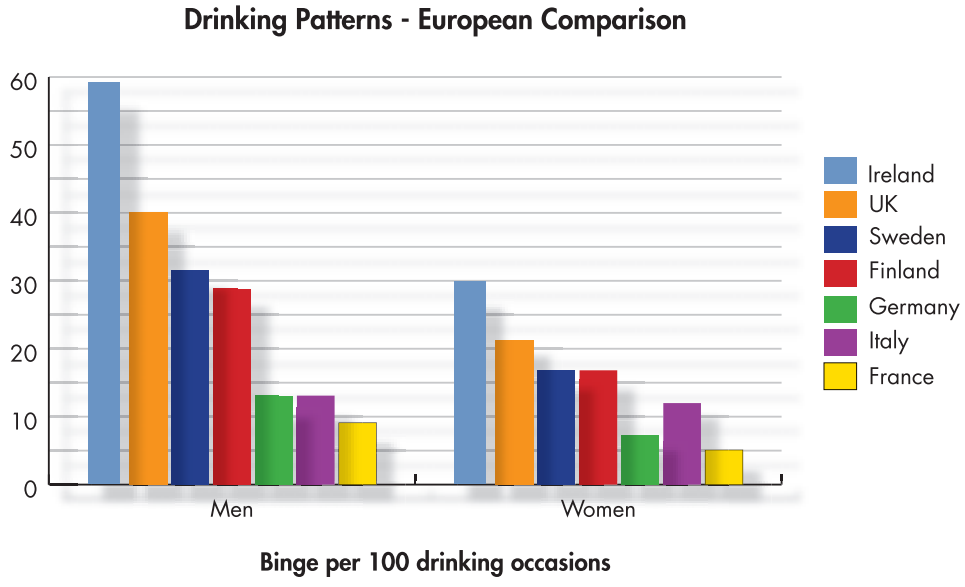
The amount of alcohol consumed per occasion and the frequency and circumstances of drinking reflect drinking patterns. High risk drinking is the type of drinking that is likely to increase the risk of harm for the drinker or for others, such as binge drinking, drinking to intoxication and regular heavy drinking. Binge drinking is a term used to describe a single occasion of excessive drinking, defined by the WHO as six or more standard drinks* (60 grams of pure alcohol) (Annex 3).

Binge drinking and drinking to intoxication is particularly linked to an increased risk of short-term (acute) harm such as accidents, injuries, violence and poisoning. Drinking above the guidelines of more than 14 standard drinks per week for women and 21 for men is linked to increased risk of long-term (chronic) harm, such as high blood pressure, cancers, cirrhosis and alcohol abuse.

2.2.1 Adults

A recent study showed that adults in Ireland had the highest reported consumption per drinker and the highest level of binge drinking in comparison to adults in other European countries[2] (Figure 3).

Figure 3: Drinking Patterns- European Comparison.

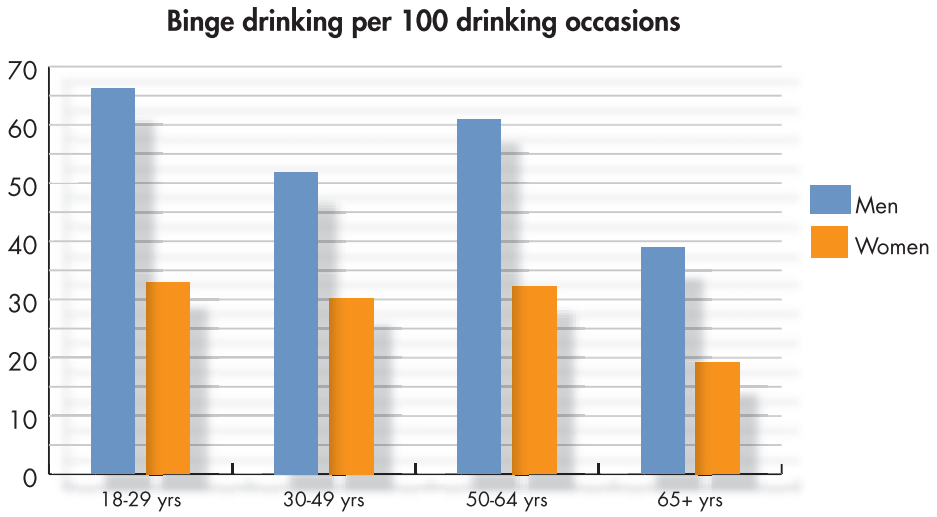


Source: Ramstedt & Hope[2]

* A standard drink is equal to a half pint of beer or a single measure of spirits or one glass of wine.

The study showed that binge drinking is the norm among Irish men; out of every 100 drinking occasions, 58 end up in binge drinking. Among women, 30 occasions out of 100 end up in binge drinking. Binge drinking was conservatively defined in this study as drinking at least one bottle of wine, or 7 measures of spirits, or 4 pints of beer or more, during one drinking occasion (75/80 grams of pure alcohol). While young Irish men (18-29 age group) reported the highest consumption of alcohol and had more binge drinkers than any other group in the population, binge drinking was common in all age groups up to 64 years (Figure 4). A summary of this research study can be found in Annex 4.

Figure 4: Binge drinking across age groups and sex



Source: Ramstedt & Hope[2]

The national lifestyle survey (SLÁN) reported an increase from 1998 to 2002 in the number of people drinking six or more drinks on one drinking occasion, (defined as binge drinking by the WHO). The same survey found that 30% of males and 22% of females consume over the recommended upper limit of 21 standard drinks for men and 14 for women, with higher levels in the younger age group[3] (Table 2).

Table 2: Percentage consuming more than the recommended upper weekly limits (14/21 standard drinks) by sex, age and educational status.

	Males *ED1	Males ED2	Males ED3	Females ED1	Females ED2	Females ED3
18-34 years	44	34	35	27	27	26
35-54 years	25	30	21	25	20	20
55+ years	28	20	34	8	20	22

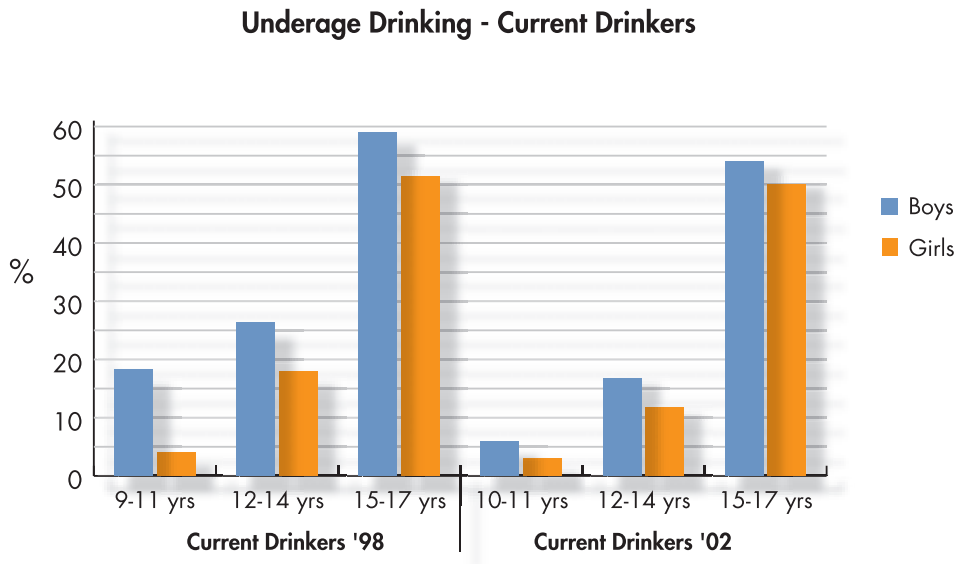
**ED1= some secondary ed; ED2=complete secondary ed; ED3= some or complete third level ed*

Source: The National Health & Lifestyle Surveys, 2003

2.2.2 Children

The 1999 international ESPAD report (European School Survey Project on Alcohol and Other Drugs) showed that Irish boys and girls aged 16 years are among the highest alcohol abusers in Europe in terms of binge drinking and drunkenness[4]. One in three were regular binge drinkers and one in four reported being drunk ten or more times in the last year. The more recent Health Behaviour in School Children (HBSC) survey reported a decrease in the number of children under 15 years of age experimenting and consuming alcohol, but there was no reported change in the drinking patterns of the 15 -17 age group between 1998 and 2002[5] (Figure 5). In 2002, among the 12-14 age group, 16% of boys and 12% of girls were current drinkers in comparison with 1998, when 26% (boys) and 17% (girls) were current drinkers. However, in the 15-17 age group, about half of the boys and girls were regular drinkers and drunkenness was also prevalent (60% boys, 56% girls).

Figure 5: Underage Drinking, percent of Current Drinkers by age groups, 1998-2002



Source: Nic Gabhainn, HBSC 2002

Between 1998 and 2002, the consumption of alcopops on a weekly basis increased dramatically among girls as did spirits consumption. In 2002, alcopops was the most popular drink among girls of all ages while beer and cider continued to be the most popular drinks among boys[5].

2.3 Availability of Alcohol

A licence must be obtained from the Revenue Commissioners in order to sell alcohol. This licence must be renewed each year. Generally, the Revenue Commissioners are not permitted to issue such a licence unless the applicant presents a certificate issued by the District or Circuit Court. The Court will

only issue a certificate when it has considered any objections to the licence. If it is satisfied that the objections are well founded, it may decide not to grant the application. However, in certain cases, e.g. wine off-licence, such a certificate is not currently a requirement and there is no opportunity for a court to consider any objections to the opening of such an outlet. For a full off-licence three separate off-licences are required, spirits and beer off-licences are obtained from the Court and the wine off-licence is obtained directly from the Revenue Commissioners. The number of wine off-licences has substantially increased in recent years (Table 3).

Table 3: Number of Liquor Licences issued in 1993 and 2002

Type of Liquor Licences	1993 Number Issued	2002 Number Issued
Retailers of Spirits		
Total publicans	10,190	9,896
Off-licences	368	808
Special restaurant	112	279
Restricted licence conversion		**3**
Retailers of beer		
On-licence	6	8
Off-licences	362	763
Retailers of Cider & Perry		
Off-licences	13	10
Retailers of Wine		
On-licence	1700	2444
Off-licences	364	2023
TOTAL	**13,115**	**16,234**

Source: Revenue Commissioners Annual Reports

Registered clubs are an additional type of outlet selling alcohol. The Revenue Commissioners' figures in Table 3 do not include registered clubs. In 1996, 919 clubs were registered[6]. Most of these clubs, established for social or other sporting purposes, can register the club in the local District Court, but do not require a liquor licence to sell alcohol. However, there are strict regulations if alcohol is served in such clubs.

The most common way to extend the regular licensed opening hours for bars and clubs is to apply to the courts for a special exemption order where the judge sets the permitted hours of extension for alcohol sales. In 1994, the number of special exemption orders granted by the courts was 55,290, up from 6,342 in 1967[7]. In 2001, 75,498 special exemption orders were granted and by 2002 the number had increased to 81,933[8]. This reflects the greater availability of alcohol beyond the regular opening hours. The increase of special exemption orders in 2002 was all the more remarkable given that the opening hours had also been extended.

2.4 Spend on Alcohol

The amount of money spent on alcohol continues to increase each year. In 2002, nearly €6 billion of personal income was spent on alcohol in Ireland, which represents €1,942 for every adult (15 years and over)[9]. Personal expenditure on alcohol was €3.3 billion in 1995.

The average weekly expenditure on alcohol represents 5.5% of the total household spend[10]. The major portion of alcohol expenditure (80%) is spent on drink consumed outside the home with the largest spend (82%) on beer, followed by spirits (14%), and wine (4%). Drink consumed at home is spread across wine (50%), beer (30%) and spirits (20%).

Alcohol products are subject to Government taxes including excise duty and value added tax (VAT). In 2002, the net excise duty receipts received were just under €1 billion (Table 4). In addition, the 2002 estimated figure for VAT was €897 million, thus giving a total of €1.8 billion in revenue to the Government from alcohol taxes[11].

