HRB Overview Series

13

HRB Health Research Board

# Alcohol: availability, affordability, related harm, and policy in Ireland

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# HRB Overview Series 13

# Alcohol: availability, affordability, related harm, and policy in Ireland

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The HRB National Drugs Library supports those working to develop the knowledge base around alcohol and other drug use in Ireland. We aim to enable evidence-informed decision making by providing a comprehensive, timely and accessible information service. To access our research collection and other resources visit https://www.drugsandalcohol.ie/

## Health Research Board

The Health Research Board (HRB) is the lead agency in Ireland supporting and funding health research. We provide funding, maintain health information systems, and conduct research linked to national health priorities. Our aim is to improve people's health, build health research capacity, and make a significant contribution to Ireland's knowledge economy.

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# List of abbreviations and acronyms

| | |
|---|---|
| **ABV** | alcohol by volume |
| **ALD** | alcoholic liver disease |
| **AUD** | alcohol use disorder |
| **AUDIT** | Alcohol Use Disorders Identification Test |
| **BAC** | blood alcohol concentration |
| **CSO** | Central Statistics Office |
| **DALY** | disability-adjusted life year |
| **DSM** | Diagnostic and Statistical Manual of Mental Disorders |
| **ED** | emergency department |
| **FASD** | fetal alcohol spectrum disorder |
| **GUI** | Growing Up in Ireland |
| **HBS** | Household Budget Survey |
| **HBSC** | Health Behaviour in School-aged Children |
| **HED** | heavy episodic drinking |
| **HEI** | higher education institution |
| **HIPE** | Hospital In-Patient Enquiry |
| **HPO** | Healthcare Pricing Office |
| **HRB** | Health Research Board |
| **HSE** | Health Service Executive |
| **IPSDS** | Irish Probable Suicide Deaths Study |
| **MUP** | minimum unit pricing |
| **NCRI** | National Cancer Registry Ireland |
| **NDAS** | National Drug and Alcohol, Survey |
| **NDRDI** | National Drug-Related Deaths Index |
| **NDTRS** | National Drug Treatment Reporting System |
| **NOSP** | National Office for Suicide Prevention |
| **NPIRS** | National Psychiatric Inpatient Reporting System |
| **NSHRI** | National Self-Harm Registry Ireland |
| **OECD** | Organisation for Economic Co-operation and Development |
| **PAE** | prenatal alcohol exposure |
| **PGSI** | Problem Gambling Severity Index |

| | |
|---|---|
| **PPAU** | parental problem alcohol use |
| **PRAMS** | Pregnancy Risk Assessment Monitoring System |
| **PQ** | Parliamentary Question |
| **RSA** | Road Safety Authority |
| **RTC** | road traffic collision |
| **SAOR** | Support, Ask and assess, Offer assistance, and Refer |
| **SATU** | sexual assault treatment unit |
| **SCOPE** | Screening for Pregnancy Endpoints |
| **SSIS** | Suicide Support and Information System |
| **UK** | United Kingdom |
| **USA** | United States of America |
| **WHO** | World Health Organization |
| **YLDs** | years lived with disability |

# Glossary

**Alcohol and drug treatment** refers to interventions delivered to an individual or group of individuals with the aim of achieving abstinence from or reducing use of alcohol and other drugs.

**Alcohol use disorder (AUD)** is defined by *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* criteria as a problematic pattern of alcohol use leading to clinically significant impairment or distress and manifested by 2 or more of the following 11 criteria occurring at any time in the last year: heavy and hazardous use leading to increased chances of getting hurt; unsuccessful attempts to quit or cut down; too much time spent on alcohol use or getting over the aftereffects of alcohol use; increased tolerance; continued drinking despite social and interpersonal problems caused by drinking; withdrawal; role impairment; reduced activities because of drinking; cravings; longer or more alcohol use than intended; and continued drinking despite psychological or physical problems. AUD severity levels can be classified as mild, moderate, or severe (2—3, 4—5, or ≥6 of the 11 criteria).

**Alcohol Use Disorders Identification Test (AUDIT)** is a 12-question screening tool approved by the World Health Organization that is designed to measure harmful alcohol use. Total scores range from 0 to 40, with higher scores indicating a greater likelihood of hazardous and harmful drinking. Scoring is computed by adding scores and risk levels are calculated based on total scores, where a score of 0–7 equates to low risk, a score of 8–15 represents hazardous drinking patterns, a score of 16–19 indicates harmful drinking patterns, and a score of ≥20 represents high-risk drinking or possible dependence.

**Alcohol Use Disorders Identification Test – Concise (AUDIT-C)** is a concise version of the full AUDIT and includes only three questions from the full AUDIT. Its performance has been evaluated and it has generally been proven to be as effective as the full AUDIT in measuring harmful alcohol use.

**GeoDirectory** is a comprehensive address database of approximately 2 million buildings that receive post in Ireland, allowing the precise geographic locations of the buildings to be mapped.

**Harmful drinking** refers to a pattern of alcohol use that results in adverse events (for example, physical or psychological harm).

**Hazardous drinking** refers to a pattern of alcohol use that places individuals at risk of adverse health events.

**Health Service Executive (HSE) weekly low-risk alcohol guidelines** are fewer than 11 standard drinks for women or fewer than 17 standard drinks for men per week. Drinks should be spread out over the week, with 2–3 alcohol-free days each week.

**Heavy episodic drinking (HED) or binge drinking** is defined in Ireland as drinking 60 grams (g) or more of pure alcohol (equivalent to 6 standard drinks) on a single occasion regardless of age or sex.

**Lifetime prevalence** refers to the use of alcohol at any point in a person's life.

**Perceived risk** refers to awareness of the physical harm or negative social consequences of alcohol use.

**Polydrug use** is the simultaneous use of two or more drugs (including alcohol) on the same occasion, or the concurrent use of two or more different drugs in a given time period.

**Protective factors** are biological, psychological, family, community, or cultural characteristics associated with a lower likelihood of substance use or which may reduce the negative outcomes of substance use.

**Risk factors** are characteristics or conditions that are associated with a higher likelihood of substance use or which may increase the negative outcomes associated with substance use.

**Sex** is also referred to as gender throughout this report depending on the terminology used in the various source documents.

**Standard drink** in Ireland is defined as a drink with 10 g of pure alcohol. Examples include: a small 100 millilitre (mL) (12.5% alcohol by volume (ABV)) glass of wine, a pub measure (35.5 mL) of spirits, or half a pint of beer (4.3% ABV).

# Summary

Alcohol use is the ninth leading risk factor for both deaths and disability-adjusted life years globally and is the leading risk factor among those aged 25–49 years. Alcohol use is responsible for over 5% of all deaths annually and causes many conditions, such as alcohol dependence and alcohol-related liver disease, as well as common health conditions, including cardiovascular disease and cancer. Historically, Ireland has had a high level of alcohol use and harmful drinking patterns have been the norm for many, but the situation is slowly changing. The COVID-19 pandemic affected our lives in so many ways, including alcohol use behaviours, and it will take years to fully realise the effects of these behavioural shifts. Many components of the Public Health (Alcohol) Act 2018 were being commenced as the pandemic continued. The Act places Ireland at the forefront of countries observing the World Health Organization's (WHO's) recommendations regarding best practices for reducing population-level alcohol use and related harms. The concurrent implementation of the Act during the COVID-19 pandemic has made monitoring the impact of this legislation complicated. However, the Health Research Board (HRB) will continue to observe alcohol use and trends, as well as the consequences of our alcohol use, by collecting information on the alcohol epidemiological indicators through the publishing of these overviews on the current alcohol use and related harms situation in Ireland. This is the fifth alcohol overview that the HRB has undertaken.

# Data sources

The data in this overview are based on published Irish and international literature and existing information systems and surveys. We used the HRB National Drugs Library in order to identify and access Irish literature on alcohol. Data from surveys, including the Healthy Ireland surveys, the National Drug and Alcohol Survey (NDAS), and the Planet Youth survey, were used in order to describe the prevalence of alcohol use among various populations. We examined the consequences of alcohol use using a variety of information systems, including the Hospital In-Patient Enquiry (HIPE) scheme; the National Drug-Related Deaths Index (NDRDI); the Global Burden of Disease (GBD) study; the National Drug Treatment Reporting System (NDTRS); the National Psychiatric Inpatient Reporting System (NPIRS); the National Self-Harm Registry Ireland (NSHRI); the Primary Care Reimbursement Service (PCRS); the Police Using Leading Systems Effectively (PULSE) system; the National Cancer Registry Ireland; and Revenue, the latter allowed us to calculate per capita alcohol use as well as liquor licence prevalence.

# Purpose

This overview updates the information contained in the previously published overviews and provides new sources of alcohol-related information where available. This examination of the literature and data assesses the current situation in Ireland regarding alcohol use and harm, as well as policy responses; analyses trends over time; and can contribute towards assessing the impact of the Public Health (Alcohol) Act 2018. It is intended to be a reference document and to signpost readers to the data sources available.

# Alcohol use in Ireland

In 2023, per capita alcohol use per person aged 15 years and over in Ireland was 9.9 litres of pure alcohol; this corresponds to 37 bottles (700 millilitres (mL)) of vodka, 104 bottles (750 mL) of wine, or 400 pints of beer (with an alcohol by volume (ABV) concentration of 4.3%). Per capita alcohol use has decreased since 2022 (10.2 litres), and it remains lower than the pre-pandemic levels recorded in 2019 (10.8 litres). As survey data indicate that approximately one-third of the population of Ireland abstains from alcohol completely, those who drink alcohol are consuming even greater quantities than what is indicated by per capita estimates. Since the last overview published in 2021, Ireland's per capita alcohol use has dropped from the 9th highest among 38 Organisation for Economic Co-operation and Development (OECD) member countries to the 16th highest.

In 2023, on average, the adult population of Ireland drank

**9.9 litres of pure alcohol.**

This corresponds to


Ireland's low-risk alcohol guidelines remain unchanged despite advice from the WHO that no level of alcohol use is safe, and because the majority of alcohol use now takes place in the home, it is increasingly difficult for drinkers to monitor their alcohol use.

# Patterns of alcohol use in Ireland

Patterns of alcohol use are measured through prevalence surveys, including the Healthy Ireland surveys and the NDAS. Although approximately one-half of drinkers in Ireland can be classified as hazardous drinkers (65.7% of males and 36.5% of females), a decline in this pattern of drinking has been observed since 2010. More than one-half (52%) of drinkers drink at least once per week, and 32% reported drinking multiple times per week.

**More than one-half**
of drinkers drink at least once per week (52%)

**Almost one-third**
drink multiple times per week (32%)

The COVID-19 pandemic had a profound effect on many people's lives, and drinking patterns changed for some during this period. The Healthy Ireland Surveys in 2021 and in 2022 found that 13% of respondents reported drinking more since the beginning of COVID-19 restrictions, more commonly reported among those aged 35–44 years (18.6%) and among females (14.0%) compared with males (11.8%). Of concern is the finding that parents of children aged under 18 years were more likely to report increasing their alcohol use since the beginning of the pandemic (16.4%) compared with those without children aged under 18 years (11.5%). This difficult period may have resulted in some using alcohol to cope with the situation. The Healthy Ireland Survey 2021 found that of those who had increased their alcohol use since the beginning of the COVID-19 pandemic, 19.8% reported that their mental health had worsened, 25.2% reported that their sleep was negatively affected, and 27.5% reported that their energy levels were negatively affected.

# Alcohol use and drinking patterns among children and young people

Central to the Public Health (Alcohol) Act 2018 is preventing or delaying alcohol use among children and young people. There has been a delay in the initiation of alcohol use among children, from 15.6 years of age to 16.6 years, between 2002 and 2019. A decline in the share of young people who drink has also been observed during this period: in 2002, 17.7% of 15–24-year-olds were non-drinkers compared with 28.2% in 2019, and not drinking was more common among females (31.5%) than males (25.0%) in this age group. However, it is important not to become complacent about alcohol use among young people as a high percentage (64%) of young people drink in a hazardous manner (a pattern of alcohol use that places the individual at risk of adverse health events), and 46% reported heavy episodic drinking (HED) on a typical drinking occasion. Among a sample of adolescents aged 14–16 years, 29% reported that they had been drunk in their lifetime and 13% reported being drunk in the previous month. Of those aged 15–24 years, 37.5% can be classified as having an alcohol use disorder (AUD).

The evidence indicates a number of risk and protective factors associated with alcohol use among children and young people, including age of initiation, sexual orientation, participating in sports or the arts, exposure to alcohol marketing, socioeconomic status, parental alcohol use, conflict in the home, and school experiences.

# Alcohol availability in Ireland

In 2021, there were close to 15,000 premises that had a liquor licence in Ireland, which corresponds to 1 liquor licence for every 345 people nationally; 73% of the population of Ireland lives within 300 metres of a liquor licence. A decrease in the number of pub licences (-20% over the 18-year period from 2003 to 2021) has been offset with a 95% increase in the number of off-licences in the same period. Despite the decline in the number of pubs in Ireland, we still rank 3rd highest for the number of pubs per capita in the world: there is 1 pub for every 684 adults nationally. Geospatial analysis of liquor licences in Ireland reveals that liquor licences are more common in areas of higher deprivation, with almost twice as many liquor licences per capita in such areas compared with more affluent areas.

# Alcohol affordability and expenditure

Unsurprisingly, the price and affordability of alcohol influence how much we drink: the more affordable alcohol is, the more is consumed. The cost of alcohol in Ireland is the fourth highest in the European Union – and Irish households spent 2.9 billion euro (EUR) on off-trade alcohol in 2021 (equivalent to 0.7% of Ireland's gross domestic product).

The average Irish household spent more money on alcohol for consumption at home than on alcohol for consumption outside the home. Despite the rising costs, in 2019 Ireland had the second most affordable alcohol of OECD members.

The cost-of-living crisis has affected most households in Ireland, and consumer goods have continued to increase in price; most notably, housing, water, electricity, gas, and other fuels increasing in price by 16.9% in just 1 year, between September 2022 and September 2023. In comparison, the cost of alcohol increased by 4.5% in off-licences and by 7.3% in licenced premises in the same time period. In the 10-year period from 2013 to 2023, the price of a pint of draught lager in licenced premises has increased by EUR 1.51; in the off-trade, the largest price increase observed was for a 700 millilitres (mL) bottle of brandy (which increased by EUR 17.79) or vodka (which increased by EUR 6.36). Although alcohol prices have increased, the price of alcohol purchased in licenced premises has kept in line with inflation, whereas alcohol purchased in the off-trade has remained unchanged since 2003 when considering inflation.

# Alcohol-related harm

Alcohol-related harm can be caused not only by the volume of alcohol consumed, but also by patterns of drinking, and can include harms to health, violence, and social harms. An effective estimate of alcohol-related harm is the number of hospitalisations due to alcohol use. In Ireland, the HIPE scheme collects clinical and administrative data on discharges (including deaths) from acute Irish hospitals. For this overview we examined all alcohol-related discharges that were wholly attributable to alcohol. The number of alcohol-related hospitalisations increased by 16.4% between 2001 and 2021, from 16,219 to 18,877 but when considering the population growth Ireland has seen in this period, it represents a 17.1% decrease per 100,000 of the population. Adjusting for population growth, rates of alcohol-related liver disease per 100,000 of the population have increased by 79.9% in the 20-year period from 2001 to 2021.

Survey data indicate that more than one-quarter (27.6%) of drinkers aged 15–24 years reported experiencing harm due to their own alcohol use in the 2019–20 NDAS. Hazardous or harmful drinkers were more likely to report experiencing harm from their own drinking. Accidentally hurting oneself (10.2%) and harms to health (8.0%) were the most common harms reported from their own drinking. One in every 10 respondents reported experiencing harm to family (10.8%) and 6.0% reported being a passenger with a drunk driver as the harms experienced from others' drinking.

# Alcohol use and mental health

Globally, alcohol use was associated with 27% of suicides and self-harm incidents in 2019. In Ireland, alcohol was found to be associated with one-third of self-harm hospital presentations in 2020, and a regional study found that alcohol was present in the toxicology reports of 44% of suicide cases.

# Alcohol-related crime in Ireland

We examined alcohol-related crime using data from the PULSE system. In 2022, there were 5,527 incidents recorded on PULSE for drink driving; 9,917 incidents of 'drunkenness'; and 237 liquor licensing incidents. Between 2012 and 2022, there was a 31.3% decrease in the number of drink-driving incidents recorded on PULSE and a 12.5% increase for incidents of drunkenness, although trends should be interpreted with caution due to data quality issues with earlier PULSE data.

Probation Service data indicate that it is common for clients to have a history of substance use problems. Probation Service clients' alcohol use was commonly found to be connected to the crime for which they were referred to the Probation Service; 42% of males and 32% of female clients. This is a decrease from the previous Probation Services report published in 2012 which found 71.3% of clients reported that their alcohol use was linked to the offence perpetrated.

# Alcohol and gambling

At-risk or problem gambling was found to be more prevalent among those who reported monthly HED and those with possible AUD. Gambling and alcohol use were found to be closely connected when examining cases who presented for treatment for their problem gambling.

# Alcohol-related mortality in Ireland

Data from the NDRDI indicate that approximately three people die every day in Ireland as a direct result of alcohol use. The GBD study estimates that when accounting for partially attributable alcohol-related deaths, this increases to four people dying in Ireland every day due to alcohol. The GBD study indicates that alcohol use has risen from being the 13th leading cause of death in the population of Ireland in 1990 to the 8th leading cause of death in 2019.

# Alcohol treatment

We analysed alcohol treatment using data from the NDTRS and the NPIRS. Between 2015 and 2022, the number of cases that received treatment for alcohol as the main problem drug decreased by 2.6%. The most common treatment intervention received is brief intervention, followed by counselling and detoxification from alcohol.

Treatment for alcohol is commonly delivered in a community setting, however, for some, psychiatric treatment in a hospital setting is necessary. According to data from the NPIRS, there were 806 cases admitted to psychiatric hospitals with an alcohol-related diagnosis in 2022. However, this figure does not include those receiving treatment in residential treatment settings.

# Alcohol policy in Ireland

The most important development in alcohol policy in Ireland in recent years has been the enactment of the Public Health (Alcohol) Act 2018. The legislation, based on the WHO's 'best-buy' recommendations, sees alcohol as a public health issue and is world-leading in addressing alcohol use at a population level. Evidence from other jurisdictions that have implemented similar legislation is examined in this chapter, for example, MUP and its impact in Scotland. Also considered is the proposed Sale of Alcohol Bill (2022) that aims to streamline the liquor licensing process, to extend opening hours and increase alcohol availability, in conflict with the aims of the Public Health (Alcohol) Act.

# Conclusion

The data presented in this overview indicate that there have been changes in alcohol use behaviours since the previous HRB alcohol overview was published in 2021. The observed trends in use and harm are important contexts for considering policy impacts but there is considerable uncertainty regarding this. Ireland still has a high level of per capita alcohol use that remains above the Department of Health's aim to reduce per capita alcohol use to 9.1 litres and well above the current HSE low-risk drinking guidelines. Hazardous and harmful alcohol use remains commonplace, and this overview shows the consequences of such drinking, including alcohol-related hospitalisations, alcohol-related deaths, and the number of individuals receiving treatment for problem alcohol use. This overview also explores the availability of alcohol and indicates that there is easy availability for the population, and that alcohol remains affordable despite price increases.

The Public Health (Alcohol) Act in 2018 is ground-breaking legislation that aims to tackle population-level alcohol use, with a particular focus on protecting children and young people from alcohol-related harms. Implementation of the final components of the Act will mean benefits for people's health, as well as a reduction of pressure on the healthcare system and fewer premature deaths. We will continue to monitor per capita alcohol use and alcohol-related harms in Ireland through our overviews.

# 02

# Introduction

## 2.1 Background

Globally, alcohol use is responsible for over 5% of all deaths every year and is a causal factor in more than 200 disease and injury conditions, affecting not only the individual, but also their family, friends, community, and society at large [1]. Alcohol use in Ireland remains high although since the last Health Research Board (HRB) alcohol overview was published in 2021, per capita alcohol consumption has declined, and much has happened since that report was published. The repercussions of the COVID-19 pandemic are slowly revealing themselves, including changed drinking patterns; additionally, many components of the Public Health (Alcohol) Act 2018 have been commenced between 2021 and 2023 in a concerted attempt by the Irish Government to reduce population-level alcohol use. In order to monitor alcohol use and trends and the consequences of alcohol use in Ireland, the HRB collects information on the alcohol epidemiological indicators by periodically publishing overviews. This is the fifth alcohol overview that the HRB has undertaken.

## 2.2 Purpose

The purpose of this overview is to update the data and information contained in the previously published overviews to assess the current situation in Ireland regarding alcohol use and harm, as well as policy responses, and to analyse trends over time. It was compiled using published Irish literature and existing Irish information systems and surveys. Analysis of this information allows for a greater understanding of the complex and multifaceted situation of alcohol use. It is important that preventative measures and interventions addressing alcohol use and associated harms are based on evidence and informed by an understanding of the current alcohol situation. It may also be used in order to help assess the impact of the policy measures introduced in the Public Health (Alcohol) Act 2018.

## 2.3 Data sources

The data in this overview are based predominantly on published Irish literature and information systems. We used the HRB National Drugs Library (http://www.drugsandalcohol.ie) in order to identify Irish literature, including journal articles, reports, and policy documents. This website provides one point of access to all Irish alcohol research and policy material, as well as a comprehensive collection of key international evidence.

### 2.3.1 Surveys

Alcohol use in the general population in Ireland is described using survey data from the Healthy Ireland surveys and the National Drug and Alcohol Survey.

#### 2.3.1.1 National Drug and Alcohol Survey

The National Drug and Alcohol Survey (NDAS) is a nationally representative cross-sectional survey of adults aged 15 years and over in Ireland. The survey that was carried out in 2019–20 was the fifth wave of the survey, with previous survey waves undertaken in 2002–03, 2006–07, 2010–11, and 2014–15. Waves 1–4 were commissioned on an all-island basis by the National Advisory Committee on Drugs and Alcohol (NACDA) in the Republic of Ireland and the Department of Health, Social Services and Public Safety in Northern Ireland with respondents from the entire island of Ireland; however, Wave 5 was limited to the Republic of Ireland and was managed by the HRB. Only the latter two survey waves (those carried out in 2014–15 and 2019–20) included older people aged 65 years and over.

A total of 5,762 respondents took part in Wave 5 of the NDAS, equating to 87.8% of the initial target of 6,560. Face-to-face interviews in each respondent's home were completed between February 2019 and March 2020. Field work was halted due to the restrictions associated with the COVID-19 pandemic and the last 127 interviews were conducted by telephone during April and May 2020. The survey used stratified and multistage area probability sampling methods to select a representative sample of the Irish population aged 15 years and over living in private households, and the data were weighted in order to ensure representativeness. Further information regarding the methods used are detailed in the 2019–20 Irish national drug and alcohol survey: technical report [2].

#### 2.3.1.2 Healthy Ireland Survey

The Healthy Ireland Survey has been carried out annually since 2015. The ninth wave of the survey was undertaken in 2023. Healthy Ireland is a nationally representative survey of Irish adults aged 15 years and over, and 7,498 respondents took part in Wave 9 [3]. The survey provides an insight into individuals' health behaviours, including alcohol use. In Wave 9 of the Healthy Ireland Survey, respondents were asked about their alcohol use in the previous 12 months. Wave 9 also asked respondents whether they notice or pay attention to alcohol labelling and if so, whether they examine the information provided. Given that health warning labels will be mandatory in Ireland in 2026, this information provides important baseline information to be examined again following their introduction.

#### 2.3.1.3 Planet Youth survey

Alcohol use among schoolchildren and young people was covered extensively in the HRB overview published in 2022, *Alcohol and other drug use among children and young people in Ireland* [4]. Publications that have been released since then are presented in this report, including the Planet Youth survey. The Planet Youth survey is a cross-sectional survey of adolescents aged 14–16 years that has been conducted by both the Western Region Drug and Alcohol Task Force (WRDATF) in 2018, 2020, and 2022, and the North Dublin Regional Drug and Alcohol Task Force in 2021. The survey explores substance use, including illicit drugs, alcohol, and vaping; social circumstances and attitudes; and the risk factors associated with substance use [5].

## 2.3.2 Information systems

This report examines the consequences of and responses to alcohol use primarily using national information systems. These valuable sources of information allow an examination of trends and the impact that various policies or legislation may have on alcohol outcomes. The HRB manages three of the main sources of data (NPIRS, NDTRS, NDRDI); data from information systems outside of the HRB were obtained from publications, or, where not publicly available, requests were made to access the data for the purposes of this report.

### 2.3.2.1 Hospital In-Patient Enquiry

Alcohol-related hospitalisation data were obtained from the Hospital In-Patient Enquiry (HIPE) scheme of the Health Service Executive (HSE). HIPE is a health information system designed to collect demographic, clinical, and administrative information on discharges from and deaths in acute hospitals nationally.

### 2.3.2.2 National Drug-Related Deaths Index

Data on alcohol-related deaths were obtained from the National Drug-Related Deaths Index (NDRDI). The NDRDI is an epidemiological database which records cases of death by drug and alcohol poisoning, as well as deaths among people who had a history of drug use and/or those who were alcohol dependent.

### 2.3.2.3 Global Burden of Disease study

This report also examines alcohol-related deaths using the Global Burden of Disease (GBD) study. The GBD is a global enterprise supported by a team of more than 7,000 researchers in 202 countries, including Ireland. The data capture premature death and disability from more than 350 diseases and injuries in the included countries by age and sex since 1990, which allows for comparisons over time, across age groups, and among populations using standardised methodologies [6,7]. GBD estimates report 95% uncertainty intervals for the estimation of attributable deaths and disability-adjusted life years (DALYs). Alcohol as a cause of death and/or DALYs is calculated using GBD estimates of exposure, relative risks, and the theoretical minimum risk exposure level among the population, which are then multiplied by disease-specific estimates of deaths and DALYs in order to calculate the total attributable burden.

### 2.3.2.4 National Drug Treatment Reporting System

Information regarding the number of cases treated for alcohol use was obtained from the National Drug Treatment Reporting System (NDTRS). The NDTRS provides information on the number of cases that receive treatment for their drug and/or alcohol use in Ireland each year. Further demographic details, as well as the treatment type received, were also obtained from the NDTRS.

#### 2.3.2.5 National Psychiatric Inpatient Reporting System

When an individual is hospitalised due to an alcohol-related psychiatric disorder, their details are recorded on the National Psychiatric Inpatient Reporting System (NPIRS). The NPIRS provides information on all admissions to inpatient psychiatric services in Ireland however does not include psychiatric treatment received in the community.

#### 2.3.2.6 National Self-Harm Registry Ireland

The National Self-Harm Registry Ireland (NSHRI) is a national system of population monitoring for the occurrence of hospital-treated self-harm. It collects data on persons presenting to hospital emergency departments (EDs) in Ireland as a result of self-harm.

#### 2.3.2.7 Primary Care Reimbursement Service

Aggregate-level pharmacy claims data on prescription drugs commonly used to treat alcohol dependency and withdrawal were obtained from the HSE Primary Care Reimbursement Service (PCRS). The medications are based on claims data by the PCRS from community pharmacists and only include items reimbursed by the PCRS. The data do not capture items dispensed outside of community drug schemes where the prescription is paid for privately, or claims which are under the Drugs Payment Scheme monthly threshold amount.

#### 2.3.2.8 Police Using Leading Systems Effectively

Police Using Leading Systems Effectively (PULSE) is a central reporting database for An Garda Síochána to record details of crime incidents. The PULSE system is an operational database and its main function is to record Garda activity. A crime incident is recorded on PULSE if a member of An Garda Síochána determines that, on the balance of probabilities, a criminal offence defined by law has taken place. Not all incidents recorded on PULSE will result in a conviction, and therefore the data presented in this report are not definitive numbers of arrests and charges.

#### 2.3.2.9 National Cancer Registry Ireland

The National Cancer Registry Ireland (NCRI) collates data on the number of cancer cases diagnosed in Irish hospitals. Population-level exposure to risk factors (including alcohol use, tobacco use, infection, being overweight or obese, sunburn, sunbed use, radiation, consumption of processed meat, hormonal replacement therapy, oral contraceptive use, lack of physical activity, and exposure to fine particulate air pollution) are examined in order to determine the number of cancer cases attributable to each risk factor.

#### 2.3.2.10 Revenue

##### *2.3.2.10.1 Revenue volume of sales of alcohol*

The per capita alcohol use figure in Ireland is obtained from Revenue volume of sales of alcohol per calendar year. Revenue compiles annual alcohol sales figures based on the volume of each alcoholic beverage type released from bonded warehousing on payment of excise duty. The volume of alcohol sold is applied to the population estimates derived from the census of the population from the Central Statistics Office (CSO) to determine per capita alcohol use.

##### *2.3.2.10.2 Revenue Register of Renewed Liquor Licences*

Revenue records the number of liquor licences in Ireland that are issued or renewed for each reporting period. These publicly available data are available according to the address of each licence and by licence type.

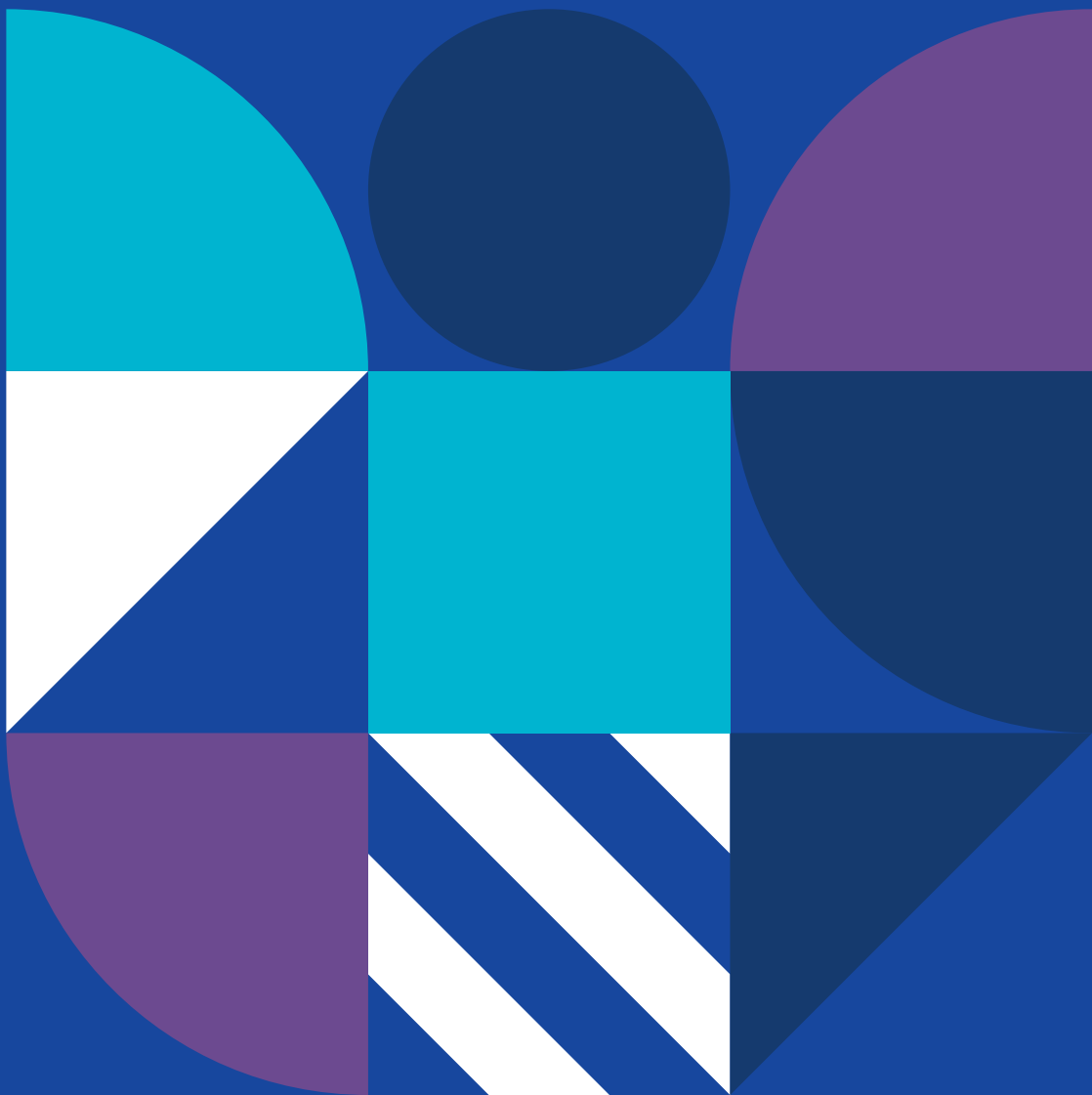
## 2.4 Report structure

This overview presents the information available on alcohol use in Ireland; alcohol availability and affordability; alcohol-related harm; and alcohol policy. This is derived from published Irish and international literature, information systems, and surveys. Following this introductory chapter, Chapter 3 provides an outline of alcohol use in Ireland based on alcohol sales data provided by Revenue and on alcohol use data available in population surveys. Chapter 4 examines alcohol use patterns using data from general population surveys. Chapter 4 also includes a section on alcohol use among young people in Ireland and the risk and protective factors that may influence alcohol use or protect schoolchildren from alcohol use.

Chapter 5 describes the availability of alcohol by examining the prevalence of liquor licences throughout the country. Chapter 6 examines the affordability of alcohol and how much is spent on alcohol in Ireland. Chapter 7 provides an overview of alcohol-related harm (including harms to health), examining alcohol-related hospitalisations and harms that individuals have experienced from others' drinking and from their own drinking. Chapter 8 examines the prevalence of alcohol in cases of suicide and self-harm, Chapter 9 examines alcohol's involvement in crime as recorded on the PULSE system, and Chapter 10 summarises what we know about alcohol and its association with gambling. Chapter 11 examines alcohol-related deaths, while Chapter 12 provides detailed information about those who receive treatment for alcohol use. Lastly, Chapter 13 examines the legislation related to alcohol, most notably the Public Health (Alcohol) Act 2018.

# 03

# Alcohol use in Ireland



'Per capita alcohol use' refers to the volume of pure alcohol consumed per person aged 15 years and over each year in Ireland. Ireland's per capita alcohol consumption is calculated annually using alcohol sales data from Revenue and population estimates from the CSO [8]. Revenue provides annual alcohol sales figures for each beverage type (beer, spirits, wine, and cider). The alcohol sales figures represent the volume of alcoholic beverages released from bonded warehousing and where excise duty has been paid. Beer and spirits volumes are provided in litres of pure alcohol. Wine volumes are provided in litres of alcohol and converted to pure alcohol based on an assumed alcohol by volume (ABV) concentration of 12.5%. Cider volumes are converted to pure alcohol based on an assumed ABV concentration of 4.5%, as most cider products sold in Ireland are at this strength. The population figures provided by the CSO are based on the census data collected every 5 years and are estimated for the intervening years by the CSO. After a census year, the estimated population figures for the preceding years are revised based on the actual census data. This means that previously calculated consumption figures for the years between census data collections may change due to revised population figures [9,10]. It is important to note that Revenue data do not account for alcohol consumed in Ireland that was bought outside the Republic of Ireland, including cross-border alcohol sales, or alcohol consumed by Irish residents while abroad. Finally, home-brewed alcohol or alcohol products not for human consumption (e.g. hand sanitiser, mouthwash) are not included in the alcohol sales figures.

