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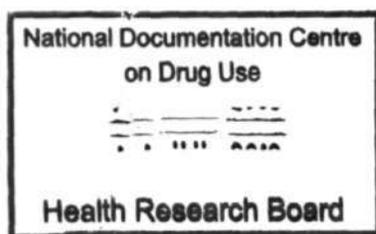
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National Alcohol Policy

IRELAND



/

September 1996

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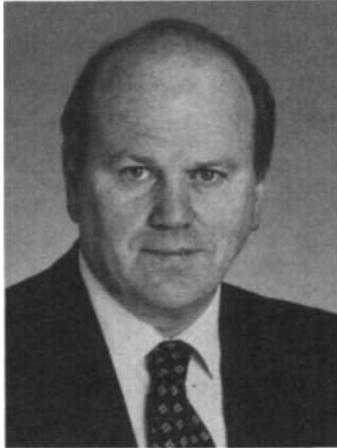
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FOREWORD



The Health Strategy, published by the Government in 1994, set a target of promoting moderation in alcohol consumption. The emphasis in the Strategy and in the subsequent Health Promotion Strategy is on encouraging people to take responsibility for their own health and on providing the environmental support necessary to achieve this.

An alcohol policy requires both individual and environmental initiatives. A clear national policy is necessary to bring together the separate efforts that are required to give it effect. The actions required of statutory and non-statutory organisations must be complementary and co-ordinated if the Policy is to be successful.

The Policy affords an opportunity for public debate on the role of alcohol in our society as we approach the beginning of a new millennium. The Government believes that the Irish people are mature, reflective and willing to develop a healthy, long-term moderate approach to alcohol and its part in our culture. We owe to our young people in particular the opportunity to grow up in an environment which respects and enjoys alcohol and in which public policies support sensible behaviour.

The Government will monitor the implementation of the Policy and I am confident that the actions arising from it will make a positive contribution to public awareness and healthier use of alcohol in (his country).

Michael Noonan TD,
Minister for Health.

Septembt-i L996

ACKNOWLEDGEMENTS

The National Alcohol Policy was prepared by the Health Promotion Unit of the Department of Health and is based on the report of a Working Group which was established by the Advisory Council on Health Promotion (Annex 1). The Department also wishes to acknowledge the literature review carried out by Dr. Ann Hope, Department of Health Promotion, University College, Galway. The Policy draws, in addition, on the proceedings of the World Health Organisation Conference on *Health, Society and Alcohol* which was held in Paris in December 1995.

Department of Health
September 1996

NATIONAL ALCOHOL POLICY

SUMMARY

Alcohol consumption is set to increase in the Irish population over the next number of years, given:- the current and projected economic growth; an anticipated increase in the number of people drinking more beer which is less sensitive to price increases; possibly greater access to alcohol through increased special exemptions for longer opening hours, a greater number of young people starting to drink at a younger age and a higher percentage of regular drinkers by the age of 18 years with a preference for beer; strong alcohol advertising campaigns in all media in terms of volume, exposure and extensive sponsorship promotions with highly visible sports.

Mortality rates continue to increase in the cancers which are strongly associated with alcohol consumption. The association of alcohol consumption with breast cancer, although not conclusive at this time, is a worrying development given that it is the leading cause of cancer among women in Ireland. The social consequences of harmful drinking such as family violence and financial stress are well established in the international literature. In Ireland, it is more difficult to assess as few extensive research evaluations have taken place. However, the public submissions did provide much anecdotal evidence to confirm that alcohol-related problems are pervasive throughout Irish society.

The National Alcohol Policy is directed at reducing the prevalence of alcohol-related problems through an emphasis on moderation in alcohol consumption. The importance of a comprehensive alcohol policy was highlighted when Ireland endorsed the European Charter on Alcohol in December 1995 along with 48 other Member States of the WHO European Region. The alcohol-related problems are multidimensional, therefore the solutions must be multi-sectoral. This means that commitment to the National Alcohol Policy must be on the agenda of policy makers in all sectors and at all levels.

An Alcohol Policy requires both environmental and individual strategies. There is strong evidence that policies which influence access to alcohol,

control pricing through taxation and other public health measures, can have a positive impact on curtailing the health and social burden resulting from drinking (Edwards et al. 1994). However, a key to the effectiveness of such strategies is public support, enforcement and maintenance of the policies.

In examining the rationale for a National Alcohol Policy a number of elements have been identified. Research is urgently required to identify attitudes and patterns of alcohol consumption across the population and within sub-groups of the population. Based on sound research, a sensible drinking message of *Less is Better* should form an educational empowerment programme with regional and local initiatives as a required and integral part of such a campaign. A health education programme in all schools should be part of the core curriculum. The availability and effectiveness of treatment services need to be established.

Action to contain the availability of alcohol could be achieved by reducing the number of special exemptions for longer opening hours and controlling access to underage drinking by ID schemes nation-wide. The enforcement of drink driving legislation including random breath testing needs to be continued to reduce alcohol-related traffic accidents. All levels of the Drinks Industry should recognise that people have the right to be safeguarded from pressures to drink. Finally, a National Alcohol Policy could be co-ordinated by a wider National Substance Use Surveillance Unit.

*Section I***BACKGROUND TO THE NATIONAL ALCOHOL POLICY****1. Alcohol Use in Ireland****1.1 Introduction**

The drinking of alcohol is an integral part of Irish social life and is accepted as such by most people. It plays an important role in our social, cultural and sporting activities. However, alcohol is also a drug (BMA, 1991), which, while used and enjoyed by many people, can lead to significant problems both for the individual and for the community at large when it is taken to excess on any drinking occasion or consistently taken in large amounts for a long period of time. Alcohol misuse can result in harm to physical and emotional health, in economic loss, in violence and disruption of family life and in the maiming and killing of the drinker and others in accidents.

1.2 Historical Overview

Historically, the Irish have often been described as having a legendary and unenviable reputation for drinking. There is evidence that the description of the Irish as a particularly alcohol-prone race is a myth. Indeed, it is doubtful whether Ireland ever occupied a prominent role with regard to alcohol use or misuse. This surprising finding was noted as far back as the 1770's (Maxwell, 1956). Statistics from the 1850's, however, show that more spirits were consumed in Ireland than in England or the USA but less than in France and Scotland (Haughton, 1875). The statistics do not refer to beer or wine. Spirits were regarded as vulgar drinks and were associated more with alcohol-related problems in the last century. The consumption of spirits and indeed all other forms of alcoholic drinks declined sharply after this period, following the success of the Temperance Movement from the 1850's.

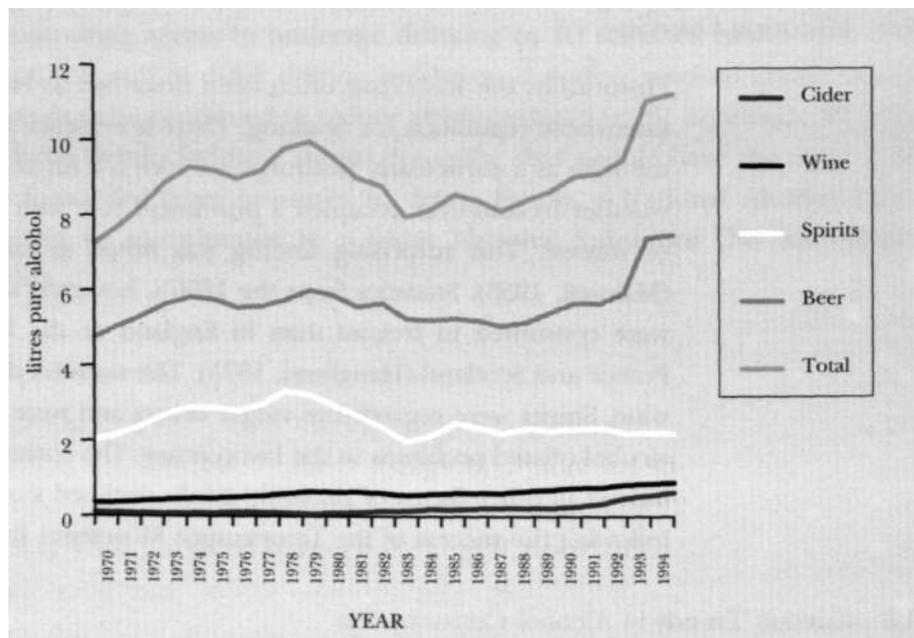
1.3 Current Trends in Alcohol Consumption

In 1994 the personal expenditure on alcohol was £2.46 billion (CSC, 1995). The reports of the Revenue Commissioners provide the basic annual data on quantities of beer, spirits and wine consumed in Ireland. The data converted to litres of pure alcohol and divided by the adult population is shown in Figure 1 from 1970 to 1994 and Annex 2. When interpreting the data it is important to remember that the average consumption per adult

understates the quantities actually consumed by alcohol drinking adults, since non-drinkers are included in the total. In Ireland the estimated numbers of non-drinkers is substantial. In 1980 it was reported about 17% of Irish adults aged 18 and over were non-drinkers while a further 7% were ex-drinkers (O'Connor & Daly, 1985). An EU survey conducted for the Europe Against Cancer programme in 1989, reported that 75% of Irish people aged 15 and over drink alcohol (EAC, 1989). This would suggest a 25% figure as non-alcohol consumers or abstainers.

In 1994, we consumed 11.23 litres of pure alcohol (ethyl alcohol) per head of population aged 15 years and over. To adjust for the number of non-drinkers (estimated at 20%) the consumption level per head translates to 13.47 litres.

FIGURE 1:
Consumption of Beer, Spirits, Wine and Cider per head of Population aged 15 and over in Litres of Pure Alcohol, Ireland 1970-1994



Sources: CSO *Statistical Abstract: various issues*
Revenue Commissioners' Annual Report, various years

In 1960 per capita consumption was 4.88 litres. There was a gradual increase in alcohol consumption through the seventies with a peak in 1979 of 9.97 followed by a decline in the eighties and the recent increase again

in the 1990's. In the case of spirits, smuggling or cross-border purchases may have slightly understated consumption in the 1980's when spirits' prices were considerably lower in Northern Ireland.

Consumption of beer rose steadily from 1960, stabilised in the mid 1970's and peaked in 1979, then declined in the mid 1980's when it began to rise again. Beer has the highest consumption rate of all alcoholic beverages. The marked increase in beer consumption for 1993 and 1994 reflects the change in method of calculation, from the number of barrels to million hectolitre litres, rather than a large increase. Consumption of spirits rose to a peak at the end of the seventies before falling in the early eighties. The fall may well be exaggerated because of the cross-border effect already mentioned. There has been a five fold increase in the consumption of wine since 1960. However, this occurs from a low base.

1.4 Demographic Factors which Influence Alcohol Consumption

1.4.1 *Age:* The legal minimum age for alcohol consumption in Ireland is 18 years. However, drinking does occur much earlier among adolescents. A survey conducted among post-primary schools in Dublin in 1984 indicated that 65% of pupils between 14 to 17 years reported having ever had a drink. Seven years later, in 1991 a repeat survey showed that 78% had taken a drink (Morgan & Grube, 1994). In the North Western Health Board Lifeskills evaluation, 83% reported ever having had a drink (Nic Gabhainn & Kelleher, 1995). A national survey reported a rate of 63% for those having ever had a drink (Murray, 1996). In the North West 17% of post primary students drank beer weekly. In the 1991 Dublin sample, 32% were regular drinkers, defined as those drinking three or more times in the last month (Morgan & Grube, 1994) while the national survey classified 29% of pupils as regular drinkers using the same definition (Murray, 1996). In the North West 42% reported being drunk at least once and of these 8% reported being drunk ten or more times (Nic Gabhainn & Kelleher, 1995). The Dublin sample reported 50% having felt drunk at least once while the national figure was 40% (Morgan & Grube, 1994; Murray, 1996).

However, in the North West 7% were reported as abstainers which were predominately young female working class adults (Nic Gabhainn & Kelleher, 1995). The number of abstainers among young people was 21% among Dublin pupils, 17% in the North West and 37% in the national

sample (Morgan & Grube 1994; Nic Gabhainn & Kelleher, 1995; Murray, 1996). If the cohorts of young people remain in Ireland, the number of non-drinkers in the population will fall as this cohort ages.

1.4.2 *Household Characteristics:* The 1987 Household Budget Survey provides information on expenditure by households on various commodities, including alcohol. Analysis of this data carried out by the ESRI for this report, suggests a number of effects of household characteristics on consumption.

Rural households spend less on alcohol than do urban ones. This is to be expected, since average rural incomes are lower than urban ones. However, there are differences over and above those due to income differences. There are definite regional differences in consumption and in income elasticities (the percentage increase in alcohol consumption for a one per cent rise in income). Analysis based on the eight planning regions showed that the Eastern region, comprising Dublin, Kildare, Meath and Wicklow, had the highest alcohol expenditure and the highest income. Alcohol consumption in the East was higher than the income differential would explain, because a higher income elasticity existed.

TABLE 1:

Comparison of Alcohol Expenditure (£/week) by Socio-economic Group.

Socio-economic Group	1	2	3	4	5	6
Sample size	1,267	1,006	924	1,447	908	1,166
Household size	3.6	3.3	3.8	4.1	3.8	3.6
Total Expenditure	349	252	222	225	172	204
Beer Expenditure	9.1	8.2	9.3	9.9	9.2	7.0
Spirits Expenditure	2.1	2.2	1.5	1.7	1.3	1.7
Wine Expenditure	2.1	0.9	0.5	0.3	0.3	0.3
Total Alcohol Expenditure	13.3	11.3	11.3	12.1	10.8	9.0

Source: *Household Budget Survey, 1987, Presented in Conniffe & McCoy, 1993.*

The Household Budget Survey also allows analysis by social class. In the 1987 Survey, the social group categorisation is based on the profession of the head of the household. There are six groups: 1- professional (including employers and managers), 2- salaried employees, 3- non-manual workers, 4- skilled manual workers, 5- unskilled manual workers, 6- farmers and agricultural workers. It is evident that income levels will vary with group, but not uniformly. For example, some farmers will have higher income

than many professionals. Table 1 shows income and expenditures on drinks, with groups numbered in the order already given.