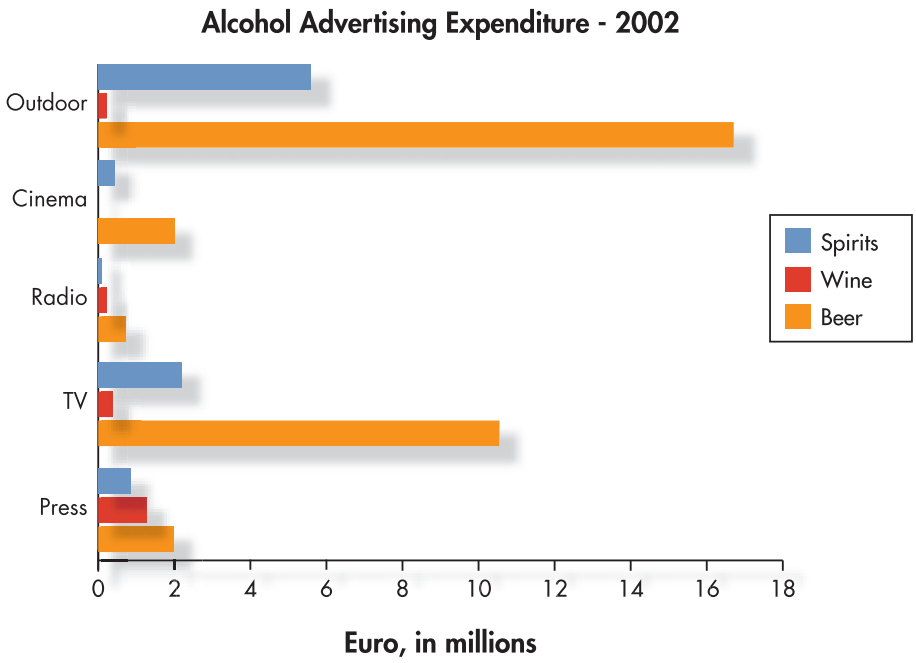
Table 4: Excise Duty receipts for alcohol products in 2002

Alcohol product	Net Excise Receipts in 2002 - euro
Beer	477,361,327
Spirits	266,461,434
Wine	152,153,947
Cider	62,147,264
TOTAL	**958,123,972**

Source: Revenue Commissioners, Annual Report, 2002

The amount of money spent on alcohol advertising, excluding sponsorship and other promotion activities, continues to increase substantially each year. In 1996, the alcohol advertising spend in Ireland was €25.4 million which increased to €30.5 million in 2000 and by 2002 the spend on alcohol advertising was €43.2 million across television, radio, cinema, outdoor and press[12] (Figure 6). There are no published figures for the total spend on alcohol sponsorship of sport.

Figure 6: Alcohol Advertising Expenditure 2002



	Press	TV	Radio	Cinema	Outdoor
Spirits	0.86	2.19	0.07	0.43	5.58
Wine	1.26	0.38	0.23		0.22
Beer	1.99	10.55	0.71	2.02	16.71

Source: IAPI Ad-spend: all figures are at rate card cost.

Section 3: Evidence of alcohol related harm Recent trends

3.1 Alcohol: a burden of premature death and ill heath

The Global Burden of Disease study, sponsored by the World Health Organisation and the World Bank, found that alcohol was the third most detrimental risk factor for European ill health and premature death[13]. In 2002, alcohol related death and disability accounted for 9.2% of all burden of disease, with only tobacco (12.2%) and high blood pressure (10.9%) causing more harm. Alcohol was a more important risk factor than high cholesterol and being overweight, three times more important than physical inactivity and five times more important than illicit drugs. The burden of disease is measured by Disability Adjusted Life Years (DALYs), which combines years of life lost to premature death with years of life lost to disability.

In 2000, the global burden of disease attributable to alcohol, by major disease category, shows that injuries (unintentional and intentional) account for the largest portion (40%) of disease burden, followed by neuropsychiatric conditions (Table 5).

Table 5: Global burden of disease attributable to alcohol by major disease categories

Disease conditions	%
Neuropsychiatric conditions: alcohol dependency syndrome, depression, anxiety disorder, organic brain disease	37.7
Accidents and unintentional injuries: road and other transport injuries, falls, drowning and burning injuries, occupational and machine injuries, alcohol poisoning	27.2
Intentional and self-inflicted injuries: suicide and assaults	12.9
Gastrointestinal conditions: liver cirrhosis, pancreatitis	7.8
Cancers: head and neck cancers, cancers of the gastrointestinal tract including liver cancer, female breast cancer	7.2
Cardiovascular conditions: ischaemic heart disease, cerebrovascular disease	6.9
Maternal and perinatal conditions: low birth weight, intrauterine growth retardation	0.2
Alcohol-related disease burden, all causes (DALYs)	**100**

Source: Rehm et al. WHO, 2003, adapted from Babor et al. 2003

Alcohol is an even greater risk factor in the lives of young people. It is estimated that alcohol causes 1 in 4 of all deaths of young men in Europe aged between 15 and 29 years. The majority of these deaths result from injuries (unintentional and intentional). For young men, alcohol contributes to nearly half of all deaths from all motor vehicle accidents, over one-third of poisonings, drownings, homicide and falls and in one-fifth of suicides. For young women, aged between 15 and 29 years, alcohol contributes to about one in three of all deaths from poisonings, drownings and homicide and one in five deaths from motor vehicle accidents and falls[14].

3.2 Alcohol related harm in Ireland

Alcohol-related harm happens to those who don't drink, those who drink small amounts but in a risky situation, those who drink to excess sometimes and those who regularly abuse alcohol. Alcohol harm is visible throughout Ireland; on the streets, in the courts, hospitals, workplaces, schools and homes. Despite the tendency to 'blame' underage drinkers, the vast majority of alcohol harm occurs among the adult population, for example, street violence, accidents, hospital admissions, drunk driving, alcohol poisoning, suicides, alcohol dependency, cancers and cirrhosis.

3.3 Alcohol related mortality

In Ireland, alcohol related mortality has increased over the last decade. Examination of just five of the conditions, outlined in Table 6, illustrates the continuing increase in the burden of alcohol on premature death. Over the period 1992-2002, 14,223 people died in Ireland from these five main alcohol leading causes. The number of deaths in a single year was highest in 2001 at 1,542 deaths - the year that alcohol consumption per capita peaked. The corresponding figure for 2002 was 1,416 deaths for these five conditions.

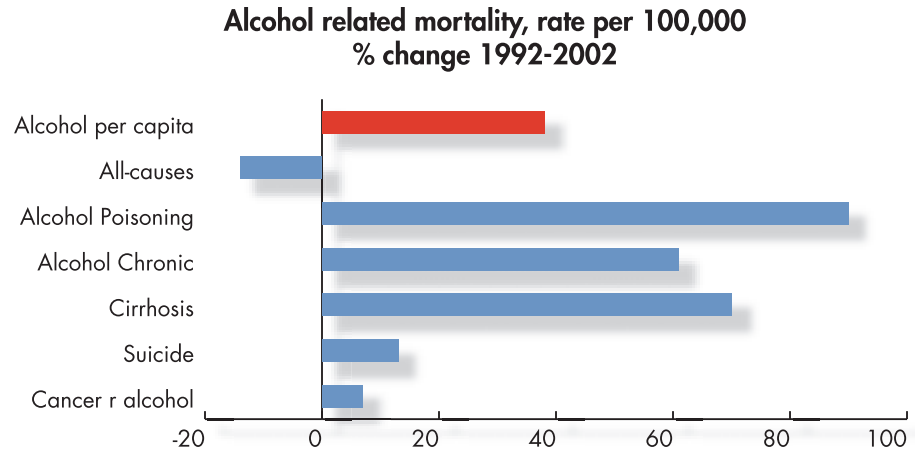
Table 6: Alcohol related mortality 1992-2002, rates per 100,000

Disease	1992	2002
1. Cancers related to alcohol: mouth, throat, oesophagus, liver	15.53	16.67
2. Alcohol chronic conditions: alcohol dependency, alcohol abuse, alcohol psychosis	1.49	2.40
3. Chronic liver disease and cirrhosis	2.70	4.60
4. Alcohol acute conditions: alcohol poisoning, toxic effect of alcohol	0.51	0.97
5. Suicide	10.20	11.50
Alcohol consumption, per capita	**8.23**	**11.31**

Source: CSO Vital Statistics, Annual Reports

The increase in alcohol consumption corresponded with an increase in alcohol-related deaths between 1992 and 2002, especially the alcohol specific chronic (+61%) and acute conditions (+90%). This contrasts sharply with a decrease in the overall number of deaths (-14% for all-cause mortality) and decreases in all cancer deaths and deaths from disease of the circulatory system such as heart disease and stroke (Figure 7). In addition, alcohol is a factor in drowning. In 2002, the Irish Water Safety reported that 37% of all deaths from drowning were alcohol related[15].

Figure 7: Alcohol related mortality, % change 1992-2002



Source: CSO Vital Statistics, Annual Reports

3.4 Health Service demand

Alcohol related problems present at different levels in the health service sector. Alcohol continues to be an important factor for those in attendance in the hospital emergency room, especially late at night and at weekends. Alcohol and drug use was identified as a significant problem among the young population of North Dublin where over 38% of those under 31 years were in attendance in the emergency room primarily due to alcohol[16]. Major sporting events are also linked to increased alcohol related injuries presenting in the emergency room. During the Football World Cup 2002, alcohol was identified as a factor in injuries in over half of all the cases presenting to the emergency department[17].

Alcohol use during pregnancy is a growing concern, because of the damage that can be done to the baby especially during the early stages of pregnancy when the central nervous system is developing. A recent study of women attending an Irish maternity hospital reported that 85% of the women continued to drink during pregnancy[18]. Alcohol is a factor in 42% (3,468) of all cases of parasuicide in Ireland with a higher incidence among males (46%) than females (38%)[19].

In a study of two health board areas (SEHB and SHB), which examined treatment service demand, over 70% of those treated for problem substance use reported alcohol as their main problem drug[20]. In 2001 and 2002, nearly 60% had never previously been treated (Table 7). These new cases were younger and were more likely to be employed than their previously treated counterparts. Although those presenting for treatment were mainly males, there was an increase in the proportion of new female cases, which suggests an increase in problem alcohol use among women. Polydrug use was also evident, in that one-fifth of the cases reported using alcohol with other drugs, chiefly cannabis. The data in this report is from the statutory and voluntary treatment services (residential and non-residential) but does not include those accessing treatment in the in-patient psychiatric services or the acute psychiatric departments of the general hospitals.

Table 7: Treatment demand for problem alcohol use in the South Eastern and Southern Health Board Areas 2001-2002

	SEHB 2001		SEHB 2002		SHB 2001		SHB 2002	
	No	(%)	No	(%)	No	(%)	No	(%)
Main problem substances								
Alcohol	1472	(76.7)	1498	(71.5)	852	(61.0)	1160	(64.2)
Drugs (licit or illicit)	447	(23.3)	598	(28.5)	544	(39.0)	647	(35.8)
Problem Alcohol Use								
Newly treated cases	846	(57.5)	842	(56.2)	585	(68.7)	669	(57.7)
Previously treated cases	604	(41.0)	638	(42.6)	254	(29.8)	488	(42.1)
Treatment status unknown	22	(1.5)	18	(1.2)	13		3	
Cases under 18 years old								
All problem alcohol use	83	(5.6)	78	(5.2)	22	(2.6)	24	(2.1)
New	72	(8.5)	68	(8.1)	20	(3.4)	19	(2.8)
Previously treated	8	(1.3)	9	(1.4)	1	(0.4)	4	(0.8)
Treatment status unkown	3		1		1		1	
Male cases								
All problem alcohol use	1094	(74.0)	1075	(71.8)	571	(67.0)	740	(63.8)
New	648	(76.6)	623	(74.0)	397	(67.9)	432	(64.6)
Previously treated	431	(71.4)	437	(68.5)	167	(65.7)	307	(62.9)
Treatment status unknown	15		15		7		1	

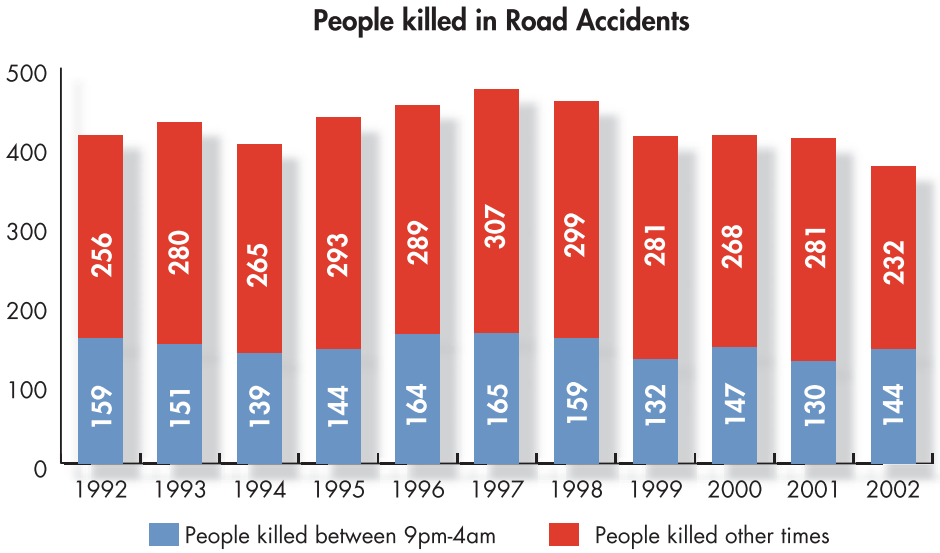
Source: Long et al., 2004, Health Research Board

In 2002, alcoholic disorder was the second highest cause for admission to psychiatric hospitals, after depressive disorders, for males and the fourth highest for women[21].

