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Research report

Changes in consumption and harms, yet little policy progress

Trends in alcohol consumption, harms and policy: Ireland 1990–2010

ABSTRACT

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Changes in consumption and harms, yet little policy progress. Trends in alcohol consumption, harms and policy: Ireland 1990–2010

This paper reports on trends in alcohol consumption and related problems in the Republic of Ireland during the years 1990–2010, and on alcohol policy developments over this same period. Prior to the collapse of the Irish economy in late-2008, Ireland had enjoyed almost fifteen years of unprecedented economic growth, with commensurate increases in levels of personal disposable income. As predicted by economists, economic growth was accompanied by substantial increases in levels of alcohol consumption, with corresponding increases in all the main indicators of alcohol-related problems. Although numerous policy reports from the health sector advocated alcohol control strategies, due to the generally neo-liberal ethos of this era and active lobbying from the drinks industry, little or no implementation of such strategies occurred. Reflecting the current economic down-turn, levels of alcohol consumption have now stabilized. It is concluded, however, that implementation of comprehensive, top-down, alcohol strategies remains unlikely, and that bottom-up, community mobilization offers the best prospect for change in this sphere.

Introduction

This paper will review trends in alcohol consumption and related problems, alongside developments in alcohol policy in the Republic of Ireland, for the period 1990–2010: years which, in the spirit of the Chinese curse, could well be considered ‘interesting times’. These were, for the most part, years of unprecedented economic growth and increased disposable income, helping to confirm what had previously been a matter of myth or stereotype, namely that the Irish like to drink heavily. On a more positive note, however, these were also years when Irish health policy explicitly adopted a health promotional perspective and when wider developments in public sector management emphasized the importance of ‘joined up’ government, so that it seemed reasonable to expect integrated policy responses aimed at reducing alcohol-related harm. From a policy perspective, therefore, this paper will report on the extent to which such policy develop-

submitted 15.06.2010;
initial review completed 05.11.2010
final version accepted 11.11.2010

■ KEYWORDS
Alcohol consumption, trends, harms, alcohol policy, Ireland

ments succeeded in implementing evidence-based strategies in relation to alcohol.

Trends in alcohol consumption

■ Recorded consumption

Alcohol sales figures provided by the Revenue Commissioners in Ireland are used to calculate alcohol consumption and represent the volume of alcohol beverages released from warehouse where excise duty has been paid, in other words the amount of alcohol available for sale in any given month. During the time period under review, alcohol consumption per adult (15 years+) increased from 10.96 litres of pure alcohol in 1990 to a peak of 14.3 litres in 2001, a 30% increase (Hope 2007). In 2003, consumption declined by 6% and remained relative stable until 2008 when consumption declined further (Figure 1). While beer continues to be the most popular drink, the market share for beer has declined to 51% in 2009 from 69% in 1990. Spirits has maintained a market share of around 21% for most of the time period, although a drop of 2% in the market share for spirits was observed in 2009. The real growth has been in wine consumption, where the market share increased from 7% (0.76 litres of pure alcohol per adult) in 1990 to 23% (2.65 litres) in 2009. Since 2004, wine is the second highest beverage category, after beer, for recorded alcohol consumption. There are no available estimates for unrecorded consumption in Ireland.

■ Drinking patterns

Ireland has a high proportion of non-drinkers which has remained relatively stable over the last 20 years at about 23% (Ramstedt & Hope 2005; TNS Opinion & Social 2010). The national drinking survey of 2002 showed that men drank about three times more alcohol than women. Men were more likely to drink beer while wine and spirit were more common among women (Ramstedt & Hope 2005). Alcohol became an important social lubricant for *all* social occasions and there was a cultural tolerance of excessiveness and drunkenness that strongly influenced the collective drinking environment in Ireland. The prevalence of risky drinking patterns was common, with the highest level among men and younger adults, both men and women (Ramstedt & Hope 2005). A comparison across all EU Member States showed that Ireland

had the highest proportion of risky drinking adults (TNS Opinion & Social 2007). Two-thirds (68%) of Irish adults reported risky drinking, defined as 5+ drinks per occasion, at least once a month in comparison to an EU average of 44%. The most recent European survey reported that Ireland continues to have the highest proportion of risky drinking adults (62% at least once a month) among European countries (TNS Opinion & Social 2010).