## 3.1 Per capita alcohol consumption

A total of 42,266,785 litres of pure alcohol was sold for consumption in Ireland in 2023. This is then divided by the number of people aged 15 years and over in the population, which was 4,270,000 in 2023 according to CSO estimates [10]. This means that per capita alcohol use in Ireland in 2023 was 9.9 litres of pure alcohol per person aged 15 years and over, a 2.9% decrease from 2022, (based on 2022 population estimates).

Because per capita alcohol consumption is based on all adults aged 15 years and over in Ireland, this rate of consumption includes those who abstain from consuming alcohol. Data from the 2023 Healthy Ireland Survey indicate that 30% of adults in Ireland aged 15 years and over had not consumed alcohol in the previous 12 months [3]. When abstainers (n=1,281,000 according to the 2023 Healthy Ireland Survey) are excluded, alcohol consumption among drinkers aged 15 years and over increases to 14.1 litres of pure alcohol per person in 2023. This is considerably more than the Department of Health's stated aim to reduce per capita alcohol consumption in Ireland to 9.1 litres.

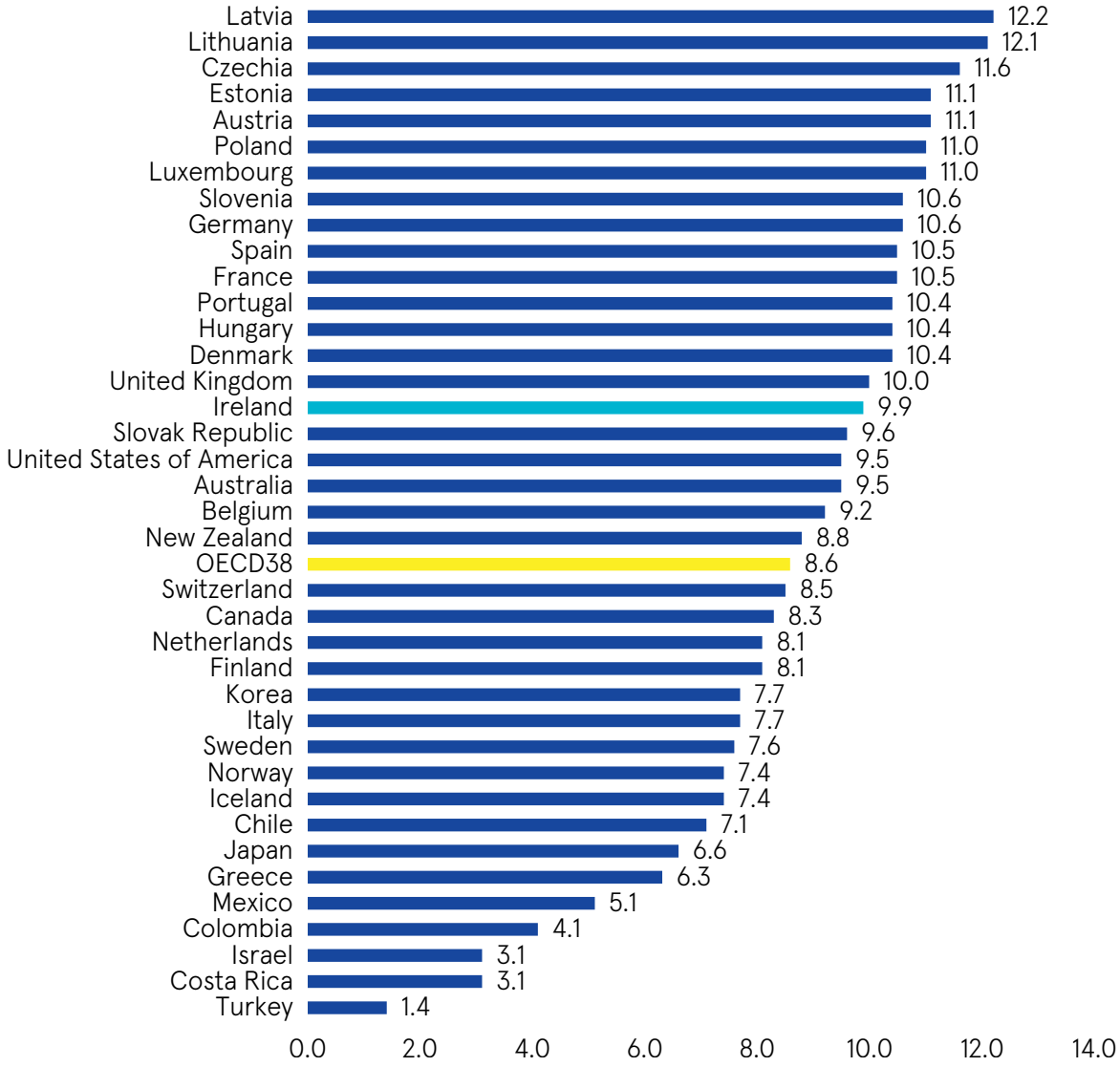
Globally, up to one-quarter of alcohol use is not officially recorded [11]. A study of 25,728 respondents from 33 European countries (including Ireland) was carried out in 2021 in order to establish the prevalence of unrecorded alcohol use. The study found that seven countries (including Ireland) had high levels of unrecorded alcohol use, with 11.3% of per capita alcohol use in Ireland estimated as being unrecorded. Ireland was above the European average for unrecorded alcohol use among male drinkers (14.2% compared with the European average of 13.9%). Females' unrecorded alcohol use was noted as 7.9% in Ireland (compared with the European average of 9.9%). The study concludes that when unrecorded alcohol use is

considered along with Revenue figures, the true rate of per capita alcohol consumption is substantially higher than what is officially reported [12].

### 3.1.1 How does Ireland compare with other countries?

The Organisation for Economic Co-operation and Development's (OECD's) average recorded per capita alcohol consumption was 8.6 litres per adult in 2021 [13]. The most recent per capita alcohol consumption figures available for the 38 OECD member countries are presented in Figure 1. Ireland is ranked 16th out of the 38 included countries for per capita alcohol consumption but it is important to note that the figure for Ireland is based on 2023 per capita use but for the other countries, the year varies.

Figure 1 Annual per capita alcohol consumption (litres of pure alcohol) in OECD member countries based on the most recent available data from each country, 2023




Source: OECD, 2023 [13]

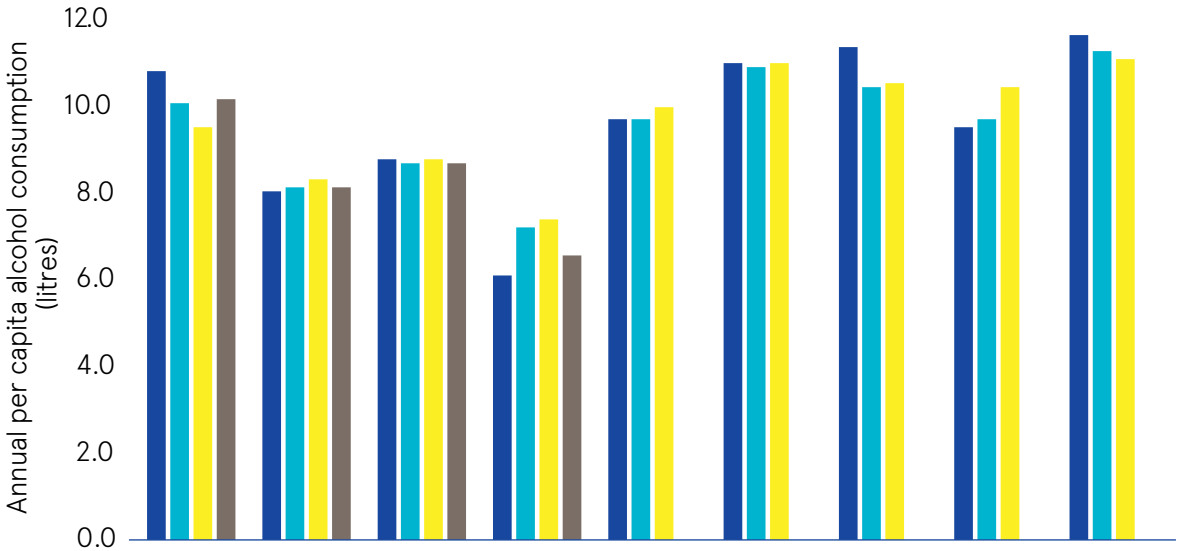
Ireland is ranked

**16th out of 38 OECD countries for rates of per capita alcohol use**

Figure 2 examines the changes in per capita alcohol use in a number of countries globally before, during, and after (where available) the COVID-19 pandemic. Only time will tell if changes in alcohol use during this period persist and what challenges these changes may mean going forward. In addition to the pandemic, national and global societal issues that may change individuals' drinking behaviours include the increasing cost of living, climate change challenges, war, and immigration, all of which contribute to a sense of unease and worry, all of which have been associated with the decline in youth drinking [15].

In Ireland, per capita alcohol use decreased during the pandemic before increasing again in 2022, although not to pre-pandemic levels. The period of the pandemic also coincided with several components of the Public Health (Alcohol) Act 2018 being commenced (structural separation in 2020, alcohol sponsorship in 2021 and MUP in 2022). It is notable that while some countries saw an increase in alcohol use during the pandemic, Ireland saw a decrease. Canada and New Zealand saw little variation in the 4-year period from 2019 to 2022, and Norway saw an increase in per capita alcohol use during the pandemic, which remains higher in 2022 than it was pre-pandemic. Note that at the time of writing, the per capita alcohol use figures were unavailable for 2022 for a number of countries.

Figure 2 Per capita alcohol use in a sample of OECD member countries, 2019–2022




| | Ireland | Canada | New Zealand | Norway | United Kingdom | Poland | France | Denmark | Austria |
|---|---|---|---|---|---|---|---|---|---|
| 2019 | 10.8 | 8.0 | 8.8 | 6.1 | 9.7 | 11.0 | 11.4 | 9.5 | 11.6 |
| 2020 | 10.1 | 8.1 | 8.7 | 7.2 | 9.7 | 10.9 | 10.4 | 9.7 | 11.3 |
| 2021 | 9.5 | 8.3 | 8.8 | 7.4 | 10.0 | 11.0 | 10.5 | 10.4 | 11.1 |
| 2022 | 10.2 | 8.1 | 8.7 | 6.6 | | | | | |

Source: OECD, 2022 [13]

## 3.1.2 Trends in per capita alcohol consumption

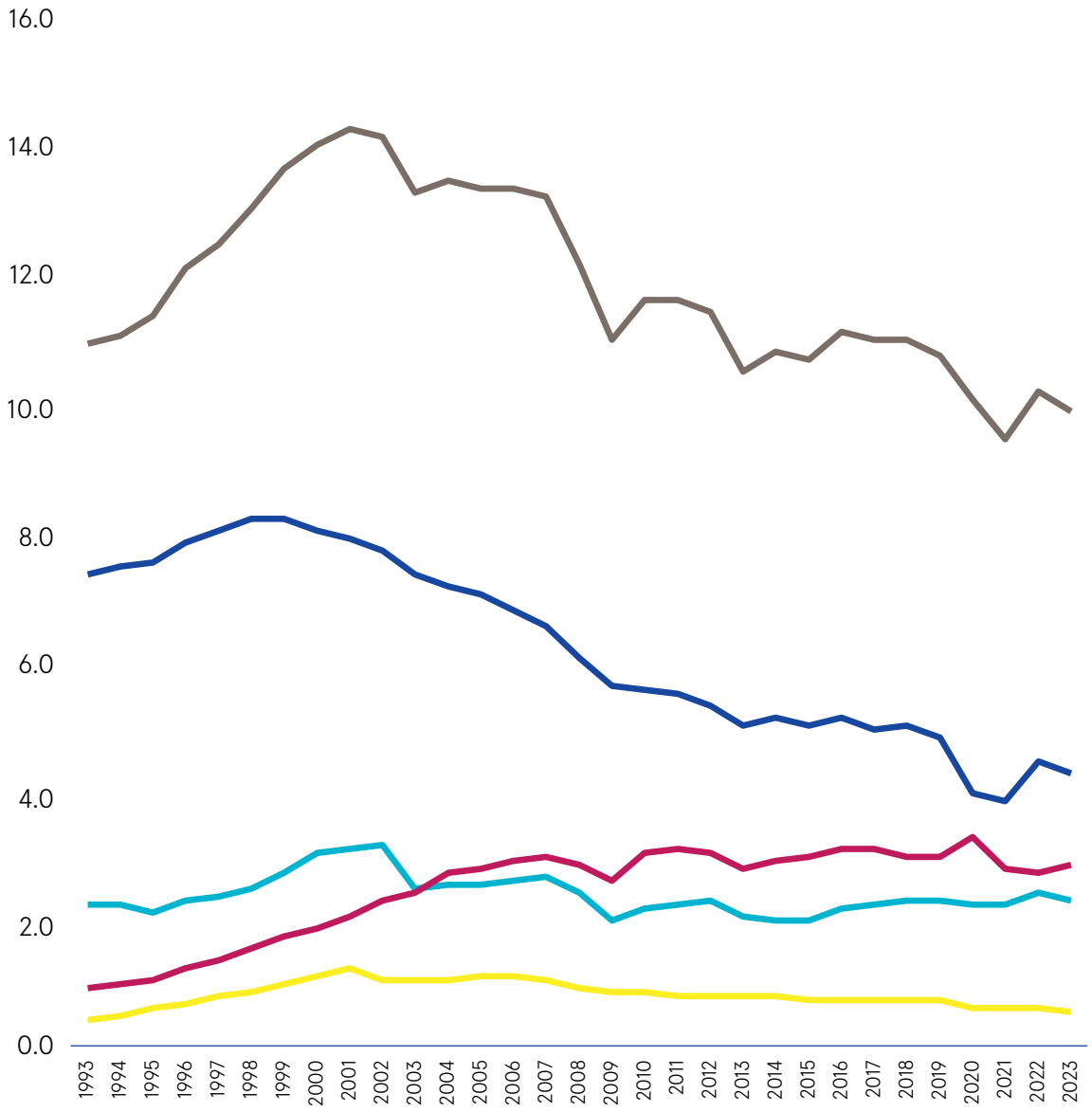
Ireland's per capita alcohol consumption from 1993 to 2023 by total consumption and by beverage type is presented in Figure 3. There has been considerable variation in per capita alcohol consumption over this 30-year period. Per capita alcohol use increased from 11.1 litres in 1992 to 14.3 litres in 2001. Alcohol use remained particularly high between 2001 and 2007, coinciding with the 'Celtic Tiger' period of economic prosperity, before declining in 2008 as Ireland entered an economic recession. In 2009, excise duty on all alcohol products was reduced by 20–21%, resulting in an increase in per capita alcohol use in 2010. Alcohol use declined again in 2013, reflecting the excise duty increase that was introduced in 2012. Between 2013 and 2022, alcohol consumption has remained relatively stable.

Although beer remains the most commonly consumed alcoholic drink in Ireland, its popularity has decreased considerably since 1992, from 7.7 litres per capita in 1992 to 4.3 litres per capita in 2023. In 2023, Ireland consumed the following of pure alcohol per capita in 2022:

- 4.3 litres of beer
- 2.8 litres of wine
- 2.3 litres of spirits, and
- 0.6 litres of cider.

This means that, on average, every person aged 15 years and over in Ireland drank 174 pints of beer, 26 pints of cider, 29 bottles of wine, and 9 bottles of vodka in 2023. (Figure 3).

Figure 3 Trends in per capita alcohol consumption among adults (aged 15 years and over) in Ireland, by total consumption and by drink type, 1993–2023




| | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Beer | 7.4 | 7.5 | 7.6 | 7.9 | 8.0 | 8.2 | 8.3 | 8.1 | 7.9 | 7.7 | 7.4 | 7.2 | 7.0 | 6.8 | 6.6 | 6.1 | 5.6 | 5.6 | 5.5 | 5.3 | 5.0 | 5.2 | 5.0 | 5.1 | 5.0 | 5.0 | 4.8 | 3.9 | 3.9 | 4.5 | 4.3 |
| Spirits | 2.2 | 2.2 | 2.1 | 2.3 | 2.4 | 2.4 | 2.7 | 3.0 | 3.1 | 3.2 | 2.5 | 2.5 | 2.5 | 2.6 | 2.7 | 2.4 | 1.9 | 2.2 | 2.2 | 2.3 | 2.0 | 2.0 | 2.0 | 2.1 | 2.2 | 2.3 | 2.3 | 2.2 | 2.2 | 2.4 | 2.3 |
| Wine | 0.9 | 1.0 | 1.1 | 1.3 | 1.3 | 1.5 | 1.7 | 1.9 | 2.1 | 2.3 | 2.4 | 2.7 | 2.8 | 2.9 | 3.0 | 2.8 | 2.6 | 3.0 | 3.1 | 3.0 | 2.8 | 2.9 | 3.0 | 3.1 | 3.1 | 3.0 | 3.0 | 3.3 | 2.8 | 2.7 | 2.8 |
| Cider | 0.4 | 0.5 | 0.6 | 0.7 | 0.8 | 0.9 | 1.0 | 1.1 | 1.2 | 1.1 | 1.1 | 1.1 | 1.1 | 1.1 | 1.0 | 0.9 | 0.9 | 0.8 | 0.8 | 0.8 | 0.8 | 0.8 | 0.7 | 0.8 | 0.8 | 0.8 | 0.7 | 0.6 | 0.6 | 0.6 | 0.6 |
| Total | 11.0 | 11.1 | 11.4 | 12.1 | 12.5 | 13.1 | 13.7 | 14.1 | 14.3 | 14.2 | 13.3 | 13.5 | 13.4 | 13.4 | 13.2 | 12.2 | 11.0 | 11.6 | 11.7 | 11.5 | 10.5 | 10.8 | 10.7 | 11.2 | 11.0 | 11.0 | 10.8 | 10.1 | 9.5 | 10.2 | 9.9 |

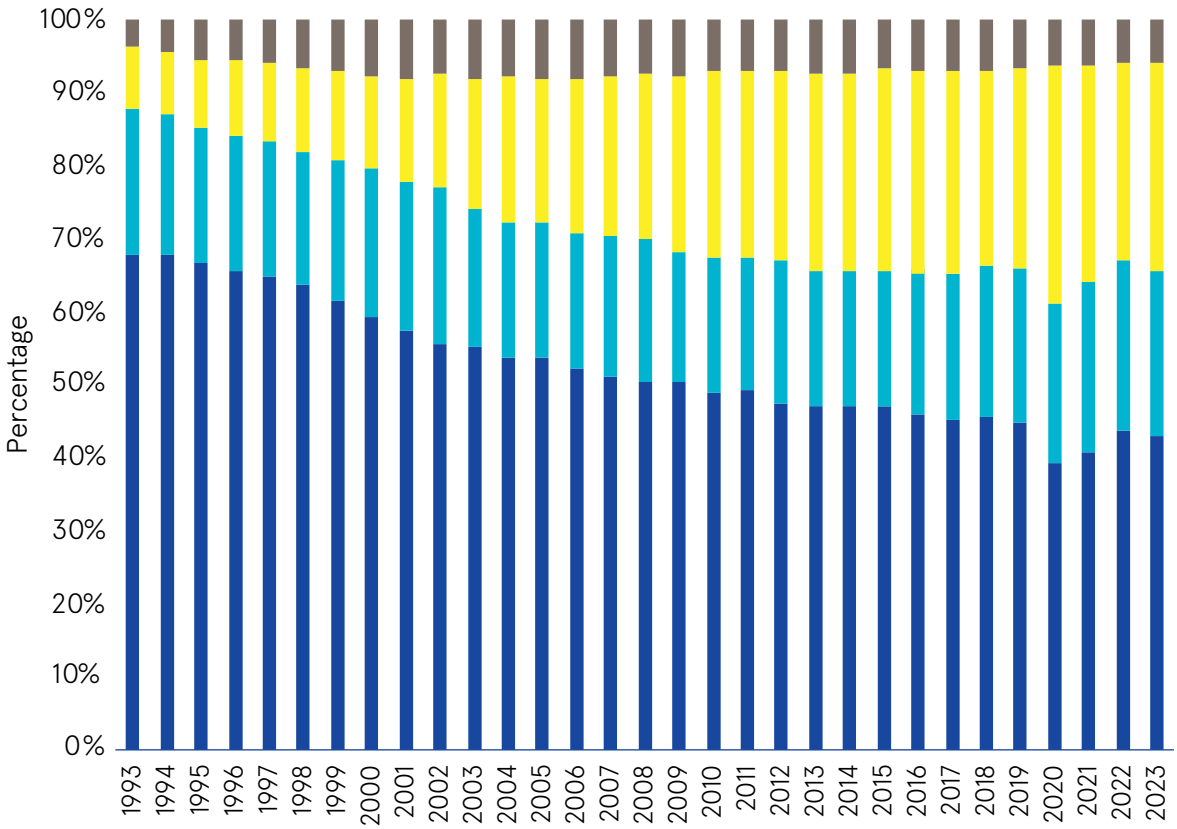
Source: Revenue, Irish Tax and Customs, 2024 [16]

### 3.1.2.1 Market share of alcohol products

Figure 4 illustrates the market share of each alcohol product type and how it has changed since 1993. In 2023, beer was the most commonly purchased alcohol type, representing 43.1% of the market share. Beer sales decreased during the COVID-19 pandemic but have increased post-pandemic. According to 2022 industry figures, of beer sales, lager was the most common (58.8% of beer sales), followed by stout (34.7%) and ale (4.8%).

Revenue sales figures indicate that 2023, wine made up 28.5% of the market share of alcohol. Wine sales during the peak of the pandemic (2020) were the highest ever seen, and although sales have decreased, they remain high. The market share of spirits in 2023 was 22.8%. Whiskey (31%), vodka (30%), and gin (13%) represented the largest share of spirits sales. The market share of cider was 6.0% in 2023.

Figure 4 Trends in the market share of each alcohol product type, 1993–2023



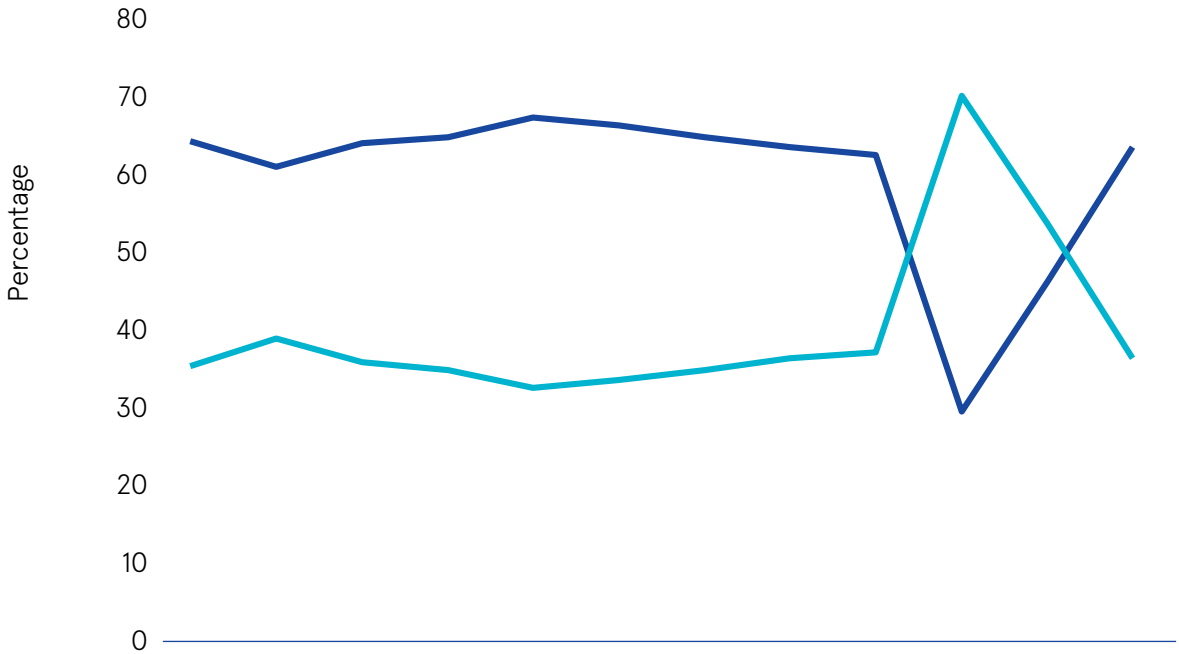

| | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cider | 3.8 | 4.3 | 5.5 | 5.7 | 6.2 | 6.6 | 7.3 | 8.0 | 8.6 | 7.5 | 8.0 | 7.9 | 8.1 | 8.2 | 7.9 | 7.5 | 7.7 | 7.1 | 7.1 | 6.9 | 7.1 | 7.1 | 6.6 | 6.8 | 6.9 | 6.8 | 6.7 | 6.3 | 6.3 | 6.0 | 6.0 |
| Wine | 8.6 | 8.8 | 9.3 | 10.4 | 10.7 | 11.7 | 12.6 | 13.3 | 14.4 | 16.0 | 18.1 | 20.1 | 20.6 | 21.5 | 22.4 | 23.0 | 23.5 | 26.1 | 26.6 | 26.3 | 27.0 | 27.0 | 27.7 | 27.8 | 27.9 | 26.9 | 27.4 | 32.4 | 29.5 | 26.9 | 28.5 |
| Spirits | 20.2 | 19.8 | 18.6 | 18.9 | 18.9 | 18.7 | 20.0 | 21.6 | 21.6 | 22.2 | 18.6 | 18.7 | 18.8 | 19.2 | 20.1 | 19.7 | 17.6 | 18.7 | 19.2 | 19.8 | 18.3 | 18.3 | 18.7 | 19.2 | 19.9 | 20.7 | 20.9 | 22.2 | 23.6 | 23.4 | 22.8 |
| Beer | 68.7 | 69.6 | 67.4 | 67.2 | 66.6 | 65.0 | 64.2 | 63.0 | 60.2 | 57.1 | 55.4 | 54.3 | 55.3 | 53.4 | 52.6 | 51.1 | 49.6 | 49.8 | 51.1 | 48.1 | 46.9 | 46.9 | 47.0 | 46.1 | 45.2 | 45.6 | 44.9 | 39.1 | 40.6 | 43.7 | 43.1 |

Source: Revenue, Irish Tax and Customs, 2024 [16]

### 3.1.2.2 Alcohol sales: On-trade versus off-trade

In 2022, the majority of beer (63.5%) was sold in the on-trade (i.e. pubs and bars), compared with 36.5% in the off-trade, returning to pre-pandemic patterns [16]. Figure 5 shows how beer reversed between on-trade and off-trade during the COVID-19 period.

Figure 5 Trends in percentage of on-trade versus off trade beer sales, 2011 - 2022




| | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| On-trade | 64.5 | 61.0 | 64.0 | 65.0 | 67.3 | 66.3 | 65.0 | 63.5 | 62.7 | 29.7 | 46.4 | 63.5 |
| Off-trade | 35.5 | 39.0 | 36.0 | 35.0 | 32.7 | 33.7 | 35.0 | 36.5 | 37.3 | 70.3 | 53.6 | 36.5 |

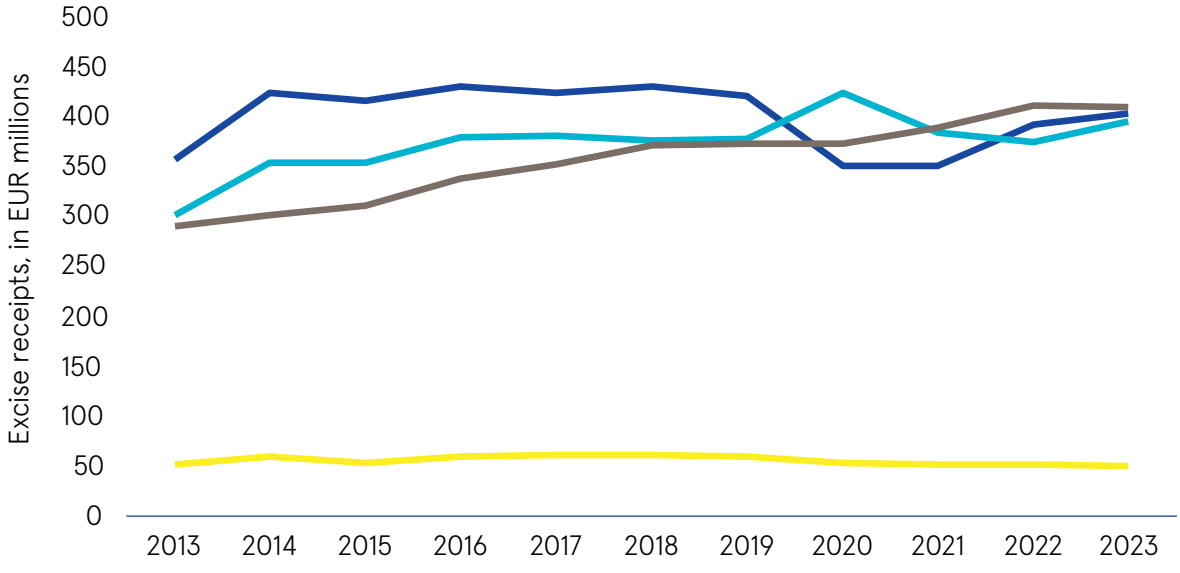
Source: Revenue, Irish Tax and Customs, 2022 [16]

In 2022, stout was more commonly sold in the on-trade (65.7%) compared with the off-trade (34.2%), whereas lager was more commonly sold in the off-trade (59.9%) compared with the on-trade (40.1%) [17]. Spirits were also more commonly sold in the off-trade (77.5%) compared with the on-trade (22.5%) [17].

## 3.1.3 Excise receipts for alcohol

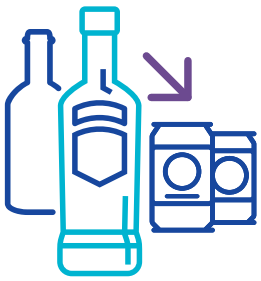
Excise tax is a legislated tax on alcohol at the point of purchase by the wholesaler. Figure 6 indicates that in 2023, spirits generated the most excise receipts (410 million euro (EUR) or 33.4% of the total excise receipts for alcohol), followed by beer (EUR 392 million or 31.9%) and wine (EUR 375 million or 32.5%). In 2023, alcohol generated EUR 1.26 billion in excise receipts.

Figure 6 Trends in net excise receipts from alcohol sales, 2013–2023



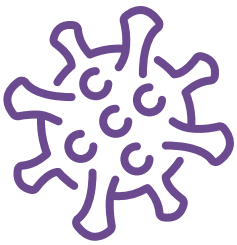

| | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Beer | 358 | 425 | 417 | 430 | 424 | 430 | 421 | 351 | 351 | 392 | 404 |
| Wine | 302 | 355 | 355 | 380 | 382 | 376 | 378 | 425 | 385 | 375 | 396 |
| Spirits | 290 | 302 | 311 | 338 | 353 | 372 | 373 | 374 | 389 | 411 | 410 |
| Cider | 52 | 59 | 54 | 59 | 61 | 61 | 60 | 53 | 51 | 52 | 50 |

Source: Revenue, Irish Tax and Customs, 2024 [16]



## Alcohol use declined during COVID

and although has increased, not to the same level as before the pandemic.



Beer sales fell during the pandemic but have almost returned to pre-COVID levels

## Wine sales during the pandemic were the highest ever seen

but have returned to pre-COVID levels

## 3.2 Low-risk alcohol guidelines and standard drink sizes

The World Health Organization (WHO) advises that any level of alcohol use is harmful to health. Alcohol is the leading risk factor for global disease burden and causes substantial health loss according to a study that used the GBD study to examine the relationship between alcohol use and health [18,19]. Given the global impact of alcohol-related harms to health, and given that young people are particularly vulnerable to such harm, the evidence in the literature suggests that low-risk alcohol guidelines should be tailored by age as well as by sex [20].

There remains no international agreement about what a standard drink is or what constitutes low-risk alcohol use [21]. The WHO recommend that there is no safe limit established for alcohol consumption at any stage of pregnancy [22]. Ireland uses 'standard drinks' representing drinks containing 10 grams of pure alcohol, this is the measurement also used by the WHO in international studies. Evidence indicates that drinkers in Ireland underestimate the quantity of alcohol when identifying and pouring a standard drink [23]. A forthcoming commencement of legislation as part of the Public Health (Alcohol) Act 2018 (Section 12) will require the labels on alcohol products to specify the number of standard drinks in a container [24]. With precise labelling, drinkers can more easily monitor their alcohol intake, which may prove beneficial when capturing alcohol use in prevalence surveys, as intake is commonly vastly underestimated when compared with alcohol sales data [12,25].

Guidelines for low-risk drinking vary internationally, and Table 1 provides examples of low-risk alcohol guidelines and, where available, the number of grams (g) per standard drink in each country. A standard drink can vary from 8 g (e.g. in the United Kingdom (UK)) to 20 g (e.g. in Austria). Some countries provide different guidelines depending on sex, and the daily or weekly guidelines differ from country to country, with little scientific evidence to support these variations. Following a 2-year scientific process, guidelines published by the Canadian Government in 2023 recommended that two standard drinks per week represents a low-risk amount and that each additional standard drink increases the risk of harm to self and others [26]. Based on the Canadian revision of the low-risk guidelines, a 2023 study recommended that low-risk alcohol use guidelines should not be age- or cause-specific; rather, they should be based on years of life lost, and drinkers should be guided by 'risk zones', enabling drinkers to assess their own risk while also encouraging healthier behaviours [27].

In Ireland, a standard drink is defined as a drink containing 10 g of pure alcohol, and the weekly low-risk alcohol guidelines are fewer than 11 standard drinks (110 g of pure alcohol) for females and fewer than 17 standard drinks (170 g of pure alcohol) for males spread out over the course of the week, with at least 2 or 3 alcohol-free days as recommended by the Health Service Executive (HSE) [28]. Establishing the number of standard drinks in a beverage requires knowing both the volume of alcohol in the container and its ABV concentration. To calculate the grams of pure alcohol in an alcoholic beverage, the serving size of the drink (in millilitres) is multiplied by the percentage ABV of the drink and divided by 1.25 (1.00 mL = 1.25 g) in order to establish the grams of pure alcohol in that specific drink [29].

Examples of one standard drink in Ireland include:

- Approximately half a pint of beer (meaning that one pint is equal to two standard drinks)
- One pub measure (35 mL) of spirits (meaning that a typical 700 mL/37.5% ABV bottle of spirits is equal to 21 standard drinks), and
- One small (100 mL) glass of wine (meaning that a typical 750 mL/12.5% ABV bottle of wine contains 7.5 standard drinks).