3.5 Drink driving

Alcohol continues to be a major factor in road deaths and road injuries. It is estimated by the National Safety Council that alcohol is involved in 40% of road deaths and at least 30% of all road accidents each year in Ireland. The overall number of road deaths and persons injured in 2002 showed a significant decrease from the 2001 figures (35 fewer deaths and 1,016 fewer injuries), which was due mainly to the introduction of the penalty point system. However, the number of people killed and injured between 9pm and 4am, the time most associated with drinking and driving, did not decrease, in fact 14 more people died in 2002 than in 2001[22] (Figure 8). Drink driving offences have also steadily increased each year since 1995. In 2002, the number of arrests for drink driving offences was 13,441 compared to 5,975 in 1995[23].

Figure 8: People killed on the roads between 9pm - 4am



Source: Annual Reports of Road Accidents Facts, National Roads Authority

3.6 Public Safety

In 2003, the National Crime Council published a report on public order offences in Ireland[24]. Two of the key findings were: firstly, a substantial increase in the number of public order offences and secondly that alcohol was a primary factor in such offences. Between 1996 and 2001, public order offences increased by 161%. In 2001, intoxication in a public place and threatening and abusive behaviour accounted for 80% of proceedings taken under the Criminal Justice (Public Order) Act, 1994. The number of offences relating to *intoxication in a public place* in 2002 was 22,701 - an increase of 27% from the previous year. The growth in public order offences among adults during this period (1996-2001) was replicated among juveniles (+162%) although at a lower magnitude. In 2002, the number of offences, *intoxication in a public place*, among juveniles was 1,898 in comparison to 22,701 offences among adults[23]. The number of public order offences is not a full reflection of the level of street disturbances. Over half of the public order incidents observed in the study were dealt with informally by members of An Garda Síochána[24]. The report also demonstrated the usefulness of geographical mapping of public order offences for tracking high incident locations.

The Intoxicating Liquor Act, 2000 provided for a "temporary closure order" if convicted of selling or serving alcohol to a person under 18 years, as a measure to reduce underage access to alcohol. Since the introduction of this provision in July 2000, the courts handed down 275 closure orders, with 43 currently under appeal[25] (Table 8). A more detailed breakdown is in Annex 5.

Table 8: Results of Prosecutions taken for sales of alcohol to minors since the Intoxicating Liquor Act 2000 came into force, July 2000 to February 2004

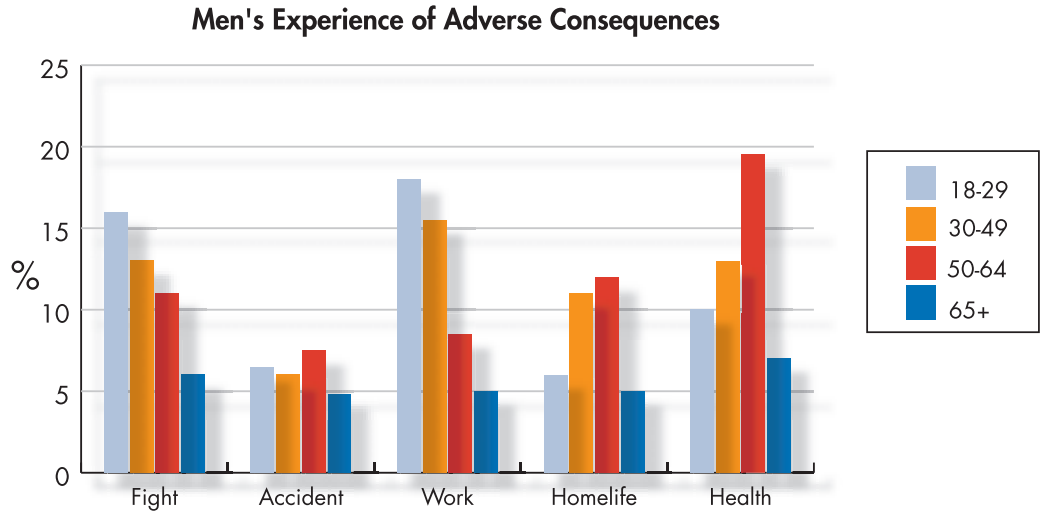
Garda Regions & Divisions	Prosecutions	Convictions	Closure orders	Pending	Dismissed, struck out	Closure orders Appeal
Eastern	67	37	29	16	14	8
Dublin Met	63	18	14	28	17	3
Northern	92	30	19	39	23	10
South Eastern	101	51	33	33	17	2
Southern	172	99	73	51	22	7
Western	218	142	107	35	41	13
TOTAL	**713**	**377**	**275**	**202**	**134**	**43**

Source: Department of Justice, Equality and Law Reform

3.7 Alcohol related problems

As reported earlier (Section 2.2.1), adults in Ireland consume more alcohol per drinker, have higher levels of binge drinking and as a consequence experience more harm than in other European countries[2]. The harm experienced as a result of their drinking had personal, economic and social consequences. Young Irish men (18-29 age group) reported the highest consumption of alcohol, had the highest number of drinkers and experienced more acute harm (work, fights) than any other group in the population (Figure 9). However, older men (50-64 age group) experienced more chronic harm (home-life or marriage, health) than others. Young women (18-29 years) experienced more negative consequences than older women, especially harming their work and friendships, getting into fights and having accidents (Summary of Research, Annex 4).

Figure 9: Men's Experience of Adverse Consequences



Source: Ramstedt & Hope[2]

The national lifestyle survey, SLÁN, also reported negative experiences as a result of consuming alcohol, with more problems experienced by young men and women (18-24 age group) than in older age groups (SLAN, 2002). Two-thirds of young men and women (18-24 years) reported being drunk. Also in this age group, 14% of men and 10% of women missed work days, 17% of men and 8% of women reported unprotected sex and 17% of men and 7% of women experienced financial difficulties as a result of their drinking[26].

3.8 Cost of alcohol related problems

An update of the estimated alcohol related cost imposed on Irish society was €2.65 billion in 2003[27] (Table 9). This represents 2.6% of GNP and is a 12% increase from the previous estimate. It is also important to note that these estimates err on the side of caution and if more comprehensive data were available the figure could be considerably higher. The reduction in the number of road accidents in 2003 was a major positive contributing factor in keeping the overall costs down. However, should the increase in road deaths and injuries during 2004 continue, the estimated costs will again rise substantially.

Table 9: Cost of alcohol related problems in Ireland

	2001 EURO million	2003 EURO million
Healthcare costs	279	433
Cost of road accidents	315	322
Cost of alcohol related crime	100	147.5
Loss of output due to alcohol related absences from work	1,034	1,050
Alcohol related transfer payments	404	523.3
Taxes not received on lost output	234	210
TOTAL	**2,366**	**2,652.8**

Source: S. Byrne, Update on estimates of the cost of alcohol related problems in Ireland, 2004

Section 4: STFA Interim Report 2002 - Recommendations implemented

International experts presented a comprehensive review of the most effective alcohol policy measures to the Strategic Task Force on Alcohol which was subsequently discussed by the Group. Following these discussions, the Interim Report of the STFA was published in May 2002[28], which contained twenty-one recommendations in six key areas for immediate action (Annex 6). The main thrust of the measures was to protect health and public safety by reducing overall alcohol consumption and in particular harmful consumption, to protect children and to reduce harm on the roads and in the drinking environment. This section outlines the STFA recommendations which have been implemented.

4.1 Increase in alcohol taxes

The STFA recommended increased taxes on alcohol products, as part of a set of effective measures to reduce overall alcohol consumption and related harm. Excise duty on alcohol products was increased in January 1994, followed by a seven-year period with no rise in excise duty, although overall alcohol prices did increase. During the last two years, the Minister for Finance increased excise duty on cider and spirits as part of the annual Government Budget (Table 10). In December 2001, excise duty on cider was increased significantly to bring the rate in line with excise duty on beer, a similar product. In December 2002, excise duty on spirits was increased and the duty on spirit-based "alcopops" was also increased to the full spirit rate.

Table 10: Alcohol Excise Duty (EURO)

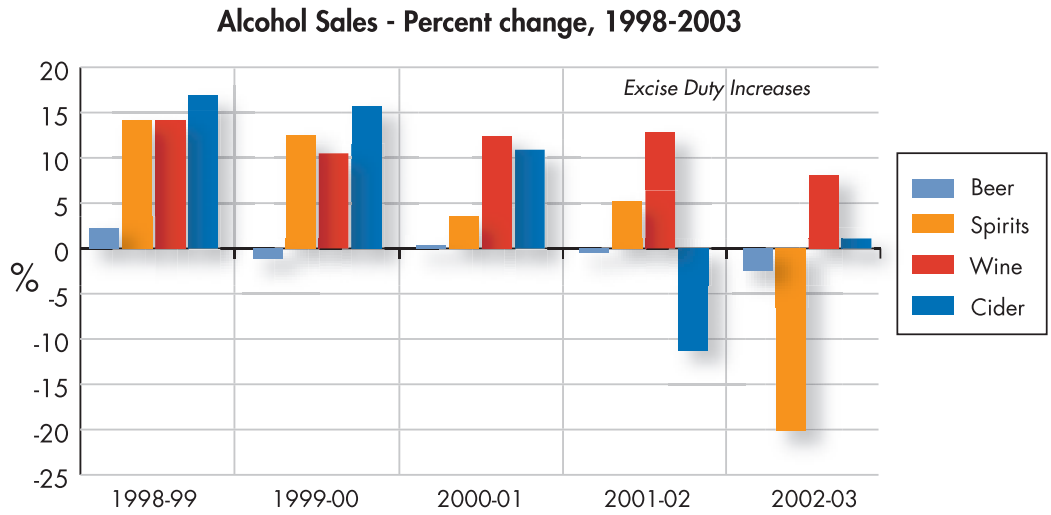
Year	Beer per hectolitre of pure alcohol	Spirits per litre of pure alcohol	Alcopops ≤ 5.5% per litre of pure alcohol	Wine 5.6% -15% per hectolitre	Cider ≤ 6% per hectolitre
2001	19.87	27.61	19.97	273.00	44.48
2001 Dec	19.87	27.61	19.87	273.00	83.25
2002 Dec	19.87	39.25	39.25	273.00	83.25

Source: Revenue Commissioners

Following the increases 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 (Figure 10). A comparison of alcohol sales figures for 2001 and 2002 shows that cider sales significantly decreased (-11.3%) while wine (+12.8%) and spirits (+5.2%) increased and beer sales remained

relatively stable (-0.5%). A comparison of sales figures for 2002 and 2003 shows that following the tax increase on spirit products, spirit sales sharply decreased (-20.1%) while wine continued to increase (+8%) and beer (-2.5%) and cider (+1%) showed marginal changes. 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.

Figure 10: Alcohol Sales- Percent change in litres of pure alcohol, 1998-2003



Source: Revenue Commissioners

4.2 Limiting harm in the drinking environment

The STFA recommended measures to reduce high risk drinking and drunkenness in the drinking environment. These recommendations were based on the evidence which suggests that active enforcement of alcohol laws, holding servers legally liable for serving to drunken persons, better trained staff in responsible serving practices and effective management of potential problem behaviours among customers can prevent and limit harm in the drinking environment.