One weakness of Household Budget Survey data must be mentioned. It is known that understatement of alcohol expenditure occurs and that it is substantial. The deductions of this section therefore depend on assuming that the tendency to understate is not strongly related to household characteristics. For example, it is being assumed that all social groups are equally truthful or untruthful about alcohol consumption.

As would be expected, expenditure on alcohol is highest for social group 1, since it has the highest average income. Beer consumption is lower for this group than for groups 3, 4 and 5, but spirits and particularly wine expenditure is higher. Indeed, it is only in social group 1 that expenditure on wine matches that on spirits.

As regards alcohol expenditure, the differences between groups can be expressed as follows. If households had equal incomes in all groups, then social group 1 would actually spend less on alcohol than the other groups which would spend 1.18, 1.31, 1.43, 1.79 1.13 times more on alcohol respectively. Thus social group 5, unskilled manual workers, would have the highest relative spending on alcohol. Of course social group 1 actually spends more on alcohol, but this is because these 'professional' households have more money to spend.

1.5 International Alcohol Consumption Comparisons

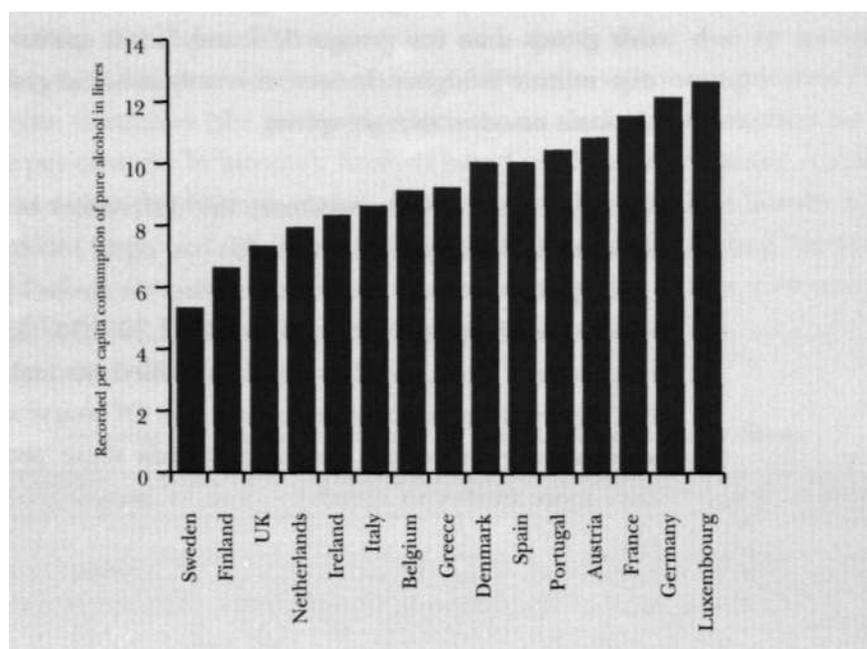
When comparisons are made with other E.U. countries, Ireland ranked 11th in 1993 for quantity of alcohol consumed per head of population (Figure 2). The trend in alcohol consumption among European Union Member States shows that Ireland and Greece are increasing while most other Member States shows a decrease (Belgium, France, Italy, Netherlands, Portugal, Spain) or remain stable. The four countries with the lowest alcohol consumption rates (Sweden, Finland, United Kingdom, Netherlands) all have comprehensive alcohol policies.

It is important to remember that comparative data for alcohol consumption are expressed per head of population. This clearly depends on the population distribution between children and adults as well as the

changing proportions of non-drinkers among adults as mentioned previously. A recent review of current consumption levels in Europe highlighted the age effect. Harkin et al (1995) reported that Ireland with 27% of its population aged 0-14 years changes from 11th to 8th place in terms of quantity of alcohol consumed when adjusted for age. If adjustments were made for non-drinkers, given that Ireland has an estimated higher proportion of abstainers, the ranking among EU countries would be even higher.

FIGURE 2:

Recorded consumption of pure alcohol in litres per capita in the Member States of the European Union in 1993



Source: Harkin, AM (1995). *Profiles in the Member States of the European Region of the World Health Organisation*. WHO Regional Office for Europe.

The alcohol consumption patterns among European youth show interesting profiles. When comparisons were made between 15 year old post-primary students from the North Western Health Board and the international Health Behaviour in School (HBSC) data, Irish boys and girls had the highest number of non-drinkers (81% boys; 67% girls) in Europe and nearly the highest number of weekly drinkers (47% boys; 35% girls), (Nic Gabhainn & Kelleher, 1995). This could suggest sensible drinking habits.

1.6 Alcohol-Related Problems

The adverse effects of alcohol are pervasive throughout Irish society. The alcohol-related problems extend beyond the physical health issues to psychological and social problems (Table 2). Problems can arise from a single episode of drinking such as a car crash, accidental fall or injuries from an assault or fight. Regular drinking can contribute to the chronic conditions of cancers, stroke, work and money problems, and heavy drinking may result in cirrhosis of the liver, alcohol psychoses and, for some homelessness. Though Ireland may not be ranked high on the EU league table for alcohol consumption per capita, the real consumption per drinker is much higher, there is ample evidence to suggest that alcohol related problems, as identified in the international research literature, are also quite prevalent in Ireland.

TABLE 2:

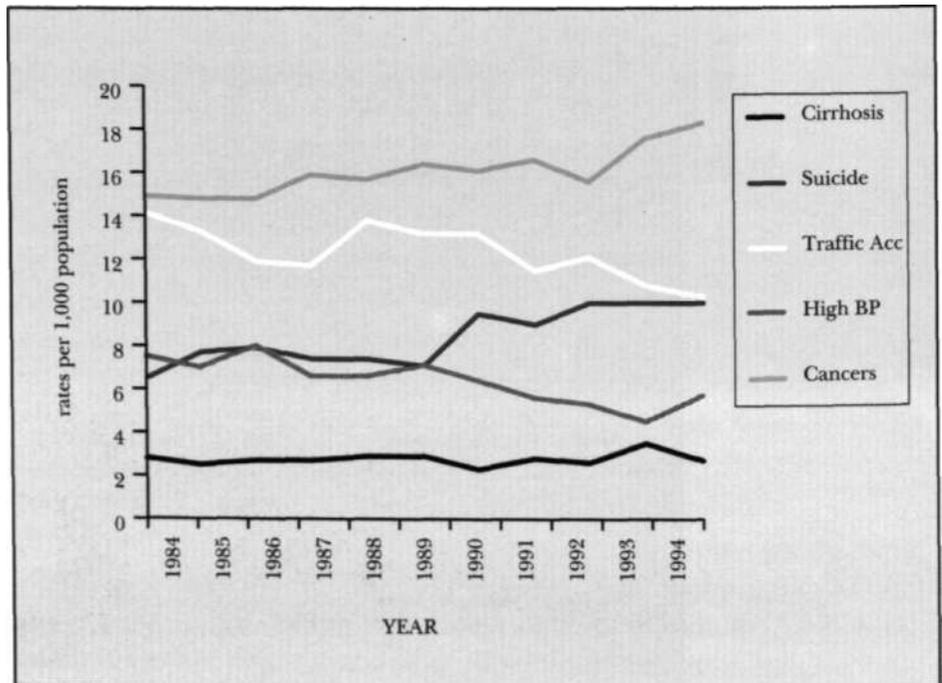
Types of Alcohol Related Problems

Physical Health Problems	Cirrhosis of the liver Cancers of Mouth, Pharynx, Larynx, Oesophagus, Liver Breast Colon/Rectum High Blood Pressure Stroke Road Traffic Accidents Accidental Falls Assault injuries from fights Homicide
Mental Health Problems	Suicide Depression Alcohol Abuse Alcohol Psychoses
Social Health Problems	Family Violence Crimes of Violence Drunkenness with Aggression Drink Driving Work Problems Financial Stress Intoxication Offences Homelessness

1.6.1 *Mortality:* Alcohol consumption plays an important role in many deaths in Ireland each year. The International Agency for Research on Cancer reported that alcohol is causally related to cancers of the mouth, pharynx, larynx, oesophagus and liver (IRAC, 1988). In Ireland, mortality rates from these cancers have been gradually increasing over the last ten years (Figure 3). Alcohol consumption contributes to hypertensive disease, motor traffic accidents and suicide and there is a causal relationship with chronic liver disease and cirrhosis. By European standards, Ireland has a relatively low death rate from cirrhosis, but it has to be borne in mind that rates of cirrhosis may be affected by the type of alcoholic beverage and the pattern of drinking in a particular society. Alcohol consumption has been shown to have a moderate association with breast cancer (Edwards et al 1994). This is of major importance given that breast cancer is the leading cause of cancer among women in Ireland. In 1994, 657 women died from this disease.

FIGURE 3:

Death rates per 100,00 population for Cancers: Mouth, Pharynx, Larynx, Oesophagus, Liver; Hypertensive Disease, Road Traffic Accidents & Suicide



Source: Central Statistics Office

1.6.2 *Accidents:* In 1994, 121 people were killed between 9.00 pm and 3.00 am (the hours most associated with drinking and driving) and 1,155

injured. Given the fact that only 13% of travel is undertaken between these hours and that 29% of road deaths and 19% of all road injuries in 1994 occurred during these hours, there is little doubt but that the combination of alcohol and driving during darkness are important contributory factors in road accidents (National Roads Authority, 1994). It was estimated that the cost of a fatal accident in 1994 was £832,000 and £30,000 for a serious injury accident. This highlights the financial burden in addition to the personal cost of accidents.

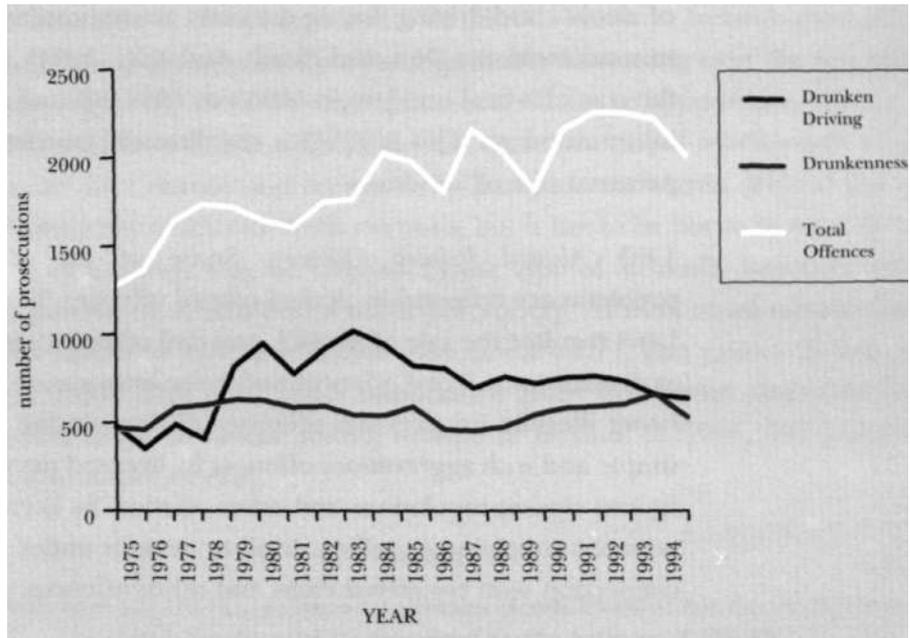
1.6.3 *Alcohol Related Offences:* Some of the alcohol-related social problems are reflected in alcohol-related offences. The Intoxicating Liquor Laws regulate the sale of alcohol, and civil offences against the person such as drunkenness. Total offences under the Intoxicating Liquor Laws include being illegally on licensed premises during closing hours; drunkenness simple and with aggravation; offences by licensed persons or their servants against closing regulations and other offences by licensed persons or their servants; supplying or selling drink to persons under 18 years; offences in connection with registered clubs and other offences.

There has been an increase of 10,000 prosecutions from 1975 to 1994 (Figure 4). After the introduction of the Intoxicating Liquor Act 1988 there was a marked decrease in the number of prosecutions for total offences. However this was short lived. The offence *drunkenness simple and with aggravation* has remained relatively steady with a range of 4,500 to 6,500 prosecutions per year over the last twenty years.

Offences for drink driving include: driving or attempting to drive a MPV (mechanically propelled vehicle) while drunk or with blood/urine/alcohol concentration above prescribed limit; being in charge of a MPV while drunk or with blood/urine/alcohol concentration above prescribed limit; refusing to provide preliminary specimen of breath or permit taking of blood/urine specimen at a Garda station.

It is interesting to observe that after the re-introduction of blood/urine tests in mid-1978, there was a marked increase in drink driving prosecutions which peaked in 1983 at 10,197 prosecutions. The lower permitted level of blood alcohol concentration (80 mg%) was introduced under the Road Traffic Act 1994. Of those who were breath tested during 1993, 32% were positive, indicating they were over the permitted limit of BAG, the comparable figure for 1994 was 30%.

FIGURE 4:
Prosecutions for Alcohol Related Offences: Intoxicating Liquor Laws Total Offences, Drunkenness and Drunk Driving Offences from 1975-1994.



Source: *Annual Reports of the Garda Commissioner*

1.6.4 Violence: Many crimes of violence have alcohol as their common denominator. During 1993 there were 596 reported assaults with wounding. In relation to violence against women, there were 368 reported indecent assaults on females and 143 reported rapes. International research has shown a link between alcohol use and these types of personal violence (Edwards et al., 1995).