Table 1 Examples of national low-risk drinking recommendations/guidelines and definitions of standard drinks/units

| Country | Low-risk alcohol consumption guidelines | | Alcohol content standard drink (g)* | Weekly grams of alcohol (max) | | Other information/ advice |
|---|---|---|---|---|---|---|
| | Males | Females | | Males | Females | |
| Australia | Up to 100 g per week; up to 40 g on any one day | Up to 100 g per week; up to 40 g on any one day | 10 | 100 | 100 | |
| Austria | Up to 24 g per day | Up to 16 g per day | 20 | 120 | 80 | Have 2 alcohol-free days per week |
| Canada | Up to 1–2 standard drinks per week | Up to 1–2 standard drinks per week | 13.45 | 27 | 27 | Each additional standard drink radically increases the risk of alcohol-related consequences |
| France | Not more than 10 standard drinks per week, and never more than 2 standard drinks per day | Not more than 10 standard drinks per week, and never more than 2 standard drinks per day | 10 | 100 | 100 | At least 1 alcohol-free day per week |
| Germany | Up to 24 g of alcohol per day | Up to 12 g of alcohol per day | 10–12 | 168 | 84 | |

| Country | Low-risk alcohol consumption guidelines | | Alcohol content standard drink (g)* | Weekly grams of alcohol (max) | | Other information/ advice |
|---|---|---|---|---|---|---|
| | Males | Females | | Males | Females | |
| Ireland | Fewer than 17 standard drinks per week | Fewer than 11 standard drinks per week | 10 | 170 | 110 | At least 2 alcohol-free days per week, and drinks should be spread out over the week |
| Italy | Up to 2 units per day | Up to 1 unit per day | 12 | 168 | 84 | |
| New Zealand | Up to 30 g per day or 150 g per week, or 50 g on one occasion | Up to 20 g per day or 100 g per week, or 40 g on one occasion | 10 | 150 | 100 | |
| Norway | Up to 20 g per day | Up to 10 g per day | 12–15 | 140 | 70 | Should not exceed 5% of total energy intake |
| Poland | Up to 40 g of alcohol per day | Up to 20 g of alcohol per day | 10 | 280 | 140 | Consume alcohol on a maximum of 5 days per week |
| UK | Up to 14 units per week (or 112 g per week) | Up to 14 units per week (or 112 g per week) | 8 | 112 | 112 | Spread over 3 or more days, and have some alcohol-free days |
| United States of America (USA) | Up to 28 g per day (avoid exceeding 70 g within 2 hours) | Up to 14 g per day (avoid exceeding 56 g within 2 hours) | 14 | 196 | 98 | |

Source: European Commission, 2023 [30]; Mongan and Long, 2015 [24]

*Note that not all countries measure alcohol use by grams or standard drinks and have been converted to grams in this table for the purpose of comparisons.

## 3.3 Summary: Alcohol use in Ireland

At 9.9 litres of pure alcohol for every person aged 15 years and over in 2023, alcohol use remains high in Ireland, and is substantially higher than the Irish Government's target of 9.1 litres per capita. As this figure includes non-drinkers and does not include unrecorded alcohol use, the true amount of alcohol use per drinker is even higher. However, it has decreased from pre-pandemic levels, and alcohol use here compared with other OECD countries ranks Ireland 16th out of 38 member countries, an improvement from the previous HRB alcohol overview published in 2021, when Ireland ranked 9th highest for per capita alcohol consumption among OECD member countries.

As well as a move towards drinking at home rather than in licenced premises, other changes noted are that the most consumed type of alcoholic drink has changed, with wine and spirits sales increasing especially during the pandemic. Overall, alcohol sales in Ireland generated EUR 1.26 billion in excise receipts in 2023.

However, despite the commercial value of alcohol sales for the country, alcohol is a product that is extremely financially costly to our healthcare and justice systems and causes much harm to our society, and the WHO states that there is no safe level of alcohol use. The HSE provides low-risk alcohol consumption guidelines, but these are now dated considering the WHO's advice and renewed evidence highlighting the risks associated with the consumption of even small quantities of alcohol. A revision of the low-risk guidelines is warranted, and the introduction of mandatory health warning labels in 2026 will go a long way in informing drinkers of the alcohol content of their drinks and of the risks involved.

# 04

# Patterns of alcohol use in Ireland

Patterns of alcohol use are an important indicator for estimating the extent of alcohol-related harm and identifying groups of people who may be at higher risk. Drinking patterns are often measured by the prevalence of monthly heavy episodic drinking (HED) or 'binge drinking' (six standard drinks or more on one occasion), or using the Alcohol Use Disorders Identification Test (AUDIT) screening tool (developed by the WHO), which is used to identify persons with hazardous and harmful drinking patterns [19,31,32]. The National Drug and Alcohol Survey (NDAS) and the Healthy Ireland surveys are important sources of information with which to determine current alcohol use, and trends in alcohol use, among the general population [3,33,34]. This chapter uses data from both of these surveys in order to examine patterns of alcohol use.

## 4.1 Non-drinkers

Non-drinkers (defined as those who had not consumed alcohol in the 12 months prior to their interview) represented 30% of respondents in Wave 9 of the Healthy Ireland Survey [35]. Those most likely to be non-drinkers were women aged 75 years and over (49%) in contrast to 41% of men in the same age group. With the exception of older women, there were few overall sex differences in non-drinkers. The number of non-drinkers increased from 25% in 2018 to 30% in 2023 and appears to be driven across both sexes and all age groups with the exception of those aged 15–24 years [35,35].

## 4.2 Frequency of drinking

More than one-third (38%) of the population as estimated in the 2023 Healthy Ireland Survey reported drinking alcohol at least once per week; 43% of men and 34% of women reported drinking alcohol at least once per week and 21% of the population (or 32% of drinkers) indicated that they drink multiple times a week [35].

## 4.3 Company and location of alcohol use

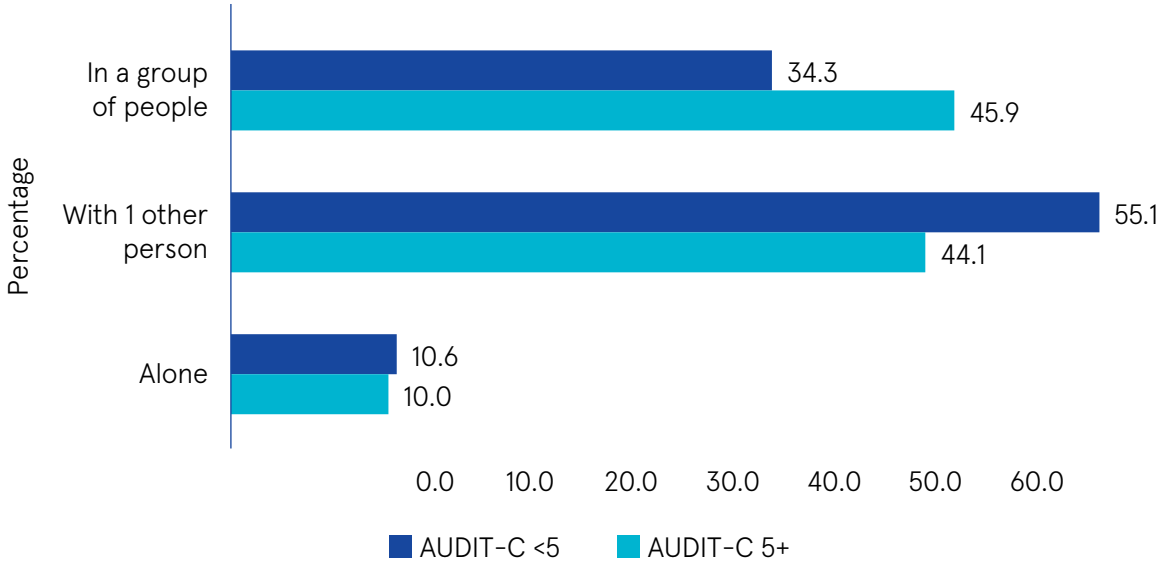
Those who said they drank alcohol in the last 6 months in the 2022 Healthy Ireland Survey were asked who they were in the company of the last time they drank [3]. Drinking in groups was more commonly reported among younger age groups (Table 2). Those more likely to drink alone on the last occasion they drank included unemployed drinkers (21%), older drinkers (aged 65 years and over) (19%), retired drinkers (17%), and male drinkers (16%). It is important to note that less frequent drinkers are typically more likely to drink in social settings and less likely to drink at home and all drinkers are combined in this analysis.

Table 2 Drinking company (on the last occasion alcohol consumed), by age group and sex, 2022

| | Males | | | | | | Females | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 15–24 years | 25–34 years | 35–44 years | 45–54 years | 55–64 years | ≥65 years | 15–24 years | 25–34 years | 35–44 years | 45–54 years | 55–64 years | ≥65 years |
| Alone | 15% | 17% | 12% | 13% | 14% | 23% | 2% | 3% | 5% | 10% | 10% | 12% |
| With 1 other person | 14% | 31% | 51% | 52% | 54% | 51% | 16% | 40% | 61% | 59% | 55% | 58% |
| In a group | 71% | 52% | 37% | 35% | 32% | 26% | 81% | 57% | 34% | 30% | 34% | 30% |

Source: IPSOS MRBI, 2022 [3]

Figure 6a Drinking company (on the last occasion alcohol consumed), by AUDIT-C score, 2022

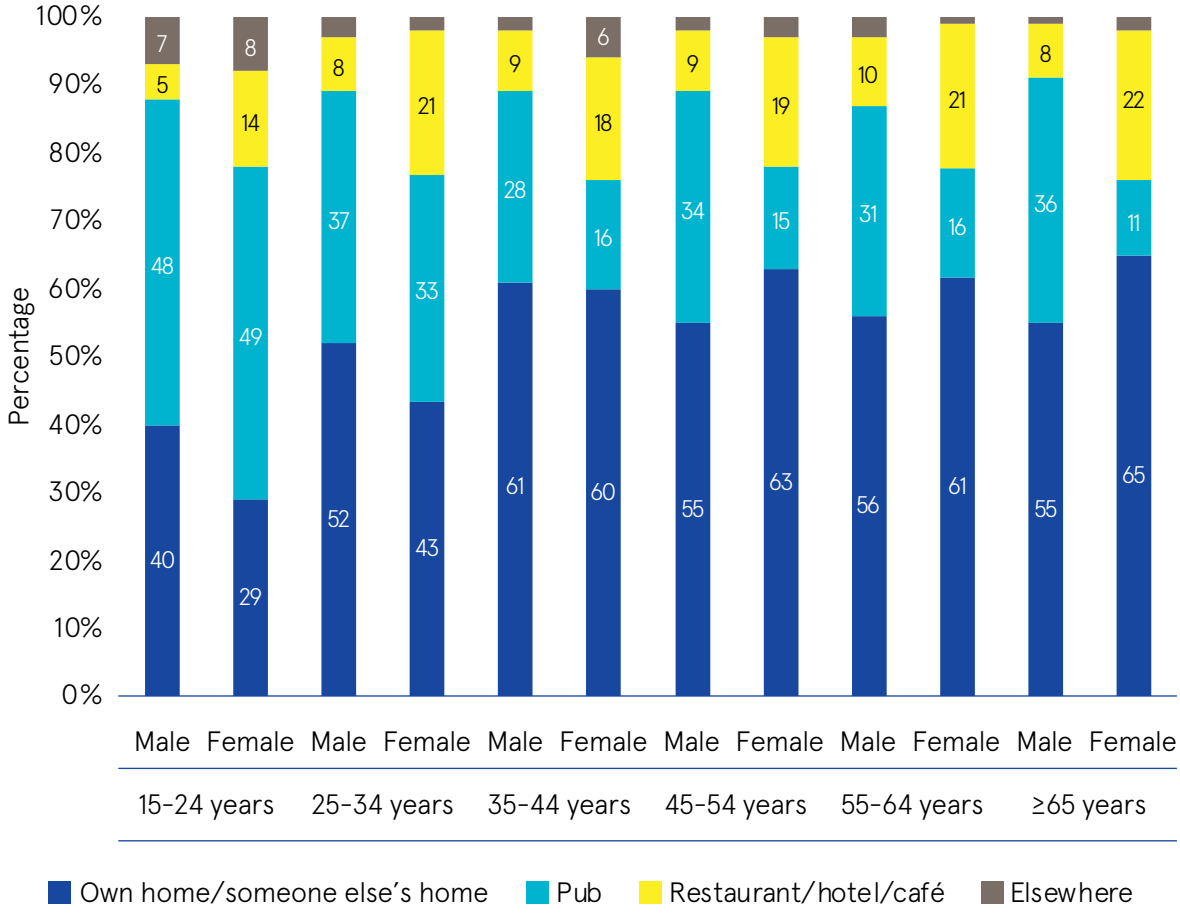



Source: IPSOS MRBI, 2022 [3]

Those with an AUDIT-C score of 5 or greater (indicating hazardous drinking), were more likely to drink with a group of people (on the last drinking occasion) (45.9%) compared to those with an AUDIT-C score of less than 5 (34.3%) (Figure 6a).

Those who said they drank alcohol in the last 6 months in the 2022 Healthy Ireland Survey were also asked where they drank the last time they consumed alcohol. The most frequently reported location for alcohol use the last time they drank was in their own home (44%), followed by drinking in a pub (30%); a restaurant, hotel, or café (13%); and drinking in someone else's home (10%) [3]. Younger drinkers (aged 15–24 years) reported drinking in pubs (42%) on the last occasion they drank alcohol, whereas those aged 35 years and over reported drinking at home (53%). Females were at least twice as likely as males in the same age group to report drinking in restaurants, hotels, or cafés (Figure 7).

Figure 7 Drinking location (on the last occasion alcohol consumed), by age group and sex, 2022




Source: IPSOS MRBI, 2022 [3]

Purchasing alcohol in a supermarket was the most common source of alcohol for those who reported drinking at home (68%), followed by convenience shops (13%) and standalone off-licences (11%); those aged 15–24 years were more likely to have purchased their alcohol in convenience shops (53%) than in supermarkets (19%) [3].

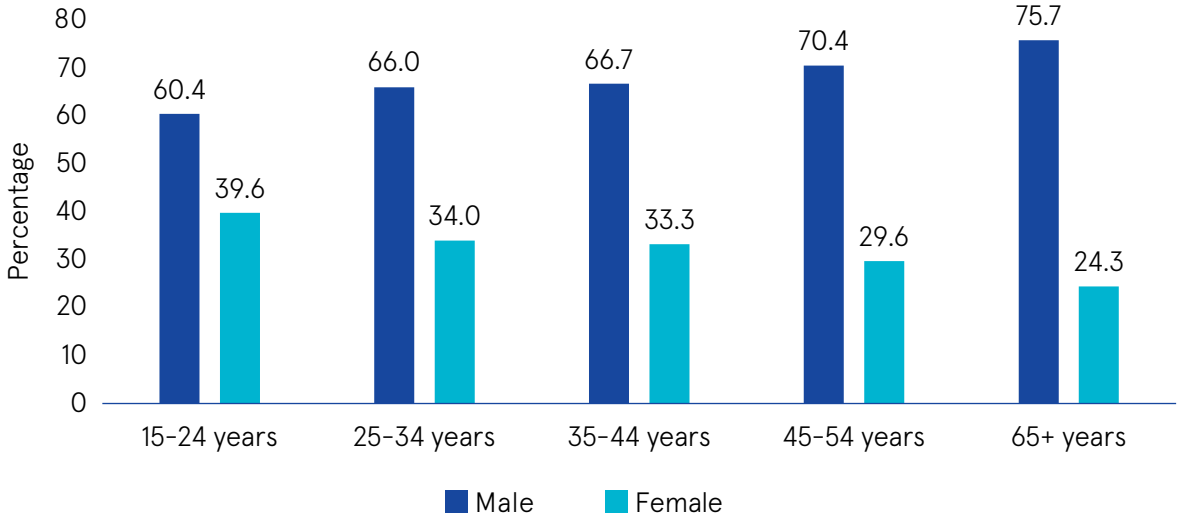
# 4.4 Hazardous patterns of drinking

Hazardous drinking can increase the risk of alcohol-related harms for the drinker – specifically the likelihood of poisoning, accidents, or falls – as well as alcohol-related conditions such as cancer and heart disease [19]. In order to measure hazardous drinking in the NDAS, the Alcohol Use Disorders Identification Test – Concise (AUDIT-C) screening tool was used, and alcohol use disorder (AUD) was measured using the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*. HED (drinking six or more standard drinks in one sitting) at least monthly may be considered a hazardous pattern of drinking [34].

## 4.4.1 The AUDIT-C screening tool

More than one-half (51.1%) of all drinkers in Ireland in the 2023 Healthy Ireland Survey were classified as hazardous drinkers using the WHO's AUDIT-C screening tool (represented by a score of 5 or higher); this was more common among males (65.7%) than females (34.2%), particularly younger males (Figure 8).

Figure 8 Proportion of drinkers who were classified as hazardous drinkers according to the AUDIT-C, by age and sex, 2023




Source: IPSOS MRBI, 2023 [35]

Deprivation level is based on the Irish Pobal HP deprivation index developed by Haase and Pratschke measuring the relative affluence or deprivation of a geographical area using data compiled from various censuses [36]. A score is given to the area based on a national average of 0 and ranging from –35 (being the most deprived) to +35 (being the least deprived). AUDIT-C scores of 5 or higher were similar across deprivation quintiles, although drinkers in the most deprived quintile were more likely to be classified as hazardous drinkers (58.5%) compared with drinkers in the most affluent quintile (50.0%).

Trends in the proportion of drinkers with a positive AUDIT-C score are available since the 2010–11 NDAS and indicate a decline from 57.6% of drinkers in 2010–11 to 53.5% in 2019–20. The greatest decline was noted in the 25–34 years age group, among whom the proportion of drinkers with a positive AUDIT-C score decreased by 8.9%, from 62.7% in 2010–11 to 57.1% in 2019–20. Drinkers aged 35–49 years showed a decrease of 8.5% in the proportion with a high AUDIT-C score, with the proportion decreasing from 55.1% to 50.4% in that period. Smaller decreases were noted among 15–24-year-olds and 50–64-year-olds (which showed a 2.9% decrease and a 1.2% decrease, respectively).

### 4.4.2 Heavy episodic drinking

The 2023 Healthy Ireland Survey indicated that almost one-quarter (24%) of the population engage in HED on a typical drinking occasion, lower than 2018 (27%) [35,36]. Among drinkers, males were more likely to engage in HED on a typical drinking occasion (37%) compared with females (12%), and this difference is reflected across all age groups (Table 3).

Table 3 Percentage of drinkers who engaged in HED on a typical drinking occasion, by sex and age group, 2023

| | Males (%) | Females (%) |
|---|---|---|
| **15–24 years** | 48 | 24 |
| **25–34 years** | 40 | 17 |
| **35–44 years** | 41 | 12 |
| **45–54 years** | 36 | 8 |
| **55–64 years** | 36 | 9 |
| **65–74 years** | 29 | 3 |
| **≥75 years** | 15 | 1 |
| **Total** | **37** | **12** |

Source: IPSOS MRBI, 2023 [35]

In the 2023 Healthy Ireland Survey, 24% of parents with children aged under 18 years reported HED on a typical drinking occasion; 39% of fathers and 11% of mothers [35].

### 4.4.3 Alcohol use disorder

Using the *DSM-5* criteria to measure AUD, one in every five drinkers (20.0%) were classified as having AUD in the 2019–20 NDAS; it was more common among male drinkers (24.8%) than female drinkers (15.1%), and was highest among those aged 15–24 years (37.5%) [34]. Young drinkers aged 15–24 years were more likely to be classified as having severe AUD (8.2%), 8.6% of females and 7.9% of males (Table 4). Drinkers aged 65 years and over were the least likely to have severe AUD (0.3%).

Table 4 Percentage of drinkers with AUD, by severity of AUD, sex, and age group, 2019–20

| | | AUD (all drinkers) | Mild AUD | Moderate AUD | Severe AUD |
|---|---|---|---|---|---|
| | | AUD (all drinkers) | Mild AUD | Moderate AUD | Severe AUD |
| 15–24 years | Male | 37.0% | 15.0% | 14.1% | 7.9% |
| | Female | 38.0% | 21.6% | 7.9% | 8.6% |
| 25–34 years | Male | 37.1% | 14.6% | 15.3% | 7.1% |
| | Female | 18.1% | 14.3% | 2.4% | 1.4% |
| 35–49 years | Male | 26.2% | 16.1% | 6.5% | 3.7% |
| | Female | 13.4% | 9.7% | 2.9% | 0.8% |
| 50–64 years | Male | 13.6% | 9.4% | 1.9% | 2.3% |
| | Female | 7.3% | 5.0% | 1.8% | 0.6% |
| ≥65 years | Male | 9.7% | 7.3% | 1.9% | 0.4% |
| | Female | 3.7% | 2.2% | 1.3% | 0.2% |
| | **Total** | **20.0** | **11.6%** | **5.4%** | **3.1%** |

Source: Mongan et al., 2021 [34]

## 4.5 The impact of the COVID-19 pandemic on alcohol use in Ireland

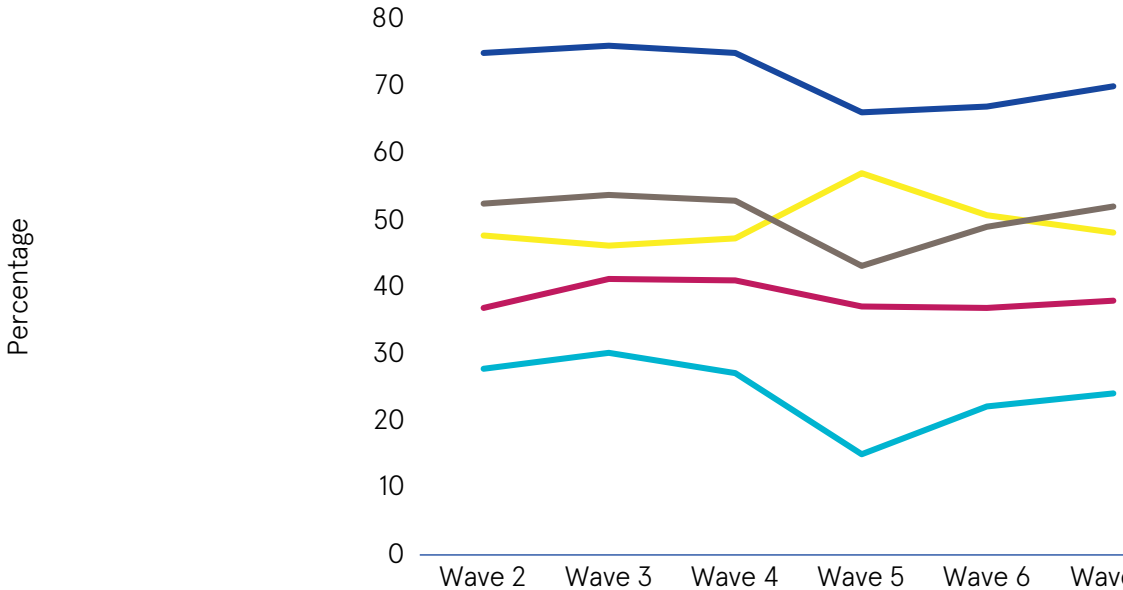
On 11 March 2020, COVID-19 was declared a global pandemic by the WHO, and Ireland subsequently entered a series of lockdowns restricting movement and resulting in the closure of non-essential shops, although off-licences remained open as they were classified as an essential business. A number of surveys were carried out during this period to examine the impact of the pandemic on alcohol use and on mental and physical health.

### 4.5.1 Changes in drinking patterns before, during, and after the COVID-19 pandemic

The COVID-19 pandemic and the associated lockdowns had an impact on people's livelihoods, health, and well-being, as well as significant mortality worldwide. The period of strict lockdowns resulted in isolation and uncertainty for many. In Ireland, people were ordered to stay at home, and all sporting and cultural events were cancelled and retail outlets and restaurants closed, along with schools and universities, and although more people reported decreasing their alcohol use since the onset of the pandemic, others took solace in alcohol [37,38].

Figure 9 illustrates changing alcohol use behaviours before, during and after the pandemic using the Healthy Ireland Surveys [3,35,36,39,40,41]. Alcohol use declined during the pandemic (Wave 7), so too did HED and hazardous drinking (AUDIT-C 5+), however wave 8 and wave 9 indicate a return to pre-pandemic drinking patterns. The Revenue sales data confirm this change in alcohol use behaviour during the pandemic, as a decline in alcohol sales was evident in 2020 and 2021 [16].

Figure 9 Alcohol use behaviours before, during and after the COVID-19 pandemic

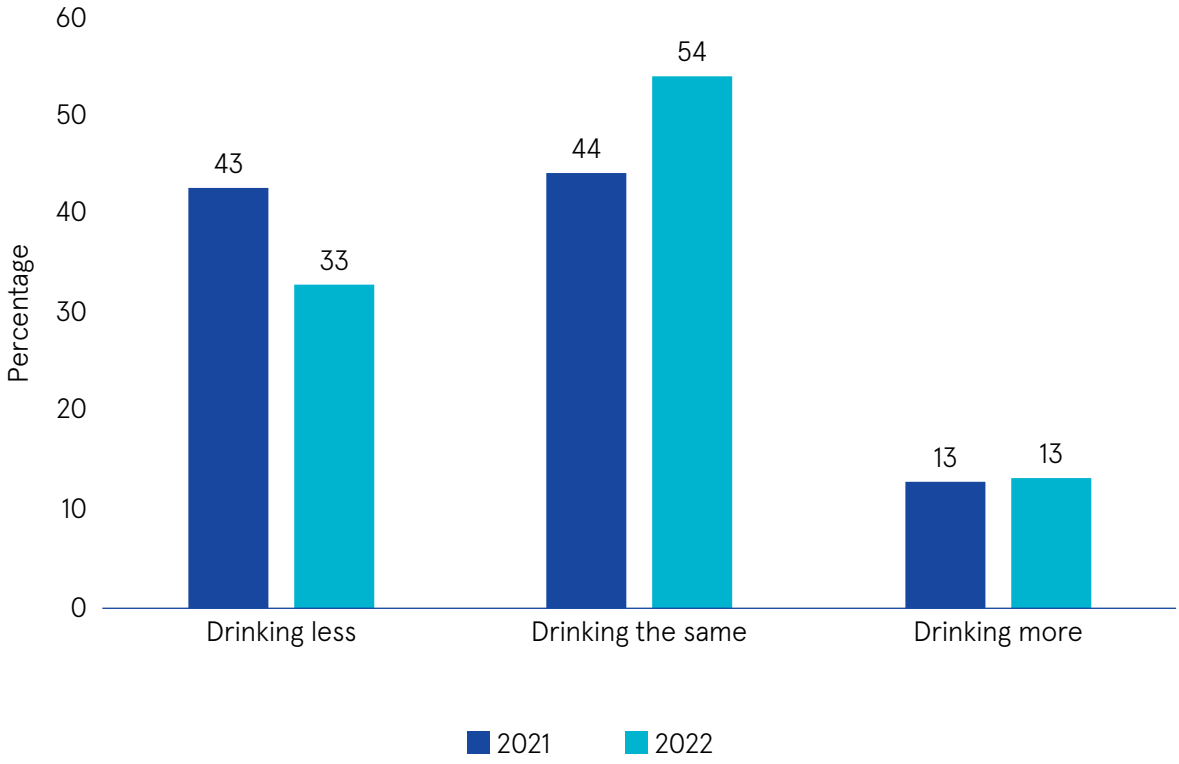



| | Wave 2 (2016) | Wave 3 (2017) | Wave 4 (2018) | Wave 5 (2021) | Wave 6 (2022) | Wave 7 (2023) |
|---|---|---|---|---|---|---|
| Alcohol use in last 6/12 months | 75 | 76 | 75 | 66 | 67 | 70 |
| Drink at least once per week | 37 | 41 | 41 | 37 | 37 | 38 |
| HED typical drinking occasion | 28 | 30 | 27 | 15 | 22 | 24 |
| AUDIT-C <5 | 48 | 46 | 47 | 57 | 51 | 48 |
| AUDIT-C 5+ | 52 | 54 | 53 | 43 | 49 | 52 |

Source: IPSOS MRBI, 2016 – 2023

Both the 2021 and 2022 Healthy Ireland surveys specifically asked respondents about their drinking behaviours since the beginning of the COVID-19 restrictions. In 2021, 43% of drinkers reported that they were drinking less, but this share decreased to 33% in 2022 (Figure 9). The percentage of drinkers who reported drinking more since the beginning of the COVID-19 restrictions remained unchanged at 13% in both surveys [3,42].

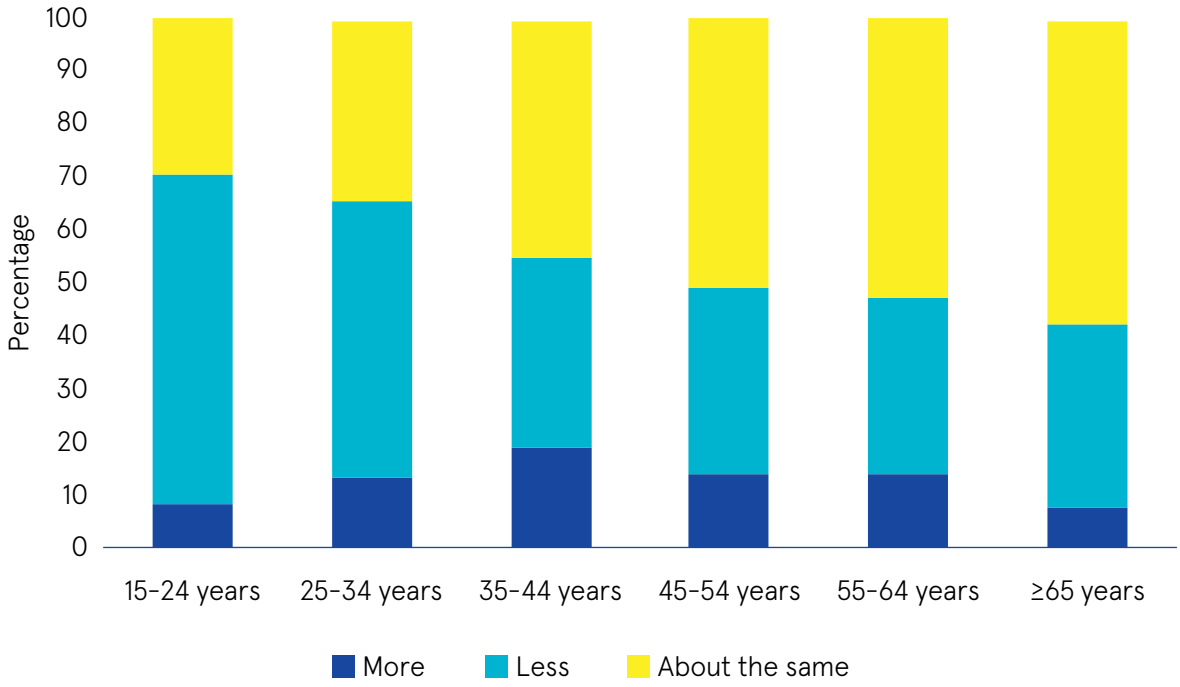
Figure 10 Percentage change in alcohol use since the beginning of COVID-19 restrictions, 2021 and 2022




Source: IPSOS MRBI, 2021 [43], IPSOS MRBI, 2022 [3]

In 2021, those aged 35–44 years were more likely to report increasing their alcohol use since the beginning of the pandemic (18.6%), while those aged 15–24 years (8.0%) and those aged 65 years and over (7.8%) were the least likely to report increased alcohol use (Figure 11) [43]. Younger people aged 15–24 years were more likely to have reduced their alcohol use since the beginning of the COVID-19 pandemic (62.3%), along with those aged 25–34 years (52.5%).

Figure 11 Percentage change in alcohol use since the beginning of COVID-19 restrictions, by age group, 2021



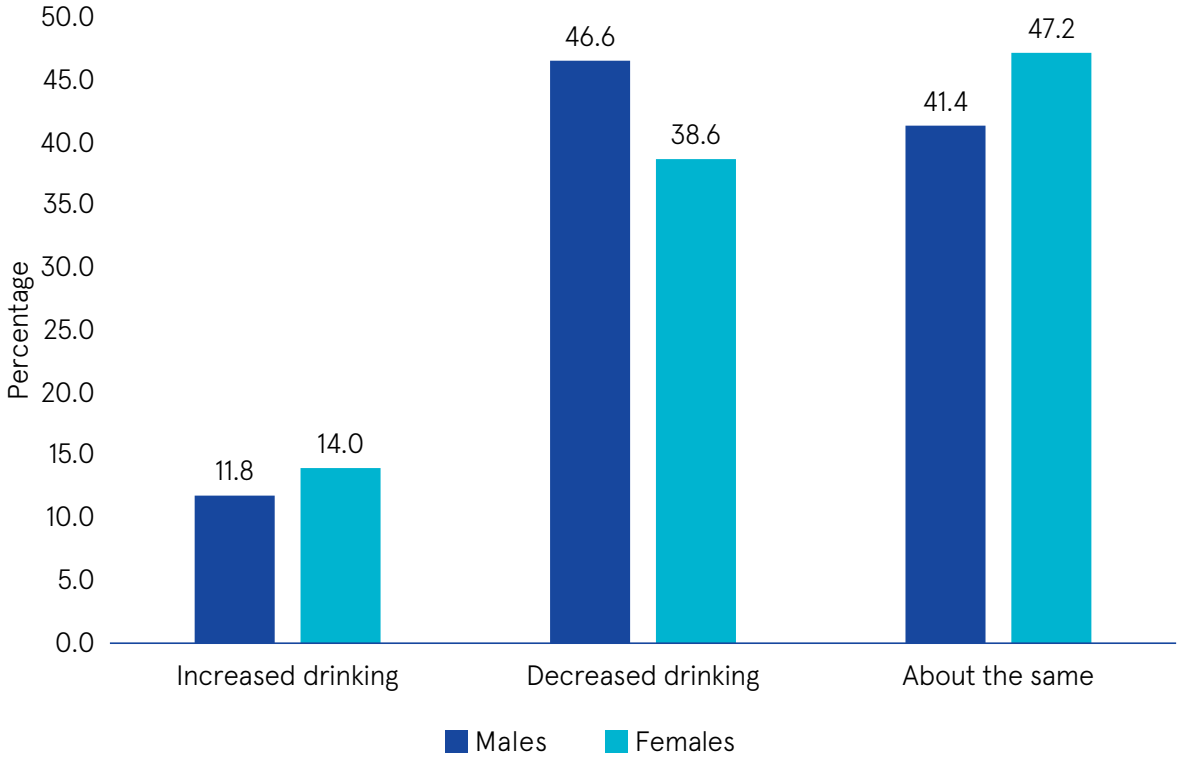

Source: IPSOS MRBI, 2021 [43]

Data from the Healthy Ireland Survey 2021 indicated that female respondents (14.0%) were more likely than male respondents (11.8%) to report increasing their alcohol use since the beginning of the COVID-19 pandemic (Figure 12). Males (46.6%) were more likely than females (38.6%) to have decreased their alcohol use since the beginning of the pandemic.

Findings from a survey that the Central Statistics Office (CSO) undertook early in the pandemic (April 2020) also found that females were more likely to report increasing their alcohol use compared with males (23.4% of females versus 20.9% of males). Females were less likely to have decreased their alcohol use as a result of the pandemic (8.6%) compared with males (26.0%) [39].

The 2021 Healthy Ireland Survey found that parents of children aged under 18 years were more likely to report increasing their alcohol use since the beginning of the pandemic (16.4%; 19.0% of females and 13.5% of males) compared with those without children aged under 18 years (11.5%) [43]. This finding is of concern, as evidence shows that children's exposure to parental alcohol use, even non-dependent alcohol use, can lead to children initiating alcohol use earlier than their peers who are not exposed to parental drinking, as well as to harmful drinking patterns in adolescence [43]. Children who witness their parents drinking, particularly if the parents' drinking is motivated by stress or other negative reasons, are more likely to experience negative outcomes such as receiving less attention from their parent(s), less time spent doing homework with their parent(s), or being put to bed earlier or later than usual [44].