Proximal contributors: alcohol policy measures

■ Alcohol policy reports

In the period 1990 to 2010, ten committees/groups were established by government to bring forward recommendations on alcohol issues with an output of fifteen reports, yet few of the recommendations have been implemented. The first report was the National Alcohol Policy (NAP) with the rationale clearly based on the WHO public health approach and outlined the most effective policy measures based on the international research evidence to reduce alcohol harm (NAP 1996). While the policy stressed the importance of a multi-sectoral approach, the action plan itself was weak and had no implementation plan. This was in contrast to a well structured, implemented and resourced policy for illicit drugs (Butler 2007). In 2000 a Commission on Liquor Licensing (CLL) was set up by the Department of Justice *"to make recommendations for a Liquor Licensing system geared to meeting the needs of consumers, in a competitive market environment, while taking account of the social, health and economic interests of a modern society" (CLL 2001).* The membership was weighted in favour of those who supported the economic perspective and the main thrust of the recommendations was for greater availability (CLL 2003). The Strategic Task Force on Alcohol (STFA) was established on foot of a recommendation from the CLL 'to provide advice on best practice in alcohol harm prevention measures'. The STFA was subsequently set-up by the Minister of Health in 2001 with a broader public health remit (DOHC 2002). The STFA recommended a comprehensive set of measures to reduce alcohol consumption and related harm (DOHC 2002; 2004). There were also several Dail (Parliamentary) committees during the period 2004–2007 which examined the alcohol issue and made policy recommendations. In 2008, the Department of Justice again set up a steering group to examine the con-

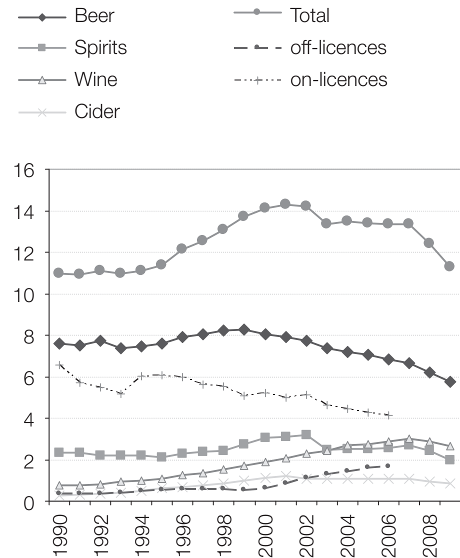

Figure 1. Alcohol consumption and availability (number of licences) 1990–2009.

ditions of the off-licence retail sector (DOJ 2008). On foot of a government decision to integrate alcohol and illicit drugs into a combined National Substance Misuse Strategy, yet another steering group was established in 2009 with a view to working out the details of how such policy integration might best be achieved; this most recent group has yet to report.

■ Pricing policy

In the early 1990s the Department of Health commissioned the Economic and Social Research Institute (ESRI) to examine the level of sensitivity to changes in income and price of alcohol as part of the development process for a national alcohol policy. The report predicted that 'increasing economic growth in Ireland will lead to a disproportionate increase in alcohol consumption' (NAP 1996) which subsequently proved to be a credible prediction. In addition, no alcohol tax increases took place in the period 1994 to 2001 despite unprecedented sustained economic growth in Ireland (CSO 2001), which further increased the affordability of alcohol. A recent European report confirmed that the affordability of alcohol increased by 50% in Ireland between 1996 and 2004, which was driven by an increase in disposable income (Rabinovich et al. 2009).

In December 2001, tax (excise duty) on cider was increased to bring the rate in line with beer, a similar product. The result was a decrease in cider sales while other products increased (wine, spirits) or remained stable (beer) (DOHC 2004). In December 2002, excise duty on spirits was increased, as recommended by the STFA. The 42% tax increase on spirits resulted in a decrease in spirits sales in 2003 by 20% and overall consumption by 6% (DOHC 2004).

In early 2006 the government abolished the Groceries Order which had banned below cost selling of certain goods, including alcohol. This policy change was undertaken for economic reasons – in the interest of achieving lower prices for consumers – and allowed alcohol to be sold at below cost to consumers in Ireland (Hope 2006). In its budget of late-2009 the government reduced alcohol taxes as a means of protecting revenue with a view to reducing incentives for citizens to engage in cross-border purchasing due to lower prices and favourable sterling exchange rates in Northern Ireland. In summary, pricing policy decision making on alcohol during this time period was mainly from an economic perspective with one exception.