The Government strengthened the **licensing laws** through enactment of the Intoxicating Liquor Act, 2003 in response to the recommendations of the Commission on Liquor Licensing and the STFA. The Act contains measures to counter drunkenness and disorderly conduct, and to combat underage drinking and binge drinking. Closing time on Thursday night reverted to the earlier closing time of 11.30 pm. In addition to the enforcement of the licensing laws by uniformed Gardaí, plain clothes Gardaí can now also enforce the licensing laws. With a view to reducing high risk drinking, the Intoxicating Liquor Act, 2003 has prohibited sales of intoxicating liquor at reduced prices during the day. This

prohibition includes a ban on "happy hours". Provision has also been made for the prohibition, by means of regulations, of practices that are intended, or are likely to, encourage excessive consumption of alcohol. The full description of the Intoxicating Liquor Act, 2003 is available on the Department of Justice, Equality and Law Reform website (www.justice.ie). The Criminal Justice (Public Order) Act, 2003 also contains provisions which enable the Gardaí to target areas where public disorder and violence occur and provides for 'closure orders'. The Intoxicating Liquor Act, 2003 made provision for a local authority role in determining the duration of special exemption orders by means of an approved resolution submitted to the District Court. Preventing drunkenness and public disorder by limiting the opportunities for binge drinking (i.e. shortening the duration of exemptions) can effectively reduce harm.

Training bar staff in **responsible serving practices** is now provided by Fáilte Ireland, through the Responsible Serving of Alcohol (RSA) programme, and to date 2,355 bar staff have participated in the training programme[29]. Club Cork Alcohol and Drugs awareness programme, a partnership between the Southern Health Board, Gardaí and local publicans, provides a nine-hour training programme in responsible serving practices for staff of pubs and clubs in the Cork and Kerry region[30]. NOFFLA, the independent off-licences organisation developed a Responsible Trading in the Community Programme in 2002, and in 2003 RGDATA piloted workshops on the responsible sale of alcohol in shops with an off-licence. The workshops are being delivered nationwide in 2004[31].

4.3 Protecting Children

The STFA recommended restricting children at certain times and circumstances from licensed premises to protect and reduce pressure on children to drink. The measures contained in the **Intoxicating Liquor Act, 2003** included the prohibition of those under 18 years from bars after 9pm, a requirement that 18-20 year olds carry an age document and that alcohol consumption by a person under 18 years in a private residence is conditional on the explicit consent of that person's parent or guardian.

The STFA recommended that exposure of children to alcohol marketing be significantly reduced. The Minister for Health and Children received Government approval for the **drafting of the Alcohol Products Bill** (Control of Advertising, Sponsorship and Marketing Practices/Sales Promotions). This will allow the Minister to introduce legislation which will provide for the introduction of a series of regulations which will restrict where alcohol advertisements can be placed, limit content, ban drinks industry sponsorship of youth leisure activities and require a health warning on alcohol advertisements. The Office of the Parliamentary Counsel is currently working on drafting the Bill.

In 2003, the Drinks Industry Group (DIG) established a company, **Central Copy Clearance Ireland** (CCCI) to vet alcohol advertisements, prior to airing or publishing, to ensure the content of such advertisements are in compliance with the Advertising Standards Authority of Ireland (ASAI) code[32]. In addition, Mature Enjoyment of Alcohol in Society Ltd (MEAS), (established by the Drinks Industry), published in May 2004 a revised Code of Practice on the Naming, Packaging and Promotion of Alcoholic Drinks which aims to promote high standards in the sale and promotion of alcoholic drinks in a socially responsible manner.

The STFA recommended the promotion of alcohol-free sporting environments by all national sporting organisations. The Irish Sports Council produced the *Code of Ethics and Good Practice for Children's Sport in Ireland* in 2000 to protect children from harm, which was in line with Government guidelines on child protection[33]. The Code's policy in relation to alcohol, states that alcohol use is incompatible with a healthy approach to sporting activity and should be actively discouraged. Alcohol-free environments should be used for underage team events and celebrations and adults should also refrain from drinking alcohol at such events. Children's sport should not be sponsored by the alcohol industry. To date 62 of 67 governing bodies of sport have signed up to the Code and have appointed National Children's Officers to implement the guidelines at local level. The Local Sports Partnerships and Health Boards provide training for club officers and since September 2002, fifteen courses have been delivered to over 200 children's officers[34].

4.4 Reducing drink driving

The Road Traffic Act, 2003 extended the grounds on which a member of the Garda can request a preliminary breath specimen and represents a move towards random breath testing. Gardaí can now request a motorist who has been involved in a collision or who has committed a road traffic offence to submit to a preliminary breath test. This is in addition to circumstances where a Garda has formed an opinion that a motorist has consumed alcohol. MEAS launched a Designated Driver Programme during December 2003.

4.5 Providing information and education

A three-year alcohol awareness campaign (2001-2003), *Less is More*, implemented by the Health Promotion Unit, was developed to raise awareness and create debate on alcohol issues and to highlight the necessity for a public health and multi-sectoral approach to reducing alcohol problems. The main issues were excessive consumption of alcohol in the population, harmful drinking patterns, the impact on health of excessive consumption and the extent of alcohol related harm in Ireland. A variety of initiatives were used to communicate the issues including media events, an international conference,

seminars for various groups including NGO's and public health workers and presentations to a wide range of bodies, agencies and Government Committees. The campaign also included a number of initiatives aimed at addressing high risk drinking among the key target audiences, through community projects, advertising campaigns (TV, radio, cinema) and the development and dissemination of a variety of informational materials. The importance of the NGO's advocacy role was demonstrated by Barnardos when running an advertising campaign *Families under the influence* which sought to draw attention to the impact of alcohol abuse on the lives of children. The Drinks Industry developed a TV advertisement promoting responsible drinking, and MEAS also developed an advertising campaign, "Is your drinking affecting their thinking?"

The STFA recommended the development of health education and alcohol policy and support services in the school and out of school setting. The Department of Education and Science has made the provision of health education **mandatory** (Social Personal and Health Education - SPHE) on the school curriculum at primary and secondary level junior cycle since September 2003. To assist second level schools implement the programme, support is provided by the Post Primary SPHE Support Service which includes 10 Regional Development Officers (from Education) and 10 Health Promotion Officers (from the Health Boards). There is additional support for schools in the Local Drugs Task Force areas. At primary level, services are also available to support the implementation of the SPHE programme from the Health and Education sectors.

In the out of school setting, the Substance Abuse Prevention Programme is implemented in Youthreach and Senior Traveller Training Centres as well as in FAS Community Training Workshops. Linkages on substance abuse issues between schools and the community were created through the Local Drug Task Forces, the Home School Community Liaison Scheme and the School Completion Programme. The School Completion Programme expanded in July 2002 and now has 82 projects involving 276 primary and 106 second-level schools. The Home School Liaison Scheme of the Department of Education and Science aims to raise awareness in parents of their capacity to enhance their children's educational progress. Currently 278 primary and 188 second levels schools are involved in the Scheme.

Under Action 43 of the National Drugs Strategy all schools are required to have a Substance Use Policy. The Department of Health and Children, in partnership with the Department of Education and Science and the Health Boards, support schools in the area of policy development. The policy includes tobacco, alcohol and drug use within a framework which includes the education and prevention measures within the school with input from teachers, parents and young people.

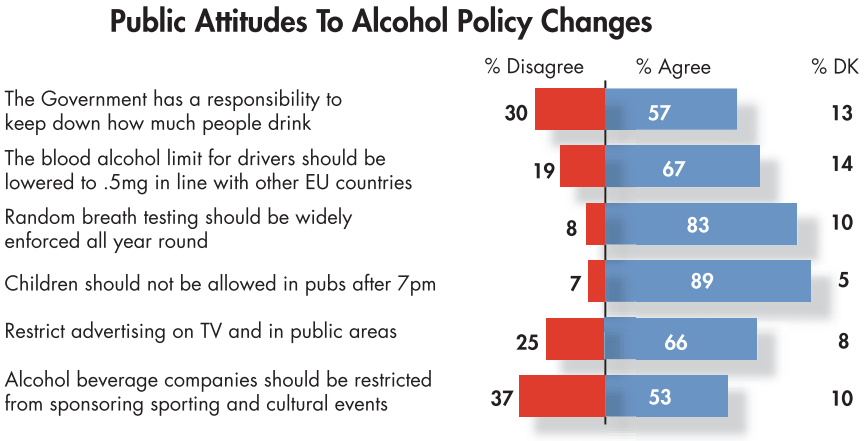
4.6 Alcohol Research

Since the publication of the STFA Interim Report 2002, a number of research projects have been undertaken to monitor and inform alcohol policy decision-making. The research projects published since 2002 include lifestyle surveys, a European comparative study on drinking patterns, a survey on public attitudes to proposed alcohol policy changes and the ICGP alcohol aware project. A number of other research projects will be published later this year.

The **national lifestyle surveys** (SLAN), reported that binge drinking had increased among adults between the first survey in 1998 and the second survey in 2002. There were fewer children under 15 years experimenting and abusing alcohol in 2002 than in 1998 (HBSC). But there were no reported changes in drinking patterns (use and abuse) in the four-year period for those in the 15-17 age group. A European Comparative study on drinking patterns and related harm showed high levels of risky drinking and related harm among Irish adults in comparison to other European countries. A more detailed commentary on drinking patterns is reported in Section 2.

Following the publication of the STFA Interim Report 2002, the Health Promotion Unit commissioned a national survey to evaluate **Public Attitudes To Alcohol Policy Changes**[35]. Overall, 83% of people believed that alcohol related problems in Ireland had increased over the past five years. At a national level teenage drinking was perceived as the most serious problem (70%), followed by alcohol related street violence (62%), drinking and driving (61%) and drunkenness in public places (53%). There was strong support for alcohol policy measures in the following areas; protecting children (no children in pubs after 7 pm, limit alcohol advertising/sponsorship), reducing drinking and driving (RBT, Lower BAC) and limiting harm in the drinking environment (enforce laws to prevent drunkenness) (Figure 11). Over two-thirds of people were in favour of health warning labels. There was little support for greater availability with only 8% wanting longer opening hours. Only one in four (23%) were in favour of lower taxes and about one in three (31%) were in favour of an increase in the number of outlets where alcohol can be bought for take away. Drinking patterns influenced the level of support for some policy measures, in that regular binge drinkers were less supportive of stricter drink driving measures, restricting the promotion of alcohol or health board intervention.

Figure 11: Public opinion survey on attitudes to STFA recommendations



DK= don't know

Lansdowne Market Research, 2002

The Irish College of General Practitioners (ICGP) pilot project '**Alcohol Aware Practice**', part-funded by the Health Promotion Unit, was developed as part of a major training initiative for General Practitioners. The main aim of the project was to develop, at a General Practice level, screening and brief intervention, in order to prevent, detect and treat patient problems associated with alcohol. The ten practices involved in the pilot project were trained in screening and detection, brief intervention and referral. The results of the project showed that 19% of patients randomly screened were drinking at a hazardous or harmful level. Over twice as many males (29%) to females (12%) were in the hazardous/harmful risk category[36]. After brief intervention by the GP or practice nurse, at least 20% had reduced their drinking pattern to low risk at the three-month follow-up period. The figure may have been higher, but 32% were not followed-up at the three-month stage. The evaluation also reported increased confidence levels amongst the practice staff and that most GPs intended to continue to screen and treat patients with alcohol problems.

Section 5 : STFA 2004 Recommendations

5.1 Strategic Task Force on Alcohol - Objectives

The STFA affirms the core principle of a public health approach in preventing and reducing alcohol related harm in Ireland with the following key objectives:

- To reduce total per capita consumption to 9 litres per annum, the EU average. To reduce harmful consumption of alcohol at the individual level, especially binge drinking and regular heavy drinking.
- To provide greater protection for children* from pressures to drink.
- To prevent and reduce the risk of alcohol related harm in a variety of settings and situations.

5.2 Purpose of the STFA 2004 Report

1. To bring forward recommendations to enhance society's capacity to prevent, and respond to alcohol related harm, at community level and across Government sectors.
2. To bring forward recommendations to achieve the targets set out in the WHO Declaration on Young People and Alcohol+ (Annex 7) by implementing policy measures which provide protection, promote education, create supportive environments and reduce harm.
3. To bring forward recommendations for early intervention to ensure effective treatment to reduce high risk and harmful drinking, and alcohol related problems.