Figure 12 Change in drinking behaviours since the beginning of the COVID-19 pandemic, by sex, 2021




Source: IPSOS MRBI, 2021 [43]

## 4.5.2 The mental health impact of the COVID-19 pandemic and alcohol use

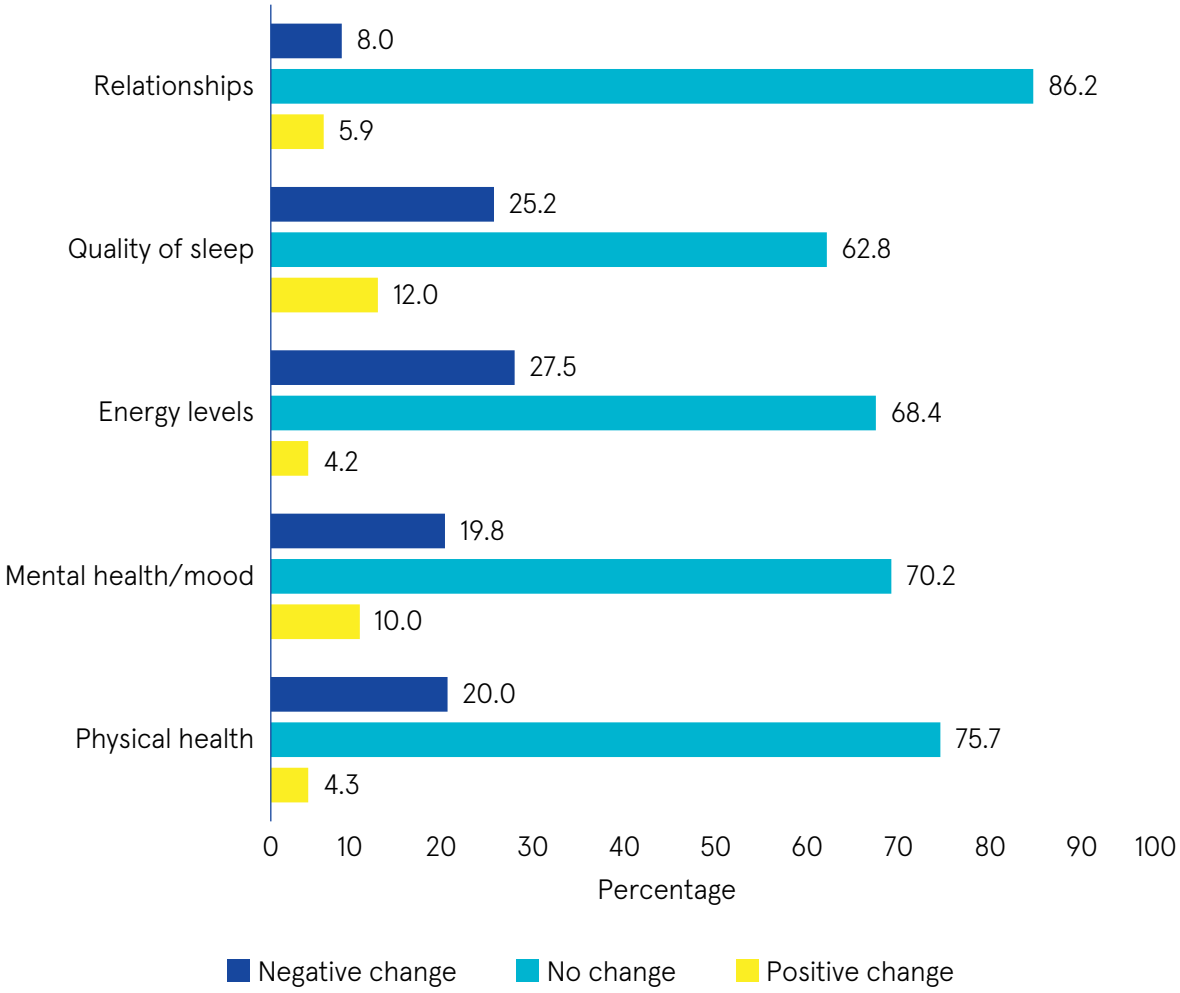
Alcohol is commonly used to cope with difficult situations, and a high percentage of respondents in the 2021 Healthy Ireland Survey reported that their mental health had deteriorated since the beginning of the COVID-19 pandemic; this was more commonly reported by females than males [43]. The mental health ill-effects of the COVID-19 pandemic and associated lockdowns and restrictions have been documented, with many experiencing anxiety and depression as a result [45]. Findings from the CSO survey on the social impact of COVID-19 found that women (37.6%) were more likely than men (23.0%) to report low overall life satisfaction when rating their financial situation, their personal relationships, and their overall life satisfaction since the beginning of restrictions related to the pandemic [39].

A further study using the CSO survey data on the social impact of COVID-19, which aimed to examine the factors associated with changes in alcohol use, found that the pandemic-related restrictions, working from home, and living in urban areas were associated with increased alcohol use [46].

Figure 12 and Figure 13 illustrate the reported changes in aspects of respondent's lives as a result of increasing alcohol use and of those who decreased alcohol use since the beginning of the pandemic as asked in the 2021 Healthy Ireland Survey. More respondents who had

increased their alcohol use since the beginning of the pandemic reported that their mental health and/or mood remained unchanged (70.2%); however, one in every five respondents who had increased their alcohol use (19.8%) reported that their mental health had worsened since the beginning of the pandemic, one-quarter (25.2%) found that their sleep was negatively affected, and 27.5% reported that their energy levels were negatively affected (Figure 12).

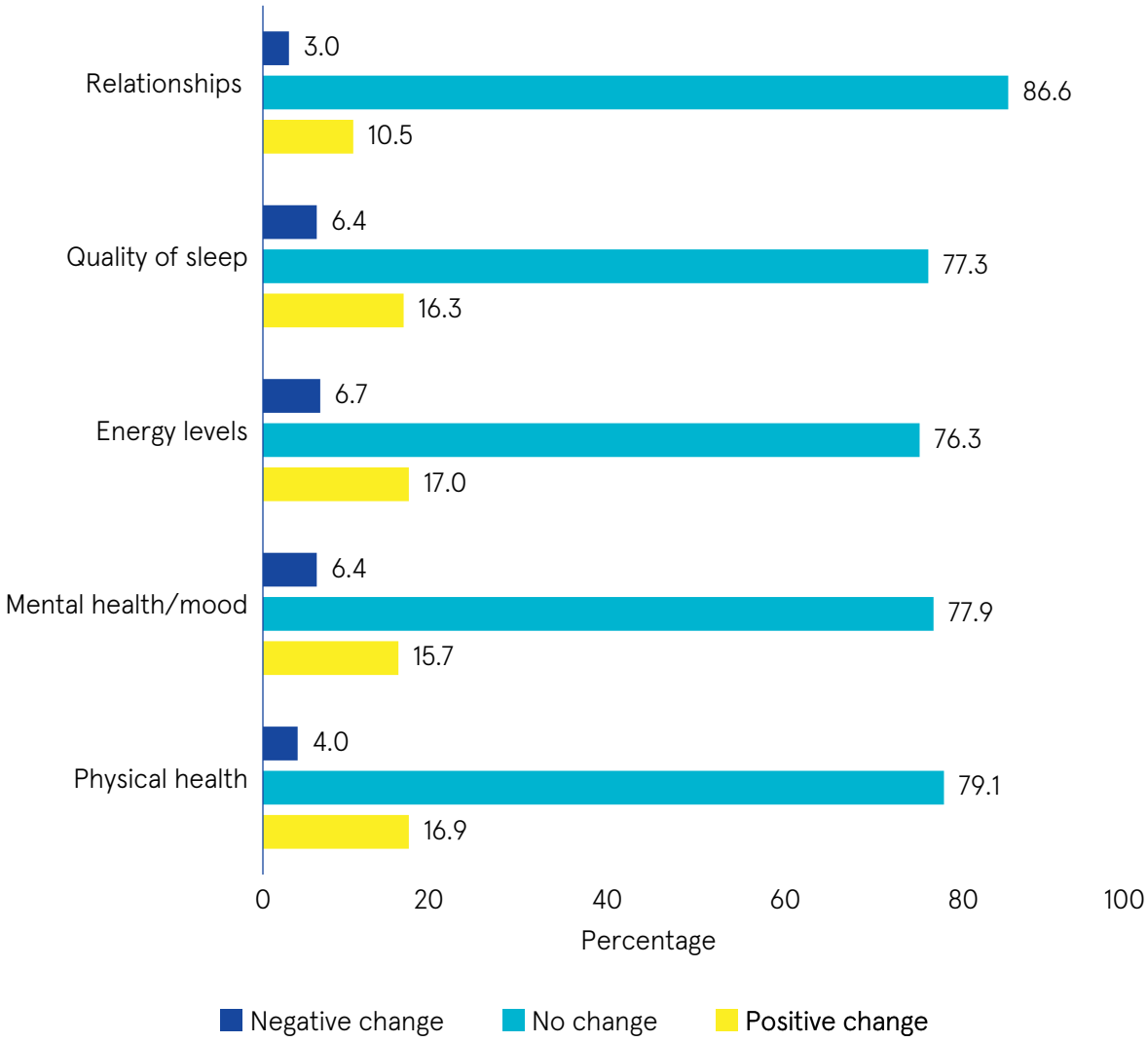
Figure 13 Changes in aspects of life among those whose alcohol use increased since the beginning of the COVID-19 pandemic, 2021




Source: IPSOS MRBI, 2021 [43]

Of those who reported decreasing their alcohol use since the beginning of the COVID-19 pandemic, the majority reported no change to their life; however, positive changes were more likely to be noted compared with negative changes. For example, 17.0% reported that reducing alcohol use had a positive impact on their energy levels, 16.9% reported a positive impact on their physical health, and 15.7% found that their mental health/mood had improved (Figure 14).

Figure 14 Changes in aspects of life among those whose alcohol use decreased since the beginning of the COVID-19 pandemic, 2021




Source: IPSOS MRBI, 2021 [43]

The 2021 Healthy Ireland Survey also asked respondents if their mental health had improved, stayed the same, or worsened since the beginning of the COVID-19 restrictions, and 29.9% of respondents reported that their mental health had worsened. Of those whose mental health had worsened since the beginning of the pandemic, 20.6% reported that they had also increased their drinking. The use of alcohol when experiencing poor mental health can lead to an increased risk of developing alcohol dependence, and alcohol use worsens feelings of depression and anxiety.

A study involving 1,983 participants examined individuals' reported mental health as the restrictions associated with the pandemic eased [47]. More than one-quarter (27.7%) of participants reported depression and anxiety symptoms, and moderate to heavy drinkers were among the most at risk of experiencing depression and anxiety compared with non-drinkers or occasional drinkers.

A survey of 713 adults indicated that older age and drinking in order to cope with the impact of the pandemic to relieve negative mood were associated with increased alcohol use [38]. Those who were less likely to report social purposes for drinking prior to the pandemic were also more likely to consume alcohol during the pandemic, and depression and hostility (e.g. anger or frustration) were the strongest predictors of individuals drinking as a coping mechanism. The study highlighted older people's vulnerability to the vicious cycle of drinking to reduce anxiety and then experiencing the depressogenic effects of alcohol as a result, thus worsening anxiety symptoms.

## 4.6 Alcohol use and drinking patterns among children and young people

In acknowledgement of the harmful impact that alcohol can have on children and young people, preventing or delaying alcohol use is central to the Public Health (Alcohol) Act 2018 in Ireland [25]. Many of the Act's components specifically target young people's alcohol use, as well as aiming to prevent and reduce alcohol-related harms. Alcohol is widely recognised as particularly harmful to young people, not only because of the higher levels of harmful drinking (including HED) among young people, but also because they are developing both biologically and psychosocially and are thus especially vulnerable to the neurotoxic effects of alcohol [48]. The WHO has identified addressing alcohol use among young people as a health priority [49]. The 2022 HRB overview, *Alcohol and other drug use among children and young people in Ireland: prevalence, risk and protective factors, consequences, responses, and policies*, provides extensive information on patterns and trends in alcohol use among children and young people, as well as the consequences of alcohol use among this cohort [4]. Additional literature that has been made available since the publication of that report is examined here, including the 2022 and 2023 Healthy Ireland Surveys, the Planet Youth survey carried out in the North Dublin area in 2021, and the Planet Youth survey carried out in the west of Ireland in 2022, and this is supplemented with data from the NDAS [3,5,34].

### 4.6.1 Risk and protective factors associated with alcohol use among children and young people

The risk and protective factors that influence alcohol use are also detailed in the 2022 HRB overview *Alcohol and other drug use among children and young people in Ireland* and are summarised in Table 5 [4].

Table 5 Summary of risk and protective factors associated with alcohol use among children and young people

| Risk/protective factors | Summary of findings |
|---|---|
| **Personal factors** | |
| Age of initiation | Early alcohol initiation increases the likelihood of risky drinking and alcohol-related harms. |
| Sex | Hazardous drinking patterns are more common among young males. |
| Ethnicity | Young Irish people are more likely to report alcohol use and HED compared with non-white ethnic minorities. |
| Sexual orientation | Young people who are concerned about their sexual orientation are more likely to drink alcohol regularly compared with peers without such concerns. |
| **Personality characteristics** | |
| Participation in sport or physical activity | Young people participating in sport are more likely to report alcohol use and hazardous drinking patterns compared with those not participating in sport or physical activity. |
| Participation in music, art, drama, or dance | Young people participating in music, art, drama, or dance are less likely to report hazardous drinking patterns compared with those not participating in such activities. |
| Availability of, and access to, alcohol and drugs | Young people reported that accessing alcohol is relatively easy, and such ease of access increases the risk of drinking and of drinking hazardously. |
| Exposure to alcohol marketing | Multiple studies included in the 2022 HRB overview of young people's substance use *Alcohol and other drug use among children and young people in Ireland* outline the extent of alcohol marketing that children are regularly exposed to. Such exposure has been shown to increase the likelihood of binge drinking. |
| **Family factors** | |
| Socioeconomic status | Young people from higher-income families were more likely to drink and to drink hazardously. |
| Family support/parental relationships | The evidence indicates that the degree of warmth parents convey to their children influences alcohol use; those who report that it is easy to receive support from their parents are less likely to report hazardous drinking patterns. |

| Risk/protective factors | Summary of findings |
|---|---|
| Parental monitoring | Adolescents who report that their parents monitor their whereabouts and know their friends are less likely to report alcohol use. |
| Parental substance use | Witnessing parental alcohol use is associated with early alcohol use initiation. |
| Family composition | Having separated or divorced parents or a deceased parent has been shown to be predictive of alcohol use. |
| Parental conflict and violence in the home | High levels of family conflict increases the risk of alcohol use. |
| Parental attitudes to substance use | Liberal parental attitudes to alcohol use increase the risk of children reporting alcohol use and hazardous drinking. |
| Parental provision of alcohol | Parents providing children with alcohol, even small amounts, is linked to earlier alcohol initiation and hazardous drinking. |
| **Social factors** | |
| Peer substance use | Alcohol use is more likely when adolescents report that their peers drink. |
| School experiences (skipping school, grades, socioeconomic status of the school) | Having a negative experience in school is a risk factor for alcohol use. Those who report skipping school regularly, poor school grades, and negative relationships with teachers, as well as those in schools of lower socioeconomic status, are more likely to report alcohol use. |

Source: Doyle et al., 2022 [4]

## 4.6.2 Prevalence of alcohol use among young people

The NDAS results indicate that the age of alcohol initiation increased from a mean age of 15.6 years in 2002 to 16.6 years in 2019, and that there has been an increase in non-drinking young people [34]. The age group 15–24 years is widely used in international research to describe young people but given the evidence of increasingly low rates of alcohol use among those aged 15–17 years, it is important to consider that much of the non-drinking cohort may in fact refer to the younger adolescents of this age group [15].

In the most recent NDAS, more than one-quarter (28.2%) of those aged 15–24 years reported not consuming alcohol in the year prior to their interview for the 2019–20 NDAS compared with 17.7% of all 15–24-year-olds in the 2002–03 NDAS [34,50]. Not drinking was more common among 15–24-year-old females (29.6%) than males in the same age group (23.3%), and 1.8% classified themselves as ex-drinkers.

The prevalence of alcohol use among children and young people was reported as follows:

- In the 2022 Healthy Ireland Survey, 71% of 15–24-year-olds reported alcohol use in the 6 months prior to their interview (68% of males and 74% of females) [3]. In the 2023 Healthy Ireland Survey, 75% of 15–24-year-olds reported alcohol use in the previous 12 months; 76% of males and 74% of females [35].
- Among adolescents aged 14–16 years participating in the Planet Youth survey in North Dublin in 2021, 63% reported alcohol use in their lifetime, 29% indicated that they had consumed alcohol in the last month, and 35% indicated that they tried alcohol at the age of 13 years or under [5].
- Among 15–16-year-olds in the west of Ireland, lifetime use of alcohol ranged between 67.4% in Galway City and 77.8% in Roscommon [51].
- The Health Behaviour in School-aged Children (HBSC) study was carried out in 2022, and the results were not available at the time of publishing this report.

#### 4.6.2.1 Hazardous and harmful drinking among young people

Hazardous drinking was most common among 15–24-year-olds (64.2%), particularly males in this age group (70.4% compared with 57.3% of females). However, a decrease in hazardous drinking was noted since the 2010–11 NDAS (66.1%) [34,51].

##### *4.6.2.1.1 HED among young people*

In the 2022 Healthy Ireland Survey, 46% of those aged 15–24 years reported HED on a typical drinking occasion in the previous 6 months; HED was more frequently reported among males (67%) than females (26%) [3]. In the 2023 Healthy Ireland Survey, 36% of those aged 15–24 years reported HED on a typical drinking occasion in the previous 12 months; 48% of males and 24% of females [35].

One-quarter (25%) of adolescents aged 14–16 years participating in the North Dublin Planet Youth survey indicated HED in their lifetime [5].

##### *4.6.2.1.2 Reports of being drunk among adolescents*

In the Planet Youth survey among North Dublin adolescents aged 14–16 years, 29% reported that they had been drunk in their lifetime and 13% reported being drunk in the previous month [5]. In the 2022 Planet Youth survey in the west of Ireland, 38.0% of 15–16-year-olds in Galway City reported HED in their lifetime and 26.2% reported being drunk in the previous month [52].

##### *4.6.2.1.3 AUD among young people*

AUD, which the 2019–20 NDAS measured according to the *DSM-5* criteria, was found to be highest among respondents aged 15–24 years (37.5%); 38.0% of females and 37.0% of males and 8.6% of female drinkers were classified as having a severe AUD and 7.9% of males [34,52].

#### 4.6.2.2 Frequency of alcohol use and quantity consumed among young people

Almost one-half (47.4%) of young people aged 15–24 years participating in the 2019–20 NDAS reported drinking alcohol one to three times per week; this was 55.2% among males and 38.6% among females. More than one-third (35.0%) reported drinking alcohol one to three times per month; this was 43.8% among females and 27.1% among males [34].

The mean number of standard drinks consumed on a typical drinking occasion was 6.1; males consumed a mean of 7.0 standard drinks and females consumed a mean of 5.1 standard drinks, and 17.9% of respondents aged 15–24 years reported drinking a mean of 10.0 or more standard drinks on a typical drinking occasion. More than one-third (35.6%) of respondents reported drinking 10–19 standard drinks on a single occasion in the previous year, and 14.4% reported drinking 20 or more standard drinks on one occasion; this was more common among males (19.8%) than females (8.3%).

Among adolescents aged 14–16 years participating in the Planet Youth survey in North Dublin, 15% reported drinking alcohol one or two times in the previous month, while 12% reported drinking alcohol three times or more in the previous month.

#### 4.6.2.3 Location of alcohol use among young people

Adolescents aged 14–16 years in the North Dublin Planet Youth survey were most likely to report drinking alcohol outdoors (19%), followed by in someone else's home (18%), at a party or other organised event (18%), in their own home (13%), before a party or other organised event (13%), and 5% reported drinking in a pub [5].

#### 4.6.2.4 Sourcing alcohol by young people

Young drinkers aged 15–24 years in the 2022 Healthy Ireland Survey were more likely to report purchasing alcohol for drinking at home or in a public place in a convenience shop (53%), and 19% bought alcohol in a supermarket [3].

Adolescents aged 14–16 years participating in the North Dublin Planet Youth survey indicated that they sometimes or often get their alcohol from friends or schoolmates (13%). Adult provision of alcohol to adolescents was also frequently reported; 12% of respondents indicated that their parent(s) provided them with alcohol, 11% indicated that alcohol was provided by another adult, and 6% reported that a friend's parent provided alcohol to them [5].

# 4.7 Summary: Patterns of alcohol use in Ireland

How people drink is a valuable yardstick with which to measure the extent of alcohol-related harm within a population. For example, regular HED is associated with an increased risk of hazardous and harmful drinking which in turn can result in hospitalisations and criminal behaviour. More than one-half of drinkers in Ireland can be classified as hazardous drinkers, and this is more commonly reported among males than females, particularly younger males, although there has been a decline in this pattern of drinking since 2010.

Survey data indicate a growing minority choosing not to drink, particularly young people, but those who do drink do so regularly, with at least one-half drinking at least once per week. When asked about the last occasion they drank alcohol, young people reported drinking in groups, whereas unemployed and retired drinkers reported drinking alone.

The COVID-19 pandemic changed many people's drinking patterns, and although the majority reported no change to their alcohol use, 13% reported drinking more since the beginning of the pandemic. This is a concern given the duration of the pandemic and how difficult it can be to change alcohol use behaviours after such a prolonged length of time.

The mental health impact of the pandemic was also noted in a number of surveys, with mental health deterioration more frequently reported among women than men. Anxiety, depression and overall life dissatisfaction caused by the restrictions may have lead to some increasing their alcohol use, particularly for those living in urban areas and those working from home. Increased alcohol use was associated with a deterioration in mental health/mood for one in every five respondents of the Healthy Ireland Survey in 2021, whereas 15.7% of those who reduced their alcohol use reported improved mental health/mood. Only time will tell if the behaviour changes as a result of the COVID-19 pandemic will extend into the future, and the HRB alcohol overviews will continue to monitor the data available for evidence of this.

This chapter also examined alcohol use among children and young people, and although there has been a decline in the number of young people drinking and a delay in alcohol use initiation, HED is still commonplace among adolescents and young people.

# 05

# Alcohol availability in Ireland

How accessible or easy it is to obtain alcohol for an individual, a community, or the population as a whole is referred to as alcohol availability. Limiting alcohol availability is one of the WHO's 'best-buy' recommendations in order to reduce alcohol-related harm [53]. Current legislation in Ireland limits the availability of alcohol by restricting the number of outlets licenced to sell alcohol, limiting the hours of sale, setting a minimum purchase age, having minimum unit pricing, preventing sales to intoxicated people, and limiting drinking in public places. Proposed changes to the legislation in the form of the Sale of Alcohol Bill (2022) plan to increase the availability of alcohol [54].

## 5.1 Alcohol licensing

Data from Revenue indicated that 19,910 liquor licences were issued or renewed in Ireland during 2021. This figure includes situations where two or more licences may be issued for the same premises: for example, a publican licence may be issued along with a wine retailer on-licence where a pub serves food but also trades as a bar. Revenue issues various different licences in Ireland, which are summarised as follows:

- A publican licence allows the holder to sell alcohol for consumption both on and off its premises and includes ordinary pubs (7-day ordinary, 6-day, and 6-day with early closing licences), hotel bars, theatres, holiday camps, greyhound racetracks, horse racetracks, and railway refreshment rooms.
- An off-licence allows the sale of alcohol in small quantities in closed containers for consumption off the premises and can be held singly or in combination for wine, beer, spirits, cider, and/or sweets.[1]
- A wine retailers on-licence refers to establishments that only sell fine wine, sherry, and fermented liquor containing less than 23% alcohol by volume. This licence type is confined to houses, rooms, shops, or buildings kept open for public refreshment, resort and entertainment but not licenced for the sale of beer, cider, wine or spirits.
- A special restaurant licence refers to that required to sell all types of alcohol for consumption on the premises to persons who have ordered a meal (before, during, or within 30 minutes following the end of their meal). Such an establishment may not have a bar on the premises, and other non-alcoholic beverages must be available, including drinking water. The licence holder must take payment for the alcohol at the same time as payment for the meal.
- A wholesale dealer's licence allows the sale of alcohol in bulk quantities.
- A manufacturer's licence allows the manufacturing of liquor and the wholesale of the manufactured liquor from the manufacturing premises (e.g. brewers, distillers, cider manufacturers, rectifiers or compounders, and sweet makers).

[1] 'Sweets' refers to mead, an alcoholic beverage made by fermenting honey mixed with water.

- Other licences include those for passenger aircrafts, passenger vessels, aerodrome, railway restaurant cars, National Cultural Institutions Licences, and producers' retail on- and off-licences.[2]

Revenue retains the final monthly register for each licensing year as an annual register. It is important to note that each annual register represents only those liquor licences that were issued or renewed during the licensing year. The annual register can never be seen as a full representation of liquor licences, as there will always be licences that fail to renew during the licensing year for any number of reasons. To the best of our knowledge, the list is as comprehensive as possible but it is important to note is that licences may transfer and change hands during the licensing year and from one licensing year to the next, and that licences may be extinguished by the courts in favour of a new and different class of licence, often in a different geographical location. The licensing year runs from 1 October to 30 September for most liquor licences, but for wholesale dealer's licences and wholesale dealer with retail off-licences, the licensing year is from 1 July to 30 June.

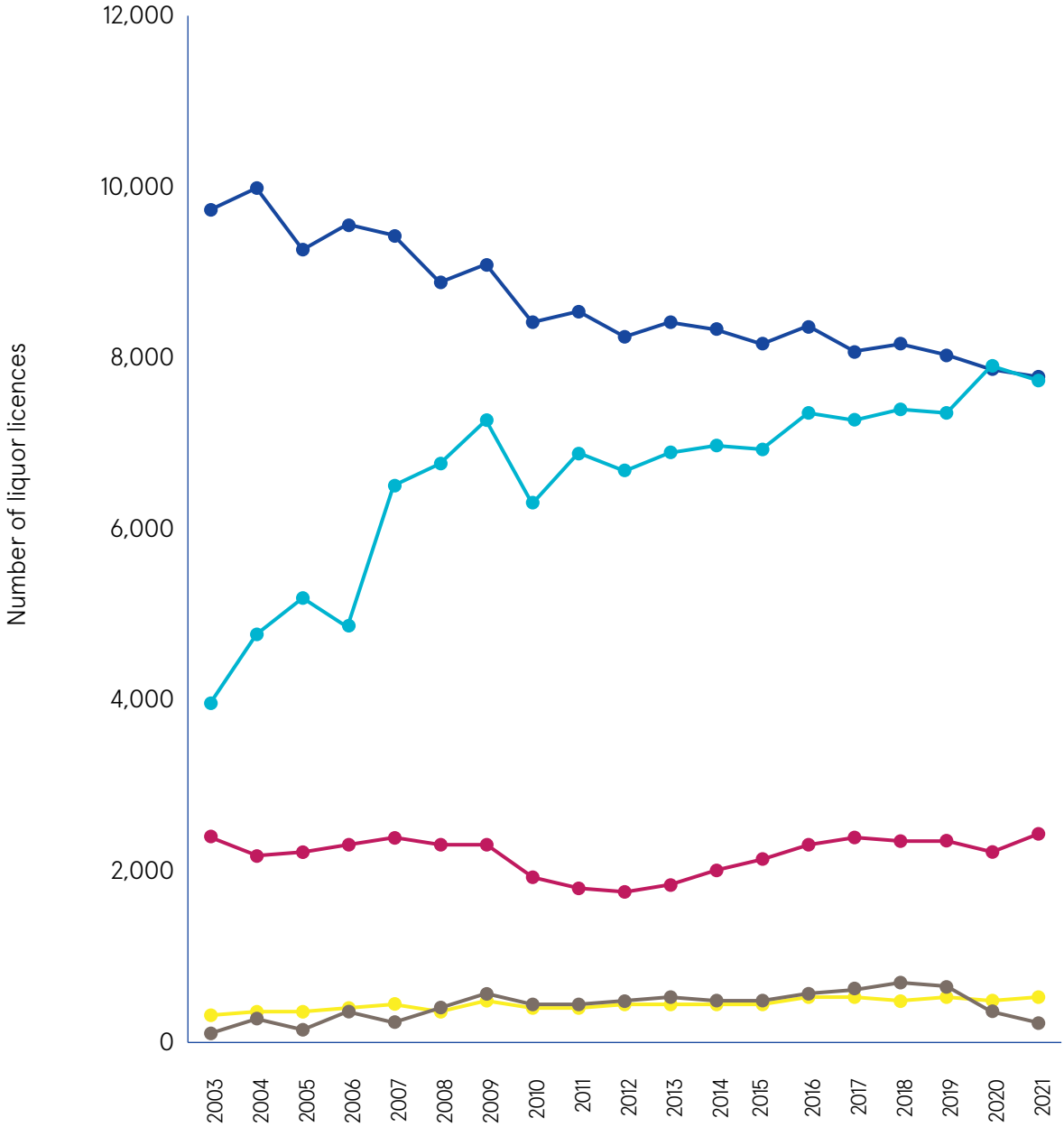
The Intoxicating Liquor Act, 2000 abolished the restriction on the geographical movement of licences across the country. Before the introduction of this Act, pub licences could only be transferred through a process that involved extinguishing one or more licences and issuing another licence for the new premises. In addition, the abolishment of the Groceries Order in 2006 to allow the below-cost selling of alcohol resulted in a substantial increase in the number of outlets selling alcohol; this increase is obvious in Figure 15, which shows the sharp increase in off-licences from 2006 onwards.

The number of licences issued for pubs and bars has continued to decline in Ireland, falling 20.3% in 18 years, from 9,731 in 2003 to 7,753 in 2021 (Figure 15). Between 2019 and 2021, there was a 3% decrease in the number of pubs and bars across Ireland; the COVID-19 pandemic was undoubtedly responsible for a number of these closures, as pubs and bars were forced to close for extended periods in 2020 and 2021 due to lockdowns.

The decrease in the number of pub licences issued is also indicative of the move from consuming alcohol in on-trade premises (pubs, bars, and nightclubs) to consuming alcohol purchased in off-licences (including supermarkets, petrol stations, and other retail outlets that sell alcohol). Data from Revenue indicate that as the number of pubs and bars has declined, the number of off-licences has almost doubled, increasing by 95% in the 18-year period from 2003 to 2021 and, unlike pubs and bars, increased by 6% between 2019 and 2021 [55]. Off-licences were considered essential businesses during the pandemic and thus were not affected by closures; on the contrary, they thrived, as drinking in pubs and bars was replaced with drinking at home.

[2] Allows manufacturers to sell alcohol produced on their premises to visitors to the premises. Visitors who have completed a guided tour can avail of off sales between 10.00 am and 7.00 pm each day.

Figure 15 Trends in liquor licences in Ireland, by licence type, 2003–2021

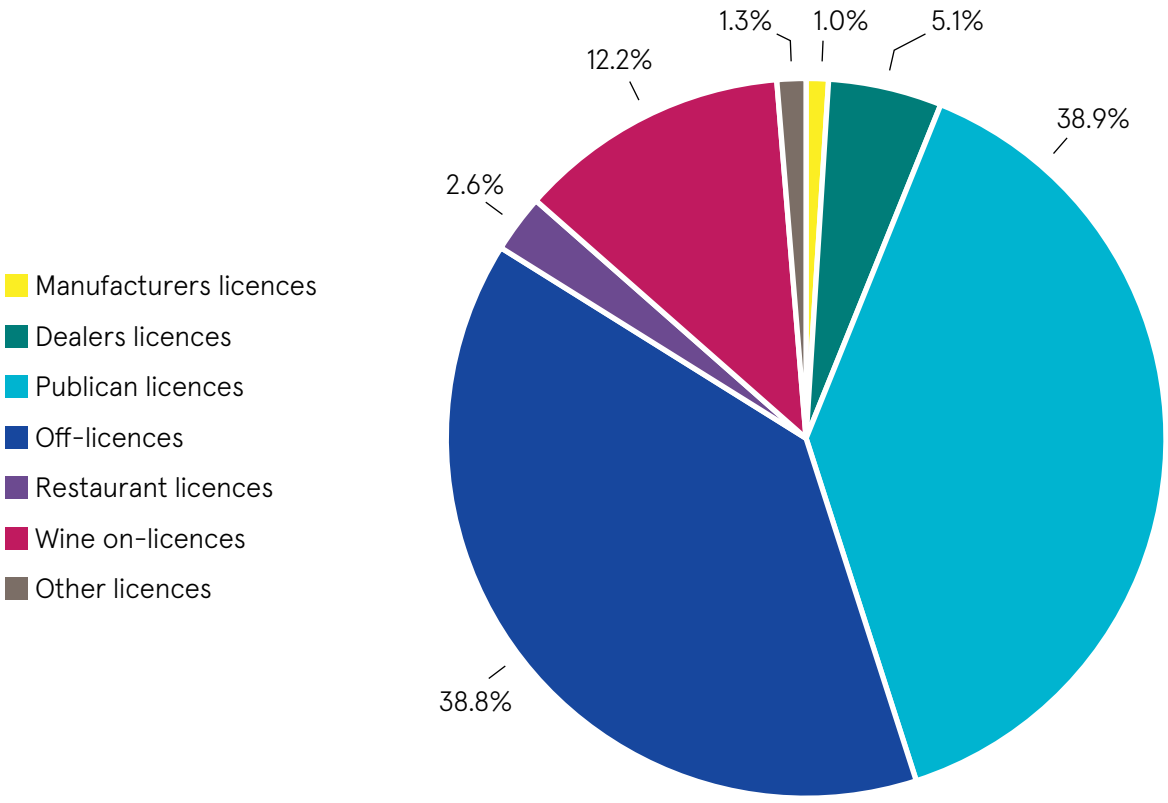



| | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Publican licences | 9,731 | 9,964 | 9,234 | 9,552 | 9,415 | 8,867 | 9,082 | 8,405 | 8,523 | 8,250 | 8,412 | 8,300 | 8,129 | 8,338 | 8,081 | 8,142 | 8,005 | 7,843 | 7,753 |
| Off-licences | 3,974 | 4,774 | 5,177 | 4,841 | 6,479 | 6,744 | 7,269 | 6,298 | 6,865 | 6,685 | 6,880 | 6,968 | 6,912 | 7,333 | 7,245 | 7,389 | 7,324 | 7,877 | 7,734 |
| Wine on-licences | 2,401 | 2,181 | 2,231 | 2,297 | 2,400 | 2,307 | 2,287 | 1,906 | 1,776 | 1,763 | 1,856 | 2,010 | 2,153 | 2,303 | 2,388 | 2,329 | 2,350 | 2,229 | 2,430 |
| Special restaurant licences | 334 | 375 | 357 | 391 | 450 | 375 | 491 | 405 | 412 | 428 | 421 | 445 | 450 | 506 | 514 | 497 | 532 | 496 | 539 |
| Other licences | 98 | 281 | 155 | 348 | 217 | 395 | 580 | 447 | 459 | 475 | 523 | 467 | 491 | 568 | 628 | 678 | 635 | 365 | 239 |

Source: Revenue, Irish Tax and Customs, 2022 [56]

The on-trade (pubs, bars, and restaurants) accounted for more than one-half (53.8%) of liquor licences issued or renewed for the period 2021–22, with publican licences being the most common licences issued (38.9%). The off-trade (off-licences, shops, supermarkets, and garage forecourts) totalled 38.8% of liquor licences issued or renewed for the period 2021–22 (Figure 16).