■ Availability

A Dail (Parliament) Select Committee on Legislation and Security was established in 1996 to review the alcohol licensing code, in response to calls for longer opening hours from the retail drinks, hospitality and tourist sectors (Report of the Joint Committee on Justice, Equality and Women's Rights 1998). The Dail committee recommended extending the opening hours and consequently, the Intoxicating Liquor Act (ILA) 2000 increased normal opening hours by one hour (from 11.30pm to 12.30am plus 30 mins drinking up time) three evenings (Thur-Sat) a week, introduced early morning opening for off-licences (7.30am) and increased the number of permits for late openings (exemptions) (ILA 2000) In 1994, the number of special exemption orders granted was 55,290 and by 2006 the number had increased to 91,157, a 65%

increase (DOHC 2002; DOJ 2008). The restriction on the geographical movement of licences was also abolished in the 2000 Act, allowing for the transfer of licences across the country. This resulted in many rural pub licences being sold to the supermarket and petrol station chains and transferred to urban areas. In addition, restrictions were removed on the granting of wine retailer's off-licences. The outcome of these changes resulted in a decrease in the number of on-premise licences and a substantial increase in the number of off-licences with the largest increase in wine off-licences. Between 1990 and 2006 the number of on-premise licences decreased by 16%, while the number of off-licences increased five fold (Figure 1). The largest increase in off-licences took place after the 2000 Act, in particular in the number of wine off-licences which went from 550 off-licences in 1999 to 3485 off-licences in 2006.

The Intoxicating Liquor Act 2003 offered the potential to limit harm in the drinking environment, with a range of measures which banned serving alcohol to drunken persons with a sanction of temporary closure if caught, a ban on 'happy hours', and a ban on children from pubs after 9pm, some of which were based on the STFA recommendations (DOHC 2002). However, there is very little evidence of enforcement and sanctions for the offence of serving alcohol to intoxicated persons. The court figures show there was only one temporary order imposed in 2005, three in 2006 and four in 2007 (DOJ 2008). In the 2003 Act, local authorities were given scope, by means of a resolution, to limit the expiry time of exemptions in their area and could consider views in relation to any health aspects. This was seen as giving health boards the opportunity to have input into special exemptions. However, this process was seldom used. The Intoxicating Liquor Act 2003 also reverted to the earlier closing time on a Thursday night, due to concerns raised by public groups of increased absenteeism in work and school on Friday mornings (CLL 2003).

Some provisions of the Intoxicating Liquor Act 2008, were based on recommendations of the advisory group which included public health representatives (DOJ 2008). These provisions included a reduction of opening hours for off-licences, regulations to restrict promotions that encourage excessive drinking, structural separation of alcohol from other goods on sale, and test purchase. However, subsequent to the enactment of the legislation, the drinks industry and retail sector lobbied the Minister of Justice, Equality and Law Reform, who agreed to shelve the regulations regarding structural separation and promotion in favour of self-regulation by the retail sector. The reduction in opening hours of off-licences was the only significant measure put in place, but no evaluation of its impact has taken place. The test purchase provision (which allows the police to determine whether retailers will sell alcohol to underage consumers) was put in place during the second half of 2010. In summary, the availability of alcohol substantially increased through longer opening hours and an increase in off-licence outlet density, and while some alcohol laws were strengthened enforcement was not evident.

■ Alcohol marketing

The impact of alcohol marketing has become a focus of public debate in Ireland in

Table 1. Alcohol consumption and related harm indicators in Ireland, 1994–2009

	1994	1995	1996	1997	1998	1999	2000
Consumption –litres/adult	11.1	11.4	12.1	12.5	13.1	13.7	14.1
Alcohol Morbidity (HIPE) patient contacts		**9254**	**10646**	**11263**	**12266**	**13535**	**14499**
Acute		4711	5431	5276	5111	5932	6951
Chronic		3829	4446	5051	6060	6424	6230
Liver disease		705	756	914	1078	1158	1306
Detox in-patient		28	21	55	197	243	185
Alcohol mortality per 100,000 pop (adult)		**3.8**	**4.8**	**6.3**	**6.4**	**6.2**	**5.9**
Acute		0.3	0.9	1.1	1.0	0.9	0.7
Chronic		2.1	1.6	1.5	2.2	1.9	2.4
Liver disease		1.2	1.3	2.1	2.0	2.4	2.2
Alcohol problems, per 100,000 pop (NDTRS)							
Road deaths (total)	404	437	453	472	458	413	415
Social problems*							
Drunkenness offences	5299	3183	6049	7724	9334	11009	14687
Public order	8153	10209	16384	25755	27945	30993	37749
Assaults	7992	8601	9272	9694	11516	11311	11996