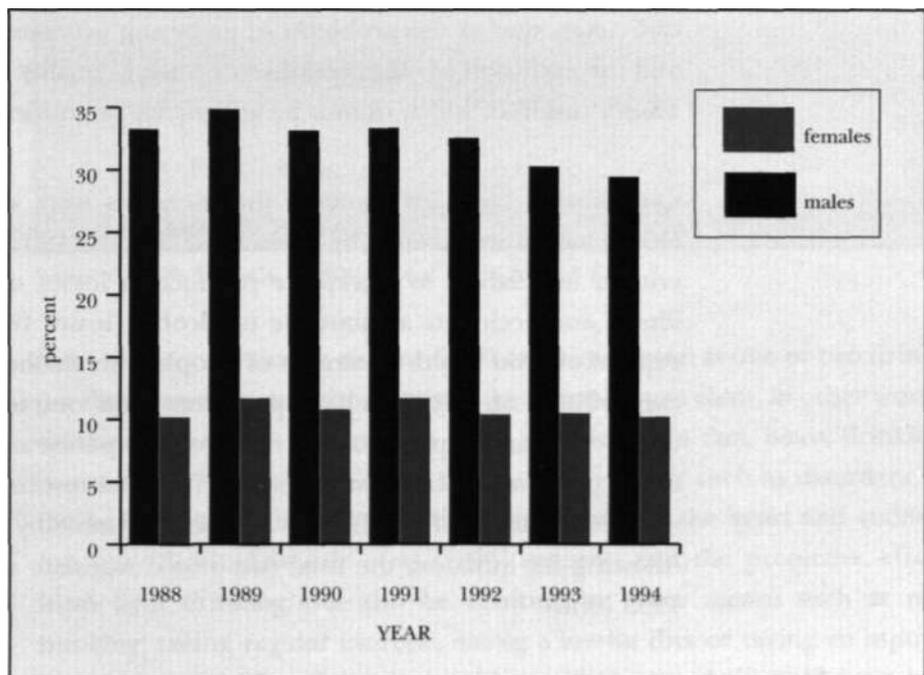
1.6.5 Mental Health: The number of admissions to psychiatric hospitals and units is a measure used to estimate the number of those with alcohol dependence or what is called alcohol-related disorders. The absence of data on those who treat themselves or who are treated for alcohol-related disorders in centres other than psychiatric hospitals and units is a major limitation to our understanding of alcohol dependence in Ireland.

In 1988, there were 5,147 men and 1,331 women admitted to psychiatric hospitals for alcohol abuse and alcoholic psychoses. However by 1993, the corresponding figures for admissions had dropped to 4,405 and 1,313

respectively. The number of alcohol related admissions as a percentage of total admissions are presented in Figure 5 which shows a decrease in 1992 and 1993. However this fall may be due to the growth of alternative treatment centres outside the psychiatric hospital. All socio-economic groups were represented in the 1993 admission figures to psychiatric hospitals and units for alcohol-related disorders but the unskilled manual and the unspecified category were over-represented.

FIGURE 5:

Admissions to Psychiatric Hospitals for Alcohol Disorders as a percentage of Total Admissions for male and females



Source: *Health Statistics, Department of Health*

There was a wide variation across health board regions of admission rates for alcohol-related disorders to public psychiatric hospitals and units in 1993. The highest rate, 369 per 100,000, is in the North Western Health Board and the lowest in the North Eastern Health Board, a rate of 98.7 per 100,000. The variation in rates reflects in the main the different arrangements in each health board for the treatment of alcohol-related disorders.

The number of admissions for alcohol-related disorders to private psychiatric hospitals and public psychiatric hospitals is quite similar, 19.5%

and 21.1% of the total respectively. The pattern of admissions to private hospitals for alcohol-related disorders has been substantially influenced by the availability of cover for treatment costs under the Voluntary Health Insurance (VHI) Board. The length of stay in public hospitals in 1991 for just over half of patients admitted for alcohol dependence was less than three months. Of the remainder, 8.5% had spent 10 or more years in the psychiatric hospital.

1.7 Economic Cost of Alcohol Misuse

Estimating the economic cost of alcohol related problems is fraught with difficulties due to the problems of gathering accurate data on true costs and the exclusion of other social costs, such as quality of life, the pain and misery suffered, which cannot be adequately quantified.

Quantifiable costs for some of the measures were estimated by Walsh (1980) and more recently by Conniffe & McCoy (1992) both using similar criteria in relation to workplace production losses due to absenteeism, illness and accidents attributable to alcohol, losses from road accidents, expenditure on health treatment of people with alcohol related problems, expenditure on social welfare payments paid out to drinkers or their dependants and expenditure of resources on police and social workers in dealing with alcohol related problems. The total cost based on 1988 figures was £263 million, of which £138 million was borne by the State (Table 3). Allowing for inflation, the total cost would translate to £325.6 million in 1995 terms.

1.8 Protective Effect of Alcohol

There is evidence that alcohol appears to reduce the risk of coronary heart disease (CHD) for middle-aged men and older women, despite its adverse effects on blood pressure and the association with an increased risk of stroke (Harkin et al 1995). The biological explanation for this alcohol protective effect is believed to be through the HDL cholesterol mechanism and coagulation mechanism in blood clotting and thrombosis (Rankin, 1994). There is no substantial reductions in absolute risk from light drinking for men under 35 and for pre menopausal women (Edwards et al). This is because CHD is not an important cause of mortality for these age groups.

TABLE 3:
Economic Cost of Alcohol Misuse in Ireland (1988)

	£ million
Cost of Accidents	80
—one seventh of cost of all road accidents	
Disability/Retirement/Invalidity pensions	55
Loss of Work Output	45
—due to absence, illness or working efficiency	
Health Care Costs	40
—3% of total non-capital expenditure of Department of Health	
Social & Community Costs	28
—Police and Social Workers time (non-road accidents)	
Loss of Tax Revenue	15
	—
ESTIMATED TOTAL	263

Source: Conniffe & McCoy (1992). *Alcohol Use in Ireland*. ESRJ

Most of the reduction in risk for CHD can be achieved at one or two drinks per day. However, no dose response relationship is evident, in other words drinking more does not provide more protection. In fact, heavy drinking is associated with increased risk of heart conditions such as disorders of the heart rhythm, diseases affecting the muscles of the heart and sudden coronary death. Edwards et al (1994) suggests that the protective effect from light drinking can also be attained by other means such as not smoking, taking regular exercise, eating a low-fat diet or taking an aspirin every other day. Therefore, those with reasons to avoid alcohol have other options to reduce their risk for CHD.

1.9 Economic Role of Alcohol in Ireland

There are three areas where the alcohol industry makes a significant contribution to the Irish economy, namely employment, revenue by taxes and balance of payment.

1.9.1 *Employment:* The production, distribution and consumption of alcohol brings benefits to the Irish economy in many forms. A survey of licensed premises in 1994, commissioned by the Drinks Industry reported

that 32,100 (52.7%) full time staff and 28,800 (47.3%) part-time staff are employed in the drinks retailing business. Of the part-time staff 4,900 work less than five hours a week. Proprietors make up a high proportion of the full-time staff. The majority of premises experienced no change in numbers employed in the last five years, however there was a net percentage gain of 7.4% and this occurred mainly in Dublin premises whose turnover was over £150K (Scott, 1994). In 1975 7,790 people were employed in Ireland in drinks production. By 1991 this figure had fallen to 4,600. This represented 2.1% of total industrial employment and 0.41% of the total at work in 1991 (ESRI 1992). There is, in addition, related employment in other sectors such as distribution, retail and agriculture. A report published by the Drinks Industry Group in 1982 estimated the linkage at 10,000 but this was considered by the ESRI "to be much too high".

1.9.2 *Tax Revenue:* Alcohol yields considerable revenue to the State. This revenue is obtained in two main ways — excise duty on drinks and value added tax which is passed on to the consumer. Other sources are the licence fees paid by publicans and the income tax paid by employees of the alcohol industry. Excise duty on alcohol is a substantial source of revenue, yielding £495.5 million in 1994, about 4% of total current government receipts. The receipts from excise duties on alcohol as a percentage of total tax receipts declined from 13.1% in 1975 to 5.2% in 1992. This is not because excise revenue had fallen drastically, but rather because other sources of Government revenue have been expanding.

1.9.3 *Balance of Payments:* The alcohol industry is a positive contributor to Ireland's balance of payments (the exports we use to pay for our imports) because alcohol exports have exceeded alcohol imports over the years, with the value of alcohol exports being nearly three times that of imports in 1991. Because of developments in other sectors of the economy, the share of alcohol in total exports has fallen, although volume and value have risen.

Section II

NATIONAL ALCOHOL POLICY

2. Public Health Considerations

2.1 Alcohol — The Health Policy Context

The Health Strategy *Shaping a Healthier Future* published in 1994 and Health Promotion Strategy published in July 1995, both contain recommendations concerning the development of a national alcohol policy. The health strategy document identified alcohol consumption as a key risk factor which contributes to the three main causes (heart disease, cancer and accidents) of premature death in Ireland. A four-year action plan was identified for implementation of the Health Strategy with specific targets and actions. The goal in relation to alcohol use is

to promote moderation in alcohol consumption and reduce the risks to physical, mental and family health associated with alcohol misuse.

The importance of a comprehensive alcohol policy was highlighted at the WHO European Regional meeting in Paris, December 1995, as part of the European Alcohol Action Plan. During the Paris Conference *Health, Society and Alcohol*, a European Charter on Alcohol was endorsed by the Minister of State at the Department of Health, Mr. Brian O'Shea TD, on behalf of the Irish Government along with other European countries. The European Charter on Alcohol called on all Member States to give expression to ethical principles and goals:—

- 1. All people have the right to a family, community and working life protected from accidents, violence and other negative consequences* of alcohol consumption.*
- 2. All people have the right to valid impartial information and education, starting early in life, on the consequences of alcohol consumption on health, the family and society.*
- 3. All children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption and to the extent possible, from the promotion of alcohol beverages.*
- 4. All people with hazardous or harmful alcohol consumption and members of their families have the right to accessible treatment and care.*

5. All people who do not wish to consume alcohol, or who cannot do so for health or other reasons, have the right to be safeguarded from pressures to drink and be supported in their non-drinking behaviour.

(European Charter on Alcohol, Paris, December 1995)

The European Region also identified ten strategies for alcohol action (Annex 3) which would give effect to the ethical principles and goals in accordance with differing cultures, social, legal and economic environments in each Member State.

2.2 The National Alcohol Policy

The National Alcohol Policy is directed at encouraging moderation, for those who choose to drink, and reducing the prevalence of alcohol-related problems in Ireland. The availability of alcohol in a society has much stronger influence on alcohol consumption than individually directed messages. Therefore an Alcohol Policy requires both environmental and individual strategies. Environmental strategies are the structures, policies and systems which support the healthier choice such as access to alcohol, legislation, pricing, taxation and advertising. Individual strategies promote positive change in lifestyle habits at an individual level through educational processes and personal skill development. Providing services to help individuals end their abuse or dependence on alcohol is equally important.

2.3 Rationale

The response of individuals exposed to alcohol ranges along a continuum from abstainers, to light/ moderate/ heavy drinkers, to those who have a dependence on alcohol. There is also a continuum of problems from minor to major, from single to multiple, from one-time events to sustained dependence or chronic illness. Therefore primary, secondary and tertiary prevention are required to respond to these diverse needs.

Many alcohol-related problems stem from the drinking habits of the 'social drinkers'. The impact of these problems not alone impinge on the health of the nation but also on road safety, the workplace, violence, crime and poverty levels in our society.

A multi-sectoral approach is required as many other sectors have an impact on alcohol consumption which are outside the control of the health sector. Therefore it is essential that there is a health dimension to policies both in the private and public sector. These agencies must take responsibility for ensuring that the health implications of their policies are properly assessed.

The Alcohol and Public Policy Project, supported by the WHO European Office, reviewed a comprehensive body of research and identified key factors which underlie the rationale for the National Alcohol Policy:

- Alcohol is a major public health issue which is pervasive and very costly.
- The level of a population's alcohol problem experience is not set for all time.
- The overall level of a population's drinking is significantly related to the level of alcohol-related problems which that population will experience.
- The individual's level of drinking is related to the risk of that individual encountering a problem with alcohol.
- Prevention measures which influence the generality of drinkers will often also impact on heavy or problematic drinkers.
- Many of the target problems are widely distributed in the drinking population, rather than being concentrated only among heavy drinkers.

(Edwards et al. 1994)

INDIVIDUAL STRATEGIES

Health Promotion enables people to acquire information and develop personal skills that will help them in making positive decisions in relation to their health. Individual change also needs a supportive environment so that the healthier choice becomes the easier choice.

There are three key areas, namely awareness raising, health promotion interventions and treatment services, where effective individual strategies

can be developed to achieve the alcohol related goal. Individual strategies need to be implemented in the various settings of the family, school, workplace, community, general practitioner and hospitals to successfully achieve a broad based approach and meet the needs of specific groups.

3. Raising Public Awareness

3.1 International Research

There is no evidence to date which supports the efficacy of promotional campaigns which seek to teach the population not to exceed a "safe limit" by counting the number of units of alcohol which they drink. The selection of the "safe limit" figures are arbitrary and many would argue that there is no "safe limit", merely a continuum of risk (Edwards et al 1994). This "safe limit" strategy requires focused learning through a barrier of translations from drinks to units and back to drinks again. This strategy also runs the risk of encouraging light drinkers to drink up to the limit. At the Paris Conference (WHO European Region) the message *Less is Better* was supported by Member States as the preferred message.

Mass media campaigns conducted in various Western societies during the 1970's and 1980's had limited effect on beliefs and attitudes to alcohol and no effect on alcohol behaviour, as reported by Edwards et al (1994). More recent mass media campaigns, when combined with other intervention strategies, did show positive change in alcohol behaviour (Barber et al 1989; Hingson et al. 1993). However, Edwards et al (1994) suggests that mass media campaigns may have their most potent effect on the social and political climate surrounding alcohol consumption. The media can provide an important forum for discourse on alcohol policy initiatives.

School based alcohol education programmes have been successful in increasing knowledge but few have shown impact on alcohol behaviour (Moskowitz 1989). However, a recent evaluation of the North Western Health Board *Lifeskills* programmes in Ireland did report positive outcomes, in that young adults who participated in the programme while at post primary school had more sensible drinking habits, drank less frequently and were drunk less often, than those who did not receive the programme while at school (Nic Gabhainn & Kelleher, 1995).

Community programmes and local action are important ways of supporting healthier lifestyles and can exert a powerful influence on local policy towards alcohol. The Lahti Project, a small urban community in

Finland, demonstrated how community collaboration between interested individuals, groups and decision makers in the community developed realistic and effective tools for prevention of alcohol and drug problems. In Stockholm, an accident prevention unit has been established to reduce mortality and morbidity due to alcohol-related problems. The programme involves working with a network of agencies and groups to develop specific safety issues and a countrywide injury surveillance system (Ritson, 1995).