Figure 16 Percentage of liquor licences issued or renewed in Ireland for the period 2021–22




Source: Revenue, Irish Tax and Customs, 2022 [56]

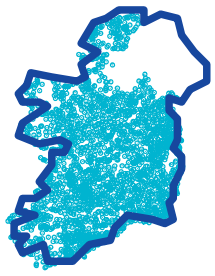
## 5.1.1 Rate of pubs per 100,000 of the population: International comparison

Using data available on openstreetmap, the University of Sheffield examined the number of pubs in 25 countries globally [56,57]. The analysis found that Ireland has the third-highest number of pubs per capita in the world (excluding countries with populations below 1 million); just the Slovak Republic and Hungary have more pubs per capita (Table 6). When bars, nightclubs, and beer gardens are included in the count, Ireland ranks fourth (Figure 17).

Table 6 Top 10 countries globally for number of pubs per 100,000 of the population

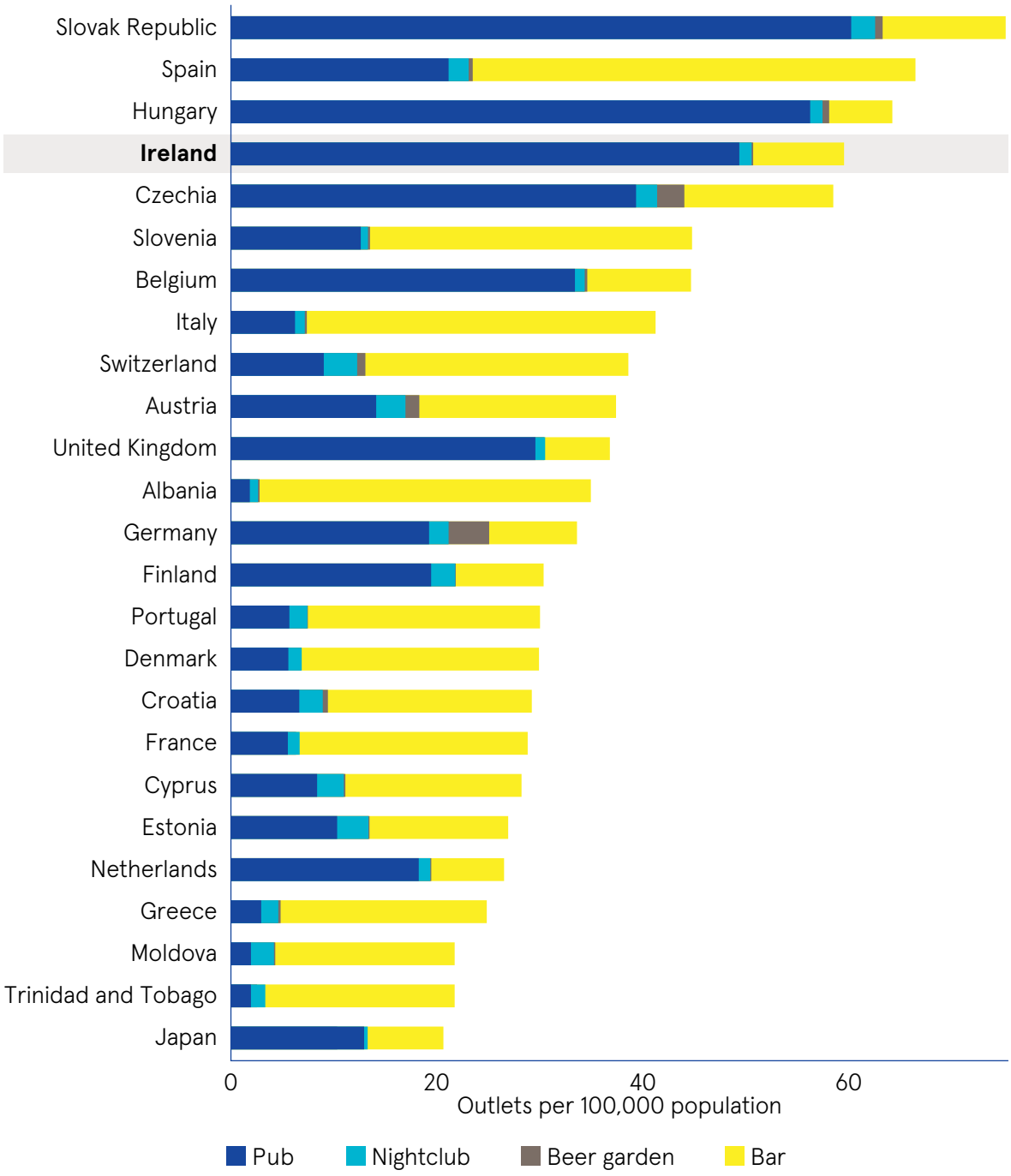
| Ranking | Country |
|---|---|
| 1 | Slovak Republic |
| 2 | Hungary |
| **3** | **Ireland** |
| 4 | Czechia |
| 5 | Belgium |
| 6 | United Kingdom (UK) |
| 7 | Spain |
| 8 | Finland |
| 9 | Germany |
| 10 | Netherlands |

Source: OpenStreetMap by @VictimOfMaths [57]



Ireland has the
**third-highest number of pubs**
per capita in the world

Figure 17 Number of pubs, bars, nightclubs, and beer gardens per 100,000 of the population in 25 countries globally




Source: OpenStreetMap by @VictimOfMaths [57]

## 5.1.2 County breakdown of liquor licences

### All liquor licences

Table 7 describes the distribution of the 14,840 liquor licences issued or renewed for the various premises in Ireland for the period 2022–23 by county and examines the percentage change since 2012–2013. Since 2012–13, the number of liquor licences issued has increased by 4.6%. The majority of counties saw an increase in the number of liquor licences issued since 2012–13. The number of people per licence was calculated using CSO population estimates in order to measure the density of liquor licences in Ireland. There is 1 liquor licence for every 345 people nationally, or 2.9 licences per 1,000 of the population. Rural counties have the highest rate of licences per capita; the rates are highest in counties Kerry (190 people per licence, or a rate of 5.3 licences per 1,000 of the population), Leitrim (221 people per licence, or a rate of 4.5 licences per 1,000 of the population), and Mayo (225 people per licence, or a rate of 4.4 licences per 1,000 of the population).

### Pub licences

There were 7,486 pub licences issued or renewed in the period 2022–23, an 8.2% decrease since 2012–13. Other than Co Dublin, where no change was noted, and a 1.8% increase in Co Meath, all other counties saw a decrease in the number of pub licences issued or renewed in 2022–23 compared with 2012–13. The counties with the largest percentage decrease were Monaghan (–16.1%), Roscommon (–15.7%), and Waterford (–12.7%). Nationally, the rate of pub licences per 1,000 of the population is 1.5, or 1 pub licence for every 684 adults (Table 7).

Rural counties had the highest rate of pub licences per capita, with 1 pub licence for every 330 people in Co Kerry (or a rate of 3 pub licences per 1,000 of the population); similarly, in Co Leitrim, there is 1 pub licence for every 328 people (or 3 pub licences per 1,000 of the population), and in Co Mayo, there are 382 pub licences, or 1 pub for every 359 people representing a rate of 2.8 pub licences per 1,000 of the population. In Co Dublin, there is 1 pub licence per 1,519 people (or 0.7 pub licences per 1,000 of the population). Despite the decrease in the number of pubs, particularly in rural areas, there remains a high number of pubs in Ireland.

**The number of pubs has declined by 8.2% since 2012 but off-licences have increased by 7.7%**

73% of the population live within 300 metres of a liquor licence

More licenced premises in deprived areas compared to affluent areas

### Off-licences

Unlike pub licences, the number of licences issued or renewed for off-licence premises (including supermarkets, standalone off-licences, garage forecourts, convenience stores/ small retailers, etc.) increased by 7.7% between 2012–13 and 2022–23. Every county saw an increase, with the exception of Co Leitrim, which decreased by 4.5%, and Co Longford, where the number of off-licences remained unchanged. Counties Offaly, Waterford, and Donegal saw the largest percentage increases in the number of off-licences issued or renewed, increasing by 45.0%, 19.5%, and 18.4%, respectively.

There was 1 off-licence for liquor for every 1,442 people nationally in 2022–23, or 0.7 off-licences per 1,000 of the population (Table 7). The counties with the highest rate of off-licences per 1,000 of the population were Donegal, with 1 off-licence for every 996 people (or a rate of 1 off-licence per 1,000 of the population), and Kerry, which had a similar rate of 1 off-licence per 1,000 of the population (or 1 off-licence for every 1,042 people). Co Meath had the smallest number of off-licences per capita, with 1 off-licence for every 1,735 people (or 0.6 off-licences per 1,000 of the population).

Table 7 Percentage change in the number of liquor licences issued/renewed between 2012–13 and 2022–23, rate of li

| | # liquor licences 2012–13 | # liquor licences 2022–23 | % change in # of liquor licences since 2012–13 | # people per liquor licence 2022–23 | Rate of liquor licences per 1,000 of the population 2022–23 | # pub licences 2012–13 | # pub licences 2022–23 |
|---|---|---|---|---|---|---|---|
| Carlow | 177 | 188 | +6.2 | 329 | 3.0 | 109 | 101 |
| Cavan | 296 | 286 | −3.4 | 284 | 3.5 | 205 | 192 |
| Clare | 503 | 485 | −3.6 | 263 | 3.8 | 330 | 301 |
| Cork | 1,738 | 1,732 | −0.3 | 336 | 3.0 | 1,052 | 927 |
| Donegal | 653 | 673 | +3.1 | 247 | 4.0 | 431 | 381 |
| Dublin | 2,707 | 3,115 | +15.1 | 466 | 2.1 | 955 | 955 |
| Galway | 938 | 979 | +4.4 | 282 | 3.5 | 566 | 525 |
| Kerry | 791 | 816 | +3.2 | 190 | 5.3 | 503 | 470 |
| Kildare | 425 | 466 | +9.6 | 530 | 1.9 | 201 | 196 |
| Kilkenny | 319 | 320 | +0.3 | 324 | 3.1 | 214 | 192 |
| Laois | 222 | 231 | +4.1 | 397 | 2.5 | 134 | 120 |
| Leitrim | 159 | 159 | 0.0 | 221 | 4.5 | 122 | 107 |
| Limerick | 621 | 629 | +1.3 | 327 | 3.1 | 391 | 356 |
| Longford | 134 | 147 | +9.7 | 317 | 3.2 | 90 | 89 |
| Louth | 379 | 398 | +5.0 | 349 | 2.9 | 215 | 194 |
| Mayo | 614 | 609 | −0.8 | 225 | 4.4 | 424 | 382 |
| Meath | 409 | 453 | +10.8 | 486 | 2.1 | 217 | 221 |
| Monaghan | 191 | 170 | −11.0 | 381 | 2.6 | 118 | 99 |
| Offaly | 207 | 223 | +7.7 | 371 | 2.7 | 140 | 123 |
| Roscommon | 278 | 263 | −5.4 | 266 | 3.8 | 217 | 183 |
| Sligo | 240 | 247 | +2.9 | 283 | 3.5 | 164 | 149 |
| Tipperary | 655 | 620 | −5.3 | 270 | 3.7 | 456 | 399 |
| Waterford | 388 | 410 | +5.7 | 310 | 3.2 | 244 | 213 |
| Westmeath | 310 | 310 | +0.0 | 309 | 3.2 | 185 | 175 |
| Wexford | 495 | 517 | +4.4 | 316 | 3.2 | 297 | 270 |
| Wicklow | 336 | 394 | +17.3 | 395 | 2.5 | 178 | 166 |
| **Total** | **14,185** | **14,840** | **+4.6** | **345** | **2.9** | **8,158** | **7,486** |

quor licences per 1,000 of the population, and number of people per liquor licence, by county

| % change in # of pub licences since 2012–13 | # people per pub licence 2022–23 | Rate of pub licences per 1,000 of the population 2022–23 | # off-licences 2012–13 | # off-licences 2022–23 | % change in # of off-licences since 2012–13 | # people per off-licence 2022–23 | Rate of off-licences per 1,000 of the population 2022–23 |
|---|---|---|---|---|---|---|---|
| −7.3 | 613 | 1.6 | 42 | 47 | +11.9 | 1,318 | 0.8 |
| −6.3 | 423 | 2.4 | 66 | 71 | +7.6 | 1,144 | 0.9 |
| −8.8 | 423 | 2.4 | 96 | 98 | +2.1 | 1,300 | 0.8 |
| −11.9 | 627 | 1.6 | 363 | 383 | +5.5 | 1,518 | 0.7 |
| −11.6 | 437 | 2.3 | 141 | 167 | +18.4 | 996 | 1.0 |
| 0.0 | 1,519 | 0.7 | 815 | 847 | +3.9 | 1,713 | 0.6 |
| −7.2 | 527 | 1.9 | 211 | 224 | +6.2 | 1,234 | 0.8 |
| −6.6 | 330 | 3.0 | 130 | 149 | +14.6 | 1,042 | 1.0 |
| −2.5 | 1,260 | 0.8 | 141 | 146 | +3.5 | 1,692 | 0.6 |
| −10.3 | 540 | 1.9 | 58 | 63 | +8.6 | 1,646 | 0.6 |
| −10.4 | 764 | 1.3 | 63 | 73 | +15.9 | 1,256 | 0.8 |
| −12.3 | 328 | 3.0 | 22 | 21 | −4.5 | 1,671 | 0.6 |
| −9.0 | 577 | 1.7 | 139 | 146 | +5.0 | 1,407 | 0.7 |
| −1.1 | 524 | 1.9 | 33 | 33 | 0.0 | 1,413 | 0.7 |
| −9.8 | 717 | 1.4 | 96 | 97 | +1.0 | 1,434 | 0.7 |
| −9.9 | 359 | 2.8 | 113 | 117 | +3.5 | 1,173 | 0.9 |
| +1.8 | 997 | 1.0 | 114 | 127 | +11.4 | 1,735 | 0.6 |
| −16.1 | 655 | 1.5 | 49 | 50 | +2.0 | 1,297 | 0.8 |
| −12.1 | 672 | 1.5 | 40 | 58 | +45.0 | 1,425 | 0.7 |
| −15.7 | 382 | 2.6 | 40 | 47 | +17.5 | 1,489 | 0.7 |
| −9.1 | 469 | 2.1 | 56 | 57 | +1.8 | 1,225 | 0.8 |
| −12.5 | 420 | 2.4 | 121 | 130 | +7.4 | 1,290 | 0.8 |
| −12.7 | 597 | 1.7 | 77 | 92 | +19.5 | 1,381 | 0.7 |
| −5.4 | 548 | 1.8 | 71 | 78 | +9.9 | 1,229 | 0.8 |
| −9.1 | 606 | 1.7 | 116 | 132 | +13.8 | 1,239 | 0.8 |
| −6.7 | 937 | 1.1 | 85 | 99 | +16.5 | 1,571 | 0.6 |
| **−8.2** | **684** | **1.5** | **3,298** | **3,552** | **+7.7** | **1,442** | **0.7** |

### 5.1.3 Liquor licence geospatial analysis

Using the addresses listed for the liquor licences issued or renewed in 2022–23 that are publicly available from Revenue, 14,840 addresses were geocoded (matched) by GeoDirectory in order to allow the data to be converted for geographic information system (GIS) mapping and analysis [58]. Using the GeoDirectory service, 42% of the addresses provided by Revenue were matched in an initial matching exercise, a further 38% were matched using 'address fix', and the final 20% (2,685) of addresses (which were the hardest to match due to very limited detail in their database entries) were matched manually using other information from the database (name, ownership, etc.) and individually checked using Google Maps, resulting in all 14,840 addresses being geocoded. Since 2018, new applications for liquor licences require the Eircode to be entered, so with time, the list will have exact coordinates, making geospatial analysis more straightforward. This will help significantly in terms of future data quality.

The coordinate system used to match the addresses, World Geodetic System 1984 (WGS 84), assigned 12-digit latitude and longitude coordinates to each point; these were entered into two distinct fields, with latitude coded as a northing and longitude coded as a westing. The fully geocoded data were imported into ArcGIS Pro v3.1.2, and the liquor licence locations were matched within the GIS interface to an Irish national grid coordinate system for more effective display as a set of points on a background map displaying Small Areas[3] (Figure 18).

[3] Small Areas correspond to approximately 80–120 households within a neighbourhood or townland and are the lowest level of geographic boundary in Ireland.

Figure 18 Location of liquor licences issued or renewed in Ireland for the period 2022–23, by Small Area

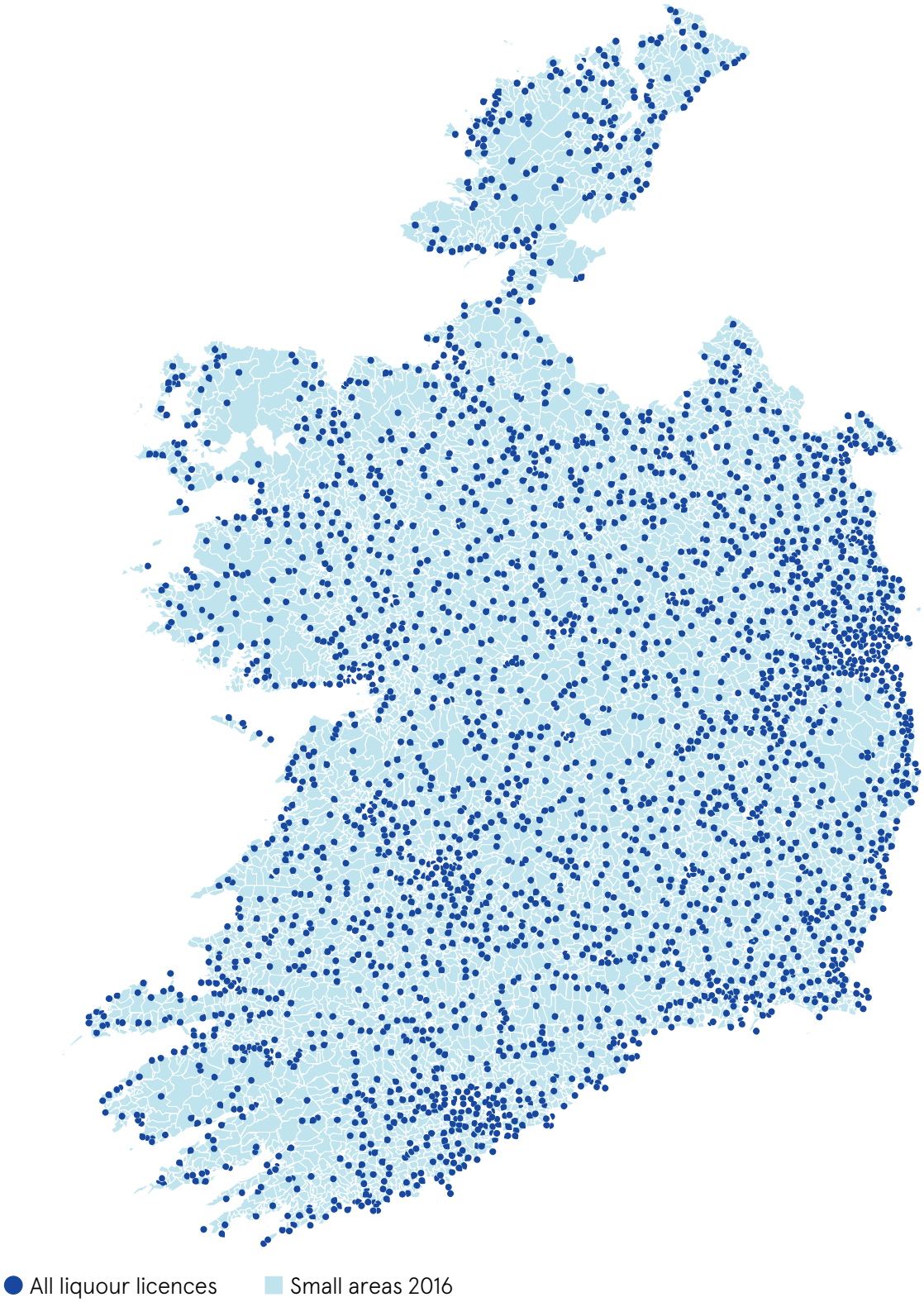
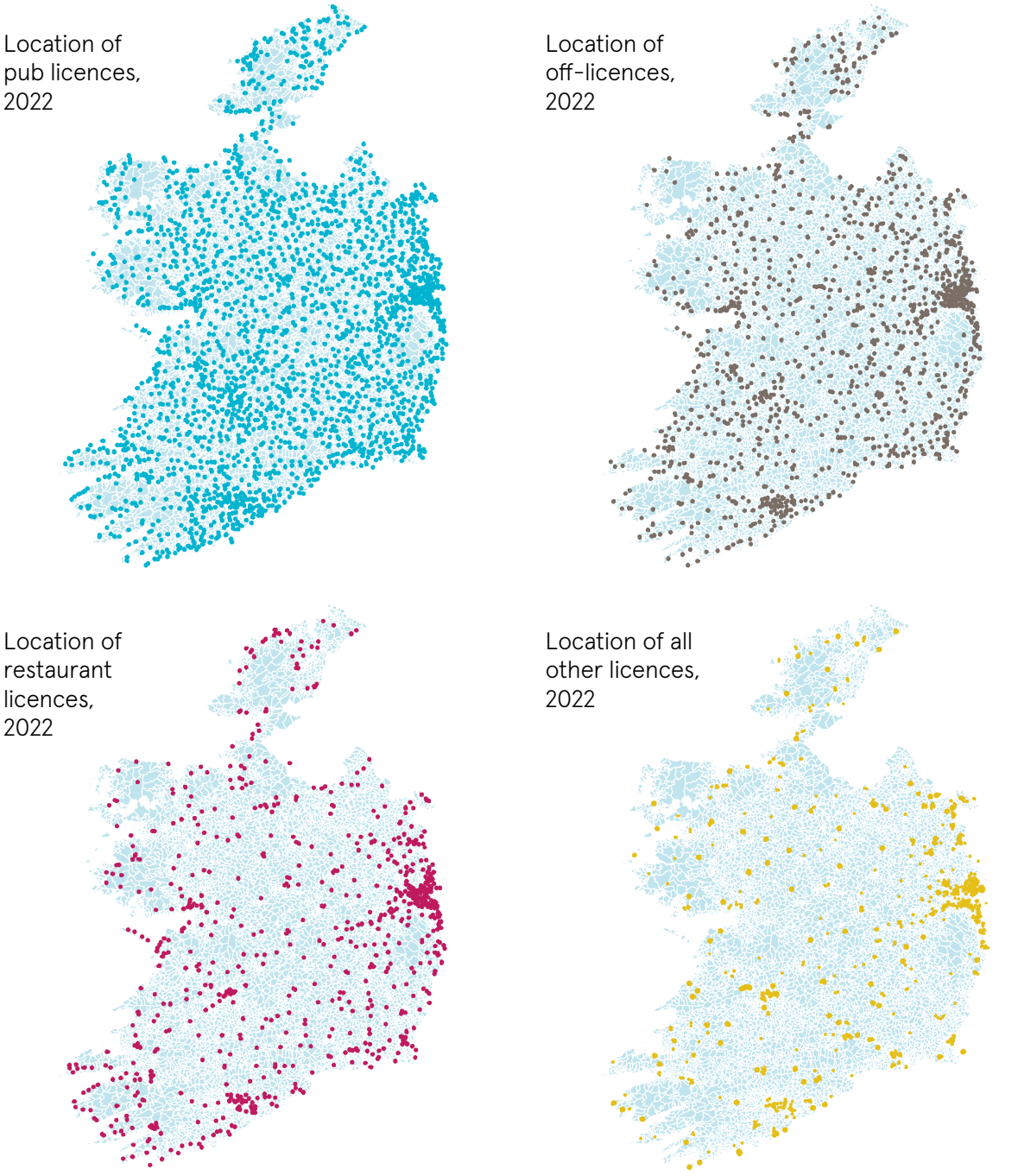


Figure 19 displays the location of the different types of liquor licences and shows the general distribution of licences across the country. While the maps look similar in that each of the licence types – such as for pubs and off-licences – have quite a broad geographical reach, some are sparser in terms of geographical spread.

Figure 19 Location of liquor licences issued or renewed in Ireland for the period 2022–23, by type of liquor licence



#### 5.1.3.1 Liquor licence location by area of deprivation

In order to examine the location of liquor licences by area of deprivation, the Pobal HP Deprivation Index was applied to the licensing data [37]. Using a specific 'database join' command in ArcGIS Pro v3.1.2, each liquor licence was assigned a deprivation score within the GIS by using a spatial join command to identify the specific coordinates of the licence location.

The Pobal HP Deprivation Index, developed by Haase and Pratschke in 2017, uses 2016 census data[4] to classify each Small Area on a scale from disadvantaged to affluent using a score of more than 30 (extremely affluent) and less than 30 (extremely disadvantaged), following a normalised distribution curve where approximately 70% of the population lives in an area with a score between 10 and −10. Each band of 10 represents one standard deviation from the mean.

The deprivation scores were divided into octiles based on their standard deviations from the mean. The liquor licence location scores were then separated out and reclassified based on these categories, and a count of the number of licences within each octile was created. This was then divided by the population of each Small Area and recalculated as a rate. The results are presented in Table 8.

Table 8 Number of liquor licences by Pobal HP Deprivation Index band

| Pobal HP Deprivation Index band | Number of Small Areas | Percentage of Small Areas | Number of liquor licences | Population (n) | Number of liquor licences per 1,000 of the population |
|---|---|---|---|---|---|
| Extremely affluent | 14 | 0.1% | 16 | 6,044 | 2.7 |
| Very affluent | 353 | 1.9% | 461 | 209,305 | 2.2 |
| Affluent | 2,671 | 14.3% | 1,889 | 585,708 | 3.2 |
| Marginally above average | 6,564 | 35.2% | 4,529 | 1,186,688 | 3.8 |
| Marginally below average | 6,160 | 33.1% | 5,250 | 1,151,776 | 4.6 |
| Disadvantaged | 2,300 | 12.3% | 1,997 | 404,861 | 4.9 |
| Very disadvantaged | 554 | 3.0% | 243 | 53,851 | 4.5 |
| Extremely disadvantaged | 24 | 0.1% | 4 | 947 | 4.2 |

[4] The most recent Pobal HP Deprivation Index was launched on 2 November 2023.

Taking into account the very small numbers in the highest and lowest deprivation bands, there is a clear gradation from most affluent to most deprived, with the number of liquor licences per 1,000 of the population increasing steadily from 2.2 per 1,000 of the population in the 'very affluent' deprivation band to 4.5 liquor licences per 1,000 of the population in the 'very disadvantaged' band. This shows that in the more deprived areas, there were typically more liquor licences per 1,000 of the population compared with more affluent areas, where the rate of liquor licences was lower.

### 5.1.3.2 Liquor licence density per 1,000 of the population

Using ArcGIS v3.1.2 to look at the relative distribution between urban and rural areas, the number of liquor licences within each individual settlement was counted and the rate per 1,000 of the population based on 2016 census figures was calculated. In general, the settlements (towns/regions) with the highest rates of liquor licences were smaller villages and towns, many of which are along the west coast and/or in popular tourist areas. In contrast, many of the settlements with the lower densities of liquor licences are new suburban towns which have expanded rapidly in population terms, but where population growth has not been matched by the same rate of facility development.

Table 9 looks at a sample of the larger settlements (i.e. those with a population of 10,000 residents or more based on the 2016 census) to examine the towns or regions with the highest density of liquor licences. Killarney, Co Kerry, has the highest density of liquor licences with a total of 116 in the town, representing 8 licences per 1,000 of the population in the town. Ballina and Kilkenny follow Killarney in terms of the highest liquor licence densities (Table 9).

Table 9 Liquor licence rate and density, by town and region

| Town/region | Population as of 2016 census | Number of liquor licences | Liquor licence rate per 1,000 of the population | Number of liquor licences per square kilometre | Number of people per liquor licence |
|---|---|---|---|---|---|
| Killarney | 14,504 | 116 | 8.0 | 11.0 | 125 |
| Ballina | 10,171 | 70 | 6.9 | 7.6 | 145 |
| Kilkenny | 26,512 | 142 | 5.4 | 8.5 | 187 |
| Castlebar | 12,068 | 63 | 5.2 | 5.9 | 192 |
| Sligo | 19,199 | 94 | 4.9 | 6.6 | 204 |
| Cavan | 10,914 | 53 | 4.9 | 4.7 | 206 |
| Wexford | 20,188 | 98 | 4.9 | 3.7 | 206 |
| Tralee | 23,691 | 111 | 4.7 | 4.5 | 213 |
| Enniscorthy | 11,381 | 53 | 4.7 | 3.9 | 215 |
| Longford | 10,008 | 46 | 4.6 | 4.7 | 218 |
| Clonmel | 17,140 | 76 | 4.4 | 5.5 | 226 |
| Athlone | 21,349 | 92 | 4.3 | 4.3 | 232 |
| Tullamore | 14,607 | 58 | 4.0 | 3.3 | 252 |
| Midleton | 12,496 | 45 | 3.6 | 4.4 | 278 |

| Town/region | Population as of 2016 census | Number of liquor licences | Liquor licence rate per 1,000 of the population | Number of liquor licences per square kilometre | Number of people per liquor licence |
|---|---|---|---|---|---|
| Ennis | 25,276 | 89 | 3.5 | 3.4 | 284 |
| Mullingar | 20,928 | 71 | 3.4 | 3.9 | 295 |
| Tramore | 10,381 | 35 | 3.4 | 4.6 | 297 |
| Letterkenny | 19,274 | 61 | 3.2 | 2.8 | 316 |
| Dundalk | 39,004 | 123 | 3.2 | 3.8 | 317 |
| Carlow | 24,272 | 74 | 3.0 | 4.7 | 328 |
| Limerick (city and suburbs) | 94,192 | 285 | 3.0 | 3.6 | 330 |
| Waterford (city and suburbs) | 53,504 | 161 | 3.0 | 2.5 | 332 |
| Portlaoise | 22,050 | 62 | 2.8 | 3.8 | 356 |
| Skerries | 10,043 | 28 | 2.8 | 6.4 | 359 |
| Mallow | 12,459 | 34 | 2.7 | 3.2 | 366 |
| Cork (city and suburbs) | 208,669 | 562 | 2.7 | 2.5 | 371 |
| Wicklow | 10,584 | 28 | 2.6 | 4.0 | 378 |
| Naas | 21,393 | 55 | 2.6 | 4.9 | 389 |
| Drogheda | 40,956 | 105 | 2.6 | 5.2 | 390 |
| Cobh | 12,800 | 32 | 2.5 | 4.8 | 400 |
| Maynooth | 14,585 | 36 | 2.5 | 5.2 | 405 |
| Arklow | 13,163 | 32 | 2.4 | 4.6 | 411 |
| Malahide | 16,550 | 39 | 2.4 | 5.0 | 424 |
| Navan | 30,173 | 67 | 2.2 | 3.8 | 450 |
| Bray | 32,600 | 69 | 2.1 | 6.4 | 472 |
| Greystones and Delgany | 18,140 | 38 | 2.1 | 3.2 | 477 |
| Newbridge | 22,742 | 45 | 2.0 | 3.8 | 505 |
| Dublin (city and suburbs) | 1,173,179 | 2,268 | 1.9 | 5.3 | 517 |
| Ashbourne | 12,679 | 23 | 1.8 | 5.2 | 551 |
| Swords | 39,248 | 56 | 1.4 | 4.0 | 701 |
| Balbriggan | 21,722 | 27 | 1.2 | 4.1 | 805 |
| Leixlip | 15,504 | 18 | 1.2 | 2.7 | 861 |
| Carrigaline | 15,770 | 18 | 1.1 | 3.0 | 876 |
| Celbridge | 20,288 | 23 | 1.1 | 2.9 | 882 |
| Laytown, Bettystown, Mornington, and Donacarney | 11,872 | 11 | 0.9 | 1.4 | 1,079 |

#### 5.1.3.3 Geographical proximity to liquor licences

The Irish population's proximity to liquor licence locations was calculated using ArcGIS v3.1.2. Nationally, 73% of the population (or 3.48 million people) live within 300 metres of a liquor licence (based on Census 2016 data). Note that this estimate is based on a point-to-point calculation rather than along the road network.

An examination of the proximity of schools to liquor licences in Ireland found that more than one-half (52.3%) of all secondary schools and 42.7% of all primary schools are within 300 metres of a premises selling alcohol [59].

## 5.2 Summary: Alcohol availability

The WHO state that reducing alcohol availability is one of the most effective policies for reducing alcohol-related harm [60,61]. The availability theory suggests that the more alcohol is available, the more is consumed, and the more alcohol is consumed, the greater the risk of hazardous and harmful drinking and associated alcohol-related harms [62]. The convenience of accessing alcohol and the increased visibility of advertising through signage and marketing tools outside licenced premises influences drinking behaviours, particularly among adolescents [63,64]. Young people were found to drink more alcohol in surroundings where alcohol-related advertising is prevalent, highlighting the impact that exposure to alcohol advertising can have on an individual [65]. Furthermore, the mere presence of alcohol sales outlets and their visibility in certain areas can influence attitudes towards drinking behaviours and drunkenness among locals and visitors alike, to the extent that such behaviours become normalised and acceptable [66].

A higher density of alcohol retailers is associated with greater incidences of violence, assault, and domestic violence [67,68,69]. It is also associated with an increased risk of underage children purchasing alcohol, binge drinking, and incidents of drink-driving [70,71,72].

The data presented in this chapter indicate that Ireland has a high density of premises selling alcohol. A decrease in the number of pub licences issued or renewed has been offset by an increase in the number of off-licences issued or renewed, potentially problematic considering the substantial price difference between off- and on-sales as outlined in Chapter 6. As the Sale of Alcohol Bill (2022) proposes to increase the number of outlets selling alcohol, the evidence suggests that this proposed legislation could increase per capita alcohol use and consequently increase the associated harms to public health [55,73]. It is important that liquor licence density is regulated in order to avoid oversaturation, especially in areas of deprivation.