the past two decades. Sports sponsorship of the top major sports in Ireland by drink companies began in the early 1990's, intensified over the years and for most of the sports continues today. Subsequent to a report on the impact of alcohol advertising on teenagers (Dring & Hope 2001), the Minister for Health and Children acknowledged that children needed to be protected from exposure to alcohol advertising and questioned drinks industry sports sponsorship (Hope 2006). In 2003, the Minister for Health and Children announced his intention to introduce legislation restricting alcohol marketing which was publicly endorsed by the Taoiseach (Prime Minister). The proposed legislation was approved by government during 2003 and was sent for final drafting, namely the *Alcohol Products Bill (Control of Advertising, Sponsorship and Marketing Practices/Sales Promotions)*. However, the legislation was not enacted. In December 2005, the new Minister of Health and Children endorsed the Drinks Industry Voluntary Code after active lobbying by the industry and established, under the auspices of the Department of Health, a Monitoring Body to oversee compliance with the code, made up of industry, advertising, media and health official representatives.

■ Drink driving

In 1994 under the Road Traffic Act, blood alcohol concentration (BAC) was reduced from 100mg to 80mg and provided for licence suspension, which had all party

2001	2002	2003	2004	2005	2006	2007	2008	2009
14.3	14.2	13.3	13.5	13.4	13.3	13.4	12.4	11.3
15823	**17757**	**17541**	**17378**		**17053**	**18024**	**18400**	
7585	8836	8841	8257	ICD-10 intro	3650	3637	3319	
6641	7237	7071	7370		10096	10750	11247	
1584	1676	1616	1745		3299	3629	3827	
288	381	503	567					
7.6	**6.5**	**5.3**	**7.1**					
1.3	1.2	0.5	0.5					
2.2	1.8	1.7	2.3					
3.3	2.9	2.6	3.5					
			168.3	176.0	182.9	222.6	243.3	
411	376	335	374	396	365	338	279	239
			New code					
17804	22701	21818	11707	13036	11890	10476		
42754	56822	53488	26964	29752	35329	40824		
14437	16629	13136	12441	12518	13650	15105		

Source: alcohol related morbidity and alcohol related mortality – Morgan et al. 2007; treated alcohol problems – HRB at www.drugsandalcohol.ie/12770 ; road deaths – Annual Reports, National Roads Authority and Road Safety Authority; social problems – An Garda Siochána Annual Reports and National Crime Council Report (up to 2003), Mongan et al. 2009 (2004 to 2007) based on a new classification system, therefore figures from 2004 to 2007 are not directly comparable with 1994 to 2003.

support in the Dail. After strong opposition from the vintners (pub owners) and the Irish Hotel Federation, the sanctions were weakened in 1995. However, the new BAC level was maintained (Butler 2002). The road safety strategy in 2004 called for the introduction of full random breath testing as did the STFA (DOHC 2002; Department of Transport 2004). The delay in the introduction of random breath testing became a recurring political issue with opposition parties demanding action. While the government cited legal problems, clarification was sought from the Attorney General and mandatory alcohol testing became law in 2006. The enforcement of RBT has reduced road deaths each year since its introduction (Table 1). Between 2006 and 2009, 126 fewer people died on roads, representing a 34% decline (Road Safety Authority, Annual Reports 2006–2009).

Distal contributors: social policy, economic, demographic changes

■ Economic growth

For almost 40 years after self-government in 1922, successive Irish governments had pursued policies of industrial protectionism and economic isolationism. Such policies, which reflected a political philosophy of *Sinn Féin* ('ourselves alone'), were almost uniformly disastrous, leading to low levels of disposable income, high levels of unemployment and continuously high rates of emigration. From the 1960s onwards, these policies were gradually reversed, the most obvious manifestation of change being Ireland's accession to then European Economic Community in 1973. In this more open economy, with a well-educated work force and strong incentives for direct foreign investment, change eventually occurred. It was not until the early-1990s, however, that substantial economic improvement occurred and, in an economy popularly referred to as the 'Celtic Tiger', unemployment was virtually eliminated, standards of living rose and the Irish economy became the fastest growing economy in the European Union (Nolan et al. 2000). The real economic growth which characterised much of the period under review was compromised by ill advised investment in property development and, in line with similar downturns in other developed countries, the Irish economy went into recession from late-2008. From a demographic perspective, the Celtic Tiger years were characterized by population growth (for instance, the total population of the state increased by 20% from 3,540,643 in 1986 to 4,239,848 in 2006), and uniquely by an influx of job-seeking migrants from the rest of the European Union and elsewhere. As previously stated, predictions that increased disposable income in this buoyant economy would result in increased alcohol consumption proved accurate.