3.2 Awareness of Alcohol Use

In creating a greater level of awareness and understanding of alcohol use and misuse among the Irish population, three important messages are identified:

- 3.3 Sensible Drinking Guidelines
- 3.4 Avoidance of Alcohol by Pregnant Women
- 3.5 Detecting Early Signs of Alcohol Dependency.

3.3 Sensible Drinking Guidelines

Alcohol is a drug which, while used and enjoyed by many people, can lead to significant problems both for the individual, the family and the wider community. Alcohol-related problems arise both from the excess alcohol intake on a single occasion to the more frequent heavy drinking over many years. To reduce the risk of developing alcohol related problems, it is advisable to develop sensible drinking practices. Moderation is the key to sensible drinking which can be achieved through the promotional message of *Less is Better*. Being sensible means avoiding drinking to excess on any one occasion, giving your liver a few days rest each week and never drinking and driving.

3.4 Avoidance of Alcohol by Pregnant Women

There is scientific evidence that alcohol use by pregnant women can result in a variety of birth defects in unborn children. When alcohol is consumed, by the pregnant woman, it crosses the placenta and enters the foetal bloodstream in a concentration equal to that in the mother's bloodstream. This has a major impact on the developing foetal brain. Daily drinking has been shown to be associated with low birthweight (Mills et al 1981). Binge

drinking is considered hazardous. Babies born to mothers with a severe drink problem can be found to have certain physical and mental abnormalities known as the foetal alcohol syndrome.

Therefore, because of the critical growth and development that occurs during the first few months of foetal development, women who have any reason to believe they are pregnant should refrain from alcohol consumption during this time. The best message to pregnant women is *less is better for you and the baby*. An occasional drink may do no harm, but cutting out drink completely eliminates any possible risks.

3.5 Detecting Early Signs of Alcohol Dependency

There is no sharp dividing line between prevention of alcohol misuse and alcohol dependence. Good prevention measures would ensure that the public is much better informed about the danger of excessive consumption of alcohol. There is also a need for greater awareness, among the public, of the symptoms of dependence on alcohol.

Some signs of alcohol dependence are widely recognised, such as public drunkenness, blackouts and absence from work. There are many other signs of a person's growing dependence on alcohol which are not widely known. Measures which would sensitise the public to these aspects of excessive drinking could enable people to recognise the danger signs of alcohol dependence at an earlier stage and to seek help for themselves, a spouse, a member of their family, a friend or a work colleague.

4. Health Promotion Interventions

Health Promotion interventions require greater individual involvement, and focus in particular on the developing of personal and social skills which empower and enable individuals to make changes in their lives appropriate for them. The match of the specific needs of groups within different settings requires careful planning.

4.1 Health Education

4.2 Family Initiatives

4.3 Community Initiatives

4.4 Workplace

4.5 Professional Preparation.

4.1 Health Education

The White Paper on Education *Charting our Education Future* contains a commitment to the implementation of broadly based programmes of social, personal and health education in all schools. The National Council for Curriculum and Assessment (NCCA) is currently developing programmes of Social, Personal and Health Education for both primary and post-primary schools.

The White Paper specifically supports the health-promoting school approach which has three strands: the school climate, the involvement of parents and the wider community and positive educational interventions. It highlights the importance for each school to outline a coherent programme of health promotion and well-being. The Departments of Education and Health and the health education personnel of the Health Boards have successfully developed a number of health education initiatives for teachers, pupils, parents and high risk youth groups.

4.1.1 *Health Education Programmes:* Sustained and continuing efforts from the Departments of Education and Health have increased the availability of health education programmes in schools. However some schools do not include a health education programme in their school curriculum as it is not a core requirement.

At primary school level, health education tends to be mainly cross-curricular. The more recent substance abuse prevention programme for post-primary schools, *On My Own Two Feet*, specifically addresses alcohol, smoking and drug use. The Department of Education is currently working on a similar substance abuse awareness and protection programme for primary schools. As in most of the school health education programmes, the focus of the substance abuse programme, *On My Own Two Feet*, is on developing life-skills. These include both personal (building self-esteem, decision making) and social (coping with peer pressure) skills which will enable students to make healthy choices appropriate for them. The

students are active participants in their own learning while the teacher acts as a facilitator.

This new methodology is a radical approach for teachers who have traditionally been used to didactic teaching. Therefore both pre-service (teacher training) and in-service (current teachers) training in health education methodology is necessary to empower teachers with the skills and confidence to deliver quality health education in a single subject and/or in a cross-curricular setting in the school.

At third level colleges and universities, campus student health centres and student unions do provide some health education. However, alcohol education is singularly lacking as reflected in the dearth of campus policies on drinking, drink industry sponsorships and student abuse of alcohol. A recent survey on student poverty reported that the average expenditure on alcohol per month represented 15% of student income for those living away from home and 23.5% for students living at home. Alcohol was the highest expenditure for students living at home and the third highest after accommodation and food for students living away from home (USI, 1995).

4.1.2. *Health Education in the Non-formal Sector:* Voluntary youth organisations involve young people in activities which seek to foster their personal development and facilitate social education. The *National Youth Health Programme* is a partnership between the Youth Affairs Section of the Department of Education, the National Youth Council of Ireland (NYCI) and the Health Promotion Unit. It aims to provide, in the non-formal education sector, a broad-based, flexible health education programme for young people incorporating information, training and programme development. A number of programmes have been developed on the issues of alcohol abuse, solvent abuse and cancer prevention and materials and training have been made available on a nation-wide basis to youth workers, youth leaders, teachers, trainee gardai, FAS staff and Health Board staff. The *Drink Awareness for Youth (DAY)* programme was initiated in 1989 and a broad-based Health Promoting Youth Service initiative is currently being developed.

The Minister of State at the Department of Education with responsibility for sport has recently published a code of ethics and good practice for adults working with children and young people up to the age of 18 years

in Irish sport. A section on substance abuse outlines good practices in relation to alcohol use by sport leaders and coaches, alcohol-free underage functions and sponsorship (Code of Ethics & Good Practice for children's sport in Ireland, 1996).

4.2 Family Initiatives

The family unit, parents and siblings, provide a valuable and natural setting where alcohol issues can be discussed openly and honestly. Parents need to recognise their responsibility as good role models for their children. Parents who adopt sensible drinking habits as part of their lifestyle can reinforce positive attitudes for their children towards alcohol. The home is also an environment where parents can, if they so wish, introduce their teenage son or daughter to alcohol in an open and natural setting.

4.3 Community Initiatives

4.3.1. *Community Health:* Community action has the potential to be a powerful influence for both social and environment-directed interventions. Exploring the alcohol culture with such initiatives as drama, art and peer-led education projects also provide opportunities for active debate on alcohol use in the community (Ritson, 1995).

Within the Southern Health Board, there is broad-based and extensive health education training for professionals, semi-professionals and volunteers who work in and with community groups. The trained tutors work with specific groups within the community such as men's and women's groups on health and well-being, parents on family communication, and the more recent "Health and Empowerment for Older People". These programmes in turn make an important contribution to the physical and mental well-being of the community.

4.3.2 *Parent Initiatives:* The *No Name Club*, alcohol-free teenage discos, is a parental innovation in parts of Ireland, which provides a positive social activity for teenagers who wish to have fun. Teenagers are the "bar staff" and are encouraged to make interesting alcohol-free cocktails drinks for their dancing colleagues. It provides an alternative to the pressure of underage drinking.

4.4 Workplace

Throughout Europe, alcohol problems at the workplace are a major factor in accidents, absenteeism and reduced productivity (Morawski et al 1991). The cost to the employers runs into millions each year in addition to the personal, financial and social impact on the drinker and their family. The recognition of the cost to industry of alcohol related problems has given impetus to the development of services aimed at the prevention, early identification and treatment of problems.

As many of the alcohol related problems are represented across the drinking population at large, the workplace provides an ideal setting where the issues of alcohol use and alcohol abuse can be dealt with through a comprehensive worksite programme. The programme should include the promotion of a healthier lifestyle, a greater awareness of sensible drinking habits, the early signs of alcohol abuse and alcohol dependency and special assistance to employees whose problems require individual attention through an employee assistance programme (EAP).

4.4.1 Employee Assistance Programme: Broadly based programmes are generally regarded as more acceptable to employees and less prone to labelling than those exclusively aimed at alcohol related problems. In Ireland, EAPs deal with a variety of employee problems including addiction, stress, bereavement, physical health, social welfare, financial and legal matters. A quality EAP programme (Annex 4) provides an excellent framework for addressing many of the issues in the Safety, Health and Welfare at Work Act, 1989.

4.4.2 Irish Employers: A number of Irish companies have had well established EAPs in operation for some years. These include public service bodies, private sector companies and semi-state organisations. These are generally large organisations with an established commitment to employee welfare, several of whose programmes could reasonably claim to constitute models of good practice. Although such models demonstrate what is possible for other companies of comparable size, their example can only be applied to that proportion of the Irish workforce that is employed by large organisations. A survey carried out by IBEC in 1988 showed that out of 775 companies, only 4% had a formal employee assistance programme in operation. That figure had increased to 5.4% in 1995 for companies

with formal EAP programmes and another 16.7% reported informal programmes.

Within the public service the Minister of Justice launched a *Programme to deal with Alcoholism and Problem Drinking in the Prison Service* in December 1995, through the Prison Service Employee Assistance Programme. Its purpose is to confirm the commitment of the Employer, the Union, the Governor of the Prison and Welfare representatives to the promotion and support of this programme to assist employees, at all levels, who have developed or may develop alcohol related problems.

Economies of scale dictate that an in-house traditional EAP is only economically justified in large organisations which may have welfare and medical officers available and the means to ensure that they are properly trained. As the vast majority of Irish companies are small (less than 50 employees) it is not realistic for them to provide their own EAPs, so they are currently unable to obtain access to employee assistance programme in any practical or organised way.

4.5 Professional Preparation

The importance of the multi-sectoral approach to health promotion has been highlighted in the 1995 Health Promotion strategy document. Professionals and voluntary groups in both the health and other sectors can make a significant contribution to the health and social gain of the community. An awareness and understanding of the National Alcohol Policy and how it could be implemented in their respective areas of responsibility could create an effective support network. Sectors which experience directly the fall-out from alcohol-related problems include health professionals such as the doctors, nurses and addiction counsellors, the Gardai, social welfare officers, the judiciary, teachers and the many voluntary agencies who provide support for those who have been affected by alcohol misuse.

5. Treatment Services for Alcohol Abusers *Sc* Alcohol Dependence

The aim of treatment services for alcohol dependence is to help individuals end their dependence on alcohol and to rebuild relationships with their spouses, families, friends and colleagues. The concept of "treatment" does

not fit easily with the process involved in helping a person overcome his/her dependence on alcohol. There is no medical procedure or pill that will "cure" a person of his/her dependence. The essential ingredient of recovery is the motivation of the individual to overcome his/her dependence. Skilled therapists can provide invaluable assistance in this area. For those whose dependence has progressed to the stage that they have become homeless and destitute, the services they require are shelter, care and treatment for the physical and mental illnesses associated with advanced alcohol dependence.

5.1 International Research

The research evidence on individually directed alcohol treatment interventions, as reported by Edwards et al (1994), can be summarised as follows:

- Brief interventions directed at excessive drinking or at an early stage of an alcohol problem show benefits.
- Nearly all treatment regimes show some improvement at the completion of the programme when compared with pre-entry to programme. However, outcome measures such as being alcohol-free are shown to be less successful.
- Both intensive in-patient treatment and out-patient treatment provide similar benefits.
- There is a relationship between AA membership and a reduction in alcohol-related problems including cirrhosis rates in some countries.

5.2 Current Position in Ireland

The current position in Ireland is examined in relation to the following areas:

5.3 Role of General Practitioner

5.4 Treatment Services

5.5 Specific Needs for Vulnerable Groups

5.3 Role of the General Practitioner

The importance of early intervention to change drinking patterns that are associated with alcohol dependence also underlines the role of the health care professions in dealing with the problem. It is well known that some persons who are dependent on alcohol consult their general practitioner about other problems but fail to disclose their drinking habits. The general practitioner is particularly well placed to advise on sensible drinking and to connect presenting signs and symptoms with alcohol dependence. The Irish College of General Practitioners (ICGP, 1991) has recommended that general practitioners should be pro-active in the education, identification, diagnosis and treatment of patients with alcohol-related problems.

Few general practitioners can in isolation provide the intensive treatment required for a person who wishes to break their dependence on alcohol. The general practitioner needs in many cases to be able to call on the support of a specialised alcohol service to provide the intensive therapy which may be required. This service should be as local as possible and provide therapy on an out-patient basis.

5.4 Treatment Services

Treatment services for alcohol-related disorders will never provide an effective response on their own to alcohol dependence. Treatment services are essential, but they are only one aspect of the multi-faceted approach to combating alcohol-related problems in our society. A treatment programme will be more effective if it is supported by national policies which help people avoid health damaging behaviour.

5.4.1 *Service Structures:* Treatment services within the psychiatric services have tended to deal with people whose alcohol dependence was long standing and/or particularly harmful to themselves or others. The appropriateness of the psychiatric hospital model of treatment for alcohol dependence came under scrutiny in Ireland in the 1970's. The Report on the Development of Psychiatric Services, *Planning for the Future*, recommended in 1984 that alternative community based services be developed.

The Green Paper on Mental Health, published by the Government in June 1992, comments that in the years since the publication of *Planning for the*

Future, some Health Boards have developed local alcohol/drug services and recruited addiction counsellors to work in sector services. It also pointed to the extremely high rate of admission to psychiatric hospitals for alcohol-related disorders in some health boards and suggests that such rates demonstrated the need to develop alternative treatment facilities in the community.