# 06

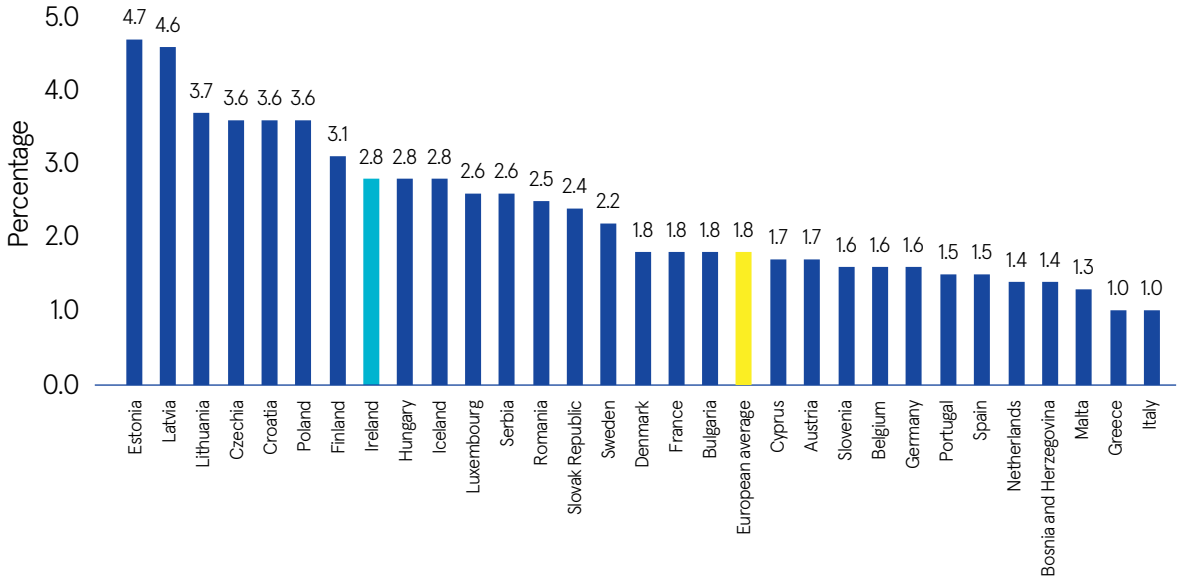
# Alcohol affordability and expenditure

The WHO recommends that in order to reduce alcohol use while raising additional revenue, its affordability should be decreased through increasing taxation [74]. Decreasing the affordability of alcohol results in less drinking and, consequently, fewer harms and problems [75]. Tax increases reduce population-wide alcohol use, especially among the heaviest drinkers and young people, as well as providing the government with tax revenues which in turn can be used to offset the costs of treatment, prevention, and enforcement; however, alcohol taxes need to be substantial in order to be effective. In Lithuania, a 14–18% reduction in deaths was observed between 2012 and 2019 following substantial alcohol tax increases [76]. Furthermore, minimum unit pricing (MUP), product-specific pricing, and special taxes targeting drinks favoured by children and young people are recommended as good practices due to their effectiveness in reducing alcohol use and related harms [76].

# 6.1 Household expenditure on alcohol

A Eurostat comparison of household spend on alcohol in 2021 indicated that households in Ireland spent more than 2.9 billion euro (EUR) (equivalent to 0.7% of Ireland's gross domestic product (GDP)) on alcoholic beverages in the off-trade, representing 2.8% of the total household consumption expenditure, but this does not include alcohol purchased in restaurants and hotels (Figure 20) [77]. Expenditure on alcohol in Irish households was above the European average[5] (1.8%) and placed Ireland 8th out of 30 countries for the proportion of household income spent on alcohol.

Figure 20 Household alcohol expenditure on off-trade alcohol purchases, 2021




Source: Eurostat, 2021 [78]

[5] Data not available for all EU countries.

### 6.1.1 Household Budget Survey

In Ireland, household expenditure on alcohol is derived from the Central Statistics Office (CSO) Household Budget Survey (HBS) [78]. The HBS is part of a programme spanning the European Union (EU) to determine whether the economic circumstances and spending patterns of households are changing over time. The most recent HBS publication relates to data collected in 2015–16, which included a representative sample of 6,839 households. Data collection procedures and definitions are described in greater detail in the HBS technical report *Standard Report on Methods and Quality for Household Budget Survey* [79]. The next HBS is currently in the field work stage, with publication expected later in 2024. As the economic circumstances of households in Ireland have fluctuated with the rising cost of living in the time since the last HBS was published, and due to the introduction of MUP in January 2022, the data presented here should be interpreted with that in mind.

In 2015–16, the average household expenditure on alcohol in Ireland was EUR 20.62 weekly (with EUR 10.56 spent on alcohol consumed at home and EUR 10.06 spent on alcohol consumed outside the home), or EUR 1,072.24 annually, representing 2.5% of the overall household expenditure. The average weekly spend on alcohol decreased by 21.9% since the HBS in 2009–10, from an average of EUR 26.40 per week; the largest decrease noted was the average amount spent on alcohol for consumption outside the home, which decreased by 35.1% between the two surveys from a weekly average of EUR 15.50 in 2009–10. The weekly average spend on alcohol for consumption in the home decrease by 3.1% during this period (from EUR 10.90 in 2009–10) (Table 10).

Table 10 Average weekly expenditure on alcohol in Ireland as a percentage of total household expenditure, 2009–10 and 2015–16

| | Average weekly household expenditure on alcohol (EUR) | Total average weekly household expenditure (all items/ utilities) (EUR) | Expenditure on alcohol as a percentage of total household expenditure |
|---|---|---|---|
| HBS 2009–10 | 26.40 | 810.61 | 3.3% |
| HBS 2015–16 | 20.62 | 837.47 | 2.5% |

Source: Central Statistics Office, 2016 [79]

In 2015, wine (EUR 4.66) and beer (including pale ales, stouts, and lagers) (EUR 2.97) represented the greatest share of weekly expenditure on alcohol consumed in the home; for expenditure on alcohol consumed outside the home, beer (including pale ales, stouts, and lagers) (EUR 5.93) and wine (EUR 1.86) represented the greatest share of weekly expenditure (Table 11).

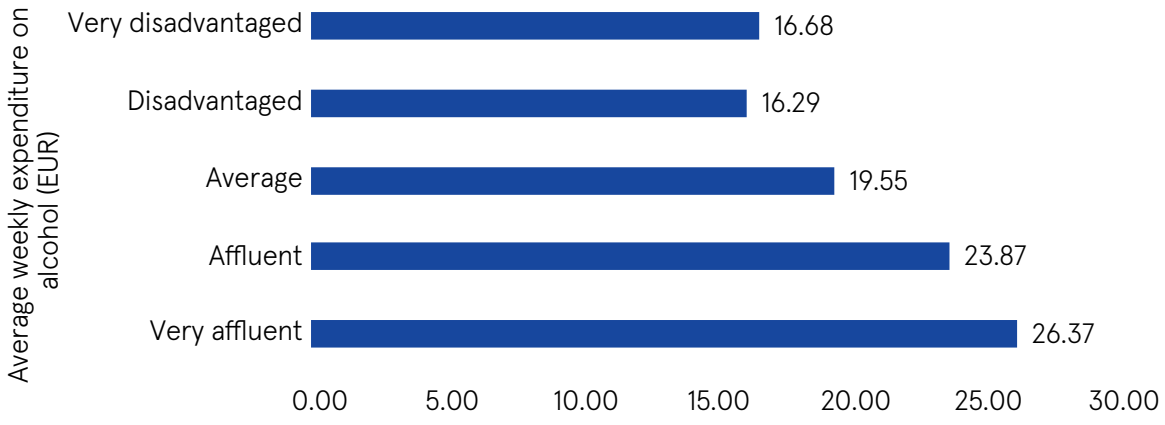
Table 11 Average weekly household expenditure on alcohol in Ireland, 2015–16

| Type of alcohol | Weekly expenditure (EUR) | | | |
|---|---|---|---|---|
| | Alcohol consumed at home (EUR 10.56) | | Alcohol consumed outside the home (EUR 10.06) | |
| | EUR | % | EUR | % |
| Spirits (e.g. gin, vodka, spirits with mixer) | 1.81 | 17.1% | 1.28 | 12.7% |
| Liqueurs and cocktails | 0.19 | 1.8% | 0.22 | 2.2% |
| Wine | 4.66 | 44.1% | 1.86 | 18.5% |
| Sparkling wine | 0.28 | 2.7% | 0.07 | 0.7% |
| Sherry and other fortified wine | 0.10 | 0.9% | 0.02 | 0.2% |
| Ciders and perry | 0.51 | 4.8% | 0.63 | 6.3% |
| Alcopops and alcoholic soft drinks | 0.04 | 0.4% | 0.04 | 0.4% |
| Beers (including pale ales, stouts, and lagers) | 2.97 | 28.1% | 5.93 | 58.9% |

Source: Central Statistics Office, 2016 [79]

The deprivation quintile of the household impacted on the level of weekly expenditure on alcohol. Very affluent households were more likely to spend more on alcohol each week (EUR 26.37) than very disadvantaged households (EUR 16.68) (Figure 21). The weekly average spend on alcohol as a percentage of total household expenditure was greater among very disadvantaged households (2.9%) compared to very affluent households (2.4%).

Figure 21 Average weekly expenditure on alcohol in Ireland, by household deprivation quintile, 2015–16




Source: Central Statistics Office, 2016 [80]

# 6.2 Consumer Price Index

The Consumer Price Index (CPI), Ireland's official measure of inflation, is a monthly examination of the prices of approximately 53,000 goods and services that people typically buy over time in Ireland [81]. Included in the CPI price comparison are items such as household utility bills, hairdressing services, taxi fares, etc., as well as grocery items; these are collectively referred to as the 'basket of goods and services' as determined from the HBS and represent an average household in Ireland. Comparisons are then made to the previous month and year in order to measure the change in the price of those goods or services.

The average cost of goods and services has increased across all food and beverage items as well as household utility bills. Alcohol prices have increased, but to a lesser extent than regular household grocery items in a short time period. For example, between January 2020 and September 2023, the price of an 800 g white sliced pan of bread increased by 28.8% and the price of a six-pack of eggs increased by 25.5%, whereas the price of a 700 mL bottle of whiskey increased by 1.6% in the same time period.

Comparisons can also be made to other European countries; when examining the alcohol results of the CPI, Iceland had the most expensive alcoholic beverages of the included European countries, with drink prices 186% above the average among the 27 countries in the EU. Ireland was the fourth most expensive, with drink prices 101% above the EU average.

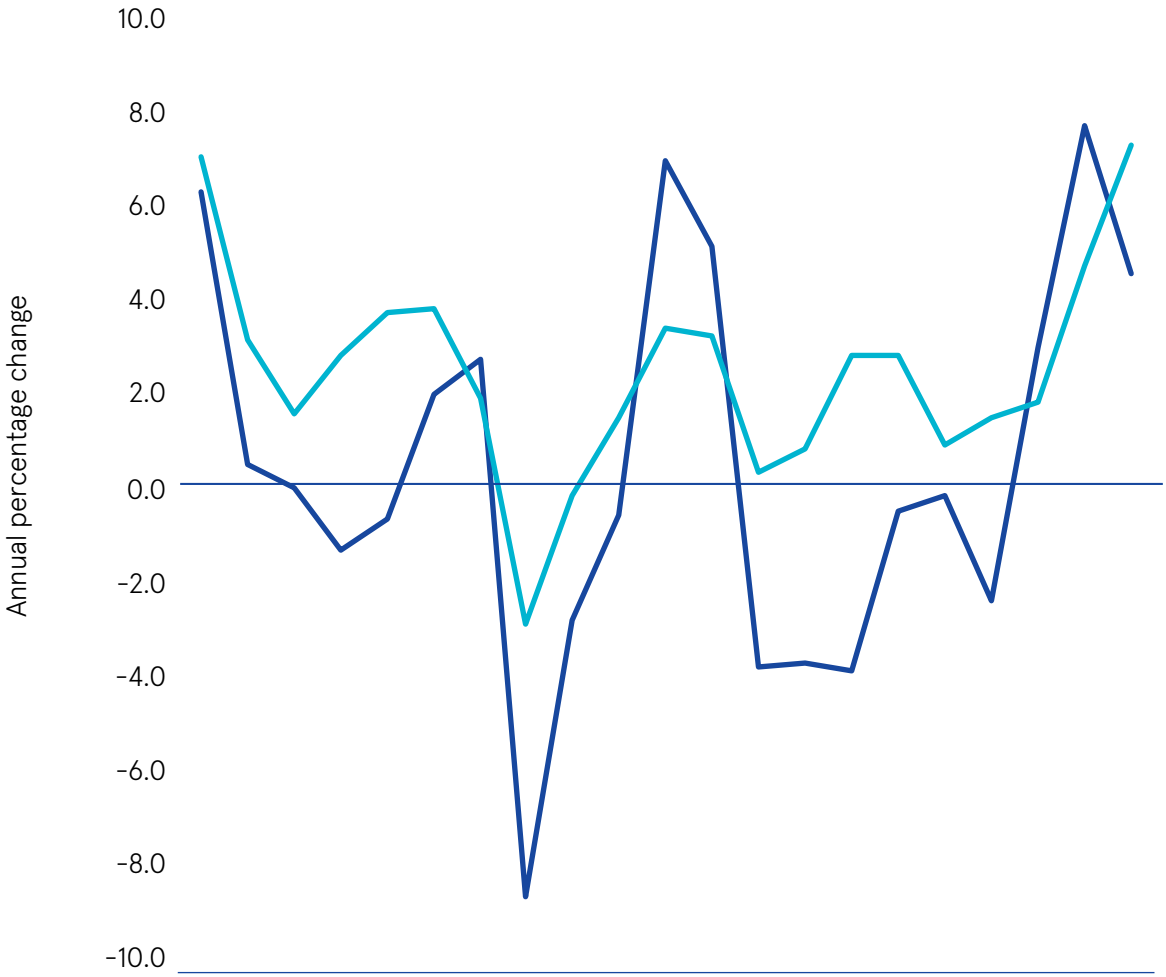
A study carried out by Alcohol Action Ireland in collaboration with the University of Sheffield examined the CPI data for alcohol affordability over a period of 20 years (2003–2023) [81]. The study found that alcohol prices have increased in the on-trade; however, they have kept in line with inflation. When examining the price of alcohol compared with other household items, the 'affordability index' shows that on-trade affordability is 14% higher than in 2004, while off-trade alcohol has become 67% more affordable between 2003 and 2023. This means that as alcohol duty rates have remained unchanged, coupled with high levels of inflation, alcohol prices in the off-trade in 2023 are the same as they were in 2003. In fact, a report published in 2021 indicted that Ireland had the second most affordable alcohol of OECD members [235].

## 6.2.1 Percentage price increases

In September 2023, the CSO published the latest CPI figures, showing that prices for consumer goods and services had increased by 6.4% on average compared with prices in September 2022 [81]. Every household in Ireland has experienced the increases in the cost of living since prices began to rise sharply in 2021. The goods and services with the largest price increases between September 2022 and September 2023 were 'housing, water, electricity, gas and other fuels' (+16.9%), and 'recreation and culture' (+9.4%). In relation to alcohol products, the cost of alcoholic beverages sold in off-licence settings increased by 4.5%, and the cost of those sold in licenced premises increased by 7.3% between September 2022 and September 2023. The annual percentage change in alcohol prices in both the on-trade and the off-trade is illustrated in Figure 22.

The price decrease is particularly noticeable in 2010 representing the drop in excise duty in 2009 and excise duty increased in 2012 and the price increase in 2013 is visible. The price increase in 2021 representes the cost of living crisis affecting all goods and services.

Figure 22 Annual percentage change from the previous year in alcoholic product prices in the on-trade and off-trade in Ireland according to the CPI, 2003–2023




| | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Off-trade alcohol | 6.3 | 0.5 | 0.0 | -1.3 | -0.7 | 2.0 | 2.7 | -8.7 | -2.8 | -0.6 | 6.9 | 5.1 | -3.8 | -3.7 | -3.9 | -0.5 | -0.2 | -2.4 | 3.0 | 7.7 | 4.5 |
| On-trade alcohol | 7.0 | 3.1 | 1.6 | 2.8 | 3.7 | 3.8 | 1.9 | -2.9 | -0.2 | 1.5 | 3.4 | 3.2 | 0.3 | 0.8 | 2.8 | 2.8 | 0.9 | 1.5 | 1.8 | 4.7 | 7.3 |

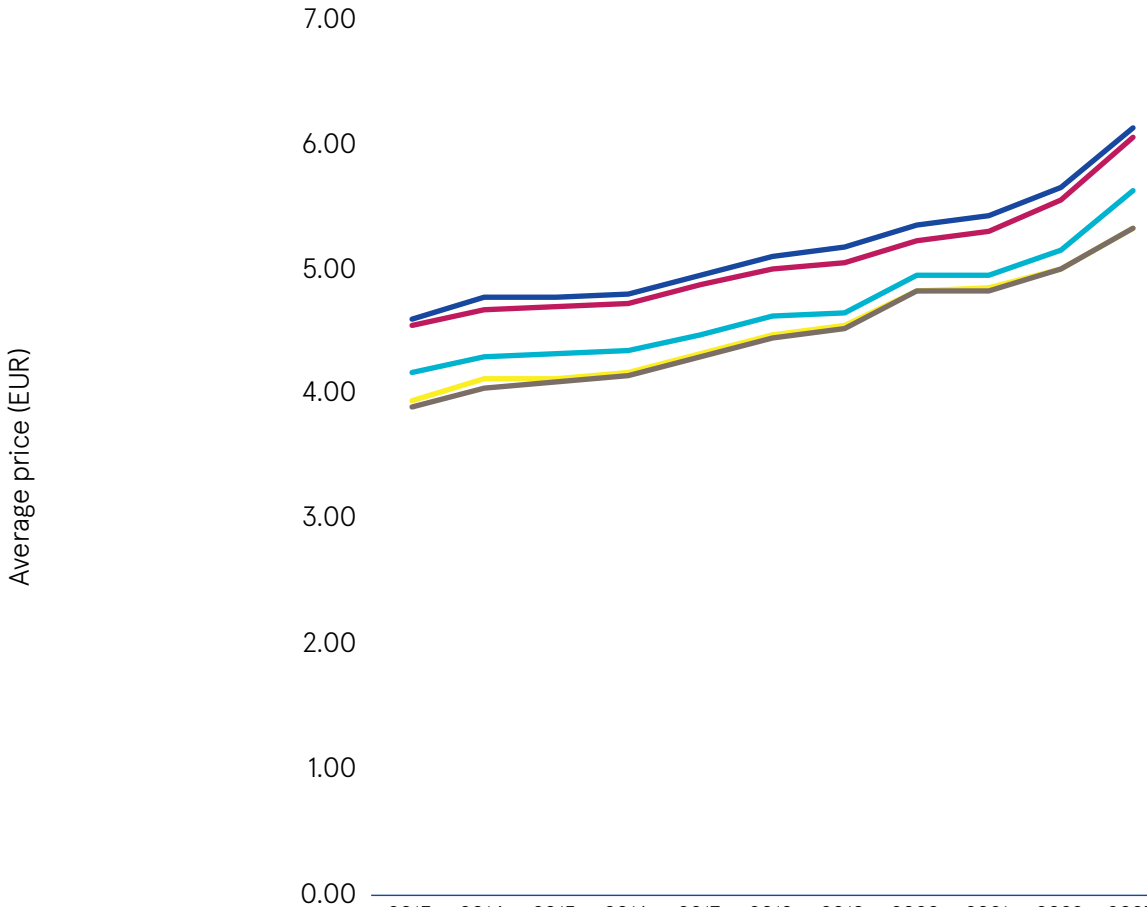
Source: Central Statistics Office, 2023 [81]

For the period from September 2022 to September 2023, the annual change in the cost of alcoholic beverages in licenced premises (+7.3%) reflects price increases for beer (+8.6%), spirits (+6.2%), and wine (+5.7%). The 4.5% increase in the cost of alcoholic beverages in off-licences reflects price increases for beer (+8.4%), spirits (+3.2%), and wine (+2.1%).

## 6.2.2 Average price of alcoholic beverages

Figure 23 illustrates the price for alcoholic products bought in licenced premises over the 10-year period from 2013 to 2023 (based on the price in September for each year). The largest price increases since 2013 were seen in the price of a pint of draught lager (with a EUR 1.51 price increase), a single glass of whiskey (a EUR 1.41 price increase), and a single glass of vodka (a EUR 1.37 price increase). The average price for wine and sherry is not included because these prices have not been available since 2016, as the criteria for pricing wine were expanded to include champagne and sparkling wine, and therefore comparisons could not be made from 2016 onwards.

Figure 23 Average price of alcoholic beverages in licenced premises in Ireland, 2013–2023

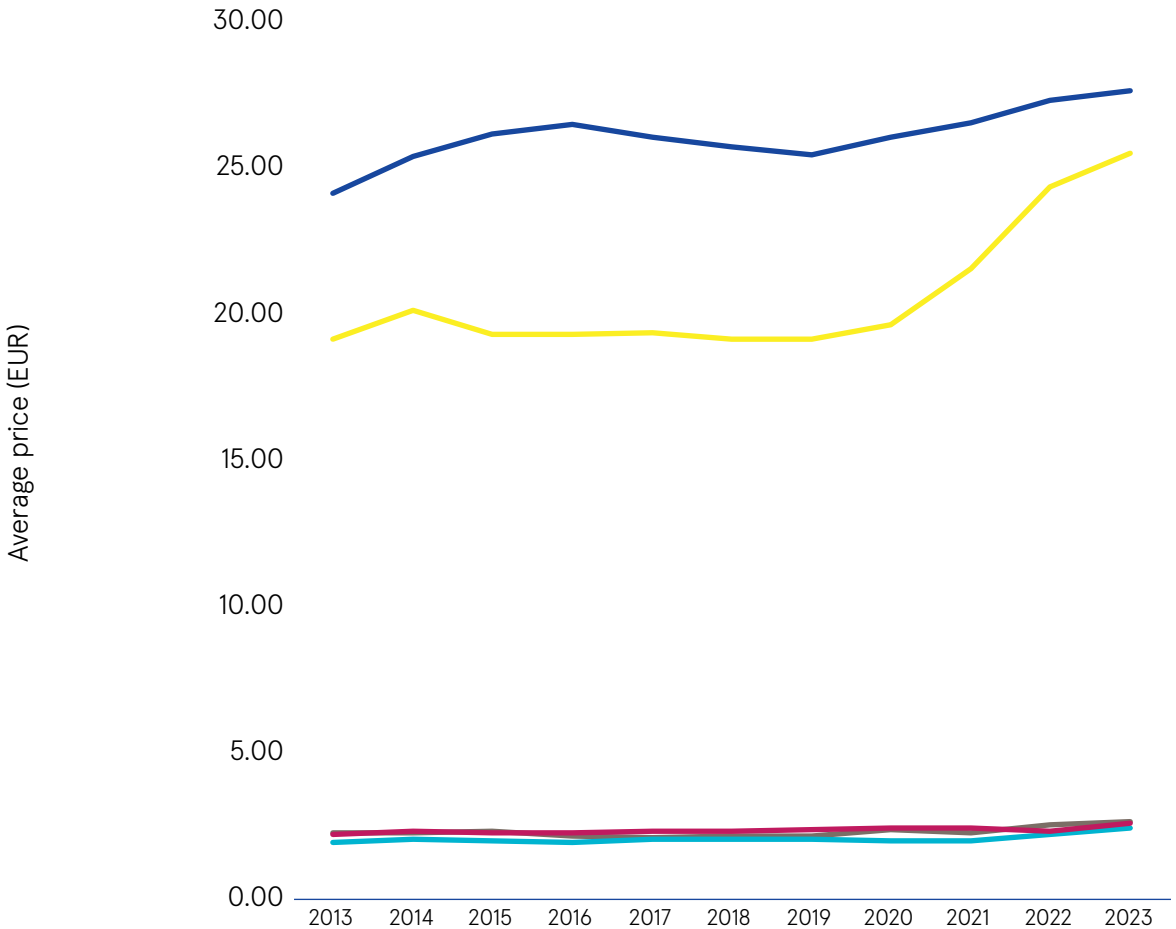



| | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Cider - draught (1 pint) | 4.60 | 4.76 | 4.77 | 4.80 | 4.95 | 5.10 | 5.17 | 5.34 | 5.41 | 5.65 | 6.13 |
| Stout - draught (1 pint) | 4.17 | 4.31 | 4.31 | 4.34 | 4.48 | 4.61 | 4.66 | 4.94 | 4.95 | 5.14 | 5.62 |
| Lager - draught (1 pint) | 4.54 | 4.68 | 4.69 | 4.72 | 4.86 | 4.99 | 5.06 | 5.21 | 5.30 | 5.55 | 6.05 |
| Vodka - (single) per ½ glass | 3.95 | 4.11 | 4.13 | 4.18 | 4.33 | 4.46 | 4.55 | 4.83 | 4.85 | 5.00 | 5.32 |
| Whiskey - (single) per ½ glass | 3.91 | 4.05 | 4.08 | 4.14 | 4.29 | 4.44 | 4.51 | 4.83 | 4.81 | 4.99 | 5.31 |

Source: Central Statistics Office, 2023 [81]

Figure 24 examines the prices of a sample of alcoholic beverages purchased in the off-trade (supermarkets, off-licences, etc.) over the 10-year period from 2013 to 2023. Brandy (not shown in Figure 24) (a 700 millilitres (mL) bottle) purchased from an off-licence premises has seen the largest price increase since 2013, increasing by EUR 17.79, followed by vodka (a 700 mL bottle) purchased from an off-licence premises, which has increased by EUR 6.36 over the same 10-year period. Smaller price increases are noted for take-home 500 mL cans of cider and lager (which have increased by EUR 0.40 and EUR 0.45, respectively). As with on-trade sales, the average price for wine and sherry has not been available since 2016, as the criteria for pricing wine were expanded to include champagne and sparkling wine; therefore, they are not included in Figure 24.

Figure 24 Average price of alcoholic beverages in off-licence premises in Ireland, 2013–2023




| | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Cider - (50cl can) | 2.20 | 2.22 | 2.26 | 2.12 | 2.06 | 2.08 | 2.07 | 2.29 | 2.21 | 2.46 | 2.60 |
| Lager - (50cl can) | 1.90 | 1.99 | 1.93 | 1.90 | 1.99 | 1.99 | 1.99 | 1.92 | 1.95 | 2.16 | 2.35 |
| Stout - (50cl can) | 2.16 | 2.25 | 2.22 | 2.20 | 2.26 | 2.25 | 2.34 | 2.35 | 2.39 | 2.28 | 2.52 |
| Vodka - (70cl bottle) | 19.11 | 20.08 | 19.29 | 19.26 | 19.35 | 19.11 | 19.09 | 19.61 | 21.54 | 24.35 | 25.47 |
| Whiskey - (70cl bottle) | 24.09 | 25.35 | 26.16 | 26.48 | 26.03 | 25.67 | 25.41 | 26.01 | 26.52 | 27.27 | 27.60 |

Source: Central Statistics Office, 2023 [81]

## 6.3 Summary: Alcohol affordability and expenditure

The affordability of alcohol is an important indicator of alcohol use, and based on extensive evidence, the WHO recommends increasing the price of alcohol in order to address problem alcohol use and related harms. Not only does increasing the price of alcohol reduce alcohol use, but it also raises revenue for the government, which in turn can be used to fund additional alcohol treatment resources. This 'polluter pays' principle means that those responsible for the damage caused (in this case, alcohol-related hospitalisations, ambulance call-outs, crime, and treatment for alcohol problems) must pay for the consequences of the harm [82].

Households in Ireland spend 2.5% of overall household expenditure on alcohol, and more is spent on alcohol that is to be consumed at home than on alcohol for consumption in licenced premises.

The cost of alcohol in Ireland ranks 4$^{th}$ highest of the 27 EU countries, with drink prices 101% above the EU average. The CPI indicates that the cost of alcohol sold in both the off-trade and on-trade has increased between September 2022 and September 2023, more notably for alcohol sold in licenced premises and particularly for beer and spirits. But alcohol is not the only consumer product affected by the cost-of-living crisis. All food and beverages have seen a price increase, as well as household utility bills, and many items have seen a more substantial price increase than alcohol has undergone. In fact, although the price of alcohol has increased, it has actually become more affordable when considering inflation, especially in the off-trade sector.

The relatively low cost of alcohol in off-licences is associated with alcohol-related harms and in response to this, the Public Health (Alcohol) Act, 2018 introduced MUP in 2022. MUP prohibits alcohol being sold at less than EUR 1 per 10 grams of alcohol (or EUR 1 per standard drink).

# 07

# Alcohol-related harm

Alcohol use, even at low levels, can increase the risk of harms. These may have instant consequences (which would more likely be the result of HED), and may include injuries such as road traffic collisions; falls; fires; drownings; violence, including assaults, suicide, sexual violence, and domestic violence; alcohol poisoning through excessive alcohol intake; and risky behaviours such as unprotected sex [76]. Long-term risks resulting from prolonged alcohol use can result in chronic diseases and other conditions such as alcohol use disorder (AUD) or alcohol dependency; cancer of the breast (female), liver, bowel, mouth, upper throat, larynx, and/or oesophagus; high blood pressure; stroke; heart disease; mental health problems; liver disease; and social problems, including employment and education problems or family and financial issues.

Several studies have reported a health benefit to moderate alcohol use and even a protective effect for a number of conditions such as cerebrovascular disease, peripheral vascular disease, diabetes, and stress reduction. However, a systematic review and meta-analysis of the study characteristics examining the apparent health benefits of low volume alcohol use found that selection bias may be misleading regarding positive health associations [83].

## 7.1 Alcohol-related harm to health

Alcohol use is the ninth leading risk factor for both deaths and disability-adjusted life years (DALYs) globally, and was the leading risk factor among those aged 25–49 years in 2019 [84]. Health harm from alcohol is caused not only by the amount of alcohol consumed, usually over long periods of time, but also patterns of drinking such as HED [1]. Harms to health due to alcohol use can be difficult to quantify, but hospitals that use international classification of diseases systems are highly valuable instruments with which to determine alcohol-related harms to health.

This overview updates the information on wholly alcohol-attributable health conditions [30]. Wholly alcohol-attributable conditions are those that are caused solely by alcohol use based on those listed in the WHO's International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10) (see Appendix 1) [85]. Examples of wholly alcohol-attributable conditions include alcohol-related liver disease, alcohol-induced pancreatitis, alcohol poisoning, and AUDs.

Conditions where alcohol is a contributory causal factor are referred to as partially alcohol-attributable conditions and include cardiovascular disease, type 2 diabetes, and seven types of cancer. With many of these conditions, the risk increases the more the individual drinks, but the extent of risk varies across the health conditions [86]. For example, for acute health conditions such as injuries, where risk is measured by blood alcohol concentration rather than by the volume of alcohol consumed over time, HED may also exacerbate harms caused by regular drinking [87]. The 2021 HRB alcohol overview *Alcohol consumption, alcohol-related harm and alcohol policy in Ireland* summarises the relationship between alcohol use and major partially alcohol-attributable health conditions [30]. This report does not include partially alcohol attributable analysis; the GBD is now a more widely used dataset to understand partially alcohol-attributable conditions.

### 7.1.1 Alcohol-related cancers

The NCRI records the number and types of cancer in Irish hospitals and these data are then used to establish the modifiable risk factors (behaviour or exposure that can be changed) associated with cancer incidence. Using cancer incidence data from 2016, the NCRI indicated that 29% of cancer cases (6,200) in Ireland were potentially preventable [88]. The NCRI estimated that cancer due to alcohol use accounted for 2.4% of all cancer cases (excluding non-melanoma skin cancer) in 2016 (2.8% of cancers among females and 1.9% of cancers among males), representing 506 cancer cases (287 cancer cases among females and 218 cancer cases among males). The three most common cancers associated with alcohol use identified were pharynx (32%), oral cavity (29%), and larynx (21%). Furthermore, NCRI analysis indicated that 7.5% of female breast cancer cases were alcohol attributable, representing 223 cases of female breast cancer. This is lower than global estimate results from a systematic review which estimated that 8.6% of all breast cancer incidence were alcohol-related [89].

The analysis predicts that if current rates of alcohol use continue, cancer attributable to alcohol use is estimated to reach 851 cases by 2035 (394 cases among males and 457 cases among females), representing a 69% increase from 2016 (a 37% increase for males and a 110% increase for females). Projections were also made if alcohol use decreased by 5% from current levels among moderate to heavy drinkers. These projections estimated that compared with 2016 alcohol-attributable cancer incidence rates, there would be a minimal decrease (0.1%) in alcohol-attributable cases for males and a 79% increase for females by 2035. Although an increase is estimated for females even with a reduction in alcohol use, the projected increase is less pronounced than it would be if current levels of alcohol use were to remain unchanged.

## 7.2 Alcohol-related hospitalisations

In order to estimate the number of alcohol-related hospitalisations in Ireland, data from the Hospital In-Patient Enquiry (HIPE) scheme were used. HIPE is a computerised health information system designed to collect clinical and administrative data on discharges (including deaths) from acute Irish hospitals and is managed by the Healthcare Pricing Office (HPO) in the HSE. HIPE uses discharges, which can be considered a proxy for admissions, to measure each patient contact.

The use of HIPE for epidemiological purposes has some limitations. The HIPE system records the number of inpatient events rather than the number of patients and, as these records do not carry a unique personal identifier, it is not possible to accurately determine how many times an individual patient was admitted for the same condition or admitted to another hospital. The records therefore facilitate analysis of hospital activity rather than epidemiological analysis of disease. Emergency department (ED) and outpatient data are not collected in HIPE. A 2018 study found that 6% of recorded ED admissions in Ireland were alcohol related and in 2024, a study in Beaumont Hospital found that 19.4% of ED presentations were alcohol-related [90,91] comparison with non-alcohol-related.

Using HIPE data to assess the burden of alcohol use on acute hospital services is an underestimation of the real impact of alcohol use. It is also important to note that even though a discharge may have an alcohol-related code, this may not have been the reason for admission to hospital.

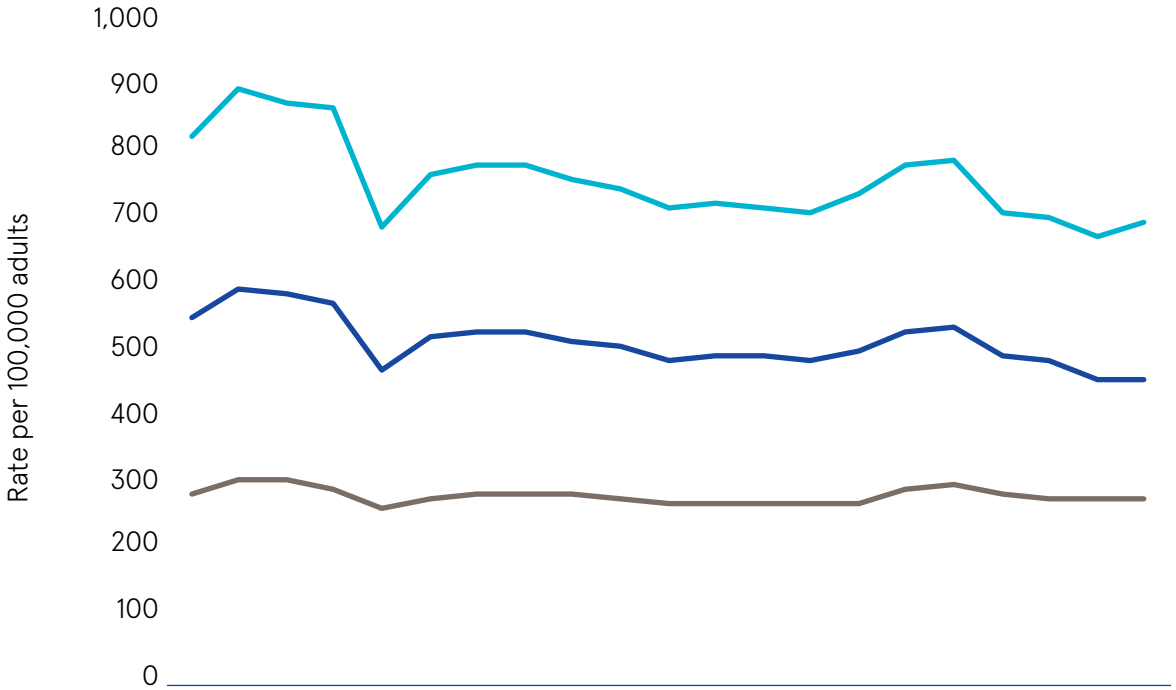
The analysis in this overview relates to the period from 2001 to 2021, and there have been several changes in HIPE's coding during this time. From 1995 to 2004, diagnoses were coded using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). Since 2005, the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) has been used. This revision resulted in numerous changes; for example, in the ICD-10-AM, there is no diagnosis of alcohol abuse. In 2020, HIPE changed its classification coding to use the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification and Australian Classification of Health Interventions (ACHI) and Australian Coding Standards (ACS), collectively referred to as ICD-10-AM/ACHI/ACS.