■ Social policy structures

It is important to sketch out both the broad policy background and, specifically, the newer approaches to public policy which gave rise to expectations that the state was on the verge of a radical new approach to alcohol policy. More detailed accounts of these developments have been given elsewhere (Butler 2002; Butler 2009a), but essentially there were two key policy initiatives – the adoption of a *health promotion* framework by the country's health sector, and the application of New Public Management (NPM) principles (known in Ireland as the *Strategic Management Initiative*) across the general public sector – which were potentially supportive of an integrated, national alcohol policy.

In 1990, in the context of a planned reorientation of the health sector, from a curative to a health promotional agenda, the Minister for Health requested that the Advisory Council on Health Promotion should draft a national alcohol policy. The process was long and eventually the first national alcohol policy for Ireland was published in 1996. The policy document, *National Alcohol Policy – Ireland*, reflected the views of the World Health Organisation as to what constituted evidence-based alcohol policy (Edwards et al. 1994) but was lacking in credible action plans or managerial structures which might make this a reality.

During the early-1990s, in common with

their international counterparts, senior civil servants and politicians in Ireland became convinced of the value of what was commonly referred to as NPM, a concept which promised to replace old-fashioned public administration with business-sector managerialism. In pursuit of managerial reform of this kind, an Irish policy document, *Delivering Better Government* (1996) recommended general initiatives aimed at having more clearly defined policy objectives and more clearly allocated responsibilities. This report also focused on complex policy issues which could not be managed within 'the functional remit and skill base of a single Department or Agency' and outlined a framework for a more rational and evidence based approach to the management of such 'cross-cutting' issues. Specifically, it was recommended that important policy issues of this kind should be managed by the following structures:

- a dedicated Cabinet sub-committee
- a nominated 'lead' department to play a co-ordinating role at central governmental level
- allocation of responsibility for policy co-ordination to a specific Minister or Junior Minister within the lead department
- 'cross-cutting' teams or structures with responsibility for ongoing management of the policy issues in question

This managerial model was applied immediately and almost precisely in this format to the establishment of a new National Drugs Strategy, dealing with the use of illicit drugs (Butler 2007) but no attempt was made to create comparable management structures so as to create an integrated national alcohol policy. However, in 2009, at the very end of this twenty-year period, the Irish Government announced that alcohol was to be included in an expanded national substance misuse strategy, combining alcohol and illicit drug issues.

Trends in alcohol-related harm

Overall, alcohol related morbidity, as measured by hospital discharges, increased by 92% between 1995 and 2002 which included acute conditions (toxic effect) (87%), chronic conditions (dependency/abuse) (89%) and liver disease (138%). In 2003 chronic conditions (dependency and liver disease) declined marginally but increased again in 2004 while acute conditions were stable in 2003 and decreased (7%) in 2004. (Table 1) (Mongan et al. 2007). Alcohol related morbidity was significantly higher for males (718.4/100,000) than for females (227.8/100,000). Acute conditions were more common among younger people (18–29 age group) while chronic conditions and liver disease were more common among older age groups (Mongan et al. 2007). The new ICD-10 classification for morbidity was introduced in 2005. While the overall trend is upwards for alcohol morbidity from 2005 to 2008, the distribution of conditions is significantly different from the previous time period (1995–2004) with chronic conditions (dependency/abuse) the largest category which would suggest recording classification issues (www.drugsandalcohol.ie). For young people under 18 years, alcohol related morbidity doubled between 1995 and 2004 with the largest single year on year increase (110%) between 2000 and 2001. There was little gender difference in the number of boys and girls admitted to

hospital with alcohol related conditions. The number of patients who received in-patient detoxification increased from 28 cases in 1995 to 567 cases by 2004. While more males than females received in-patient detoxification, the rate of increase was more pronounced in females (from 13 cases up to 133 cases) (Mongan et al. 2007). The increase in general hospital detoxification figures may reflect a policy shift from detoxification in psychiatric hospitals to general hospitals.

Alcohol related mortality increased from 3.8 deaths to 7.1 deaths per 100,000 adults, between 1995 to 2004, with higher rates among men than women (Mongan et al. 2007). Liver disease showed an increase in the time period, from 1.2 deaths per 100,000 adults in 1995 to 3.5 in 2004, although the increase was not linear (Table 1). The mortality rate for acute conditions increased between 1995 and 2001 (from 0.3 deaths to 1.3 per 100,000), then dropped back to a rate of 0.5 deaths per 100,000 in 2003 and remained at that level in 2004. Mortality for alcohol related chronic conditions fluctuated during the time period and had a rate of 2.3 per 100,000 in 2004. (Mongan et al. 2007).