5.3 Research Evidence

In the latest comprehensive global review of alcohol policy (published in 2003), sponsored by the World Health Organisation, the researchers conclude that *"opportunities for evidence-based alcohol policies that better serve the public good are more available than ever before, as a result of accumulated knowledge on which strategies work and how to make them work"* [1]. To protect the public health of the community, Babor and his research colleagues assert that:

- alcohol is no ordinary commodity and its harmful properties result in a wide range of problems.
- the public health precautionary principle should apply to alcohol policy - take preventative action in the face of uncertainty, shift the burden of proof to the proponents of a potentially harmful activity and be guided by the likely risk rather than by potential profit.

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* Children are defined as those under 18 years in keeping with the National Children's Strategy. The term 'youth' denotes those 12-17 years.

\+ WHO define young people as those under 25 years.

- an overall alcohol policy should have a set of integrated and mutually supportive strategies.

- alcohol policies should be implemented at both national and community levels and should target three groups - the general population, high risk drinkers and people already experiencing alcohol related problems.

- the 'best value' for the foundation of a comprehensive alcohol policy should combine measures targeted at the general population (taxes, limiting access, RBT, lower BAC), high risk groups (minimum age, enforcement of alcohol laws) and high risk drinkers (brief intervention).

5.4 STFA 2004 Recommendations

The recommendations of the Strategic Task Force on Alcohol 2004 Report are framed, as in the last report, using the ten strategy areas for alcohol action which were outlined in the WHO European Charter on Alcohol[37]. Given that no additional recommendations are being proposed by the STFA to reduce drink driving, (these measures were provided in the first report and included random breath testing, lower BAC to .50mg %, near zero BAC for inexperienced drivers), this strategy area will not be repeated. The Strategy areas used to frame the recommendations are:

S1. Regulate availability
S2. Control promotion of alcohol
S3. Enhance society's capacity to respond to alcohol related harm
S4. Protect public, private and working environments
S5. Responsibility of the alcohol beverage industry
S6. Provide information and education
S7. Put in place effective treatment services
S8. Support non-governmental organisations
S9. Research and monitor progress
S10. Drink Driving - Recommendations in Interim Report 2002
(not repeated here)

The following recommendations are made in keeping with the STFA brief to provide evidence-based recommendations to Government to prevent and reduce alcohol related harm in Ireland. The new recommendations build and expand on the STFA's first set of twenty-one recommendations as published in the Interim Report 2002[28]. In each of the nine strategy areas (S1-S9), the rationale and evidence supporting the STFA recommendations is provided, and is based on Ireland's public health commitments and on the scientific evidence of what constitutes an effective alcohol policy response to alcohol-related problems.

S1. Regulate availability

Raising alcohol taxes and regulating the physical availability of alcohol (minimum age, limiting number of outlets and time of sales) are among the most effective policy measures that influence alcohol consumption and related harm. The research is robust in terms of the quality and strength of the evidence and its effectiveness across cultures[1]. Frequent and heavy drinkers as well as children and young adults are influenced by alcohol price; in other words, when the price of alcohol increases, alcohol consumption decreases[38]. Over the past thirty years in the UK, the decline in the relative cost of alcohol has corresponded to an increase in alcohol consumption[39]. Raising alcohol taxes can lead to a reduction in many alcohol related problems such as drinking and driving, alcohol related violence and other crimes[38, 1]. In the UK, it is estimated that a 10% increase in alcohol taxes could reduce alcohol related mortality by up to 37%[39]. Several studies have shown that a reduction in the **physical availability of alcohol**, be it in the hours and days of sale, the number and type of alcohol outlets and restrictions on access to alcohol, is associated with reductions in both alcohol consumption and alcohol related problems[1].

Availability of Alcohol - STFA Recommendations	
R1.1	Increase excise duty on alcohol with a view to reducing overall consumption and related harm.
R1.2	Restrict any further increase in the physical availability of alcohol (number of outlets, times of sale). *
R1.3	Simplify and streamline the licensing laws to allow greater clarity in the licensing system.
R1.4	Promote greater public awareness of the individual's right to object to a liquor licence.
R1.5	Create a hotline similar to the Traffic Watch scheme to encourage communities to report breaches in alcohol laws.
R1.6	Promote responsibility among adults in order to stop the supply of alcohol to children.

Children's access to alcohol - STFA Recommendations	
R1.7	Prohibit under-18s, except family members and apprentices, from working in the bar of licensed premises.
R1.8	Discourage the sale of alcohol at events organised for children or those largely attended by children.
R1.9	Restrict distance sales, unless delivery to over-18s can be strictly guaranteed.

S2. Control promotion of alcohol

In the wider environment, alcohol marketing affects social norms about drinking throughout society[40]. Young people are influenced by exposure to

* The representative from the Department of Justice, Equality and Law Reform pointed out that the Task Force had already made recommendations in relation to the licensing system in its Interim Report.

repeated high-level **alcohol promotions**, which inculcates pro-drinking attitudes and increases the likelihood of heavier drinking[1]. Alcohol advertising promotes and reinforces positive attitudes about drinking and portrays drinking as fun, glamorous and risk free. In Ireland, research showed that children were strongly attracted to alcohol advertising and that young people believed that advertisements were targeted at their age group[41].

More recent research reports that **alcohol sports sponsorship** has an effect similar to alcohol advertising. As noted by Babor et al., alcohol sports sponsorship links masculinity, alcohol and sport and provides promotional opportunities that go beyond passive images of alcohol advertisements[1]. This 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.

Control promotion of alcohol - STFA Recommendations	
R2.1	Ensure the proposed legislation to reduce the exposure of children to alcohol advertising, sponsorship and promotions is enacted without delay.
R2.2	Recommend national sporting bodies, with high youth participation, to develop a proactive strategy to find an alternative to alcohol sponsorship.
R2.3	Ensure international agreements and EU Directives / Regulations on alcohol taxation, alcohol related promotions or sponsorship do not impinge on the Government's ability to reduce alcohol related harm.

S3. Enhance society's capacity to respond to alcohol related harm

Changing the drinking culture is a necessary step to ensuring fewer alcohol problems, and is a challenge to all citizens in every community in Ireland. At community level, the most effective way to bring about change is tackling the community 'norms' (formal and informal attitudes and activities) that give rise to alcohol related problems. While traditional prevention approaches such as public media campaigns and education programmes can play an important role in generating public debate and communicating the importance of public health policies to combat the harm done by alcohol in society, they are not effective in changing drinking habits or reducing harm[1]. What is required is a policy approach that involves environmental and structural changes. This means challenging and altering policies and practices of institutions, organisations and groups in the community to reduce alcohol related problems. A community approach should complement and enhance the implementation of the overall national alcohol policy.

S3.1 Community Mobilisation

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 (be it underage drinking, street violence, accidents) and to gain public support for policies directed at preventing or reducing the problem.

In Ireland two different community projects have been undertaken, one explored the effectiveness of a community alcohol awareness project and the second develops a community strategy response to the STFA 2002 Report (See Box 1).

Box 1; Community Mobilisation - Examples from Ireland

Community Alcohol Awareness Project (CAAP) [42]

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.

The North West Alcohol Forum (NWAF) [43]

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 NWAF 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 NWAF Report, with recommendations for immediate action to prevent and reduce alcohol problems in the North West.

The community mobilisation approach in other countries have been successful in creating awareness and support for alcohol polices in the

following areas; creating awareness,[44] reducing high risk drinking,[45, 46] underage drinking,[47, 48] reducing violence in and around licensed premises,[49, 50] alcohol related injuries,[51,46] and drink driving[52, 53, 54]. A brief summary of the activities of a project designed to reduce accessibility of alcohol to youth and its evaluation is provided in Annex 8. Based on the experiences to date, researchers recommend a five-year timescale for community projects and the transfer of such projects into existing community structures for sustainability.

Community Mobilisation - STFA Recommendations	
R3.1	Promote and support community mobilisation projects which meet the criteria for effective practice. Build capacity within local communities to prevent and reduce alcohol-related problems, based on best practice, community engagement, effective measures, relevancy and sustainability. Aim to have a minimum of one community project for a duration of 3-5 years in each regional area. Provide dedicated funding for evaluation of the projects.
R3.2	Increase the capacity of existing programmes, which have been evaluated as successful, to address alcohol related issues at community level.
R3.3	Promote and support community based initiatives aimed at reducing underage drinking and harmful drinking patterns among adults as part of a wider community action to reduce alcohol problems. Support could include building networks and funding.
R3.4	Identify mechanisms by which Regional Task Forces on Alcohol can be established or integrated into Regional Drug Task Forces to bring progress on implementing the recommendations of the STFA.

S 3.2 Professional Training

Professionals working in a wide variety of disciplines meet individuals who are affected by alcohol related problems. For many professionals, alcohol related problems can be observed on a daily basis, such as inability to concentrate at school or college, under-performance on the sports field or in the workplace, drunkenness on the street or attendance in hospital for injuries and accidents. Alcohol can also be an underlying contributory factor to other presenting problems such as high blood pressure, certain cancers, impaired liver function, absenteeism at work, difficulties with relationships or lack of money. Therefore, professional training in alcohol related issues is necessary for those in the statutory and voluntary sectors who are in regular contact with alcohol related problems[55, 56]. Two pilot projects in Ireland have demonstrated the positive response from professionals as a result of appropriate training. Professional training, provided as part of the Alcohol Aware Practice pilot project in Ireland, showed that primary care professionals reported increased confidence in their ability to deal with patients with alcohol problems[36]. The second project was the Community Alcohol Awareness Project (CAAP) where evaluation of the training provided to front line staff across various sectors was very positive (See Box 1).

Professional Training - STFA Recommendations	
R3.5	Mandate training for all those who teach SPHE, using existing professional networks (health and education), based on best practice.
R3.6	Provide approved training on alcohol issues for leaders working with young people in the voluntary sector - youth leaders, coaches, sports managers etc.
R3.7	Provide approved training for professionals in the statutory sector in regular contact with alcohol related problems - health, Garda Síochána, social welfare, judiciary and other professionals.
R3.8	Incorporate relevant alcohol issues into higher education and other relevant professional training programmes (e.g. medical, law enforcement, social, health related, etc.) at undergraduate and postgraduate level.
R3.9	Increase the level of training in alcohol education to ensure wider delivery of alcohol awareness programmes.
R3.10	Ensure that effective alcohol policy measures are known across key Government Departments.

S 3.3 Involvement of Young People

Giving youth a voice in matters that affect them is a key goal of the National Children's Strategy in Ireland[57] and supports Ireland's international commitments[58, 59, 60]. A Dáil na nÓg or National Children's Parliament has been established as a national forum where children can raise and debate issues of concern. At local level, Comhairle na nÓg provide a local forum for debate and consultation. At county level, the Donegal Youth Council is an example of youth democracy in action. The North Western Health Board and Donegal County Council, in partnership, and under the auspices of the Donegal County Development Board (CDB) have jointly established six junior councils in the six electoral areas, mirroring those of the senior County Council. Donegal Youth Council is the only democratically elected youth council in the Republic. The work of establishing and supporting the Council is carried out by a dedicated Youth Officer, who is contracted to the CDB. Several innovative projects are under way including "Teenage Kicks" which aims to illustrate young people's perceptions of the impact of alcohol on their community through art and film.

Involvement of young people - STFA Recommendations	
R3.11	Develop existing structures and networks to give a representative voice to youth (12-17 years). Models of good practice include Comhairle na nÓg, which are run by City and County Development Boards, Dáil na nÓg which is held annually and the Donegal Youth Council.
R3.12	Develop existing structures to consult with children at primary school level. Models of good practice include; the regional Dáil na bPáistí for children aged 8-12 years (elected through Comhairle na nÓg), the national consultation by the National Children's Office and the Broadcasting Commission of Ireland for children aged 8-17 years on the development of a children's code of advertising, the involvement of children aged 8-17 years in the appointment of the Ombudsman for Children and the involvement of children aged 8-12 years in the design and content of the children's version of the National Play Policy.

R3.13	Consult with and ensure participation of young people when developing policies, services and programmes designed to meet their needs. Involve networks such as student unions, youth councils, student councils, national youth organisations (National Youth Council of Ireland, National Youth Federation, Foróige) and local youth services and groups.
R3.14	Ensure children's and young people's voices and concerns are represented in the development of services. Provide guidelines on children's participation.