The organisation of treatment services can form part of the psychiatric service, as recommended in *Planning for the Future* or form part of the community care programme, as has happened in some health boards. However, if the service is part of the psychiatric services, one consultant in the catchment area should be assigned overall responsibility for the development of the services and the treatment of the most complicated cases. If the service is developed as part of the community care programme, responsibility for the development of the services should be assigned to that programme and arrangements agreed for specialist psychiatric services. Provided that there is liaison between general practitioners, the alcohol/drug service and the psychiatric services, either administrative arrangement can work. It is essential, however, that responsibility for the development of services for alcohol dependence in the catchment or community be clearly identified.

5.4.2 *Treatment Centres*: There are a number of non-statutory organisations providing treatment services for alcohol dependence. The involvement of a wide range of such organisations adds a richness and diversity to the provision of care which might be lacking if the State were the sole provider of services. The involvement of these organisations in the treatment of alcohol dependence should be encouraged subject to their meeting the Department of Health's policy aims. Many of these centres are in receipt of public funding towards the cost of their activities. In view of the thrust of policy towards a community based and out-patient service, Health Boards should be satisfied that the publicly funded services of non-statutory alcohol agencies correspond with that policy.

5.4.3 *Treatment Methods*: There is no one treatment that is clearly more effective than any other. The absence of vigorous evaluation of the outcome of treatments in different settings and using different therapies makes it difficult to provide a firm basis for recommendations. However, the present state of knowledge suggests that out-patient models of

treatment are no less effective than in-patient care and they have the advantage of being less expensive.

It was assumed in the past that an individual dependent on alcohol had to reach 'rock bottom', both physically and emotionally, before seeking treatment. One of the aims of modern therapy had been to bring forward the moment at which help is sought by the person who is dependent. Today the main therapeutic tools in the treatment of alcohol dependence are psychotherapy, counselling, family and marital therapy, either individually or in group settings. Therapy may take place in a residential or day setting. There is no evidence to date that either setting is more effective than the other but the provision of therapy in a day setting is substantially less expensive.

Some people who have consumed large quantities of alcohol in a short period need to be detoxified in a supervised environment for three or four days. Traditionally, detoxification has taken place in the controlled environment of a general or psychiatric hospital. Recent experience suggests that detoxification, in many cases, can take place successfully on a day basis in a clinic or in a person's home under the supervision of a doctor and/or nurse. Detoxification on a day basis has many advantages, not least of which is the avoidance of the expense and disruption caused by a hospital admission. Facilities for detoxification will continue to be required in hospital for people who are in an advanced stage of alcohol dependence, who are elderly, or who have complicating medical or psychiatric problems.

5.4.4 Aftercare: The importance of aftercare in the treatment of those who are trying to break their dependence on alcohol can hardly be overstated. Many services provide support for clients who have successfully completed a programme of therapy. This after-care service is often linked to participation in self-help programmes which provide social support and the fellowship of people who are also abstaining from alcohol. Although it is difficult to evaluate the effects of membership of these programmes, it is significant that one study which followed problem drinkers over eight years showed that the majority of those who achieved abstinence were regular attendees at Alcoholics Anonymous. Relapse is less common among those who participate in after-care programmes.

Support for families with an alcohol dependent spouse, who may experience many physical, psychological and social problems, is required at different levels and from various sources such as general practitioner, schools and social workers. Children at high risk may require specific counselling.

5.5 Specific Needs for Vulnerable Groups

5.5.1 *Homeless:* For some persons who are dependent on alcohol, their lives are so damaged by alcohol misuse that they are reduced to vagrancy. *Planing for the Future* recognised the need for special provisions for such people as they have become socially detached and homeless. The Eastern Health Board programme for the homeless has helped to co-ordinate services for vagrant persons dependent on alcohol who tend to be more numerous in large cities. Within the EHB, one mental health team has been assigned responsibility for the programme to ensure a comprehensive response.

5.5.2 *Travellers:* Because of the distinct lifestyle of the Travelling Community, there is a need for a specialised team to assist travellers who have become dependent on alcohol.

5.5.3 *Prisoners:* There is also a need to develop a treatment programme for alcohol/drug dependence in prisons which would address the particular problems of prisoners and of treatment in a prison environment.

ENVIRONMENTAL STRATEGIES

A basic rule of economics is that supply is related to demand. In an open economy, suppliers attempt to affect demand and to realise a greater profit, through mechanisms such as price incentives, advertising, promotions and increased product availability.

There is strong evidence that policies which influence access to alcohol, control pricing through taxation and other public health measures, can have a positive impact on curtailing the health and social burden resulting

from drinking (Edwards et al. 1994). However, a key to the effectiveness of such strategies is public support, enforcement and maintenance of the policies.

6. Licensing Code

6.1 International Research

In a recent comprehensive WHO research review it was concluded that "studies which address the availability of alcohol have usually found that when alcohol is less available, less convenient to purchase, or less accessible, consumption and alcohol related problems are lowered"(Edwards et al 1994). Research findings (Edwards et al, 1994; Lehto 1995) of relevance to this section are summarised as follows:

- Studies in Finland, UK and USA show that a high density of alcohol outlets leads to significant increases in alcohol sales.
- The introduction of medium or high alcohol content beer in grocery stores, as demonstrated in the Nordic countries, resulted in large increases in alcohol consumption (46% in Finland) and increases in violent crime (32% in Sweden).
- The availability of low alcohol beer and lager reduces the opportunity to reach high blood alcohol levels.
- Limiting the hours and days of sale have been shown to reduce overall consumption and alcohol related problems such as arrests for drunkenness, domestic disturbance and assaults.
- Studies have found that lowered alcohol age limits lead to more alcohol-involved traffic crashes for the age-groups affected by the change, while increased age limits reduced such crashes.

6.2 Current Position in Ireland

This section outlines the current legislative position in Ireland in relation to four areas of the alcohol licensing code where proposed legislative changes are recommended.

6.3 Points of Interest of Alcohol

6.4 Permitted Opening Hours

6.5 Exemptions and Extended Hours

6.6 Teenage Access to Alcohol

6.3 Points of Sale of Alcohol

In order to sell alcohol, a person must hold a licence. Under the licensing code, there are four main outlets where licences are issued allowing for the sale of alcohol: on-licences; off-licences; restaurants and clubs.

6.3.1 On-Licences: The licence permitting the sale of alcohol consumption on or off the premises is the most frequent encountered licence and is attached mainly to pubs and hotels. The Licensing Act, 1902 introduced a general prohibition against the granting of any new licences for the sale of alcohol, except where an existing licence/two licences (depending on geographical location) is/are extinguished. The net effect, therefore, is the prevention of any increase in the total number of licensed premises.

6.3.2 Off-Licences: These licences are attached mainly to off-licensed premises (which do not sell commodities other than ancillary to the sale of intoxicating liquor) and supermarkets and shops. In some supermarkets and shops, the sale of intoxicating liquor for consumption off the premises is restricted to wine, on the basis of a wine-on licence. The same restrictions that apply to the granting of on-licences also apply to off-licences (but not to wine-on licences).

6.3.3 Restaurants: Restaurants can sell the full range of intoxicating liquor on the basis of having one of two appropriate licences. First, restaurants can obtain a full on-licence (such as attached to pubs) under which intoxicating liquor can be sold under the same conditions as in pubs. Second, in 1988 the special restaurant licence was introduced, in essence a full licence, which must be granted to an applicant who satisfied Bord Failte standards. It is not necessary to extinguish another licence in order to obtain a special restaurant licence. Restaurants may sell only wine on the basis of the wine-on licence.

6.3.4 *Clubs:* Registered clubs may supply intoxicating liquor to members and their guests on the basis of having a certificate to do so from the courts. A club must satisfy the court that its rules qualify it for registration.

6.4 Permitted Opening Hours

Premises with full on or off-licences, such as pubs, hotels, some restaurants, off-licences and supermarkets and shops with a licenced section, can sell alcohol during the following basic times.

- (a) Weekdays 10.30 a.m. to 11.30 p.m. in summer
 10.30 a.m. to 11.00 p.m. in winter
- (b) Sundays 12.30 p.m. to 2.00 p.m. and 4.00 p.m. to
 11.00 p.m. (summer and winter time). On any
 Sunday that falls on the 23rd or 24th of
 December the weekdays apply.
- (c) St. Patrick's Day where it falls on a weekday 12.30 p.m. to
 11.00 p.m.
 where it falls on a Sunday the Sunday times
 apply.
- (d) Normal permitted hours do not apply on Christmas Day or Good
 Friday.

Persons can remain on licensed premises operating on the basis of on-licences for half hour after the above "closing" times for the consumption of intoxicating liquor (drinking-up time). The permitted hours for registered clubs are the same as for pubs.

Restaurants and hotels and registered clubs can sell intoxicating liquor for consumption with substantial meals until 12.30 a.m., and on Christmas Day between 1.00 p.m. and 3.00 p.m. and between 7.00 p.m. and 10.00 p.m.

Premises with special restaurant licences can sell alcohol for consumption with substantial meals. The permitted hours for such premises in Ireland are:

- (a) Weekdays 12.30 p.m. to 12.30 a.m.
- (b) Sundays 12.30 p.m. to 3.00 p.m. and 6.00 p.m. to 12.30 a.m. the following morning
- (c) Christmas Day 1.00 p.m. to 3.00 p.m. and 7.00 p.m. to 10.00 p.m.

6.5 Exemptions and Extended Hours

TABLE 4:

Licences/Exemptions granted by the District Courts in 1994

Special Exemption Orders	55,290
General Exemption Orders	875
Occasional Licences	1,062
Area Exemption Orders	393
Clubs "Special Events"	111
Extension of "Club Hours"	2,806
Renewals of Publican's Licences	1,292
Restaurant Certificates	1,169
Temporary Transfers of Licences	908
Club Certificates	786
Public Dance Licences – one month or less	520
– other	1,654
Exemption Orders – Sunday Opening (12.00-12.30 p.m.)	286
Beer Retailers/Spirit Grocers Off Licences	56
Wholesale Beer Dealers Licences	39
<hr/>	
TOTAL	67,247

Source: CSO, *Statistical Abstract*, 1995.

Aside from the extended hours allowed to restaurants and hotels in relation to the provision of alcohol with meals, the principal exceptions to the general prohibitions are set out below. Each exemption may have a different application in terms of number of hours and closing time as this is at the discretion of the courts. The 1994 figures illustrate the variation and extent of exemptions (Table 4).

- Special Exemption Orders
- General Exemption Orders
- Occasional Licences
- Exemptions for special events (area exemption orders)
- Exemption for certain types of persons on licensed premises

- Exemption for "Special Events" in sports clubs
- Festival Clubs

6.5.1 *Special Exemption Orders:* Under this provision, the holder of a full licence attaching to a hotel or restaurant can apply to the court for an extension of opening hours when there is a special occasion (as defined in the legislation) on his or her premises. A special occasion includes a function organised by a particular organisation or a private function at which a substantial meal is served or a dance held on a day that is a day of special festivity either locally or generally. This is the exemption order under which discos obtain extensions. An explanation for the additional exemptions are outlined in Annex 5.

6.5.2 *Substantial Meal:* The Intoxicating Liquor Act, 1962, defines a substantial meal "as such as might be expected to be served as a main mid-day or main evening meal or as a main course at either such meal". This definition has been interpreted by the courts. The definition applies equally in relation to hotels and restaurants operating under public house licences, restaurants operating under special restaurant licences and limited restaurant certificates. It also applies to extended hours in relation to the provision of meals in clubs and to special exemption orders which apply to occasions on which a meal must be served. The worth of the meal should be £2 or more.

6.6 Teenage Access to Alcohol

The greatest single concern voiced in submissions from the public concerned problems associated with teenage access to alcohol. There are four issues that need to be examined

- Minimum Age
- Access of persons under 18 years to alcohol
- Employment of young persons on licensed premises
- Identity Cards

6.6.1 *Minimum Age:* Intoxicating liquor cannot be sold to persons under 18 years: it cannot be purchased by persons under 18 years and it cannot be consumed in public by persons under 18 years. In the recent national survey, teenagers (12-17 yrs) were asked to identify where they usually

obtained alcohol. The top four sources were the pub (25%), the disco (19%), off-licence (14%) and older friends who bought it for them (12%) (Murray, 1996).

6.6.2 Access of Persons under 18 years to Alcohol: The Intoxicating Liquor Act, 1988 dealt comprehensively with the problem of under-age drinking. It brought together and up-dated existing provisions, generally increased the penalties for breaches of those provisions and introduced strict new provisions. It removed existing loopholes concerning the sale of intoxicating liquor to persons under 18 years and, by easing the burden of proof, made it easier to obtain convictions against persons who sold intoxicating liquor to those under 18 years of age.

A person under 15 years of age cannot be in the bar of a licensed premises at any time unless accompanied by his or her parent/guardian. A person under 18 years of age cannot be in a licensed premises during the time an exemption is in force. A person under 18 years cannot be at any time in an off-licence (i.e. a premises or part of a premises used exclusively or mainly for the sale of intoxicating liquor) unless accompanied by a parent or guardian.

6.6.3 Employment of Young Persons on Licensed Premises: A licence-holder may not employ any person under 18 years of age to sell alcohol on his or her premises. An exemption is made for close relatives who reside with the licence-holder and apprentices, in each case who are 16 years of age or older.

6.6.4 Identity Cards: Section 40 of the Intoxicating Liquor Act, 1988 provides that the Minister for Justice may by regulation provide for the issue to a person of or over the age of 18 years, if so requested by the person and subject to his or her compliance with the regulations, of "an age card" specifying the age of such person. Regulations for the purpose of implementing this section have not been made to date.

The Gardai and local communities have developed local ID schemes, (100 to date), to prevent and reduce underage access to alcohol. These schemes, could provide a "blueprint" for development across the whole country.

6.7 Conclusions

A robust research finding is that availability of alcohol can have a significant effect on alcohol consumption and alcohol related problems. Therefore limiting the availability of alcohol can produce public health benefits. In relation to changes in hours of sale, most of the studies have demonstrated increased drinking with increased opening hours. An increase in alcohol consumption has been shown to increase alcohol-related problems such as drunkenness arrests, violence, assaults, domestic disturbances and accidents (Edwards et al 1994).