From 1995 to 2001, HIPE recorded a primary diagnosis and up to 5 secondary diagnoses; this increased to 9 secondary diagnoses in 2002, 19 in 2005, and 29 in 2011. As the HIPE system counts each patient contact and not the number of individual patients, it is not possible to ascertain the incidence of alcohol-related morbidity but remains an important indicator of the burden on Irish hospitals and permits analysis of trends over time. As an alternative, for alcohol-attributable conditions, the number of alcohol-related hospitalisations per 100,000 of the population aged 15 years and over is calculated here. The HPO provided the HRB with HIPE analyses on discharges with wholly alcohol-attributable conditions. Data were available for the years 2019–2021. Trends and comparisons with earlier years were made using the 2021 HRB alcohol overview, *Alcohol consumption, alcohol-related harm and alcohol policy in Ireland* [30].

### 7.2.1 Trends in alcohol-related hospitalisations

Trends in discharges due to alcohol-attributable conditions between 2001 and 2021 are presented in Table 12 and Figure 25. Figure 25 presents the rate of alcohol-related hospitalisations per 100,000 adults aged 15 years and over from 2001 to 2021 adjusting for annual population growth. The rate of alcohol-related hospitalisations has stabilised since the mid to late 2000s, from a peak in 2002. A 17.1% overall decrease in alcohol-related hospitalisations per 100,000 of the adult population was noted between 2001 and 2021. This decrease represents the substantial population increase in that time.

Figure 25 Rate of alcohol-related hospitalisations per 100,000 adults, by sex, 2001–2021




| | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| All persons | 537 | 584 | 573 | 562 | 460 | 506 | 516 | 515 | 503 | 494 | 475 | 480 | 477 | 470 | 486 | 519 | 525 | 477 | 471 | 441 | 445 |
| Males | 814 | 885 | 863 | 855 | 676 | 755 | 768 | 767 | 745 | 735 | 704 | 713 | 704 | 695 | 727 | 767 | 773 | 694 | 686 | 663 | 684 |
| Females | 268 | 293 | 292 | 276 | 249 | 261 | 267 | 268 | 267 | 260 | 253 | 255 | 259 | 253 | 255 | 280 | 287 | 267 | 265 | 265 | 264 |

Source: Hospital In-Patient Enquiry, 2022

During this 21-year period there were 374,451 discharges with an alcohol-related diagnosis. Males accounted for 73% of all such discharges during this period, while females accounted for 27%. When examining the absolute numbers without adjusting for population growth, alcohol-related hospitalisations increased from 16,219 in 2001 to 18,877 in 2021, an increase of 16.4%. The number of bed days accounted for by alcohol-related conditions increased by 78.1% during the same period, from 99,506 to 177,230 (Table 12). The mean length of stay for alcohol-related conditions increased by 62.3%, from a mean of 6.1 days in 2001 to a mean of 9.9 days in 2021, almost double that of a non-alcohol-related condition (5.7 days) [92]. In 2021, 5.2% of all inpatient bed days were alcohol-related (not including day patients); this was unchanged from 2020 (5.2%).

Table 12 Number and length of stay of alcohol-related hospitalisations, 2001–2021

| Year | All persons | Males | Females | Mean length of stay (days) | Median length of stay (days) | Number of bed days[a] |
|---|---|---|---|---|---|---|
| 2001 | 16,219 | 12,109 | 4,110 | 6.1 | 2 | 99,506 |
| 2002 | 18,057 | 13,471 | 4,586 | 6.6 | 2 | 119,510 |
| 2003 | 18,035 | 13,378 | 4,657 | 6.5 | 2 | 117,325 |
| 2004 | 17,976 | 13,505 | 4,471 | 6.9 | 3 | 124,836 |
| 2005 | 15,088 | 10,971 | 4,117 | 7.9 | 3 | 118,569 |
| 2006 | 17,053 | 12,629 | 4,424 | 8.1 | 3 | 138,307 |
| 2007 | 18,024 | 13,344 | 4,680 | 8.0 | 3 | 144,836 |
| 2008 | 18,400 | 13,579 | 4,821 | 8.8 | 3 | 161,016 |
| 2009 | 18,109 | 13,254 | 4,855 | 8.6 | 3 | 156,464 |
| 2010 | 17,755 | 13,015 | 4,740 | 9.1 | 3 | 160,991 |
| 2011 | 17,078 | 12,457 | 4,621 | 9.4 | 3 | 159,725 |
| 2012 | 17,225 | 12,552 | 4,673 | 9.2 | 3 | 158,074 |
| 2013 | 17,120 | 12,398 | 4,722 | 10.1 | 4 | 160,211 |
| 2014 | 17,139 | 12,435 | 4,704 | 9.9 | 4 | 159,664 |
| 2015 | 17,917 | 13,128 | 4,789 | 10.8 | 4 | 175,750 |
| 2016 | 19,392 | 14,063 | 5,329 | 10.3 | 4 | 181,229 |
| 2017 | 19,892 | 14,359 | 5,533 | 10.4 | 4 | 186,378 |
| 2018 | 18,348 | 13,124 | 5,224 | 10.3 | 4 | 177,892 |
| 2019 | 18,445 | 13,177 | 5,268 | 10.6 | 4 | 183,924 |
| 2020 | 18,302 | 12,942 | 5,360 | 9.7 | 4 | 170,181 |
| 2021 | 18,877 | 13,481 | 5,396 | 9.9 | 4 | 177,230 |

[a] Note that 'Number of bed days' here includes day patients and inpatients.

Source: Hospital In-Patient Enquiry, 2022

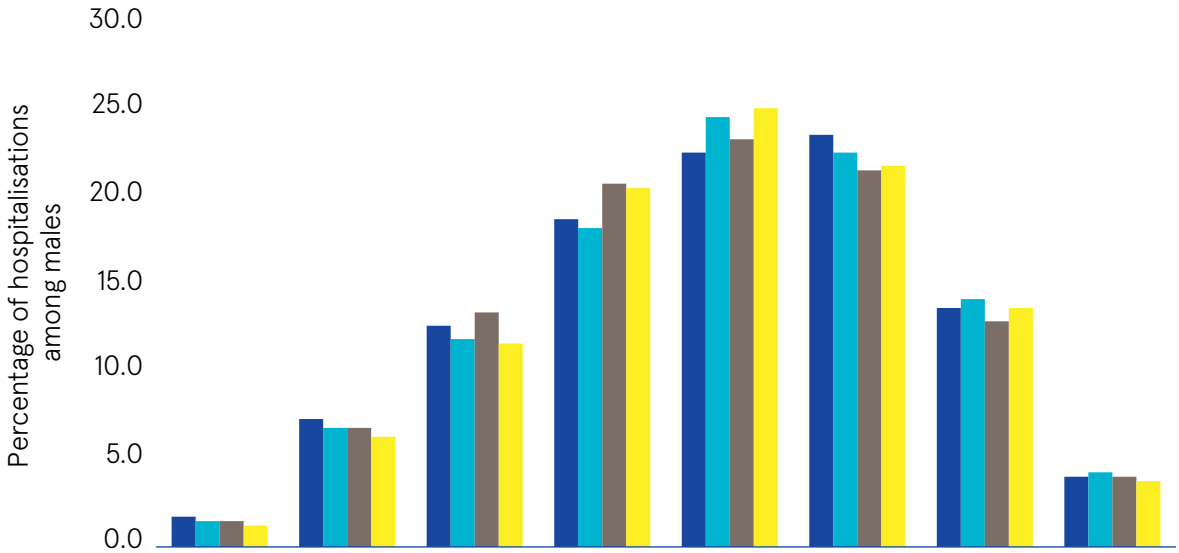
## 7.2.2 Age and sex profile of alcohol-related hospitalisations

In 2021, males accounted for 71.4% of total discharges, while females accounted for 28.6% of total discharges. Of discharges among those aged 17 years and under, females accounted for more than one-half (52.7%) of total discharges.

### *Alcohol-related hospitalisations among males*

In 2018, 20.0% of alcohol-related hospital discharges were males aged under 40 years, and this had decreased in 2021 to 17.4% (Figure 26). Males aged between 40 and 69 years accounted for most alcohol-related hospitalisations, increasing from 63.4% in 2018 to 66.1% in 2021.

Figure 26 Age profile of alcohol-related hospitalisations among males, 2018–2021



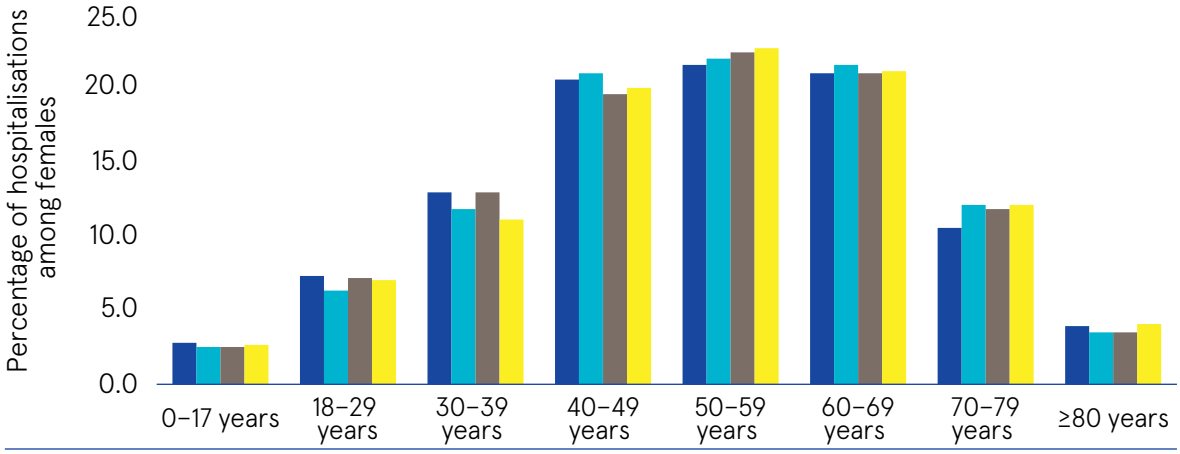

| | 0–17 years | 18–29 years | 30–39 years | 40–49 years | 50–59 years | 60–69 years | 70–79 years | ≥80 years |
|---|---|---|---|---|---|---|---|---|
| 2018 | 1.1 | 6.8 | 12.1 | 18.3 | 22.1 | 23.0 | 13.1 | 3.6 |
| 2019 | 0.8 | 6.4 | 11.4 | 17.7 | 24.0 | 22.2 | 13.6 | 3.8 |
| 2020 | 0.9 | 6.2 | 12.8 | 20.2 | 22.9 | 21.0 | 12.4 | 3.5 |
| 2021 | 0.7 | 5.7 | 11.0 | 20.1 | 24.6 | 21.4 | 13.2 | 3.3 |

Source: Hospital In-Patient Enquiry, 2022

### *Alcohol-related hospitalisations among females*

The percentage of females aged under 40 years who were hospitalised due to an alcohol-related condition decreased, from 22.7% in 2018 to 20.5% in 2021 (Figure 27). Females aged 50–59 years represented the largest age group discharged with an alcohol-related diagnosis, followed by those aged 60–69 years. Alcohol-related hospital discharges increased among females aged 70 years and over, from 14.3% in 2018 to 15.9% in 2021.

Figure 27 Age profile of alcohol-related hospitalisations among females, 2018–2021




| | 0–17 years | 18–29 years | 30–39 years | 40–49 years | 50–59 years | 60–69 years | 70–79 years | ≥80 years |
|---|---|---|---|---|---|---|---|---|
| 2018 | 2.7 | 7.2 | 12.8 | 20.5 | 21.5 | 20.9 | 10.5 | 3.8 |
| 2019 | 2.4 | 6.3 | 11.8 | 20.9 | 21.8 | 21.5 | 12.0 | 3.3 |
| 2020 | 2.4 | 7.0 | 12.8 | 19.5 | 22.3 | 20.9 | 11.7 | 3.3 |
| 2021 | 2.5 | 7.0 | 11.0 | 20.0 | 22.6 | 21.1 | 11.9 | 4.0 |

Source: Hospital In-Patient Enquiry, 2022

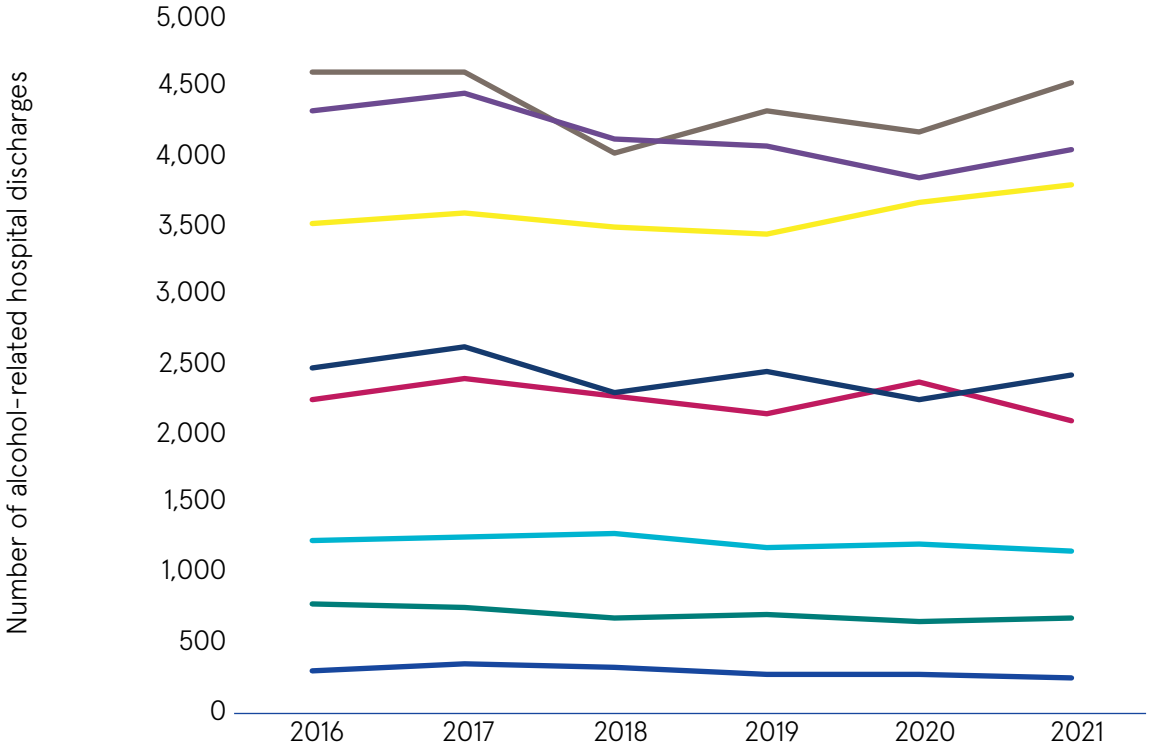
Figure 28 illustrates the age profile of the number of alcohol-related hospitalisations between 2016 and 2021. Since 2016, the number of alcohol-related hospitalisations has decreased in all age groups apart from those aged 40–49 years (7.7% increase).

**18,877 people**
were hospitalised due to wholly alcohol-related conditions in 2021

The number of bed days accounted for by alcohol-related conditions **increased by 78.1%** between 2001 and 2021

The length of stay for alcohol-related conditions has increased from a mean of 6.1 days in 2001 to a mean of 9.9 days in 2021, almost double that of a non-alcohol-related condition (5.7 days). In 2021, 5.2% of all inpatient bed days were alcohol-related.

Figure 28 Number of hospital discharges for alcohol-attributable conditions, by age group, 2016–2021




| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|---|
| <18 years | 277 | 318 | 289 | 237 | 248 | 231 |
| 18–29 years | 1,223 | 1,235 | 1,269 | 1,174 | 1,179 | 1,150 |
| 30–39 years | 2,242 | 2,382 | 2,254 | 2,125 | 2,347 | 2,080 |
| 40–49 years | 3,510 | 3,587 | 3,475 | 3,428 | 3,664 | 3,780 |
| 50–59 years | 4,600 | 4,599 | 4,021 | 4,316 | 4,162 | 4,529 |
| 60–69 years | 4,323 | 4,432 | 4,106 | 4,061 | 3,833 | 4,025 |
| 70–79 years | 2,465 | 2,610 | 2,272 | 2,426 | 2,233 | 2,420 |
| ≥80 years | 752 | 729 | 662 | 678 | 636 | 662 |

Source: Hospital In-Patient Enquiry

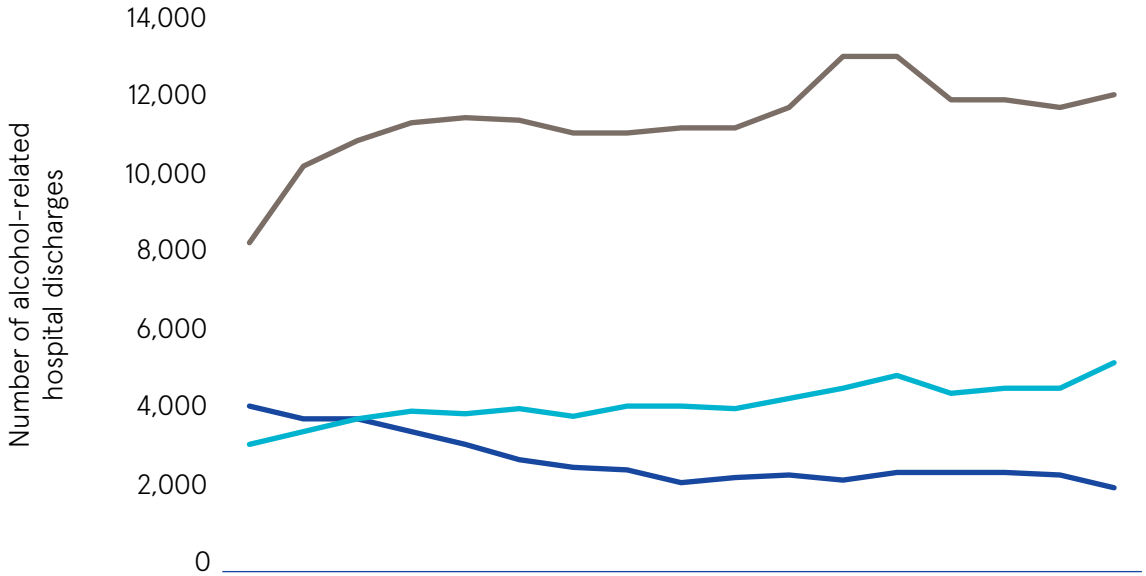
## 7.2.3 Alcohol-related hospitalisations by diagnosis

Using HIPE data, discharges were classified into acute conditions, chronic diseases, and other chronic conditions (see Appendix 1). If a case had both an acute and a chronic alcohol-related diagnosis, the chronic diagnosis was selected, and for cases with both a chronic disease and a chronic condition, the chronic disease was selected.

Figure 29 shows the number of alcohol-related acute conditions, chronic diseases, and other chronic conditions between 2005 and 2021. In 2021, acute conditions accounted for 10.0% of attributable alcohol-related hospitalisations, chronic diseases accounted for 26.9% of such discharges, and other chronic conditions accounted for 63.2%. The number of hospital discharges with acute alcohol-related conditions has decreased by 52.8% between 2005 and 2021.

Between 2019 and 2021, there was a 15.8% decrease in acute alcohol-related discharges from Irish hospitals, likely due to the impact of COVID-19 restrictions and people potentially avoiding hospitals during that period. The number of hospital discharges with chronic diseases and other chronic conditions increased by 53.1% between 2005 and 2021. As chronic alcohol-related conditions tend to take years of heavy drinking before they develop, the increase in the number of such conditions presented here may be indicative of the high per capita alcohol use recorded in the early 2000s.

Figure 29 Number of discharges for alcohol-related chronic and acute conditions, 2005–2021




| | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Acute conditions | 3,983 | 3,650 | 3,637 | 3,319 | 2,968 | 2,572 | 2,371 | 2,295 | 2,003 | 2,125 | 2,177 | 2,067 | 2,241 | 2,274 | 2,230 | 2,201 | 1,878 |
| Chronic diseases | 2,956 | 3,299 | 3,629 | 3,827 | 3,770 | 3,856 | 3,710 | 3,933 | 3,964 | 3,914 | 4,116 | 4,383 | 4,711 | 4,253 | 4,383 | 4,415 | 5,071 |
| Other chronic conditions | 8,142 | 10,096 | 10,754 | 11,247 | 11,350 | 11,312 | 10,956 | 10,977 | 11,100 | 11,090 | 11,606 | 12,930 | 12,934 | 11,815 | 11,827 | 11,637 | 11,918 |

Source: Hospital In-Patient Enquiry, 2022

Table 13 illustrates the percentage of alcohol-related hospitalisations from 2016 to 2021 by age group. Older people were more likely to be discharged from hospital with chronic alcohol-related conditions, and acute alcohol-related conditions were more prevalent among younger people. Those aged between 50 and 69 years represented 54.4% of chronic alcohol-related hospitalisations in 2021. Those aged under 30 years accounted for 28.6% of all discharges related to acute alcohol-related conditions in 2021. This is suggestive of the higher rates of HED among younger people and the consequent alcohol-related health harms experienced, as such patterns of drinking increase the risk of poisoning and alcohol-related injuries [93]. The 2022 HRB overview, *Alcohol and other drug use among children and young people in Ireland* which examined young people's alcohol use and related harms, also analysed alcohol-related hospitalisations for those aged 15–24 years and found an upward trend in hospitalisations in this age group between 2015 and 2018 (but a decrease between 2018 and 2019) [4].

Table 13 Percentage of acute and chronic diagnoses among alcohol-related hospitalisations, by age group, 2016–2021

| | 2016 | | | 2017 | | | 2018 | |
|---|---|---|---|---|---|---|---|---|
| | Acute condition | Chronic disease | Other chronic condition | Acute condition | Chronic disease | Other chronic condition | Acute condition | Chronic disease |
| <18 years | 10.0% | ~ | ~ | 10.6% | ~ | ~ | 9.4% | ~ |
| 18–29 years | 20.9% | 2.1% | 5.4% | 21.2% | 1.8% | 5.2% | 22.5% | 2.2% |
| 30–39 years | 14.5% | 11.3% | 11.2% | 17.1% | 10.9% | 11.6% | 17.5% | 10.5% |
| 40–49 years | 16.3% | 22.8% | 16.9% | 16.2% | 23.2% | 16.6% | 14.6% | 24.7% |
| 50–59 years | 16.4% | 29.7% | 23.0% | 14.6% | 29.7% | 22.3% | 13.5% | 27.2% |
| 60–69 years | 12.3% | 22.7% | 23.9% | 11.6% | 23.3% | 23.9% | 13.9% | 25.0% |
| 70–79 years | 7.6% | 9.3% | 14.8% | 6.2% | 9.9% | 15.6% | 6.6% | 9.1% |
| ≥80 years | 1.9% | 2.1% | 4.8% | 2.5% | 1.2% | 4.8% | 2.2% | 1.3% |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

Source: Hospital In-Patient Enquiry, 2022

~ Denotes percentages that represent five cases or fewer.

| | 2019 | | | 2020 | | | 2021 | | |
|---|---|---|---|---|---|---|---|---|---|
| Other chronic condition | Acute condition | Chronic disease | Other chronic condition | Acute condition | Chronic disease | Other chronic condition | Acute condition | Chronic disease | Other chronic condition |
| ~ | 8.7% | 0.0% | 0.3% | 9.1% | ~ | ~ | 9.2% | 0.0% | 0.4% |
| 5.7% | 19.8% | 1.8% | 5.5% | 19.5% | 1.8% | 5.8% | 19.4% | 1.7% | 5.9% |
| 12.0% | 15.4% | 9.9% | 11.4% | 17.6% | 9.9% | 13.1% | 15.2% | 8.8% | 11.3% |
| 17.8% | 17.5% | 21.2% | 17.8% | 17.2% | 25.2% | 18.7% | 16.6% | 22.0% | 19.7% |
| 21.8% | 16.3% | 28.3% | 22.9% | 16.9% | 28.0% | 21.9% | 16.7% | 29.6% | 22.8% |
| 23.2% | 11.5% | 25.2% | 22.8% | 10.4% | 23.4% | 22.1% | 13.3% | 24.8% | 21.1% |
| 14.8% | 8.7% | 11.0% | 14.8% | 7.3% | 9.7% | 14.1% | 7.5% | 10.9% | 14.5% |
| 4.7% | 2.0% | 2.6% | 4.4% | 1.9% | 2.1% | 4.3% | 2.2% | 2.2% | 4.3% |
| 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

### 7.2.3.1 Alcohol-related liver disease hospitalisations

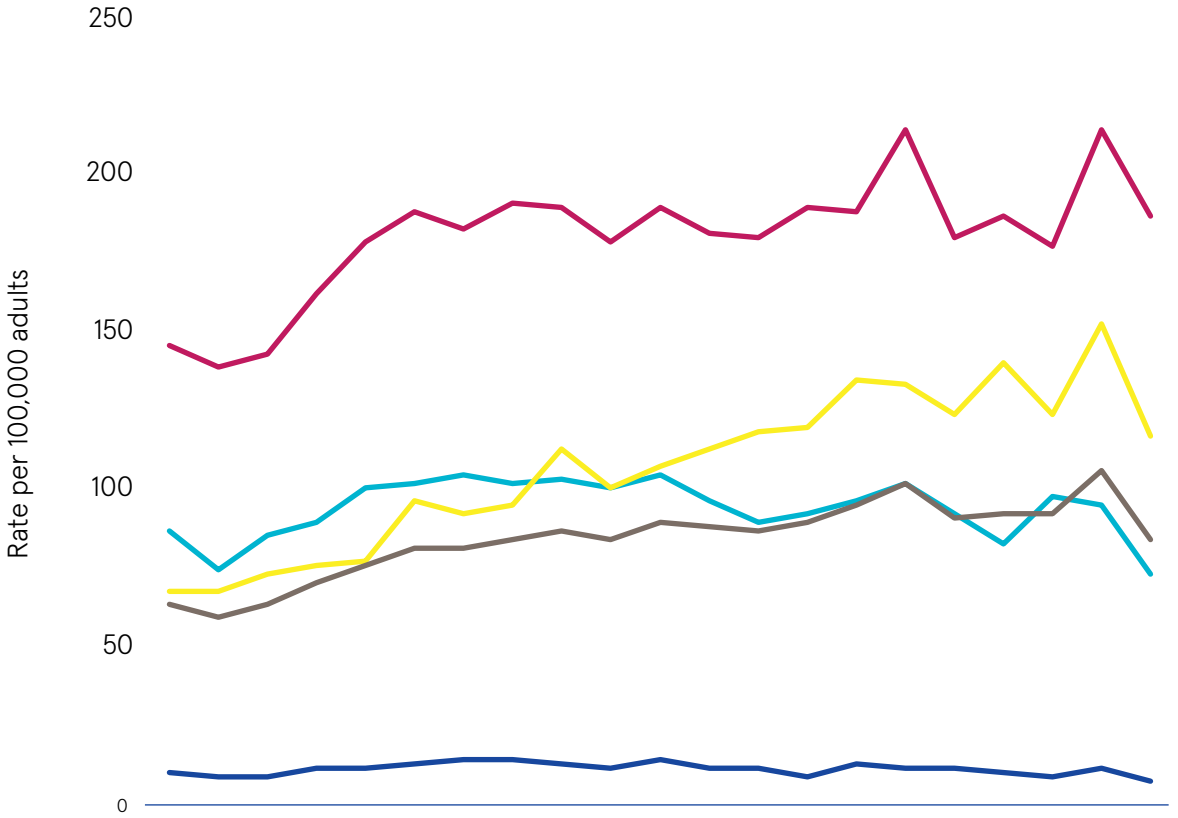
Rates of alcohol-related liver disease (ALD) discharges per 100,000 of the adult population aged 15 years and over from 2002 to 2022 are presented in Figure 30. Rates of hospital discharges due to ALD have steadily increased in the 21 years of data presented, and 2021 saw the highest rate of ALD discharges recorded, at 105.6 discharges per 100,000 adults, representing a 79.9% increase in the 21-year period. However, ALD discharge rates have decreased in 2022 to 83.5 per 100,000, representing a 42.2% increase when compared to 2001. The increase in 2021 may be a result of delayed help seeking due to the pandemic.

The largest increase in rates of ALD discharges per 100,000 adults was evident in those aged 65 years and over, increasing by 72.6% between 2002 and 2022 and by 28.5% among those aged 50–64 years. It should be noted that the population estimates are for the overall population of adults and not adjusted for each age group and Irelands population is an ageing one [94].

**Rates of hospital discharges due to alcohol-related liver disease have steadily increased**

2021 saw the highest rate ever recorded, a 79.9% increase compared with 2002 but have decreased in 2022

Figure 30 Rates of ALD hospital discharges per 100,000 adults, by age group, 2002–2022

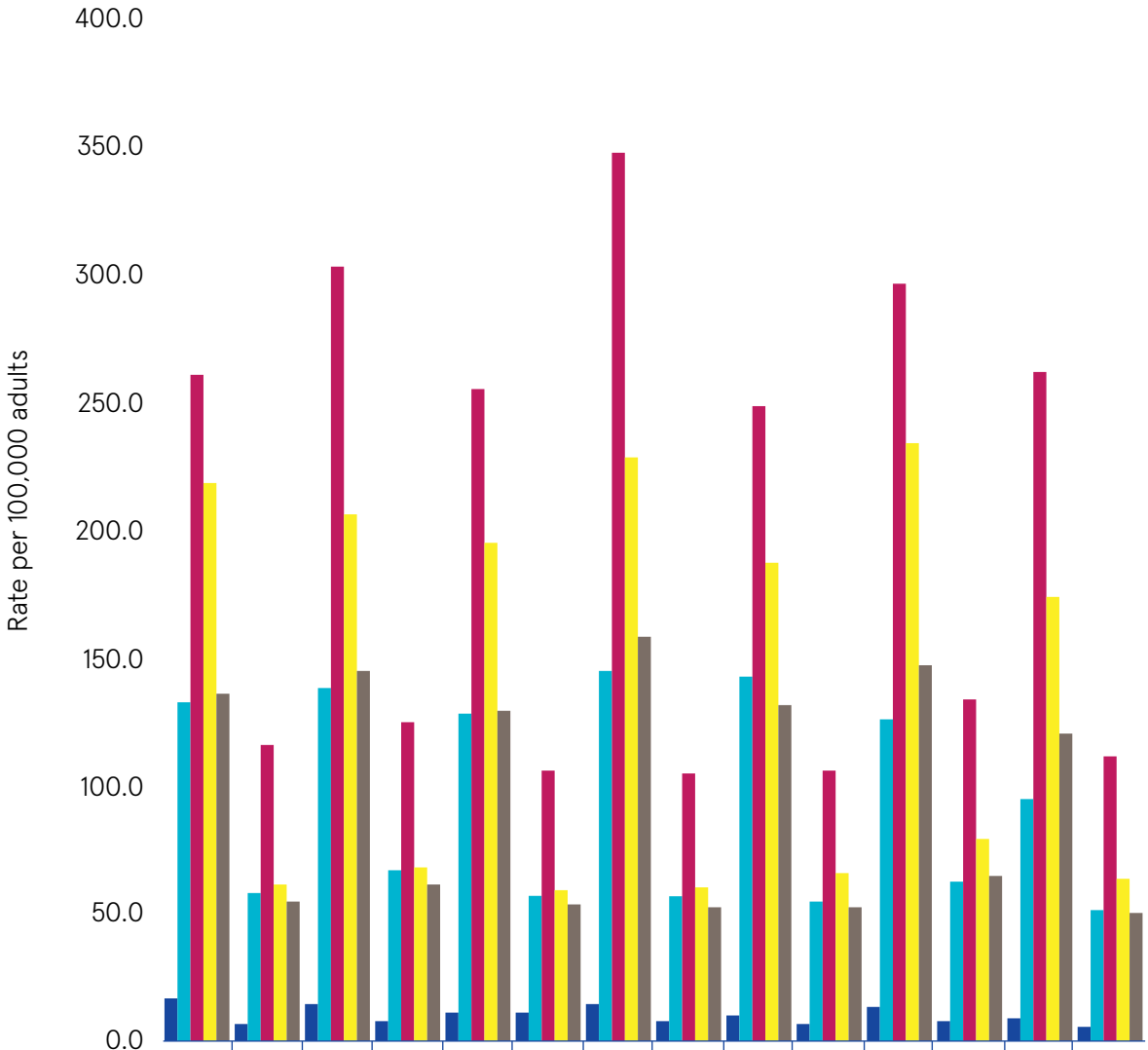



| | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 15-34 | 9.6 | 8.3 | 8.3 | 11.4 | 11.2 | 13.0 | 14.4 | 13.6 | 12.5 | 11.9 | 13.5 | 12.0 | 11.6 | 8.5 | 12.3 | 11.7 | 11.8 | 10.4 | 9.0 | 10.8 | 7.7 |
| 35-49 | 86.3 | 74.9 | 84.6 | 89.3 | 100.2 | 101.4 | 103.7 | 101.7 | 102.5 | 100.1 | 104.5 | 96.4 | 90.0 | 92.4 | 95.6 | 102.3 | 92.1 | 83.2 | 97.9 | 94.2 | 72.8 |
| 50-64 | 145.3 | 138.2 | 142.9 | 161.8 | 177.7 | 188.3 | 182.8 | 190.9 | 188.9 | 178.8 | 189.2 | 180.8 | 178.9 | 189.5 | 188.4 | 213.6 | 180.2 | 186.8 | 176.2 | 214.1 | 186.7 |
| 65+ | 67.4 | 68.1 | 73.2 | 76.1 | 77.0 | 96.2 | 92.0 | 94.4 | 112.6 | 99.9 | 107.2 | 113.2 | 117.4 | 119.1 | 134.5 | 132.6 | 122.9 | 139.6 | 123.2 | 152.2 | 116.3 |
| All | 63.5 | 59.1 | 63.6 | 70.3 | 76.1 | 81.3 | 81.2 | 83.3 | 86.8 | 83.4 | 89.9 | 87.7 | 86.2 | 89.3 | 94.6 | 102.3 | 90.8 | 92.7 | 91.7 | 105.6 | 83.5 |

Source: Hospital In-Patient Enquiry, 2023

Between 2016 and 2022, the rate of ALD discharges per 100,000 of the male adult population aged 15 years and over decreased from 136.0 per 100,000 to 120.3 per 100,000, representing an 11.5% decrease in this 7-year period. Among females, the rate of ALD per 100,000 of the adult population decreased by 7.7%, from 54.7 per 100,000 in 2016 to 50.5 per 100,000 in 2022 (Figure 31).