S 3.4 Alcohol Free Alternatives

While alcohol free alternatives (AFA) have not been shown to be effective as a single strategy in reducing underage drinking, AFA have been considered useful when combined with a community policy approach such as limiting alcohol availability through licensing laws, use of bye-laws for restricting drinking in public places and enhanced law enforcement. The National Children's Advisory Council and the National Crime Council have recommended urgent action to address alcohol free alternatives[61, 24]. *The Gaf* in Galway, set up by the Western Health Board as a social health project, is an excellent example of creating a safe space (alcohol and drug free) for young people. Young people see the centre as a café where they can go to meet and hang out with friends, listen or partake in music and access information[62]. In Ennis, the Clare Youth Service runs a similar café style service for young people at the weekends called Elmo's Attic[63]. Both these centres are used by boys and girls over 15 years of age and involve young people in the active management of the centres.

The Sports Capital Programme provides for an integrated and planned approach to facility development, prioritising the needs of disadvantaged areas. Between 2001-2003 a total of €97 million was allocated to 1,000 projects for facilities in areas designated as disadvantaged. The Irish Sports Council has prioritised youth participation programmes and allocated €6.34 million to the three major field sports (GAA, FAI, IRFU) including special schemes in designated disadvantaged areas[64]. The Irish Sports Council continues to encourage the implementation of their *Code of Ethics and Good Practice for Children's Sport in Ireland*. The Code's policy in relation to alcohol, recognises that alcohol use is incompatible with sporting activity, that alcohol-free environments should be used for underage events, that adults should refrain from alcohol use at such events and that children's sport should not be sponsored by the Drinks Industry.

Alcohol free alternatives - STFA Recommendations	
R3.15	Provide increased investment in the development of alcohol free venues as part of community wide initiatives. Provide seed capital for the development of viable alcohol/drug free venues using existing structures/agencies - CDBs, Youth Services, Health Boards etc. Alcohol free venues for music and entertainment are needed for the 12-15 age group and the 16-17 age group. Good examples - The Gaf, Elmo's Attic. This could also take the form of incentives for venues (e.g. cafes) to stay open later at night.

R3.16	Involve youth in the selection and management of alcohol free venues.
R3.17	Ensure existing alcohol free events and venues for youth are maintained alcohol free and promote the implementation of a Code of Ethics similar to the Irish Sports Council code to protect children from the pressures to drink.
R3.18	Request the Competition Authority/Director of Consumer Affairs to investigate why non-alcoholic beverages are so expensive when compared with alcoholic beverages, given that there is no excise duty.
R3.19	Increase the level and strategic focus of funding of existing mechanisms, such as Young Person's Facilities and Service Fund (YPFSF) and the Sports Capital Programme, to provide facilities for alternative recreational activities, particularly to areas of critical need.
R3.20	Ensure that capital programmes are complemented by current funding to develop and implement programmes to ensure maximum use of such facilities with particular priority to be directed at young people at risk from alcohol and drug abuse.

S4. Protect public, private and working environments

S 4.1 Family environment

The family environment is the central nucleus as the child grows and develops. Alcohol use by children poses very serious risks to bodies and minds that are still maturing and is linked to a range of social, emotional and behavioural problems during adolescence[65]. Recent research has shown that children are vulnerable to alcohol-induced brain damage, which can contribute to poor school performance[66]. In addition, children who begin drinking before the age of 15 years are 4 times more likely to develop alcohol problems than those who begin drinking at age 21[67]. Consequently there is a need for specific measures to keep children alcohol-free, in particular those under 15 years[68]. Parents have an enormous influence on their children's behaviour. A strong, open and trusting relationship between child and parent and parental involvement in their children's lives helps decrease the risk of the early onset of alcohol use[69]. Irish parents agree that they have a responsibility to model good behaviour, to know where their children are and to set age appropriate limits for freedoms[61].

Family environment - STFA Recommendations	
R4.1	Ensure that providers of parenting programmes integrate relevant alcohol awareness and education into approved parenting related programmes (Health Promoting School, Parenting programmes and Community networks).
R4.2	Encourage an open and supportive parent-child relationship. The Family Support Agency is a useful resource for promoting and supporting this initiative.
R4.3	Promote the message that parents and family members should act as role models when using alcohol.
R4.4	Highlight the message about the harm alcohol can do to children and promote measures among parents and family members to keep children alcohol free, in particular those under 15 years.

S 4.2 Public and Working Environment

Working to make where people live, work or play a healthy environment is a key health promotion strategic goal. Youth, school, colleges, workplace and communities are among the priority settings for development as set out in the National Health Promotion Strategy[70]. In relation to alcohol, the focus is on implementing policy-based measures in the environment that prevent or reduce the risk of harm rather than just targeting programmes at the individual. Alcohol related problems in the workplace carry a considerable cost in terms of job performance, absenteeism, accidents and productivity[71]. However, the level of research in the evaluation of workplace intervention programmes that address alcohol problems is minimal. There is some support for the value of Employee Assistance Programmes[72]. Although workplace programmes to prevent and reduce alcohol related harm have considerable potential, there appears to be a reluctance to develop and evaluate its potential[72].

Public and Working Environments - STFA Recommendations	
R4.5	Promote compliance with responsible serving of alcohol policies and practices where alcohol is available at public events (festivals, special events).
R4.6	Require organisations where the majority of the funding is from the Exchequer to have a workplace drug and alcohol policy.
R4.7	Require all schools and youth centres to develop an alcohol and drug policy involving teachers, parents and students.
R4.8	Ensure implementation of college alcohol policies, as outlined in the Framework for Developing a College Alcohol Policy.
R4.9	Require employers to have guidelines for workplace alcohol policies to manage the risks associated with alcohol in the workplace and promote them as part of health and safety.

S5. Responsibility of the alcohol beverage industry

Reducing alcohol related problems, within the drinking environment, is a key responsibility of the Drinks Industry[73]. Responsible server training programmes such as the **Responsible Serving of Alcohol (RSA) programme** in Ireland are designed to prevent underage drinking, alcohol intoxication and drunk driving. The evaluation of such programmes in Canada, the USA, Australia and Sweden demonstrate improvements in knowledge and attitudes of bar staff, and changes in some serving practices. However, the addition of house policies to avoid or minimise intoxication (serving food, charging cheaper prices for low or non alcoholic drink and avoiding drink specials) have shown some positive effects[74]. The overall research findings suggest that server training combined with positive changes in serving policies and regular **enforcement** by law enforcement officers can reduce high risk drinking[1].

Alcoholic drink with a lower alcohol content has a lower rate of taxation. There is evidence to suggest that making available and promoting drinks with a lower alcohol content offers the possibility of reducing intoxication[1]. Currently, alcoholic beverages with a low alcohol content or light beer (2-3% ABV) are not readily available in Ireland. There is a very limited variety (approx 3 brands) of low or non-alcoholic beverages available in Ireland.

Responsibility of the Alcohol beverage industry - STFA Recommendations	
R5.1	Where an alcohol product is labelled, list the calorie content and the ingredients on the label. Ensure that the script is of sufficient size to allow for general readability. Ensure 'light' beer products specify the meaning as 'light in calories', to avoid confusion with light in pure alcohol.
R5.2	Promote a wide variety of high-quality alcohol products with low alcohol (2-3% ABV) content at a low price.
R5.3	Establish the RSA programmes and licensed house policy as a mandatory requirement for all those working in the retail hospitality trade.
R5.4	Ensure that the implementation of the RSA house policy includes measures that avoid and minimise intoxication. In particular, avoiding serving practices that encourage high risk drinking such as serving stimulant drinks with alcohol, multiple drink measures in a single serving or other dangerous practices.
R5.5	Establish the off-licence RSA (responsible *sale* of alcohol) programme and house policy as mandatory requirements for all those working in the off-license trade (grocery stores, supermarkets, off-licences).

S6. Provide information and education

The purpose of developing information campaigns is to create a better understanding of alcohol use, its potential risk and negative consequences on the health and well being of individuals, families and communities. **Alcohol awareness** campaigns can play an important role in generating public debate and communicating the need for public health policies to combat the harm done by alcohol in society[75].

Health education programmes, including an alcohol module along with other drugs, are designed to develop life-skills to enable individuals make informed choices about their health and well being. **School health education programmes**, holistic in nature, have an inherent value and contribute to the overall social and personal development of the student. While education can influence beliefs and attitudes about alcohol, the mistaken expectation is that information and education programmes will reduce drinking or related harm. However, the overwhelming weight of the international scientific evidence, across several contexts and settings including schools, colleges and communities, conclude that educational strategies show little or no effect in reducing alcohol consumption or

related harm[1]. Therefore information and education strategies should not be the lead strategy in alcohol policy but has a role to play as part of an overall integrated multi-layered strategy.

Communicating with the general population and with different target groups requires the use of a wide variety of methods such as media advertising, **warning labels** and information at point of sale outlets. The use of warning labels on alcohol products in the USA, increased awareness of the potential risks of alcohol use in the areas specified on the labels - pregnancy, driving a car or operating machinery. Recall of warning labels was high among young people, males and heavy drinkers. Recall was also good for warning messages as in media advertisements, and on signs at point-of-sale[76]. Pregnant women who saw more messages reported more conversations about drinking[77]. In reviewing the role of warning labels, the researchers concluded *"it is possible that the impact of warning labels can be enhanced by combining it with other strategies, such as community-based campaigns"* [1].

Information and Education - STFA Recommendations	
R6.1	Require that schools and out of schools settings provide Social, Personal and Health Education for all children by approved professionals.
R6.2	Require as part of SPHE a compulsory module on alcohol and drugs education at primary and secondary levels.
R6.3	Provide a senior cycle school programme on prevention and reduction of alcohol and drug problems.
R6.4	Increase the support for parents through existing mechanisms such as the Home School Community Liaison Scheme, family resource centres and voluntary organisations.
R6.5	Support and expand programmes, targeted at high-risk groups, under the Springboard Initiative in addition to the Garda Youth Diversion Projects.
R6.6	Promote strategies to encourage children to celebrate special occasions safely (exams, graduation, end of year parties).
R6.7	Promote a responsible approach to alcohol use in colleges in keeping with the College Alcohol Policy Framework document.
R6.8	Promote greater awareness of the different contexts and situations where alcohol use should be avoided to reduce risk of harm (driving, sport, water, machinery, DIY, workplace, pregnancy).
R6.9	Promote greater awareness among employers of workplace guidelines, which meet the criteria for effective practice, to reduce the risks associated with alcohol in the workplace.
R6.10	Promote greater awareness among key target groups of the need to reduce harmful drinking patterns (at risk youth, high risk drinkers, regular heavy drinkers).
R6.11	Encourage pregnant women and women who are planning to become pregnant to avoid alcohol consumption, especially during the critical first trimester of pregnancy.
R6.12	Require a health-warning label on all alcohol products and alcohol promotional materials.

S7. Put in place effective treatment services

S7.1 Early Intervention

The purpose of early intervention is to detect high risk drinking and harmful drinking in individuals before or shortly after the early signs of alcohol related problems. High risk drinking is the type of drinking that is likely to increase the risk of harm for the drinker or others, such as drinking to intoxication or regular heavy drinking. Harmful drinking (alcohol abuse) is a pattern of drinking that has already resulted in alcohol related problems with negative health or social consequences.

Effective screening tools have been developed to match high risk and harmful drinking patterns with appropriate interventions[55]. Brief intervention is designed to motivate those who engage in high risk drinking and harmful drinking to moderate their alcohol use. It typically consists of one to three counselling and education sessions and has been shown to reduce high risk and harmful drinking and related problems[1]. Brief intervention is delivered in a variety of health care settings, with primary care and emergency room the most common. It is recommended, that screening and brief intervention should be routine in all aspects of health service delivery for an integrated system[55]. Given that binge drinking is a common drinking pattern among Irish males and among young adult females, screening and brief intervention could be an important measure as part of an integrated alcohol policy to reduce high risk drinking.

Treatment; early intervention - STFA Recommendations	
R7.1	Establish a national screening protocol for early identification of problem alcohol use, for all relevant sectors of the health care system.
R7.2	Put in place early intervention programmes:-
	a. In primary care to introduce and establish brief intervention as standard practice to reduce high risk and harmful drinking patterns.
	b. In the emergency room and general hospital for those presenting with alcohol related problems.
	c. In health clinics where excess alcohol is a contributory factor in presenting conditions (emergency contraception, STIs, parasuicide, mental illness).
	d. For those convicted in the courts of alcohol related offences (public order, drink driving etc).
	e. For those under 18 years in the Garda Juvenile Diversion Programme, the Springboard Initiative and other community based interventions.
R7.3	Require all third level colleges to provide support services (brief intervention, counselling) for students, as outlined in College Alcohol Policy Framework document.
R7.4	Require workplaces, as part of employee health and welfare, to have procedures to address workplace alcohol related problems.