In Ireland the availability of alcohol has increased substantially under the licensing code in two main areas: an increase in the number of restaurants with full licences and an increase in the number of exemptions which allow for extension of opening hours. The growth in the number of restaurants was designed to meet the increased tourism needs. There has been a nine fold increase in the number of special exemptions granted for the years 1967 to 1994 (6,342 in 1967 to 55,290 in 1994). Exemption orders may encourage the habit of drinking greater amounts of alcohol given that pubs, hotels and restaurants are open for longer hours. Therefore, it is clear that the licensing code has an influential role in the availability of alcohol which in turn impacts on public health. The Irish Medical Organisation reinforced this view at its 1996 Conference when it called on the Government not to extend the licensing hours for the sale of alcohol.

The current local ID schemes, if evaluated for effectiveness, could provide a blue print for harmonising the card to facilitate a nation-wide scheme. A recent Licensed Vintners Association survey reported that 89% of publicans are in favour of a national ID card scheme for customers (Licensing World, 1995).

7. Road Traffic Acts

7.1 International Research

It is well recognised and documented that alcohol consumption can impair the functioning of the drinker (Edwards et al. 1994). This can occur at both low or medium blood alcohol concentration (BAG) levels.

In the majority of European countries the alcohol legislation for BAC level ranges from zero to 80 mg% (Table 5). Fourteen of these countries have a level of 50mg% and ten countries have a level of 80mg% including Ireland (Harkin et al 1995). The level of BAC is based on objective evidence of risk and perceived public acceptability. The risk for young drinkers can even be greater when combined with their inexperienced driving. In Australia, a zero BAC limit set for first year drivers resulted in a significant reduction in night-time and weekend crashes (Drummond et al. 1987).

TABLE 5:

BAC limits of Some European Countries

Romania	0 mg%
Russia	10 mg%
Sweden	20 mg%
Bulgaria	20 mg%
Finland	50 mg%
Netherlands	50 mg%
France	70 mg%
UK	80 mg%
Germany	80 mg%
Ireland	80 mg%

The effectiveness of a drink driving law is determined by the certainty of detection and punishment as perceived by the general public. A successful prevention strategy requires frequent, widespread and publicly visible road checks of random breath testing. The success of such a campaign in Australia resulted in a drop of 22% of fatal crashes and a drop of 36% in alcohol-involved traffic crashes (Arthurson 1985; Homel, 1988). Licence suspension is considered the most effective punishment (Peck et al. 1985).

Although deterrence and strict enforcement of drink driving laws is the cornerstone to restricting alcohol-related crashes, some countries have also promoted the designated driver strategy or public transport schemes as a complementary strategy. However no reported evaluations have taken place to date. Responsible alcohol beverage server practices can also lead to reductions in the number of alcohol-involved traffic crashes (Edwards et al 1994).

7.2 Current Position in Ireland

The Road Traffic Code is examined in relation to two areas

7.3 Blood Alcohol Concentration

7.4 Penalties

7.3 Blood Alcohol Concentration

Recent legislative changes introduced by the Department of the Environment provide for lower blood alcohol concentration (BAC) levels, to a maximum of 80 mg%. It is hoped that, over time, the enforcement of the provisions of the Road Traffic Act, 1994, will lead to a further reduction in the number of fatalities and injuries resulting from drink driving. It will also consolidate the major positive change in the public's attitude towards such driving which has taken place in recent years.

The new legislative provision which empowers the Minister for the Environment to vary the levels of alcohol permissible in a person's blood, urine or breath and to set different limits for different classes of drivers, offers new flexibility for targeted regulations.

7.4 Penalties

The Road Traffic Act 1994 provides for new penalties attaching to convictions for DWI (Driving While Intoxicated) offences. It is suggested that persons convicted of DWI offences could be obliged, as part of a rehabilitative policy, to attend a court alcohol education programme.

8. Advertising, Promotion & Sponsorship

8.1 International Research

Alcohol advertising is intended to differentiate brands, reinforce brand loyalty and target different segments of the market. Advertising also has the potential to portray drinking as socially desirable, to reinforce pro-alcohol attitudes, to recruit new drinkers and to increase drinking among current drinkers. Alcohol advertising emphasises the desirable aspects of drinking, plays down the risk of alcohol use to individual and public health and contradicts prevention objectives (Harkin et al 1995).

The research provides evidence that some of these influences do exist. The Centre for Science in the Public Interest in the USA reported a 46% reduction in media advertising of alcohol between 1986 and 1993. During the same period, a 10% decline in alcohol consumption was observed. The incidence of alcohol related problems such as alcohol related traffic fatalities and binge drinking among high school students also fell (CSPI, 1995). Although a causal relationship cannot be concluded there clearly is an important association. OECD countries with a ban on spirits advertising have about 16% lower alcohol consumption than countries with no bans. Countries with bans on beer and wine advertising have about 11% lower alcohol consumption than countries with bans only on spirits advertising (Harkin et al 1995).

The impact of alcohol advertising on pre-drinkers (aged 10-14 yrs) was shown to influence belief and intentions to drink as adults (Grube & Walsh 1994). A longitudinal study in New Zealand, reported by Edwards et al. (1994) examined the relationship between recall of alcohol advertising and alcohol consumption at a later age. The conclusion was that the higher the number of alcohol advertisements recalled at 13 years of age, the greater the consumption of beer when those same boys reached 18 years of age. The overall research evidence confirms that advertising has a small but contributory impact on drinking behaviour (Edwards et al. 1994).

8.2 Current Position in Ireland

The regulation of alcohol advertising in Ireland is achieved through various codes of conduct which outline the ways in which the alcohol industry may promote its products. The current position in relation to broadcasting, non-broadcasting media and sponsorship will be discussed.

8.3 Broadcasting Media

8.4 Non-broadcasting Media

8.5 Sponsorship/Promotions

8.3 Broadcasting Media

The Minister for Arts, Culture and the Gaeltacht has updated (May, 1995) the codes of standards, practice and prohibitions in advertising, sponsorship and other forms of commercial promotion in broadcasting services, as provided for in the Broadcasting Act 1990. This code

(Annex 6) applies to both RTE and the Independent Radio and Television Commission. The general principle which underlies the advertising codes is that advertisements should be "legal, honest, decent and truthful".

8.4 Non-broadcasting Media

A voluntary code of advertising standards for non-broadcasting media in Ireland is administered by the Advertising Standards Authority of Ireland (ASAI). The ASAI is a self-regulatory body, established and financed by the advertising industry by means of a levy system. The Code of Advertising Standards for Ireland is administered and applied through a Complaints Committee. Complaints are investigated free of charge and the names of individual complainants are not revealed.

The new revised 1995 Code applies to all media — press, radio, television, cinema and outdoor and where appropriate, to direct marketing activities and sales promotions. The rules about the advertising of alcoholic drinks now require that anyone depicted in such an advertisement should appear to be over 25 years of age; previously this stipulation applied only to persons seen to be consuming alcohol.

In addition, the Code of the Poster Advertising Association of Ireland governing the advertising of alcoholic drinks provides that drink advertisements should not appear at or near (i.e. within 100 yards of) schools, youth centres, hospitals, churches or other places of worship. The code of the Cinema Advertising Association Limited in relation to the advertising of alcoholic drink provides that "alcohol commercials cannot be shown to an overtly young cinema audience".

8.5 Sponsorship/Promotions

8.5.1 *Sale Promotions:* The ASAI has a Code of Sales Promotion Practice which aims to regulate the nature and administration of marketing techniques which are designed to make goods or services more attractive to purchasers. Although there is no specific section on alcoholic products, it does state that the code is designed to protect the public and should be read in conjunction with the Code of Advertising Standards. It indicates that "promotional products and samples should be distributed in such a way as to avoid the risk of harm to consumers".

8.5.2 *Broadcasting Sponsorship:* The amended code under the Broadcasting Act, 1990 also addresses standards, practices and prohibitions relating to sponsorship. The provision of the code ensures editorial independence. It also indicates that a sponsor must adhere to the advertising code and must not be associated with a programme which addresses an audience to which its commercials are not permitted to appeal (e.g. alcoholic drink sponsorship of youth programmes are not permitted) or during which it would not be permitted to advertise.

8.5.3 *Non-broadcasting Sponsorship:* The Advertising Association of Ireland (AAI) along with the Chamber of Commerce have developed guidelines for sponsorship agreements. However, no specific guidelines on alcohol sponsorship are defined for the non-broadcasting media. The absence of controls over sponsorship of sporting and cultural activities in relation to youth events is a serious deficiency. The aim should be to establish, in on-going consultation and dialogue with the alcohol industry, a firm but workable voluntary code of practice.

9. Taxation & Pricing

9.1 International Research

The cost of alcohol has an important influence on consumption levels and is subject to the economic laws of supply and demand. The effect of price changes on alcohol consumption has been extensively investigated in Western societies such as North America, Australia, New Zealand and Europe. The robust finding is that if alcohol prices go up, consumption goes down, and if prices go down consumption goes up (Edwards et al. 1994). This was evident in Ireland from 1970 to 1974, where the real price of alcohol was falling and incomes rising, and alcohol consumption per head rose steeply (Figure 1). Conversely between 1979 and 1983, there were price rises in alcohol and a fall in disposable incomes, due to economic difficulties, with a related drop in the consumption of alcohol (Conniffe & McCoy, 1992). Therefore the taxation of alcohol is an important and effective public health instrument in reducing alcohol-related problems.

However, there is greater price sensitivity in spirits and wine than in beer consumption and this is especially evident in English-speaking countries

(Edwards et al. 1994). The effect of alcohol prices on alcohol consumption varies between countries, can be influenced by the social and cultural position of alcoholic beverages and can change over time.

9.2 Current Position in Ireland

This section outlines the current position in Ireland in relation to taxation and pricing.

9.3 Taxation

9.4 Pricing

9.3 Taxation

The Government obtains revenue from the consumption of drink in two main ways. These are excise duties (taxes) on alcoholic drinks and the value added tax (VAT) passed on to consumers.

9.3.1 Excise Taxes: Excise taxes are levied on units of alcohol rather than on price. This means that the higher the alcohol content of the alcoholic beverage, the higher the excise duty. Therefore low alcoholic beverages have a low excise tax. Excise taxes on alcohol provide a substantial source of revenue to the Government each year. In 1994 excise duty yielded £495.5 million, which represented about 4% of total government tax revenue. The importance of excise duties on alcohol as a component of total government revenue has been declining in the past 20 years, from 10% of revenue in 1975 to 4% in 1994. This decline is due to an expansion of other sources of revenue and not to an actual drop in excise on alcohol.

9.3.2 Value Added Tax: Value added tax is as substantial a source of taxation revenue as excise duty, as VAT amounts to roughly one fifth of the retail price. It could be argued that if people did not spend money on alcohol they would spend it on other goods subject to VAT so that the loss of tax revenue would not be as substantial as in the case of excise duties.

9.4 Pricing

The price of alcohol and the income of the individual affects the consumer's purchasing power, that is the amount of goods and services consumers can afford from their disposable income. If prices grow at a

faster rate than income, then purchasing power is reduced and the demand for most goods is reduced. However, if the price of a good grows at a rate lower than the general price level, it becomes relatively cheaper than other goods which should lead to an increase in its demand, depending on its substitutability for other goods. Therefore it is important that the real price of alcohol rises and not just the nominal price if pricing is to be used as a strategy to contain alcohol consumption.

The Economic and Social Research Institute (ESRI) has observed that a growth rate of 3% per annum in real income per head over the next number of years would translate into a 3.4% increase in alcohol consumption per head if the price of alcohol were to remain constant in real terms. From this, they calculated that it would take an annual increase of 7.6% in the price of alcohol to hold consumption at present levels.

9.4.1 Income and Price Elasticities: The level of sensitivity to changes in income and price, known as income and price elasticities, are useful in assessing the potential effectiveness of pricing policies in influencing alcohol consumption.

Spirits and wine are more sensitive to price changes than beer, so it would take huge price increases to greatly reduce consumption of beer. However there is a price sensitivity between beer and spirits. Thus, pricing policies can be effective in steering people to a particular type of alcoholic drink, even if less effective in getting people to substantially reduce overall drinking. Pricing policy could be used to encourage switching to low alcohol drinks (less than 2% alcohol per volume) which can provide the drinker with an attractive alternative with little risk of alcohol related problems (Edwards et al 1994).

The level of sensitivity to income changes is high for beer, spirits and total alcohol and very high for wine indicating that increasing economic growth in Ireland will lead to a disproportionate increase in alcohol consumption if historic trends and tastes continue to operate. A detailed explanation of income and price elasticities is presented in Annex 7.

9.4.2 Non-alcoholic Drinks: The price differential between soft drinks and alcoholic beverages was a cause of complaint in many of the submissions from the general public. The concern was that the prices of soft drinks in

on-licensed premises appeared to be so high as to make them uncompetitive with alcoholic drinks.

The Minister for Enterprise and Employment, under the Prices Acts and the Competition Act, has the power to investigate profit margins and price fixing of goods and services. In 1983 a survey, carried out by the Price Inspectorate, showed that profit margins (expressed as a percentage of the retail prices) on soft drinks ranged from 53% to 66%. Based on this investigation, the National Prices Commission recommended that the then Minister make a Maximum Prices Order which would significantly curtail the profit margin.

Under the terms of the Competition (Amendment) Act, 1996, the initiative for starting investigations into alleged anti-competitive behaviour lies with the Competition Authority. The Director of Competition Enforcement's functions includes the carrying out of an investigation, whether on his own initiative or as a result of complaints.

9.5 Conclusions

Overall, alcohol consumption is more sensitive to income increases than to price increases. Alcohol consumption is more likely to increase given the current and projected economic growth.

However, pricing policies can encourage switching to forms of drinks with lower concentrations of alcohol where excise duty is lower as it is based on alcohol strength. Low alcohol beverages can provide the drinker with an attractive alternative with little risk of alcohol related problems (Edwards et al 1994). Therefore pricing strategies in relation to low alcohol beers deserve attention since these drinks are practically as expensive in pubs as stronger beers despite the lower excise duty. The gap between the price of alcoholic and non-alcoholic drinks in licensed premises is also narrow, which may discourage people from substituting non-alcoholic drinks for alcoholic drinks.

10. European Union Dimension

At international level, many trade agreements are now being developed and formalised. Within the European Union, health advocacy needs to be recognised and promoted to ensure that public health issues are part of the equation when trade, economic, environmental and social agreements are being negotiated.