The number of people treated for problem alcohol use, as recorded by the National Drug Treatment Reporting System (NDTRS) and reported by the Health Research Board, increased both in terms of prevalence (all cases) and incidence (new cases) between 2004 and 2008. Those who presented for treatment, defined as 'any activity which aims to ameliorate the psychological, medical or social state of individuals who seek help for their substance misuse problems' and identify alcohol as their main problem drug were recorded as problem alcohol users. The prevalence of treated problem alcohol use was 168.3 rate per 100,000 population in 2004 and increased to 243.3 rate in 2008 (www.drugsandalcohol.ie/12770). The median age was 39 years and the majority of those treated for problem alcohol use were males with low levels of employment. The number of new cases under 18, although small, continues to rise, from 168 cases in 2004 to 229 cases in 2008. The NDTRS was originally set up to record treated drug misuse and was extended in 2004 to include alcohol. However, not all alcohol treatment services are included in this database, therefore the figures are an under-estimation of those using alcohol treatment services in Ireland (Mongan et al. 2007).

Social problems showed a dramatic increase over the time period, as measured by alcohol related offences of drunkenness, public order and assault. Between 1994 and 2002 drunkenness, (328%) public order (596%) and assault (108%) offences sharply increased followed by a decline in 2003 (Table 1). The sharp rise in public order and drunkenness offences during this time period was partly influenced by the introduction of the Criminal Justice Public Order Act in 1994 and the new recording system (PULSE) for (the police) in late 1999 (An Garda Siochána Annual Reports 1994–2003). The figures for alcohol related offences (drunkenness and public order) from 2004 to 2007 are not directly comparable to the previous figures, due to the introduction of a new Irish crime classification system (ICCS). However, the direction of the line is similar for public order offences to that of an increase. Between 2004 and 2007 assault

offences (+21%) and public order offences (+51%) increased while drunkenness offences declined in 2006 and 2007 (Mongan et al. 2009). Given that An Garda Siochana only record the most serious offence, it is probable that where drunkenness and public order offences occurred, only the public order offence was recorded, thus the decline in drunkenness offences. The typical profile of the offender was mostly male and young adult (18–24 age groups). The national drinking surveys (2002–2006) also reported that the risk of fights was more likely among men, younger adults (under 35 yrs) and those engaged in regular risky drinking (Mongan et al. 2009). A similar profile was evident for those who reported work problems as a result of their own drinking, while family life and friendships problems were more common among those in their middle years (35–64 years).

There are also many other health conditions and social problems in Ireland where alcohol plays a contributory role that negatively affects the drinker and inflicts harm on others, which have been documented for the time period (Hope 2008). Alcohol related acute pancreatitis hospital admissions rose rapidly, in particular for women in the 20–29 age group (O' Farrell et al. 2007). Alcohol use during pregnancy has increased (Barry et al. 2006). The role of alcohol and in particular drinking to intoxication is now a common occurrence in the proportion of rapes committed in Ireland, both in terms of perpetrator and the victim (Hanley et al. 2009). The risk to children from parental problem drinking has been documented (Butler 2009b), as has the role of alcohol in domestic violence (Watson & Parsons 2006) and interpersonal problems especially among young adults (Hope 2008).

Prevention and policy initiatives

■ NGO sector

Following the closure of the Irish National Council on Alcoholism (a voluntary body based on the traditional disease concept of alcoholism) in 1987, no dedicated NGO reflecting public health principles on alcohol operated at national level for most of the two decades under review here. Nonetheless, alcohol issues were raised periodically by individual medical professionals and by voluntary bodies which had a more generic social service agenda. For instance, the children's charity Barnardos regularly raised the issue of the impact of parental drinking on children and young people, and the National Youth Council of Ireland similarly worked to address the problems associated with alcohol consumption amongst teenagers. In 2001, however, a dedicated NGO – Alcohol Action Ireland – was established to create public awareness of the nature and scale of Ireland's alcohol-related problems and to lobby for the implementation of evidence-based alcohol strategies. This NGO, which is generally supportive of WHO policy on alcohol, has since its foundation worked to fulfil this remit, frequently in the face of direct opposition from drinks industry bodies such as the Alcohol Beverage Federation of Ireland.

■ Public opinion

To gauge the public mood and support for alcohol control measures as recommended in the Strategic Task Force on Alcohol (DOHC 2002) an opinion poll survey was

undertaken in 2002 and repeated four times in subsequent years. Six broad areas of alcohol policy were measured: role of government, drink driving, price, availability, drinking environment and promotion of alcohol. A full description of the study is reported elsewhere (Hope 2009). There was high support for drink driving countermeasures, which increased when random breath testing was introduced in 2006. The majority of adults in Ireland also supported policies to protect children such as restricting alcohol advertising on TV and in public places. While about one-third supported restrictions on availability (earlier closing time and fewer off-licences) and about one-fifth supported higher taxes, the majority favoured the status quo (remain the same). These findings would suggest that there is little demand for more liberal alcohol policies in Ireland. However, effective control policy measures (price and availability) that are perceived to threaten the individual drinker, in particular the heavy drinker, meets with most resistance.