S7.2 Specialist Treatment

Alcohol dependency, defined as a chronic disorder characterised by a cluster of recognisable symptoms including physical withdrawal and loss of control over one's drinking, requires specialist treatment. While brief intervention is not considered beneficial for alcohol dependent individuals, the screening aspect can act as a referral pathway into appropriate treatment[55].

Treatment; specialist - STFA Recommendations	
R7.5	Put in place adequate and accessible youth counselling alcohol/drugs services in each Health Board region.
R7.6	Establish an inventory of treatment services and make available to the Courts when dealing with offences arising from alcohol abuse.
R7.7	Provide a range of treatment services in each health board region that are effective, accessible, appropriate and integrated with other service areas.
R7.8	Develop explicit pathways of care for those seeking treatment for alcohol-related problems.
R7.9	Promote greater awareness of where people (individual drinker, children and family members) can access help and obtain treatment services.

S8. Support Non-Governmental Organisations

Non-governmental organisations (NGOs) play an important advocacy role in society and can influence decision-making at local, regional and national levels[78]. Many NGOs provide information, programmes, treatment and other valuable services to different groups in the community. Some NGOs and professional organisations have a broad health remit that includes alcohol concerns or policies (eg. Barnardos, Faculty of Public Health Medicine, Irish Cancer Society, the Irish Medical Organisation, the Irish College of General Practitioners, the Association for Health Promotion in Ireland), while others address a specific alcohol issue (Mothers Against Drink Driving, No-Name Club). A new NGO, Irish National Alliance for Action on Alcohol (INAAA), has been established with a remit *to mobilise Irish society toward the promotion of strategies to reduce alcohol-related harm, and to promote a low-risk drinking culture in Ireland.*

Support for NGOs - STFA Recommendation	
R8.1	Support non-governmental organisations and networks that are competent in informing and mobilising civil society, with respect to alcohol related problems, and that lobby for policy change and effective implementation of evidence based alcohol policy measures.

S9. Research and monitor progress

Ongoing research is essential to monitor alcohol and related problems across the general population and among high-risk groups. Evaluation of the implementation and outcomes of alcohol policy measures are necessary to provide a strong evidence base upon which to assess which policy measures are most effective and what further developments are appropriate.

Research and Monitor progress - STFA Recommendations	
R9.1	Establish an Independent Research and Monitoring Unit in the field of alcohol, to extend knowledge and build capacity in alcohol research; - drinking patterns, alcohol related harm, effectiveness of alcohol policy measures and other relevant areas.
R9.2	Continue to monitor the individual's drinking pattern by regular surveys (HBSC, ESPAD, CLAN, SLÁN).
R9.3	Continue to monitor the effects of alcohol related problems at the population and individual level.
R9.4	Develop links with other public health agencies to share and exchange relevant alcohol related information such as the Health Research Board.
R9.5	Investigate opportunities to develop, with other international and national agencies, collaborative research projects.
R9.6	Develop criteria for all alcohol-funded projects against which effectiveness can be evaluated.
R9.7	Carry out evaluation of selected alcohol initiatives to establish a database of effective measures.
R9.8	Evaluate the effectiveness of alcohol-free alternatives as part of a community mobilisation project to reduce underage drinking.
R9.9	Evaluate alcohol related attitudes and behaviour surrounding pregnancy.
R9.10	Research the qualitative aspects of young people's alcohol use and in particular high risk drinking.

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Annex 1

MEMBERS OF THE STRATEGIC TASK FORCE ON ALCOHOL

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Mr. Stephen Rowan	Irish National Alliance for Action on Alcohol
Mr. Pat Costello	Chief Executive Officer, National Safety Council
Mr. Christopher McCamley	Assistant Principal, Department of Education and Science
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**Mr. Pat Donnelan replaced Mr. Dan Murphy in March 2004*

Secretariat

Ms. Kathleen Lombard	Higher Executive Officer, Department of Health and Children
Mr. Kieran Cashman	Executive Officer, Department of Health and Children

Annex 2

TERMS OF REFERENCE

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

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

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

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

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

Annex 3

WHAT IS A STANDARD DRINK IN IRELAND?

Background

In the early 1970's the concept of a 'unit of alcohol', was developed in clinical practice in the UK and was devised to estimate individual alcohol consumption for comparative purposes. A nomogram was developed* as a rapid means of calculating the mass of alcohol in different measures of various alcoholic beverages. It was related to the most common drinks and strength of drinks served in the UK at that time which were a half pint, a glass of wine, a glass of sherry and a single measure of spirits. The alcoholic strength of the most popular beers at that time in the UK was 3.5% Alcohol By Volume (ABV) and a UK measure of spirits was 1/6 gill. That meant that a unit of alcohol was calculated to be 8 grams of alcohol. In Ireland, a measure of spirits is 1/4 gill (35.5ml), which calculates to 11.4 grams of alcohol, or roughly equivalent to a unit and a half in the UK.

Standard Drink in Ireland - 2000

In Ireland today, there are a wide range of drinks with varying degrees of alcoholic strength. The unit measure as used in the UK is no longer applicable. To establish what a '**standard drink'** in Ireland is currently, the alcoholic strengths of different stouts, ales, lagers, ciders, alcopops, wines and spirit drinks were examined. Discussions also took place with the Revenue Commissioners who calculate each year the excise duty on alcohol based on alcohol strength. Findings were:

The alcoholic strength of different drinks

Beer	4.3%	ABV (range 4-5%)	Spirits	40%	ABV
Cider	5.0%	ABV (range 4.5-6%)	Wine	12.5%	ABV
Alcopops	5.3%	ABV (range 5-5.5%)			

Standard drink serving size and grams of pure alcohol		
	Alcoholic strength (ABV)	Grams of pure alcohol
Half pint of beer	4.3%	9.8
Half pint of cider	5%	11.4
Single measure of spirits	40%	11.4
Bottle of alcopops (long neck)	5.3%	11.7
Small glass of wine (100ml)	12.5%	10.0

* Mellor, CS Br Med J 1970, iii 703.

Therefore a Standard Drink in Ireland today = 10 grams

Equal to a half pint of beer or a single measure of spirits or a small glass of wine

1 Standard drink contains 10g of pure alcohol

1 SD =

1/2 Pint Beer =

Single Measure Spirit =

Small Glass Wine

Weekly Drinking Limits

In Ireland, we continue to use the 14 and 21 standard drinks (spread out over the week) as a general guide for low risk drinking. The Health Promotion Unit booklet *LESS IS MORE: A guide to rethinking your drinking* provides a guide to standard drinks in Ireland.

Annex 4

Summary of
The Irish drinking Habits of 2002: Drinking and drinking - related harm in a European comparative perspective

by Dr. Mats Ramstedt, Centre for Social Research on Alcohol and Drugs (SoRAD), Stockholm University, Stockholm, Sweden, and Dr. Ann Hope, National Alcohol Policy Advisor, Department of Health and Children, Dublin, Ireland.

Purpose

This paper examines the Irish drinking habits and to what extent drinking is associated with negative consequences. The analysis is based on a survey containing similar questions that was used in a recent European comparative survey involving Finland, Sweden, Germany, UK, France and Italy, known as the ECAS countries. This provides a unique opportunity to examine the Irish results in a European comparative framework.

Data and methods

Data was collected in a survey among a national representative sample of adults aged 18 years and older, carried out by Lansdowne Market Research for the Department of Health and Children. Using face to face interviews, 1069 respondents were asked a number of questions about their background, drinking habits and harm indicators. Fieldwork was carried out in September 2002. The measure used for estimating volume of drinking was the Quantity-Frequency scale (QF-scale). The answers were then added up and calculated into yearly alcohol consumption of pure alcohol. The frequency of drinking large amounts (binge drinking) was also measured as was the prevalence of current drinking problems (acute, chronic and social harm). A full description of the methods is contained in *Ramstedt & Hope, (in press). The Irish Drinking Habits of 2002 – Drinking and drink-related harm in European comparative perspective. Journal of Substance Use.*

Main Results

Abstention

In Ireland, 23 per cent of respondents had not consumed any alcohol during the past 12 months. Abstention is more common among women (25%) compared to men (20%) and is higher in the older age group. Compared to the other European countries, abstention is about **three times as high** as in the two Nordic countries (7%) and around twice the rates seen in the other ECAS-countries.

Table 1. Self-reported alcohol consumption (litres 100% alcohol/year) and proportion of abstainers in Ireland and the ECAS-countries.

	Non-Drinkers (%)	Reported total alcohol consumption	Reported alcohol consumption per drinker
Ireland	**23**	**9.3**	**12.1**
Finland	7	4.7	5.0
Sweden	7	3.5	3.8
Germany	12	3.9	4.4
UK	11	9.0	10.1
France	13	4.8	5.5
Italy	11	5.3	6.0

Overall Drinking Level

Reported total alcohol consumption in pure alcohol per respondent (aged 18+) amounts to 9.3 litres (Table 1). This is almost twice the level reported in most of the ECAS-countries, the only exception being the UK with 9 litres. The combination of a high drinking level and high abstention rates suggests that in Ireland reported consumption per drinker is 12.1 litres, which is clearly higher than in the ECAS countries. Men drink about three times as much alcohol as women, which resembles the gender differences found in the Nordic countries, France and the UK but is somewhat higher than in Germany and Italy. In Ireland the amount of alcohol drunk tends to decrease with age, with the highest consumption found among those aged 18-29 years.

Binge Drinking

Table 2: Drinking patterns among men and women in Ireland in comparison with the ECAS countries (All respondents aged 18-64 years).

	Drinking everyday (%)	Drinking at least once a week (%)	Binge drinking at least once a week (%)	Mean drinking occasions past 12 months	Mean binge drinking occasions past 12 months	Binge per 100 drinking occasions
MEN						
Ireland	**1.6**	**69**	**48**	**78**	**45**	**58**
Finland	4	60	16	70	20	29
Sweden	3	47	8	37	12	32
Germany	12	60	9	97	13	13
UK	9	74	38	118	47	40
France	21	68	8	121	11	9
Italy	42	76	11	179	23	13
WOMEN						
Ireland	**0.2**	**51**	**16**	**46**	**14**	**30**
Finland	2	33	3	35	6	17
Sweden	1	24	1	24	4	17
Germany	5	40	2	54	4	7
UK	5	51	12	73	16	22
France	9	38	2	62	3	5
Italy	26	52	7	121	14	12

A drinking occasion in Ireland involves binge drinking more often than in the ECAS-countries (Table 2). The prevalence of binge drinking at least once a week is 48 per cent among men and 16 per cent among women. The corresponding figures for the UK are 38 and 12 per cent respectively, with the UK scoring highest among the ECAS-countries. The number of binge drinking occasions during the last 12 months show that Ireland and the UK have practically identical results, which are about **3-4 times higher** than what is found in the other ECAS countries. When frequency of binge drinking occasions are related to the overall number of drinking occasions, the results show that out **of 100 drinking events, 58 end up in binge drinking for men and 30 for women.** These binge drinking figures are the highest among the ECAS countries. This result suggests that in Ireland, binge drinking is the norm among men and occurs in about a third of the drinking occasions of women. Among both men and women, binge drinking is most common in the youngest age group and shows a decline by age (Table 3).

Table 3. Drinking frequency and binge drinking in Ireland by gender and age (drinkers and non-drinkers).

	Drinking everyday (%)	Drinking at least once a week (%)	Binge drinking at least once a week (%)	Mean drinking occasions past 12 months	Mean binge drinking occasions past 12 months	Fraction of drinking occasions being binge (%)
MEN						
18-64	**1.6**	**69**	**48**	**78**	**45**	**58**
18-29	0.0	80	59	83	55	66
30-49	2.3	69	42	79	41	52
50-64	1.7	56	36	69	42	61
65+	2.5	49	22	66	26	39
WOMEN						
18-64	**0.2**	**51**	**16**	**46**	**14**	**30**
18-29	0.0	71	26	66	22	33
30-49	0.0	48	12	40	12	30
50-64	0.9	38	11	38	12	32
65+	4.3	27	4	36	7	19

Experiences of adverse consequences from drinking

In Ireland 39% of male drinkers and 24% of female drinkers, experienced at least 1 of the 8 adverse consequences during the last 12 months, which is higher than the ECAS average, but lower than in Finland and the UK (Table 4). However, there are more problems per drinker in Ireland. Irish men have higher rates of acute adverse problems in comparison to ECAS countries in relation to "having regretted things said or done after drinking" (32%), "got into a fight" (11.5%, which is three times the average), "been in an accident" (6.3%) and adverse consequences with work/studies (12.4%, which is over two and half times the average), friendships (9.6%) and home-life (7.8%). Irish female drinkers also experience relatively high rates of

adverse consequences, but fewer than women in the UK. A similar tendency to experience more acute harms is also found among Irish women with a high prevalence of drinkers reporting "having regretted things said or done after drinking"(22%), harm to friendships (4.3%) and work (2.9%), involvement in fights (2.8%) and accidents (2.4%). Fights and accidents are over twice the average. Chronic problems such as health problems were reported less often in Ireland than in the ECAS countries both for men and women.