10.1 Single European Market

The Single European Act defines the internal market as an area without frontiers in which the free movements of goods, services and capital are ensured. To achieve this Single Market, fiscal barriers arising from different systems and levels of VAT and excise need to be modified. In 1987, the EC Commission proposed that there should be harmonised common rates of excise duties, but this was not acceptable to Member States and a new 1989 proposal was for common minimum rates. This strategy was reinstated in 1991 when some minimum rates and 'target' rates were defined. In 1993, the EU member states agreed to maintain excise duties above minimum rates for each product category. The Commission has recommended 'target rates', which, although not binding, provide a level which members states may choose to move towards over time (Table 6). There are no plans for further harmonisation of rates at the EU level in the near future, however there is a requirement to review the rates every two years.

TABLE 6:

EC minimum and 'target' rates as a percentage of 1990 Irish excise rates

	EC minimum %	EC 'target' %	Ireland %
Beer	8	17	100
Spirits	43	54	100
Wine	3	7	100

10.2 Standardisation of Alcohol Data Collection

International comparisons of expenditures between countries are complicated by the fact that the official statisticians in the various countries do not have a uniform method of treating alcohol expenditure in national

accounts. In Ireland, spending in pubs on alcohol is attributed totally to the category "alcohol" in the national account statistics. In most European countries, only off-licence type sales are attributed to alcohol, while money spent on drink in bars or restaurants is attributed to such categories as recreation, restaurants or entertainment. Therefore the rationalisation of data collection and analysis on alcohol consumption and economic profiles are required to allow for meaningful comparisons across Europe.

10.3 Trans Frontier Broadcasting

With the rapid growth of satellite broadcasting, advertising originating in other EU countries is increasingly being seen in Ireland. The European Commission is seeking to standardise the present variety of European advertising regulations in order to remove any barriers to the establishment of a single market for broadcasting. The recent updated Codes of Standards, Practice and Prohibitions in Advertising, Sponsorship and other forms of commercial promotion in broadcasting services, as provided for in the Broadcasting Act 1990, comply fully with the EU directive 69/552/EEC.

The European Advertising Standards Alliance (EASA) was established to promote self-regulation at national level throughout Europe and to demonstrate that self-regulation can be effective in promoting high standards of advertising in the context of the Single European Market. The Advertising Standards Authority of Ireland is a founder member of the EAS Alliance.

11. Research

The dearth of alcohol research in Ireland, with the exception of *youth* research, means that we over-rely on international research. We continue to need clarification on important alcohol related issues such as the economic, social and psychological causes and effects of alcohol consumption, the extent of alcohol dependence and treatment effectiveness. We also have many unanswered research questions ... relation to the most effective alcohol prevention models in different alcohol cultures with a group and settings approach.

There are three main areas where urgent research is required; consumption research, research into preventive measures and treatment

research. A comprehensive national survey of adult lifestyle patterns would provide a benchmark for monitoring progress. The implementation of the National Alcohol Policy requires co-ordination and monitoring, therefore responsibility for this function needs to be clearly identified. Alcohol research must be improved to provide important measures for public health assessment and to allow for both effective and efficient use of resources.

Section III

NATIONAL ALCOHOL POLICY PLAN OF ACTION

The National Alcohol Policy is directed at reducing the prevalence of alcohol-related problems and thereby promoting the health of the community. The policy is based on current research from the World Health Organisation and is in keeping with the European Charter on Alcohol which Ireland endorsed in December, 1995.

The aim is to influence people's attitudes and habits so that, for those who choose to drink, moderate drinking becomes personally and socially acceptable and favoured in the Irish culture. Measures targeting the whole population as well as specific at risk groups are required. No single measure will be effective if taken in isolation. High prices and restriction on the availability of alcohol are the most effective measures but cannot be sustained long term without public support through information and advocacy. Measures targeting specific groups, especially young people, and specific settings such as workplace, along with accessible and effective treatment services ensure a comprehensive policy.

A multi-sectoral commitment to the National Alcohol Policy at national level and a strong local ownership through health boards and local communities, where real influence and attitude shaping occurs, are key factors. The success of preventive measures hinges on the interaction between reducing availability, through access, pricing and promotion measures, and limiting demand by awareness, advocacy, education and training.

The Plan of Action sets out the actions required of the different partners in implementing the National Alcohol Policy. The relevant departments are undertaking, in this Plan of Action, to implement certain initiatives. It is hoped that the non-statutory sector will play its part, as proposed, to ensure a comprehensive policy.

Alcohol Awareness

The Department of Health will implement initiatives to:

- *Increase understanding of the health effects of alcohol.*

- *Increase awareness among the general population of sensible drinking guidelines.*
- *Increase awareness of the early signs of dependency across the population.*
- *Contribute to a decrease in the proportion of those who exceed moderate alcohol consumption.*

The Drinks Industry is strongly encouraged to:

- *Display the sensible drinking guidelines in all premises where alcohol is sold.*

Professional Training

The Department of Education and Colleges responsible for training teachers and health professionals will:

- *Provide appropriate skill training in methodology and content related to alcohol issues.*

Professional training of Gardai and other appropriate professionals will:

- *Include awareness and understanding of the National Alcohol Policy as it applies to their areas of responsibility.*

The Department of Health will encourage the health boards to ensure an:

- *Adequate network of professionally trained staff to provide resources, co-ordination and support to local and voluntary initiatives aimed at the prevention of drug and alcohol misuse.*

The Drinks Industry is encouraged to ensure that provision is made for:

- *Responsible server training for staff.*

Target Groups

Youth

The Department of Education will:

- *Continue to facilitate the development of Health Promoting Schools by ensuring widespread recognition of the school as a context for the promotion of health among teachers, pupils, parents and the wider community.*

- *Encourage schools to have a clear policy on substance use (drinking smoking drug use) which is known to all students, teachers and parents.*
- *Develop the school curriculum to include a significant level of education for health as part of the core curriculum, based on lifeskills education.*
- *Encourage all young people, through education programmes, to postpone the decision to drink alcohol until they are mature enough to consume the drug responsibly.*
- *Continue to support, in the non-formal sector, a youth work approach to assisting young people in developing for themselves the personal and social skills necessary to make responsible decisions regarding alcohol and other issues affecting their health.*

The Departments of Health and Education will:

- *Maintain their co-operation in the development of Health Education programmes and resources for teachers, youth workers, parents and young people.*

The Department of Justice will:

- *Encourage and facilitate Identity Card Schemes for those of or over 18 years across the whole country. These schemes will be based on an evaluated 'blueprint' with set targets.*

Parents

Parents will be encouraged, by the Departments of Health and Education, to:

- *Fully develop their role in helping their children to adopt sensible and responsible attitudes and behaviours in relation to alcohol.*
- *Reinforce the school policies and health education programmes through the health promoting school framework.*

Students

The Department of Education will encourage Universities and Colleges to:

- *Develop a Campus Alcohol Policy which would promote sensible drinking among students who choose to drink and limit campus-related drink industry sponsorships.*

At Risk Groups

The Department of Health will:

- *Encourage pregnant women and women who are planning to become pregnant to avoid alcohol consumption especially during the critical first few months of pregnancy.*
- *Continue to support initiatives for at risk youths, children of substance abusers and other vulnerable groups in society.*
- *Support the role of primary health care professionals in relation to early detection of problem drinking.*

Target Settings

Community

The Department of Health and other relevant agencies will:

- *Support community initiatives which promote the National Alcohol Policy.*
- *Support the development of peer led education especially for youth groups and outreach high risk groups.*
- *Encourage young people to develop social activities which are not centred around drinking such as drama, music, art and sports.*
- *Encourage youth leader organisations, coaches and managers of underage (<18 yrs) sports teams to refrain from seeking alcohol industry sponsorship.*

Workplace

The Department of Enterprise and Employment will:

- *Strongly recommend employers and unions to develop an alcohol policy in the workplace.*

The Department of Enterprise and Employment will encourage employers groups (IBEC, CIF, ISME, SFA) and trade unions (ICTU) to:

- *Promote Employee Assistance Programmes (EAP) as a feature of best management practice with specific measures for small enterprises.*

Consideration will be given as to how Employee Assistance Programmes can be:

- *Placed in a broad substance abuse education programme for all in the workplace with emphasis on sensible drinking habits, early identification of alcohol-related problems and education for the individual and those affected by alcohol.*

Access to Alcohol

The World Health Organisation Research Review (Edwards et al 1994) indicated that:

"the weight of the empirical evidence has supported the argument that limitation on the availability of alcohol can be an effective part of a public health approach to . . . alleviate problems associated with alcohol The counter argument to the effectiveness of alcohol availability restriction, that people will obtain alcohol no matter the difficulty, particularly heavy drinkers, is, on the showing of empirical evidence, not valid"

Section 6 of this Policy sets out the public health perspective on the Licensing Code. The Code is currently being reviewed by the Dail Select Committee on Legislation and Security. The Recommendations of the Committee will have a significant impact on the other initiatives to be implemented by Government Departments as set out in this Action Plan.

Alcohol Pricing

The Government will:

- *Have regard, in its Budgetary policy, to the effect of taxes on alcohol prices and to the impact of prices on consumption levels.*

The Competition Authority and the Director of Competition Enforcement, under the powers contained in the Competition (Amendment) Act, 1996, is enabled to:

- *Investigate the profits and margins at which soft drinks and low strength alcohol beverages are sold within the public house and hotel trade.*

The Irish Government will seek, in its dealings with the EU:

- *To preserve for itself the greatest possible freedom of action in relation to the taxation of alcohol, to the extent that this is compatible with Single Market conditions.*

Promotion of Alcohol

The Drinks Industry is encouraged to:

- *Establish a Charter for Retailers which could incorporate best practices in relation to customers, staff and promotions.*
- *Endorse and incorporate into their code "that no alcoholic drinks' sponsorship of youth activities should be undertaken directly or indirectly".*
- *Confine advertisements to factual information regarding price, availability, mode of manufacture and be in keeping with the National Alcohol Policy sensible drinking guidelines.*
- *Prohibit "the happy hour", excessive discounting and free samples in supermarkets or public places where children have access.*
- *Encourage the promotion of low-strength alcoholic beverages.*

The Creative Media, broadcasting, paper and the "new" media, are encouraged to:

- *Be aware of National Alcohol Policy objectives in the presentation of alcohol in "soaps \ sit-coms and other dramatic representations.*
- *Not use cartoon/puppet-style characters in advertisements for alcoholic products.*
- *Adhere to the established Code of Standards and Practice in relation to alcohol promotion.*

The Irish Government will:

- *Encourage the European Union to promote the highest standards in establishing European advertising regulations.*

Drink Driving

The Department of Justice will:

- *Continue breath testing throughout the year and throughout the country.*
- *Consider a pilot court alcohol education programme, including prevention and rehabilitation, for those convicted for drink driving offences.*
- *Implement the Law Reform Commission recommendation "that self-induced drunkenness or intoxication from drugs should not be admissible as a defence in criminal cases".*

The Drinks Industry is encouraged to:

- *Develop strategies such as 'designated driver' or 'safe lift schemes' to combat alcohol-related traffic accidents.*

Treatment Services

Treatment services for alcohol-related disorders will never provide an effective response on their own to alcohol dependence. Treatment services are essential, but they are only one aspect of the multi-faceted approach to combating alcohol-related problems in our society. A treatment programme will be more effective if it is supported by national policies which help people avoid health damaging behaviour. The Department of Health, in keeping with the *Planning for the Future* recommendations, will encourage the health boards to:

- *Establish at least one alcohol/drug resource centre in each community care area or catchment area of the psychiatric services with responsibility for the development of the services.*
- *Give responsibility to a designated consultant psychiatrist with a special interest in alcohol, in each catchment area, to ensure that those people who are dependent on alcohol receive appropriate services.*
- *Provide comprehensive therapy to the client and his/her family and friends, together with an after-care service.*
- *Ensure, wherever possible, that detoxification takes place on an outpatient basis. The local alcohol/drug team and general practitioners should work closely together to encourage detoxification at home where appropriate.*

The Department of Health will encourage the health boards, in consultation with relevant groups/organisation, to:

- *Put in place an alcohol treatment programme designed to assist Travellers who have become dependent on alcohol.*
- *Put in place an alcohol/drug treatment programme in prisons.*
- *Provide or support hostel accommodation for homeless persons dependent on alcohol and ensure appropriate medical care for their needs.*

The Department of Health will work with the health boards to:

- *Develop quality control mechanisms which will be required from non-statutory organisations who receive subsidies.*

The Department of Health will strongly recommend to Health Insurance companies to:

- *Provide cover for treatment of alcohol dependence in line with the National Alcohol Policy. This would include providing cover for outpatient treatment programmes.*

Research

The Department of Health will, as a matter of urgency, look to:

- *Establish a dedicated National Alcohol Surveillance function to co-ordinate and monitor the National Alcohol Policy.*
- *Undertake a comprehensive national lifestyle survey which would include alcohol consumption patterns.*
- *Investigate the current position regarding alcohol policy by requesting government departments and agencies to audit the quantitative and qualitative aspects of alcohol policies in different settings - workplaces, schools, hospitals.*
- *Investigate the availability and accessibility of treatment services on a regional basis through the health boards and the effectiveness of different treatment regimes.*
- *Begin to investigate the economic, social and psychological causes and effects of alcohol consumption.*

- *Investigate the possibility of a surveillance reporting system to examine the role of alcohol in all types of accidents.*

The Irish Government will:

- *Promote the rationalisation of data collection on alcohol consumption and economic indices, to allow for meaningful comparisons across Europe.*

ANNEXES

Annex 1

ACKNOWLEDGEMENTS

The Advisory Council on Health Promotion was requested by the Government in 1989 to develop a National Alcohol Policy. A Working Group subsequently initiated a consultative process and a Report was prepared on the basis of submissions and presentations made to the Working Group.