Concluding remarks and some challenges

■ Consumption, harm and policy

In Ireland, alcohol consumption increased during the mid-1990s to 2002 due to significant increases in disposable income, driven by strong economic growth and poor policy choices (increased affordability and availability). In 2003, alcohol consumption decreased primarily due to a tax increase and created a 'leveller' effect in a very 'wet' society. Since then consumption remained stable until 2008 when it declined further due to a combination of less disposable income as a result of the current recession and increase in cross border shopping due to sterling parity. Damaging drinking patterns prevailed during the period and continues today. Alcohol -related harm increased, in particular alcohol-related morbidity, social harm and the number of people presenting to treatment services with problem alcohol use. However, in 2003 several harm indicators did decrease such as alcohol-related morbidity, alcohol acute (toxic effect) mortality, liver disease mortality and social harms (drunkenness, public order and assaults), the same year alcohol consumption decreased and alcohol tax increased. While causality is difficult to establish, the change in several of the harm indicators would suggest a relationship between increased tax, a decrease in consumption and a reduction in alcohol harm which occurred in 2003. Conversely, a sharp rise in alcohol morbidity among young people under 18 years was highest in the year 2001 when alcohol availability substantially increased through longer opening hours. The prevalence of alcohol related harm among minors and young adults raises serious issues, going forward, for health and social services as well as the economic impact of lost or reduced educational and employment productivity due to alcohol consumption.

During the decade 1990–2000, most of the policy choices were counter to the public health evidence base with the exception of a reduction in the BAC level (Babor et al 2010). A technical/professional alcohol researcher was engaged by the Department of Health (1996–2005) to act as a policy advisor to build capacity towards a public health approach to alcohol problems. Between 2002 and 2004, there were signs of a possible policy shift towards public

Table 2. Alcohol Policy activity 1990–2010

1990	Minister of Health requested the development of a National Alcohol Policy
1994	BAC reduced to 0,80mg
1994 to 2001	No increase in alcohol taxes
1996	National Alcohol Policy published by Government
2000	Intoxicating Liquor Act 2000
	– Longer opening hours
	– Free movement of Licences
	– Lifting of restrictions for granting of certain licences
	– Temporary closure for selling to minors (u 18yrs)
2002	Tax increase on cider (Dec 01 budget)
	Strategic Task Force on Alcohol Interim Report
2003	Tax increase on spirits (Dec 02 budget)
	Intoxicating Liquor Act 2003
	– Revert to earlier closing time on Thursday nights
	– Temporary closure for serving to drunken customers
	– Ban on happy hours
	– Ban on children from pubs after 9pm (extended to 10pm later)
	Proposed legislation to restrict alcohol marketing
2004	Strategic Task Force on Alcohol Second Report
2005	Alcohol marketing legislation shelved in favour of Industry self-regulation
2006	Mandatory alcohol testing (similar to RBT)
	Below cost selling of alcohol allowed (Abolition of Groceries Order)
2008	Report of the Government Alcohol Advisory Group
	Intoxicating Liquor Act 2008
	– Earlier closing time for off-licences
	– Regulation to restrict promotions, changed to Industry self regulation
2010	Due – National Substance Misuse Strategy

health alcohol policy – large tax increase on spirits, proposed legislation to restrict alcohol marketing, new laws to restrict and sanction those who sold alcohol to intoxicated persons and restricts on cheap alcohol promotions (Table 2). However, it was short lived and by 2005 the strength of the industry lobby and the political unwillingness to take pro-health decisions resulted in a default to 'business as usual' which continues to the present time. One exception is random breath testing where road deaths have reduced since its introduction in 2006, which illustrates the benefits of evidence based policies.