Table 4. Experiences of adverse consequences of alcohol use during the last 12 months among men and women in Ireland in comparison with the ECAS-countries (All respondents aged 18-64 years).

Overall Rates			Chronic Harm		Acute Harm			Social harm		
								Drinking harmed:		
	At least 1 harm	Mean	Considered cutting down	Health	Regretted things said or done	Got into fight	Been in accident	Work studies	Homelife Marriage	Friend-ships
MEN										
Ireland	**39**	**1.21**	**20.7**	**11.6**	**32**	**11.5**	**6.3**	**12.4**	**7.8**	**9.6**
Finland	46.8	0.93	33.0	17.3	25.1	4.2	2.6	4.5	6.8	5.2
Sweden	35.5	0.54	11.0	8.0	25.8	1.3	3.5	3.0	1.9	0.6
Germany	33.5	0.51	17.8	17.3	7.2	5.5	0.5	3.3	3.0	1.6
UK	45.0	0.95	24.5	18.6	27.9	7.5	3.6	9.1	6.5	5.1
France	27.1	0.58	15.2	18.0	12.7	2.0	3.5	2.6	3.3	3.6
Italy	18.3	0.43	10.7	9.8	4.9	1.2	1.6	5.7	4.3	6.0
Average	4.5	0.66	18.7	14.8	17.3	3.6	2.6	4.7	4.3	3.7
WOMEN										
Ireland	**24**	**0.51**	**7.2**	**3.9**	**21.7**	**2.8**	**2.4**	**2.9**	**1.3**	**4.3**
Finland	28.6	0.50	18.5	6.6	17.0	1.4	0.8	2.1	2.5	2.6
Sweden	18.6	0.28	6.0	5.7	13.0	0.6	1.3	0.8	0.5	0.7
Germany	20.2	0.33	12.1	9.8	5.9	1.8	0.7	1.6	2.0	1.2
UK	32.7	0.61	19.6	8.8	21.5	3.6	3.4	4.1	4.5	5.1
France	12.1	0.20	4.7	8.0	4.4	0.0	0.4	0.4	0.2	1.3
Italy	8.5	0.17	3.5	4.3	3.6	0.2	0.2	1.7	1.3	2.3
Average 2	0.5	0.35	10.7	7.2	10.9	1.3	1.1	1.8	1.8	2.2

Acute problems are more common among the younger age groups (18-29 years) for both women and men, with the exception of accidents where higher rates are reported for men in the 50-64 age group (Table 5). Problems related to home life and marriage are concentrated in the middle age groups for both men and women, and the same is found for men regarding health problems. More women in the younger age group (18-29 years) experience higher rates in almost all of the specific harms, excluding harm to homelife/marriage.

Table 5. Experiences of adverse consequences of alcohol use during the last 12 months among men and women in Ireland by age

	One or more harms	Mean	Considered cutting down	Health	Regret	Fight	Accident	Work/ studies	Homelife/ marriage	Friends
MEN										
18-29	43.4	1.4	27.3	10.6	42.0	16.1	7.4	19.5	6.8	13.0
30-49	33.5	1.3	22.0	14.1	34.1	13.6	6.7	15.9	11.1	13.3
50-64	27.2	1.2	24.3	20.2	33.7	11.2	8.6	8.9	12.8	7.9
65+	15.4	0.6	10.9	7.3	12.7	7.0	5.2	5.3	5.4	5.4
WOMEN										
18-29	23.3	0.8	11.1	6.7	27.7	6.7	4.3	9.8	1.2	9.0
30-49	19.4	0.4	5.7	4.5	22.5	1.8	2.9	1.0	2.2	3.4
50-64	13.7	0.5	9.5	5.8	19.6	1.1	2.3	1.2	3.6	4.7
65+	8.7	0.2	6.9	0.0	11.8	0.0	0.0	0.0	0.0	0.0

The relationship between alcohol consumption and experiences of adverse consequences.

Both a high level of drinking and regular binge drinking is associated with a higher risk of problems in Ireland. The likelihood of experiencing the different adverse consequences increases significantly for both men and women with a one litre increase in consumption. Furthermore, men who binge drink at least once a month have an almost three times higher risk (271%) of experiencing adverse consequences compared with those who binge less often. The corresponding figure for women who binge drink at least once a month is almost twice as likely (180%).

Ireland – Weekly low risk limits

In Ireland, the weekly "low risk" limits recommend a weekly consumption no greater than 14 standard drinks for women and 21 standards drinks for men. On average, 29 per cent of all men and 13 per cent of women drink over these weekly limits. The experience of harm is much more common among those drinking over the low risk weekly limits (namely risky drinking). However, 27 per cent of men and 17 per cent of women within the weekly low risk limits have also experienced at least one problem. Thus, the recommended weekly low risk limits of drinking volumes do not in fact protect against some of these adverse consequences. This would suggest that the low risk weekly limits are drunk on one or two binge drinking occasions rather than spread out over the week.

Conclusion

The self reported alcohol consumption in this survey supports what is seen in official statistics on alcohol sales in Ireland today; a lot of alcohol is consumed, mostly in the form of beer. The current high level of drinking is unlikely to be as a result of declining abstention rates during the last number of years, since abstention rates continue to be relatively high in a European perspective, in

particular among women and older segments of the population. This unusual combination of a high reported drinking level and high abstention rates implies that drinkers in Ireland drink more than in other western European countries and that many have risky drinking habits.

The tendency to drink a lot of alcohol on one occasion, referred to as binge drinking, is strikingly common in Ireland. An expression of the high inclination to binge drinking is the fact that, out of 100 drinking events, 58 ends up in binge drinking for men and 30 for women, rates which are much higher than in the ECAS-countries. For men and women, drinking weekly as well as binge drinking is most common in the youngest age group and shows a decline by age. The relatively risky drinking habits of Irish drinkers are also associated with many experiences of harmful drinking-related consequences, in particular among men. On average, Irish male drinkers reported 1.2 problems (of a maximum of eight), which is about twice as high as the ECAS-average; a similar picture was found for women. The overall finding was that adverse consequences particularly related to single heavy drinking occasions were relatively common in Ireland, e.g. fights, accidents and regrettable conduct, whereas more long term problems like health ailments were typically less common than in the ECAS-countries. This outcome may be related to the concentration of harm in the younger age groups. If this is the case, there is a risk that more long term consequences will emerge in the future.

Cross-country comparisons can be problematic because various cultural idiosyncrasies are difficult to control. Nevertheless, these results contain enough evidence to conclude that Ireland has a strikingly high prevalence of binge drinking and alcohol-related harm. It will be an important challenge to find preventive measures that can reduce these problems.

Annex 5

Results of Prosecutions taken for sale of alcohol to minors since July 2000

RESULTS OF PROSECUTIONS TAKEN FOR SALE OF ALCOHOL TO MINORS JULY 2000 TO FEBRUARY 2004						
Garda Regions and Divisions	**Prosecutions**	**Convictions**	**Closure orders**	**Pending**	**Dismissed, Struck Out**	**Closure Orders Appeal**
Eastern Region	**67**	**37**	**29**	**16**	**14**	**8**
Carlow/Kildare	25	10	6	7	8	4
Laois/Offaly	23	18	17	4	1	4
Longford/Westmeath	12	6	4	4	2	0
Louth/Meath	7	3	2	1	3	0
Dublin Met. Region	**63**	**18**	**14**	**28**	**17**	**3**
Eastern	9	5	3	1	3	3
North Central	10	2	1	6	2	0
Northern	12	3	2	5	4	0
South Central	4	0	0	2	2	0
Southern	20	7	7	10	3	0
Western	8	1	1	4	3	0
Northern Region	**92**	**30**	**19**	**39**	**23**	**10**
Cavan/Monaghan	52	14	7	25	13	4
Donegal	29	7	4	13	9	3
Sligo/Leitrim	11	9	8	1	1	3
South Eastern Region	**101**	**51**	**33**	**33**	**17**	**2**
Tipperary	32	16	11	12	4	2
Waterford/Kilkenny	40	25	14	6	9	0
Wexford	29	10	8	15	4	0
Southern Region	**172**	**99**	**73**	**51**	**22**	**7**
Cork City	57	23	21	29	5	3
Cork North	16	8	6	4	4	1
Cork West	29	23	15	1	5	1
Kerry	38	25	23	7	6	1
Limerick	32	20	8	10	2	1
Western Region	**218**	**142**	**107**	**35**	**41**	**13**
Clare	13	5	5	6	2	1
Galway West	38	18	15	11	9	4
Mayo	129	86	58	17	26	6
Roscommon/ Galway East	38	33	29	1	4	2
Total	**713**	**377**	**275**	**202**	**134**	**43**

Annex 6

STFA 2002 Interim Report – Summary of Recommendations

Strategy Areas	Recommendations
R1 Regulate availability	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	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	3.1 Target hot sports – 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	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	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	6.1 Put in place systematic data collection. 6.2 Continue with appropriate research.

Annex 7

WHO Declaration on Young People and Alcohol, 2001

The Declaration aims to protect children and young people from the pressures to drink and reduce the harm done to them directly or indirectly by alcohol.

The Declaration set the following targets that should be achieved by the year 2006:

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

Annex 8

Example of a Community Mobilisation Project* designed to reduce accessibility of alcohol to youth

The Community Mobilisation for Change on Alcohol (CMCA) project was designed to reduce the accessibility of alcohol to youth (under 21 years in the USA). The project was composed of five interacting components: (1) influences on community policies and practices, (2) community policies, (3) youth alcohol access, (4) youth alcohol consumption, and (5) youth alcohol problems. The CMCA project recruited 15 communities in Minnesota and western Wisconsin. Communities were matched and randomly assigned to be in the intervention or control condition, resulting in seven intervention sites and eight comparisons, ranging in population from 8,000 to 65,000.

The project employed a part-time local organiser within each community to activate the communities to select and implement interventions designed to reduce underage access to alcohol. Such interventions could include decoy operations with alcohol outlets (in which police typically have underage buyers purchase alcohol at selected outlets), citizen monitoring of outlets selling to youth, keg registration (which requires the purchasers of kegs of alcohol provide identification information thus establishing liability for resulting problems at parties where minors are drinking), developing alcohol-free events for youth, shortening hours of sale for alcohol, responsible beverage service and developing educational programmes for youth and adults.

Evaluation data were collected before the intervention and about two and a half years after the beginning the intervention. These data included a survey of 9th and 12th grade students at baseline, 12th graders at follow-up, pre and post telephone surveys of 18-20 year olds and beverage alcohol merchants, a study using 21 year old women who appeared to be younger to see if they would be sold or served alcohol without having identification, and monitoring of mass media. Qualitative and quantitative process data were collected to capture how the intervention moved ahead and the obstacles staff and communities faced in reaching their objectives.

Merchant survey data revealed that they increased checking for age identification, reduced their likelihood of sales to minors and reported more care in controlling sales to youth[47]. The survey, using young looking purchasers, confirmed that alcohol merchants increased age identification checks and

* Presented by Harold Holder in his paper, *The role and effectiveness of alcohol policy at the local level: International Experiences*, at the Debating Public Policies on Drugs and alcohol, Trinity College Dublin, Ireland 26th September 2002. Reprinted with permission from author.

reduced their propensity to sell to minors. The telephone survey of 18-20 year olds indicated that they were less likely to consume alcohol themselves and less likely to provide it to other underage persons[54].

Finally, the project found a statistically significant net decline (Intervention compared to control communities) in drinking and driving arrests among 18-20 year olds and disorderly conduct violations amongst 15-17 year olds.

Notes

Notes

DEPARTMENT OF HEALTH AND CHILDREN