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Adelaide Hospital
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Aer Lingus
AIM
Aiseiri
Alcohol & Counselling Services & Court Programme. Porthola
Arbour House
Association of Advertisers
Association of Secondary Teachers of Ireland

Ballymun Youth Action Project
Buncrana Alcohol Programme
Castleblayney Urban District Council
Catholic Social Service Conference
Ceannanus Mor Urban District Council
Charlemont Clinic
Church of Ireland
Cider Industry Council
Clarecare
Colaiste an Chraoibhin, Parents Council, Cork
Combined Action Group
Community Addiction Counsellors
Community Alcohol & Drug Service, Mullingar
Confederation of Irish Industry
Conference of Major Religious Superiors
Coolemine
Coombe Lying in Hospital
Cork Youth Federation
Cuan Mhuire, Athy
Department of Defence
Department of Education
Department of Environment
Department of Finance
Department of Health
Department of Justice
Department of Tourism, Transport & Communication
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Federation of Irish Employers
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Health and Safety Authority
Health Research Board
Independent Radio and Television Commission
Institute of Advertising Practitioners
Institute of Community Health Nursing

Institution of Occupational Safety & Health
Irish Association of Alcohol & Addiction Counsellors
Irish Association of Holistic Medicine
Irish Association of Social Workers
Irish Cancer Society
Irish College of GP's
Irish Congress of Trade Unions
Irish Countrywomen's Association
Irish Dental Health Foundation
Irish Distillers
Irish Management Institute
Irish National Teachers Organisation
Irish Rugby Football Union
Irish Heart Foundation
Kilkenny Corporation
Lambeecher Tenants Association, Balbriggan
Legion of Mary
Licensed Vintners Association
Listowel Urban District Council
Longlands Residents Association
Loreto College, Cavan
MADD — Mothers Against Drunk Driving
Mahon Youth Development Project
Mater Dei Counselling Centre
Mater Misericordiae Hospital
Meath County Council
Mercy Heights & St Fachtna's de la Salle, Parents Council, Cork
Methodist Church
Mid Western Health Board
Midland Health Board
National Parents' Council - Post Primary
National Safety Council
National Youth Council
National Youth Federation
No Name Club
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Radio Telefis Eireann
Restaurants' Association of Ireland
Royal College of Physicians
Rutland Centre
Society of the Irish Motor Industry
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Annex 2

CONSUMPTION OF BEER, SPIRITS, WINE AND CIDER PER HEAD OF POPULATION AGED 15 AND OVER IN LITRES OF PURE ALCOHOL, IRELAND 1970-1994

Year	Total	Beer	Spirits	Wine	Cider
1970	7.26	4.75	2.05	0.35	0.11
1971	7.68	5.04	2.18	0.36	0.10
1972	8.20	5.30	2.41	0.40	0.09
1973	8.88	5.64	2.72	0.44	0.08
1974	9.28	5.82	2.90	0.47	0.09
1975	9.22	5.77	2.89	0.47	0.09
1976	8.99	5.55	2.81	0.51	0.12
1977	9.20	5.58	2.97	0.54	0.11
1978	9.78	5.75	3.33	0.60	0.10
1979	9.97	6.01	3.23	0.66	0.07
1980	9.56	5.87	2.95	0.64	0.10
1981	9.02	5.57	2.69	0.65	0.11
1982	8.78	5.66	2.36	0.61	0.15
1983	7.97	5.26	2.00	0.56	0.15
1984	8.13	5.21	2.13	0.59	0.20
1985	8.56	5.26	2.49	0.62	0.19
1986	8.40	5.20	2.36	0.62	0.22
1987	8.12	5.06	2.21	0.62	0.23
1988	8.42	5.17	2.34	0.68	0.23
1989	8.65	5.43	2.28	0.71	0.23
1990	9.03	5.67	2.33	0.76	0.27
1991	9.12	5.66	2.35	0.77	0.34
		(7.47*)			
1992	9.48	5.93	2.22	0.84	0.49
		(7.70*)			
1993	11.05	7.40*	2.22	0.87	0.56
1994	11.23	7.48*	2.21	0.90	0.64

Source: *CSO Statistical Abstract*, various issues.

Revenue Commissioners' Annual Report, various years.

* New calculation = million hector litres.

Annex 3**EUROPEAN CHARTER ON ALCOHOL****TEN STRATEGIES FOR ALCOHOL ACTION**

Research and successful examples in countries demonstrate that significant health and economic benefits for the European Region may be achieved if the following ten health promotion strategies for action on alcohol are implemented to give effect to the ethical principles and goals listed, in accordance with the differing cultures and social, legal and economic environments in each Member State.

1. Inform people of the consequences of alcohol consumption on health, family and society and of the effective measures that can be taken to prevent or minimise harm, building broad educational programmes beginning in early childhood.
2. Promote public, private and working environments protected from accidents and violence and other negative consequences of alcohol consumption.
3. Establish and enforce laws that effectively discourage drink-driving.
4. Promote health by controlling the availability, for example for young people, and influencing the price of alcohol beverages, for instance by taxation.
5. Implement strict controls, recognising existing limitations or bans in some countries, on direct and indirect advertising of alcoholic beverages and ensure that no form of advertising is specifically addressed to young people, for instance, through the linking of alcohol consumption with sports.
6. Ensure the accessibility of effective treatment and rehabilitation services, with trained personnel, for people with hazardous or harmful alcohol consumption and members of their families.

7. Foster awareness of ethical and legal responsibilities among those involved in the marketing or serving of alcoholic beverages, ensure strict control of product safety and implement appropriate measures against illicit production and sale.
8. Enhance the capacity of society to deal with alcohol through the training of professionals in different sectors, such as health, social welfare, education and the judiciary, along with the strengthening of community development and leadership.
9. Support non governmental organisations and self-help movements that promote healthy lifestyles, specifically those aiming to prevent or reduce alcohol-related harm.
10. Formulate broad-based programmes in Member States taking account of the present European Charter on Alcohol; specify clear targets for and the indicators of outcomes; monitor progress; endure periodic updating of programmes based on evaluation.

Annex 4

CHARACTERISTICS AND FUNCTIONS OF A QUALITY EMPLOYEE ASSISTANCE PROGRAMME (EAP)

- A clear statement of the aims of the policy, explaining the rationale underlying the policy in terms of employee health and welfare, reduction of absenteeism, reduction of accidents and improvement of productivity.
- The production of explicit, written policies and procedures that outline the purpose and function of the programme, emphasising the widespread nature of alcohol related problems and the benefits of prevention, early identification and intervention.
- A supportive approach by employers including a guarantee of measures to ensure confidentiality of information concerning employees availing of EAP services, along with an assurance that job prospects and security will not suffer in the future, provided recovery is maintained.
- Awareness raising and education programmes which inform employees about alcohol, about procedures for coping with problems, about the value of EAPs and the benefits of having a policy relating to the working environment.
- Appropriate training for those responsible for implementing policy in the workplace — managers, supervisors, counsellors, referral staff.
- Provision of referral arrangements to specialist help, advice and counselling where with paid sick leave/time off, provided appropriate certification is submitted to verify compliance with therapy and rehabilitation.
- Quality control measures which evaluate and monitor the benefits of services to which referral is made by the EAPs, including the overall impact of the policy and procedures adopted. This should also provide for a regular review process applied to the policy and all its component elements. It should ensure that services provided by external agencies are provided by properly trained and accredited professionals.

- The policy should include agreement between employers and employees about regulations concerning alcohol consumption at the workplace and before or during working hours. It should contain agreement about what indicators (absence, lateness, accidents, etc.) shall be recorded to monitor the prevalence of alcohol related problems.
- There should be provision for reference to normal disciplinary procedures where, in spite of the facilities and services available, an employee's work performance remains unsatisfactory and the employee refuses to avail of assistance.

Source: Working Group

Annex 5

LICENSING CODE

Principle Exemptions excluding Special Exemption Order

General Exemption Order: This order is granted for the accomodation of persons attending a public market or fair or for the accomodation of persons attending any lawful trade or calling. In the former case the exemption can be granted for anytime after 5.00 am and in the latter case for anytime after 7.00 am. An exemption for fishermen fishing in tidal waters can be granted for anytime other than between 1.00 am and 2.00 am. In Dublin a general exemption order can ony be granted to premises in respect of where a general exemption order had been in force anytime between April 1960 and April 1962.

Occasional Licences: This licence is granted to the holder of an on-licence to allow him/her to sell alcohol at a place to which no licence for such sale is attached on the occasion of a special event at that place. An occasional licence cannot be granted for more than six consecutive days This licence is commonly used when residents' associations, clubs or other such organisation are holding a dinner-dance in some premises such as the local community hall.

Exemption for Special Events (Area Exemption Orders): These orders are available on the occasion of a local event such as a festival. The holder of an on-licence must satisfy the court that a special event or events which would attract large crowds, will take place in his/her locality and that the majority of licence-holders in the locality support the application. Exemptions for special events cannot be granted for more than 9 days in total in any year in respect of the same locality. They cannot be granted at all for any place in the county borough of Dublin.

Exemption for Certain Types of Person: The exemption under this heading covers, in general, persons who by virtue of their residence or occupation are necessarily and lawfully upon the premises (i.e. pub staff)-

Exemption for "Special Events" in Sports Clubs: This exemption allows registered sports clubs to sell alcohol to persons on the occasion of a special event in the club likely to attract a considerable number of persons.

Only one such exemption can be obtained in a year and the period of the authorisation can be no longer than 5 days. An example of such a special event would be an international golf tournament.

Clubs may also apply to the court for up to 15 extensions a year of not more than 6 hours duration each during which they may supply alcohol to their members.

Festival Clubs: This permits members of a club (not a registered club) organised in connection with a festival (cultural event) to obtain an occasional licence or a special exemption order.

*Annex 6***CODES OF STANDARDS, PRACTICE AND PROHIBITIONS IN ADVERTISING,
SPONSORSHIP AND OTHER FORMS OF COMMERCIAL PROMOTION IN
BROADCASTING SERVICES**

Drawn up by the Minister for Arts, Culture and the Gaeltacht in the exercise of his powers under Section 4(1) of the Broadcasting Act, 1990

The advertising of alcoholic drink may be accepted by broadcasters, provided it complies with the following criteria:

- Alcoholic drink advertising must not encourage young people or other non-drinkers to begin drinking — it must be cast towards brand selling and identification only.
- This broadcasting code recognises a voluntary code whereby spirit based alcoholic drinks (i.e. whiskey, gin, vodka, brandy etc.) are not advertised on radio or television. The 1990 code is framed on the assumption that this situation will continue.
- This code will apply to all other alcohol drinks i.e. beers, wines, sherries, fortified wines, vermouths, liqueurs etc.
- Where soft drinks are promoted as mixers, this code will apply in full. When promoted as refreshments in their own right, soft drinks are not subject to this code, but due care should be exercised if bar or similar locations are used.
- Broadcasters will ensure that alcoholic drink advertisements are not transmitted in or around programmes primarily intended for young viewers or listeners; advertisers are required to take account of the age profile of the viewers and listeners so that advertisements are communicated, so far as it possible, to adults.
- Advertising shall not encourage immoderate consumption of alcohol or present abstinence or moderation in a negative light.
- Advertisements shall not claim that alcohol has therapeutic qualities or that it is a stimulant, a sedative, a tranquilliser or a means of resolving personal conflicts.
- Advertising shall not place emphasis on high alcoholic content as being a positive quality of the beverages.

- Advertisements for alcoholic drinks should not create the impression that consumption of such beverages contributes toward sexual attraction and success, or social success.
- Advertisements shall not link the consumption of alcohol to enhanced physical performance or to driving.

Annex 7**INCOME AND PRICE ELASTICITIES**

The level of sensitivity to changes in income and price, known as income and price elasticities, are useful in assessing the potential effectiveness of pricing policies in influencing alcohol consumption. The income elasticity is the percentage increase in consumption per adult given a one per cent rise in income. The price elasticity is the percentage decrease in consumption given a one per cent rise in price. Individual components of alcohol (spirits, beer, wine) have their own price elasticities and also cross price elasticities with each other.

Price Elasticity: Overall consumption of alcohol is not very sensitive to price, as indicated by a price elasticity of 0.4 (Table 1). What this means is that if the price of alcohol rises by 1% consumption drops by only 0.4%. Spirits and wine have higher price elasticities than alcohol as a whole, indicating that their consumption is more sensitive to price changes. In the case of wine, the price elasticity of 1.1 indicates that a one per cent increase in the price of wine results in a drop in consumption of 1.1 per cent. Beer consumption has a much lower price elasticity than wine, so it would take huge price increases to greatly reduce consumption of beer.

TABLE 1:
Income and Price Elasticities

	Income	P_a	P_b	P_s	P_w
Total Alcohol	1.1	-0.4	NA	NA	NA
Beer	1.1	NA	-0.5	0.8	0.0
Spirits	1.2	NA	0.8	-1.0	0.0
Other Alcohol (wine)	1.6	NA	1.3	-1.3	-1.1

Notes: P_a =average price; P_b =beer price; P_s =spirit price; P_w =wine price; NA=not applicable.

The cross-price elasticities are substantial in magnitude. If the price of spirits rises, another drink will be substituted unless its price has also risen. But if all prices are raised simultaneously, the scope for substitution cancels out and the overall drop in consumption is much less than the individual response might suggest. The table shows that there is a significant cross price elasticity (0.8) between beer and spirits. This indicates, for example that a 1% increase in the price of beer would cause

a 0.8% increase in the consumption of spirits. Thus, pricing policies can be effective in steering people to a particular type of alcoholic drink, even if less effective in getting people to substantially reduce overall drinking. Pricing policy could be used to encourage switching to low alcohol drinks.

Income Elasticities: The income elasticities for beer, spirits and total alcohol are relatively similar and greater than one, indicating that increasing economic growth in Ireland will lead to a disproportionate increase in alcohol consumption if historic trends and tastes continue to operate. The income elasticity for wine is very high (1.6) and this probably reflects a relatively recent upsurge in its popularity among the higher income group. Own-price and cross-price elasticities are also high, which suggest a higher price increase on wine may have some effect on alcohol consumption. However, wine consumption is still relatively low, therefore the effect on total alcohol consumption would be minimal at this point in time but the situation should be reviewed regularly. Because of the income elasticity of alcohol in general, very large across the board price increases would be required to reduce all forms of consumption of alcoholic drink.

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