■ Political will

The twenty-year period under review began promisingly, with a ministerial commitment to the drafting and implementa-

tion of an integrated national alcohol policy. However, given the broadly neo-liberal social policy ethos which characterised these boom years for the Irish economy, it is not surprising that there was little political will to implement alcohol control strategies which – however rational and evidence-based they were – were unpalatable to the drinks industry and out of keeping with the general 'party' atmosphere of 'Celtic Tiger' Ireland. Over the course of the twenty years, successive policy documents repeated the strong evidence base originally presented in *National Alcohol Policy – Ireland* (1996) for the use of strategies such as pricing measures or restrictions on access and availability aimed at reducing consumption levels. Chief among these were the two reports of the *Strategic Task Force on Alcohol* (2002; 2004), which again drew heavily on the work of the World Health Organisation to recommend the implementation of environmental strategies aimed at reducing national alcohol consumption. The credibility of such recommendations was obviously enhanced by the growing body of epidemiological data (as summarised in this paper) confirming the links between increased consumption and the prevalence of a range of related harms; but with the exception of some individual policy measures such as the tax increase in 2003 and the introduction of random breath testing for motorists in 2006, Irish alcohol policy over these years generally ignored these public health recommendations. The two policy measures (RBT and below cost alcohol), introduced in the same year, clearly illustrate what Butler (2009a) describes as a 'political' rather than a rational process in alcohol policy making in Ireland. What also became clear during the time period was that the drinks industry in Ireland, as elsewhere, would actively oppose evidence-based policy proposals which it deemed to be commercially damaging (Hope 2006).

■ Changed economic environment

With the collapse of the housing market and the ensuing banking crisis of late-2008, Ireland's economy went into almost immediate recession, creating a radically altered policy environment for the framing and implementation of alcohol policy. It soon became clear that *laissez-faire* economic policies had not served the country as well as had been thought during the boom years, and that the 'light-touch' regulation of financial institutions had been particularly disastrous. These new circumstances, one could surmise, were more likely to favour the introduction of alcohol control strategies which gave priority to the broader public good and not to the narrow financial interests of alcohol manufacturers and retailers. To date, however, the industry has continued to lobby aggressively against such strategies, arguing that consumption has already dropped and that it would be unreasonable to attack an industry which is struggling to adapt to new economic circumstances.

■ Changed policy framework

While there has been no official abandonment of health promotion within the Irish healthcare scene, it is clear that this concept and its related practices no longer hold sway here, and that it is unlikely to act in the immediate future as the policy framework for the introduction of a com-

prehensive national alcohol policy. It was announced in early-2009 that the government had agreed that alcohol would be integrated into the National Drugs Strategy: an announcement full of radical potential in that management of illicit drugs had for more than fifteen years been based on the concept of 'cross-cutting management' or 'joined-up' government. The idea of a unified 'substance misuse' strategy, applying common policy principles to alcohol as to illicit drugs, would appear to enhance the prospect of real implementation of evidence-based alcohol policy. There are two main reasons, however, to doubt whether its radical potential will ever be fulfilled. The first of these is that in the most recent drug policy document, *National Drugs Strategy (interim) 2009–2116,* the cross-cutting style of management has been seriously diluted, with control effectively reverting to the classic, single-authority tradition of civil service management. This means that senior civil servants from the department in which this substance misuse strategy is now based (the Department of Community, Equality and Gaeltacht Affairs) may now be in a position similar to that experienced in earlier times by Department of Health civil servants: namely that they can articulate clear public health principles with regard to national alcohol policy, but lack the political clout to override the vastly different policy perspectives of colleagues based in departments which are primarily concerned with trade, employment and revenue. Similarly, at the political level, the lead Minister may have difficulty at Cabinet in persuading colleagues that public health should be given priority over trade and commercial interests.

The second reason for scepticism relates to the somewhat protracted process currently under way to operationalise this proposed integration of alcohol into the policy framework for illicit drugs. While the decision to take this radical step was announced in March 2009, a steering group to work out a detailed implementation plan was only established in November 2009, with a view to reporting to the Minister at the end of 2010. Given that a great deal of detailed policy work on this issue had already been done by earlier policy groups, one would have expected that a more speedy timeframe was possible. The jury is out as to whether this promising policy development will lead to a more independent and evidence-based approach to alcohol policy in Ireland than has been the case for the past twenty years.

Going forward

From a researcher's perspective, perhaps the most positive outcome of these years was that great strides were made in improving data gathering on Irish drinking habits and their associated health and social problems. In terms of realpolitik, however, this period was one which promised much but which ultimately failed to deliver on the implementation of what public health advocates would consider to be 'evidence-based' alcohol policy.

Major challenges remain – alcohol harm continues to rise, harmful use of alcohol is common, the availability of cheap alcohol through an enlarged network of off-licences is very problematic making alcohol readily affordable. Broader challenges are also facing the Irish people in the current recessionary times. Communities are

re-engaging and social cohesion is growing and perhaps a bottom up approach (through community action) is the way forward in tackling our damaging drinking culture, given the lack of political leadership.

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