Figure 31 Rate of ALD discharges per 100,000 adults, by sex and age, 2016 - 2022




| | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2016 | | 2017 | | 2018 | | 2019 | | 2020 | | 2021 | | 2022 | |
| 15-34 Years | 17.4 | 7.2 | 15.0 | 8.4 | 11.5 | 12.0 | 14.4 | 7.9 | 10.9 | 7.1 | 13.7 | 7.8 | 9.7 | 6.2 |
| 35-49 Years | 132.9 | 58.8 | 138.0 | 67.4 | 128.6 | 56.7 | 145.2 | 56.8 | 142.5 | 55.1 | 126.7 | 63.2 | 95.0 | 51.8 |
| 50-64 Years | 261.2 | 116.7 | 303.6 | 125.1 | 255.0 | 106.7 | 347.9 | 105.2 | 248.2 | 105.7 | 296.0 | 133.8 | 262.5 | 112.0 |
| 65+ Years | 218.6 | 61.2 | 206.1 | 68.4 | 195.6 | 59.0 | 228.9 | 60.6 | 187.7 | 65.8 | 233.8 | 79.7 | 174.6 | 64.4 |
| Total | 136.0 | 54.7 | 145.0 | 61.1 | 129.3 | 53.7 | 158.2 | 52.7 | 131.4 | 53.3 | 147.5 | 65.1 | 120.3 | 50.5 |

Source: Hospital In-patient Enquiry, 2023

ALD develops following prolonged heavy alcohol use, and therefore it is not surprising to see that many ALD cases are in the middle to older age groups. The 2023 Healthy Ireland Survey indicated a high prevalence of HED on a typical drinking occasion, this pattern of drinking increases the risk of developing ALD [35].

In 2022, the mean length of hospital stay for patients with ALD was 15 days, and ALD accounted for 45,109 bed days (Table 14). The number of bed days accounted for by ALD has risen since 2016, indicating the increasing complexity of care required for these patients [95].

Table 14 Number and length of stay of ALD discharges, 2016 - 2022

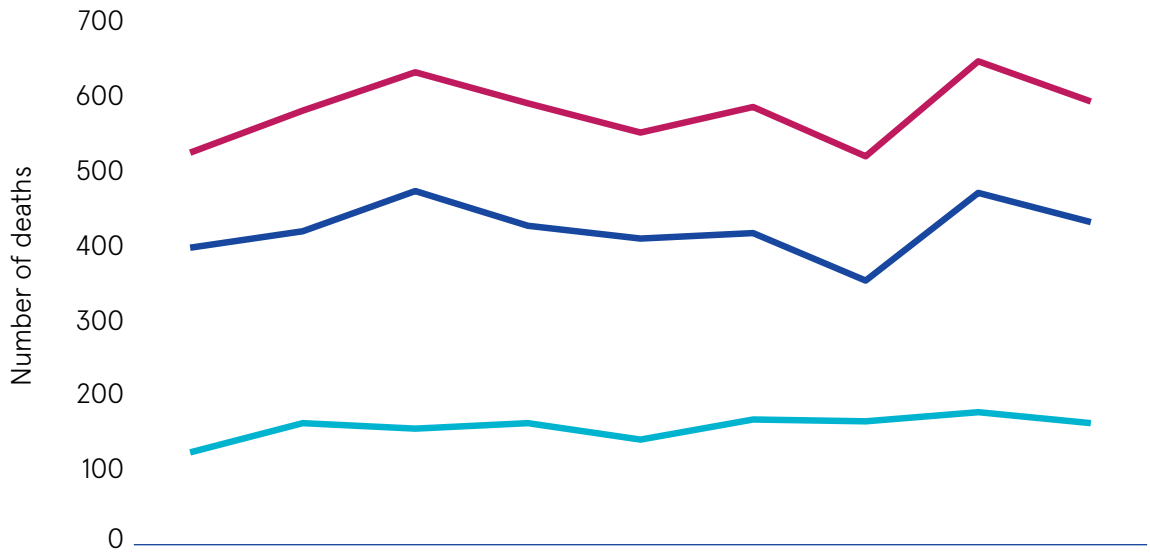
| Year | Total ALD discharges | Total male ALD discharges | Total female ALD discharges | Mean length of stay (days) | Number of inpatient bed days |
|---|---|---|---|---|---|
| 2016 | 3,533 | 2,493 | 1,040 | 13.3 | 40,557 |
| 2017 | 3,872 | 2,694 | 1,178 | 13.3 | 41,257 |
| 2018 | 3,496 | 2,444 | 1,052 | 12.2 | 37,071 |
| 2019 | 3,627 | 2,577 | 1,050 | 14.6 | 45,546 |
| 2020 | 3,643 | 2,565 | 1,078 | 13.6 | 43,260 |
| 2021 | 4,239 | 2,909 | 1,330 | 13.6 | 49,128 |
| 2022 | 3,610 | 2,458 | 1,152 | 15.0 | 45,109 |

Source: Hospital In-patient Enquiry (HIPE), 2023

## 7.2.4 Alcohol-related deaths recorded in Irish hospitals

Data from HIPE indicate that during the period from 2014 to 2022, there were 5,230 deaths in Irish hospitals with an alcohol-related diagnosis. Males accounted for substantially more alcohol-related deaths in hospital; in 2022, 72.7% of deaths in hospital were male (Figure 32). There has been a 13.4% increase in the number of recorded deaths in hospital due to alcohol-related conditions in the period 2014–2022 (8.3% increase among males and 29.6% increase among females).

Figure 32 Number of cases with an alcohol-related condition who died in hospital, 2014 – 2022




| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|---|---|---|
| Male | 399 | 419 | 475 | 428 | 411 | 418 | 354 | 471 | 432 |
| Female | 125 | 162 | 157 | 164 | 142 | 168 | 166 | 177 | 162 |
| Total | 524 | 581 | 632 | 592 | 553 | 586 | 520 | 648 | 594 |

Source: Hospital In-patient Enquiry (HIPE) scheme, 2023

Chronic diseases accounted for 59.0% of alcohol-related deaths recorded in Irish hospitals; other chronic conditions accounted for 38.3% of such deaths, and acute alcohol-related diagnoses accounted for the remaining 2.8%. Of all discharges with a diagnosis of ALD, 8.6% died while in hospital, remaining relatively unchanged since 2001 and suggesting little improvement in the prognosis of patients with ALD. The number of cases with a diagnosis of ALD who died in hospital was 285 in 2022.

## 7.3 Alcohol and the emergency department

As data on the number of alcohol-related emergency department (ED) presentations are not routinely collected in Ireland, the extent of their burden on EDs is unknown. Previous studies have estimated that between 5% and 23% of ED presentations are alcohol-related, representing a significant burden on already-stretched EDs throughout Ireland [91,96,97].

A study examining mental health ED presentations referred to psychiatric services between 2018 and 2020 in Beaumont Hospital in Dublin found that 'mental and behavioural disorders due to use of alcohol' was the most common diagnosis for presentations during that period and was more commonly diagnosed during normal working hours than out of hours [98].

A further study examining all ED presentations in a Dublin hospital during two different periods, before and after commencement of MUP, found alcohol-related presentations accounted for 19.4% of all ED presentations [92]. The study found that 63.1% of alcohol-related presentations were male and a higher prevalence was noted among the 40 – 50 years age group. Presentations for acute injuries were the most common purpose of the ED visit (32.6%), followed by chest complaints (19.1%) and mental health issues (16.3%). Alcohol-related presentations to the ED decreased significantly between the two periods (from 22.8% before MUP to 16.1% following MUP implementation), however, an increase of 19.8% was noted for acute wholly-alcohol related presentations between periods. The study demonstrates the burden of alcohol on ED presentations and the authors recommend alcohol-care teams to reduce alcohol-related ED presentations, hospital admissions and mortality.

# 7.4 Disability-adjusted life years due to alcohol

The Global Burden of Disease (GBD) study calculates deaths due to particular causes, disability-adjusted life years (DALYs) and years lived with disability (YLDs). DALYs is a calculation of the years lost due to a disease or health condition. One DALY represents the loss of 1 year of full health. DALYs were calculated using the GBD Compare dataset for 2019 for alcohol use [6,7]. Table 15 indicates that there were 62,237 DALYs in 2019 in the population in Ireland – in other words, more than 62,000 years of full health were compromised due to alcohol use, with men in particular being more likely to lose years of healthy life (44,538 years) as well as those aged 15–49 years (28,418 years).

Table 15 Total DALYs from all causes attributable to alcohol in 2019 in Ireland, by age and sex

| | Number of alcohol-attributable DALYs (95% uncertainty interval (UI)) | Rate of DALYs per 100,000 of the population (95% UI) | Percentage of total DALYs (95% UI) |
|---|---|---|---|
| **Sex** | | | |
| All | 62,237 (52,062–73,939) | 1,268 (1,060–1,506) | 5.3% (4.6–6.0%) |
| Male | 44,538 (37,377–52,278) | 1,834 (1,539–2,152) | 5.2% (6.6–8.6%) |
| Female | 17,699 (14,096–22,191) | 713 (568–894) | 3.0% (2.4–3.6%) |
| **Age group** | | | |
| <5 years | 0.18 (0.08–0.36) | 0.57 (0.024–0.11) | 0.0% (0.0–0.0%) |
| 5–14 years | 126 (81–188) | 18 (12–27) | 0.4% (0.2–0.5%) |
| 15–49 years | 28,418 (22,983–34,925) | 1,219 (986–1,498) | 7.9% (6.6–9.1%) |
| 50–69 years | 21,671 (18,294–25,087) | 2,014 (1,700–2,332) | 6.0% (5.1–7.0%) |
| ≥70 years | 12,022 (9,064–15,335) | 2,493 (1,879–3,179) | 3.0% (2.3–3.8%) |

Source: Global Burden of Disease Study [7]

Alcohol use disorder (AUD) and alcohol-related cancers (neoplasms) are the top causes of alcohol-attributable DALYs in the total population (Table 16).

Table 16 DALYs attributable to alcohol use in 2019 in Ireland, by illness

| | Number of alcohol-attributable DALYs (95% UI) | Rate of DALYs per 100,000 of the population (95% UI) | Percentage of total DALYs |
|---|---|---|---|
| Respiratory infections and tuberculosis | 1,901 (1,012–2,788) | 38.7 (20.6–56.8) | 0.2% |
| Neoplasms | 14,566 (12,566–16,478) | 294.4 (255.7–335.6) | 1.2% |
| Cardiovascular diseases | 4,214 (1,065–7,822) | 85.8 (21.7–159.3) | 0.4% |
| Digestive diseases | 8,523 (6,743–10,205 | 173.6 (137.3–207.8) | 0.7% |
| Neurological disorders | 1,780 (843–3,291) | 36.2 (17.2–67.0) | 0.2% |
| Alcohol use disorders | 19,838 (14,479–26,373) | 404.0 (294.9–537.1) | 1.7% |
| Transport injuries | 1,454 (840–2,093) | 29.6 (17.1–42.6) | 0.1% |
| Self-harm and interpersonal violence | 6,137 (3,586–8,693) | 125.0 (73.0–177.0) | 0.5% |

Source: Global Burden of Disease [7]

## 7.5 Years lived with disabilities due to alcohol

YLD is a measure to show the impact an illness has on quality of life before the illness resolves or leads to death, or the number of years of what could have been a healthy life that were instead spent in an unhealthy state. Using the GBD Compare dataset for 2019, the risk factor for alcohol use and YLD was calculated [6,7]. Males were more likely to have a higher number of YLDs attributable to alcohol use (16,535) compared with females (7,208) (Table 17).

Table 17 Total YLDs from all causes attributable to alcohol use in 2019 in Ireland, by sex

| Sex | Number of alcohol-attributable YLDs (95% UI) | Rate of YLDs per 100,000 of the population (95% UI) | Percentage of total YLDs (95% UI) |
|---|---|---|---|
| All | 23,744 (16,374–32,722) | 484 (333–666) | 3.8% (3.1–4.5%) |
| Male | 16,535 (11,474–22,808) | 681 (472–939) | 6.0% (4.9–7.1%) |
| Female | 7,208 (4,786–10,344) | 290 (193–417) | 2.0% (1.5–2.6%) |

Source: Global Burden of Disease [7]

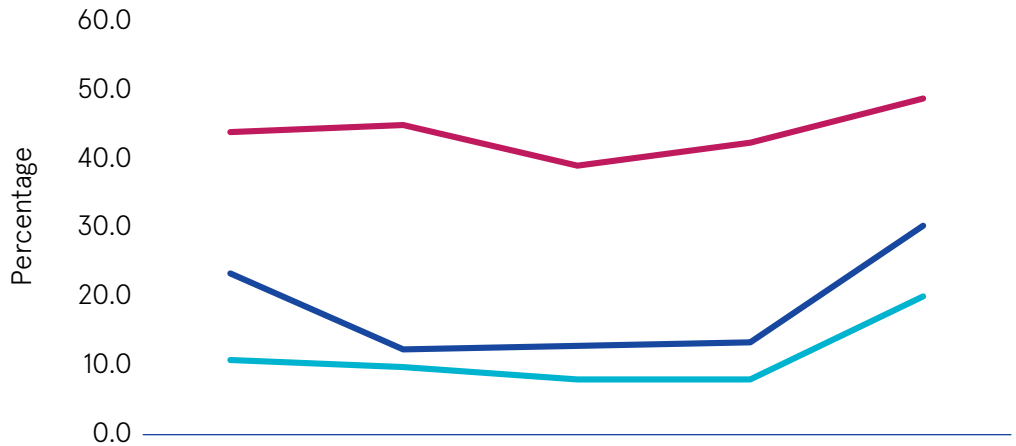
## 7.6 Alcohol and sexual assault and violence

There are six sexual assault treatment units (SATUs) in Ireland, and in 2022, there were 1,072 attendances at these units, increasing by 24.8% from 859 attendances in 2021 [99]. Of the perpetrators, 26% were described as being strangers to the victims; however, 11% were described as an intimate (or ex-intimate) partner, and 16% as a friend or family member.

Due to under-reporting, it is particularly challenging to estimate alcohol-related sexual violence, but data from the sexual assault treatment units (SATUs) indicated that in 2022, when such information was recorded, 48.5% of the patients treated across the six SATU locations had consumed more than six standard drinks in the 24 hours prior to the incident (Figure 34) [100].

Under-reporting of sexual violence and assault is commonplace for a number of reasons, including the stigma associated with such crimes; victims' perception that they might not be believed or that the criminal justice system is ineffective; fear of reprisal if the crime is reported; or that sexual assaults often occur in private, with the assailant known to the victim [101]. Note that this data is limited to the alcohol use of the victims of sexual assault and no information is available on what caused the sexual assault or details about the perpetrator committing the assault. There is no research available on what the perpetrator was drinking prior to the assault, and it is important to recognise that victims of sexual assault are not being blamed for their alcohol use.

Figure 33 Alcohol consumed by SATU patients in the 24 hours prior to the sexual assault, 2018–2022

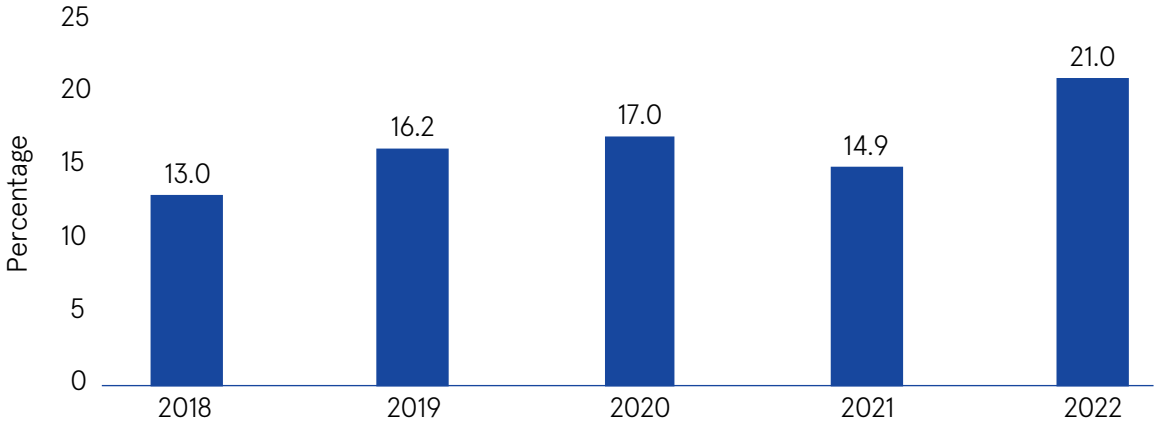



| | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|
| No alcohol consumed | 23.0 | 12.0 | 12.6 | 13.2 | 30.0 |
| ≤6 standard drinks | 10.6 | 9.6 | 7.6 | 7.7 | 19.9 |
| >6 standard drinks | 43.6 | 44.8 | 38.8 | 42.0 | 48.5 |

Source: Eogan, 2023 [100]

Where such information was recorded, 21% of patients who attended a SATU reported being concerned that drugs (including alcohol) had been used by the perpetrator to facilitate the sexual assault[6]. This represents an increase from 13% of patients in 2018 (Figure 34).

Figure 34 Percentage of sexual assault patients who reported being concerned that drugs (including alcohol) had been used by the perpetrator to facilitate sexual assault, 2018–2022




Source: Eogan, 2023 [100]

[6] When alcohol and/or drugs are used to compromise an individual's ability to consent to sexual activity

### 7.6.1 Alcohol-related sexual violence in third-level education

Sexual violence in third-level settings is a relatively common occurrence, and the evidence indicates that alcohol and other drugs play a role in many such incidents. In a study of first-year third-level students from 21 higher education institutions (HEIs) in Ireland, 1,778 students aged 18–25 years were surveyed about their experiences of sexual violence [102]. Students completed information on their gender identity, sexual orientation, ethnicity, and relationship status, as well as on their alcohol and drug use. Alcohol and cannabis were the most commonly used substances among the first-year students.

Since starting higher-level education, unwanted sexual touching was the most common form of sexual violence reported by students. Hazardous alcohol use[7] predicted all forms of sexual violence among female students; for male students, this increased the likelihood of unwanted sexual touching. Depending on the drug being controlled for (cannabis, cocaine, ecstasy, or ketamine), female students who reported hazardous alcohol use were 2.3–2.4 times more likely to experience unwanted sexual touching and/or non-consensual attempted penetration; 2.0–2.1 times more likely to experience non-consensual completed penetration; and 2.2–2.3 times more likely to experience rape. Male students who reported hazardous alcohol use were 1.8–2.0 times more likely to experience unwanted sexual touching, but hazardous alcohol use did not increase the likelihood of experiencing non-consensual attempted penetration, non-consensual completed penetration, or rape for male students. The study has limited information on the perpetrator but does include information about the most frequently reported tactic used by the perpetrator which was reported as incapacitation (taking advantage of the victim when they were too drunk or out of it to stop what was happening).

The study highlights the risks associated with alcohol and other drug use among this young and potentially vulnerable population, whose mean age was 19 years. It serves as an important reminder of the need for education on the risks associated with alcohol and drug use (and especially so if mixing both), and the recommendations from the study suggest that urgent consent communication programmes be delivered early in the third-level experience, but ideally before that. Sexual assault prevention programmes should be prioritised in third-level settings and wider.

Another study examined the experiences of 7,901 students and 3,516 staff in relation to sexual violence and harassment in HEIs [103]. The survey included questions about experiences of sexual violence when the individual was too drunk or out of it to stop what was happening. Among the student respondents, 31.3% experienced non-consensual sexual touching and 13.5% reported experiencing non-consensual oral sex when they were too drunk or out of it to stop what was happening.

[7] Hazardous alcohol use was determined by a score of 5 or higher on the Alcohol Use Disorders Identification Test – Concise (AUDIT-C).

Those students who reported experiencing sexual violence were asked a further set of questions about the sexual violence and whether alcohol or drugs were being used by the other person prior to the incident. Alcohol was the most commonly reported substance used by the person who was responsible for the violence, and was reported by 52% of the students who responded (Table 18).

Table 18 Perpetrator's use of drugs and/or alcohol prior to sexual violence

| | Female | Male | Non-binary | Total |
|---|---|---|---|---|
| Using alcohol | 51.4% | 60.0% | 40.0% | 52.0% |
| Using drugs | 0.7% | 0.4% | 1.7% | 0.7% |
| Using both alcohol and drugs | 11.7% | 9.8% | 18.3% | 11.6% |
| Using neither alcohol nor drugs | 18.2% | 11.8% | 21.7% | 17.7% |

Source: MacNeela et al., 2022 [104]

Students were also asked if they had been using drugs and/or alcohol prior to experiencing sexual violence. Over two-thirds of students who had experienced sexual violence reported consuming alcohol before the incident occurred (68.5%), while 0.3% of students said they had used drugs prior to the incident and 25.9% stated that they had not been using drugs or alcohol before the incident. The report raises important concerns regarding the role of alcohol in sexual violence among students in HEIs.

**Over one-half of perpetrators of sexual violence in third-level settings**

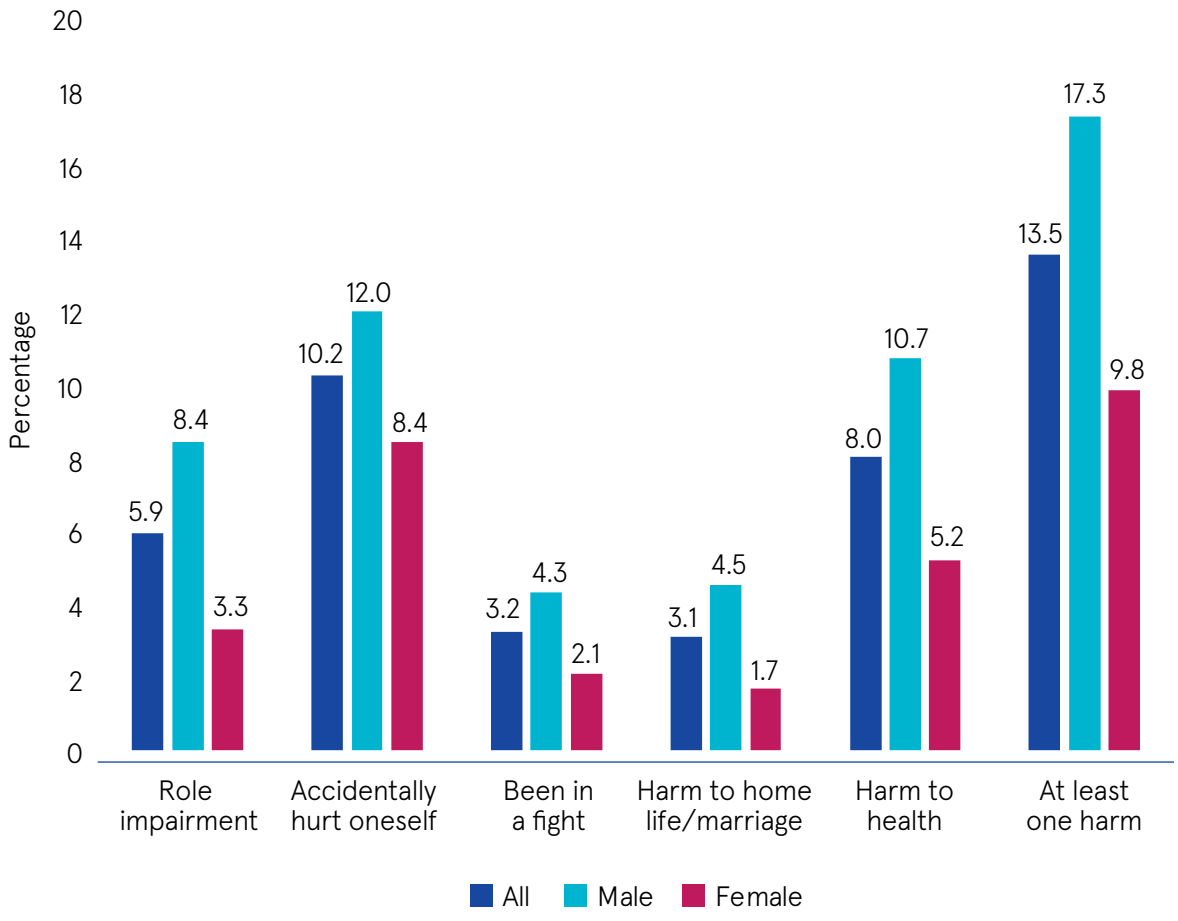
had been drinking before the incident (52%).

**11.6%** had been using both alcohol and other drugs

# 7.7 Harm from own alcohol use

In the 2019–20 National Drug and Alcohol Survey (NDAS), 13.5% of drinkers reported experiencing at least one harm due to their own alcohol use; this was more commonly reported among males (17.3%) and younger drinkers (27.6%) [34]. When examined by drinker type, those who met the criteria for AUD were substantially more likely to have experienced harm from their own drinking (67.1%) and 29.0% of those who reported engaging in monthly HED experienced harm from their own drinking, whereas those who did not engage in HED or were not classified as having an AUD were less likely to have experienced harm from their own drinking (5.2%). The most common harm experienced from one's own drinking was accidentally hurting oneself (10.2%; 12.0% of males versus 8.4% of females) and harms to health (8.0%; 10.7% of males versus 5.2% of females) (Figure 35).

Figure 35 Percentage of drinkers who experienced harms in the previous year from their own drinking, by sex, 2019–2020




Source: Mongan et al., 2021 [34]

## 7.8 Harm from others' drinking

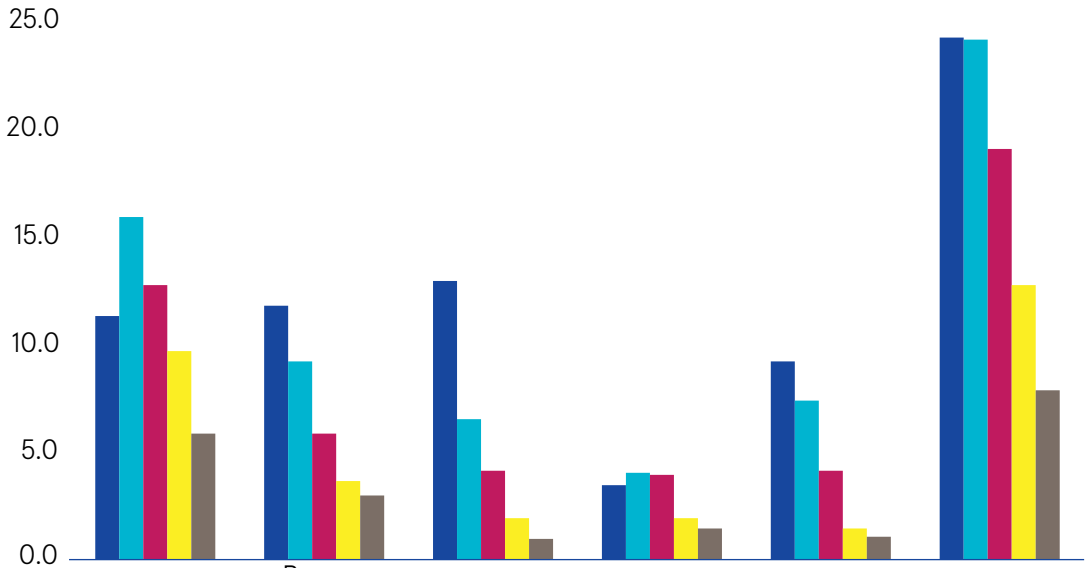
One-third (33.0%) of respondents in the 2019–20 NDAS reported that they had someone in their life – be it a family member, friend, co-worker, or someone else – who they considered to be a heavy drinker or drinks a lot on occasions, and 13.8% of these respondents reported that they were affected because of this [34].

Respondents were also asked if they had experienced specific harm from others' drinking, and 17.0% reported that they had (18.3% of males versus 15.7% of females). The most common harm experienced was harm to family (10.8%; 8.5% of males and 13.1% of females) and being a passenger with a drunk driver (6.0%; 8.5% of males and 3.6% of females). Non-drinkers and low-risk drinkers were less likely to have experienced harm from others' drinking (11.8% and 13.1%, respectively), compared with 23.7% of those who reported monthly HED and 43.4% of those who met the criteria for AUD.

When examined by age group, those aged 25–34 years were more likely to have experienced harm from others' drinking (23.9%) (Figure 36). Harm to family was the most common harm reported by all age groups with the exception of those aged 15–24 years, who were more likely to report being assaulted (12.6%) and being a passenger with a drunk driver (11.5%). Females aged 35–49 years were almost twice as likely as males in the same age group to report harm to family as a result of someone else's drinking (16.1% of females compared with 8.7% of males). In addition, 4.3% of females aged 25–34 years reported financial harm as a result of others' drinking; the comparable figure for males in the same age group was 3.1%.

Elsewhere, among a sample of the population of Ireland, 51% of respondents reported experiencing harm due to stranger's drinking in the previous 12 months [236].

Figure 36 Percentage of respondents who experienced harms in the previous year from others' drinking, by age group, 2019–2020




| | Harm to family | Been a passenger with drunk driver | Assaulted | Financial harm | Property vandalised | At least one harm |
|---|---|---|---|---|---|---|
| 15–24 years | 11.0 | 11.5 | 12.6 | 3.1 | 8.9 | 24.0 |
| 25–34 years | 15.6 | 8.9 | 6.2 | 3.7 | 7.1 | 23.9 |
| 35–49 years | 12.5 | 5.5 | 3.8 | 3.6 | 3.8 | 18.8 |
| 50–64 years | 9.4 | 3.3 | 1.6 | 1.6 | 1.1 | 12.5 |
| ≥65 years | 5.5 | 2.6 | 0.6 | 1.1 | 0.7 | 7.5 |

Source: Mongan et al., 2021 [34]

## 7.8.1 Harm from parental drinking

The 2022 HRB overview, *Alcohol and other drug use among children and young people in Ireland* indicated that an estimated 325,291 children live with at least one parent who binge drinks regularly, and a further 56,745 children live with at least one parent who is dependent on alcohol, meaning that 31.7% of children in Ireland are living with at least one parent who is either a regular binge drinker or dependent on alcohol [30].

Experiencing parental problem alcohol use (PPAU) in the home has long been recognised as an adverse childhood experience (ACE) [104]. A study published in 2022 found that one-quarter of an adult sample had grown up with a 'problem drinker' in the home [237]. Silent Voices is an initiative of Alcohol Action Ireland that seeks to highlight the harm caused by PPAU and how the impact can be felt into adulthood [105]. Silent Voices gives those impacted by PPAU a voice to share their experiences and to help them find the right supports to manage the trauma they endured.

Despite the widespread prevalence of children (including adult children) living with PPAU, there are no specific supports available in Ireland for those affected. A study examining the experience of mental health professionals working with clients who have experienced PPAU found that 70% had not received PPAU-specific training [106], and that less than one-quarter (24%) of the mental health professionals routinely asked their clients about their experiences of PPAU. The study highlighted areas where interventions and programmes are most needed in order to reduce the impact of PPAU, and specifically how supports outside the family home should be accessible and available to children.

#### 7.8.1.1 Prenatal alcohol exposure

Fetal alcohol spectrum disorder (FASD) can occur because of prenatal alcohol exposure (PAE), as alcohol crosses the placenta and disrupts fetal development [107]. The World Health Organization (WHO) advises that alcohol should be avoided at all stages of pregnancy [23]. The 2021 Healthy Ireland Survey found that the majority (84%) of the population correctly identified that drinking during pregnancy was unsafe; 90% of female respondents of reproductive age were aware of this [43]. Globally 9.8% of pregnant women drink alcohol and the rate of FASD is estimated to be 7.7 cases per 1,000 of the general population (19.8 per 1,000 in the WHO European region); the rates are highest in South Africa (111.1 per 1,000), Croatia (53.3 per 1,000), Ireland (47.5 per 1,000), Italy (45.0 per 1,000), and Belarus (36.6 per 1,000) [108].

There are limited data on the prevalence of FASD, as it is commonly diagnosed later in childhood, if at all; in addition, it is difficult to diagnose and can often be masked by other symptoms of the condition. HIPE collects this information where it is recorded, and in 2021, there were 10 cases of discharges from Irish hospitals where the diagnosis was either fetal alcohol syndrome (ICD-10-AM code Q86.0) or damage to the fetus or newborn due to maternal use of alcohol (ICD-10-AM codes Q35.4 and P04.3); this recorded number of cases is substantially lower than the estimated prevalence of FASD in Ireland.

Analysis of the Pregnancy Risk Assessment Monitoring System (PRAMS), an Irish information system collating the experiences and behaviours among women around the time of pregnancy, examined the prevalence of preventive health counselling during pregnancy of 718 women who had recently given birth [109]. Data from the PRAMS study indicated that 75.9% of these women reported pre-pregnancy alcohol use. Just under one-half (48.4%) indicated that they had received alcohol use advice during antenatal care and reports of alcohol use before pregnancy did not significantly increase the likelihood of receiving alcohol use advice. Alcohol use advice was less likely to be given to women who had previously given birth and to those with private health insurance. The study found that 59.8% of the women in the sample stopped drinking during pregnancy. Given that 19.3% of pregnancies among the cohort who consumed alcohol pre-pregnancy were unplanned, the study highlights the importance of brief interventions both before and during pregnancy in order to address health behaviours.

Elsewhere, another study examining alcohol use during pregnancy using data from the PRAMS study (N=718), the Screening for Pregnancy Endpoints (SCOPE) Ireland study (N=1,766), and the Growing Up in Ireland (GUI) study (N=10,953) found that rates of alcohol use during pregnancy ranged from 20.1% in the GUI study to 45.1% in PRAMS and 81.8% in SCOPE [110].

# 7.9 Summary: Alcohol-related harm

This chapter illustrates some of the harm caused by alcohol due to one's own drinking and that of others, including prenatal exposure to alcohol. What is presented here is only part of the picture of alcohol-related harm. Alcohol-related ambulance call-outs are not routinely captured in Ireland. In other jurisdictions such as parts of the UK including Scotland, it is estimated that alcohol-related ambulance call-outs are in the vicinity of 10–18% of all ambulance call-outs [111,112]. In addition, alcohol-related ED presentations are not routinely collected in Ireland, but a study carried out in a busy Dublin hospital found that 19.4% of all ED presentations were alcohol-related.

Globally, alcohol is the ninth leading risk factor for deaths and DALYs. The WHO states that even at small amounts, alcohol can harm your health. For example, alcohol use is estimated to cause 2.4% of all cancer cases in Ireland; this percentage is higher for female breast cancer, where 7.5% of all cases are estimated to be alcohol related. At current per capita alcohol consumption levels, these figures are predicted to rise substantially.

We used the HIPE scheme dataset in order to examine alcohol-related hospitalisations. Between 2001 and 2021 there were 374,451 hospitalisations with an alcohol-related diagnosis, and males consistently accounted for approximately three-quarters of such hospitalisations. Adjusting for population growth during the period, the number of alcohol-related hospitalisations has decreased by 17.1% during this 21-year period, from 537 to 445 hospitalisations per 100,000 of the adult population, with a more notable decline among males than females. Length of stay for alcohol-related hospitalisations is almost double that for non-alcohol-related hospitalisations, and more than 5% of inpatient bed days were alcohol-related in 2021.

Rates of ALD have steadily increased, and in 2021 they were the highest ever recorded, at 105.6 per 100,000 of the population aged 15 years and over, although rates have declined in 2022. The largest increase in rates of ALD was noted among those aged 65 years and over, but all age groups saw an increase in this period. In 2022, ALD patients typically stayed 15 days in hospital and accounted for more than 45,000 bed days.

Alcohol-related hospitalisations highlight the considerable burden on the Irish health system and the substantial loss of life for what can be preventable. The financial cost is likely to be higher due to the complexity of care required for these patients and the under-reporting of alcohol-attributable conditions.

The GBD Compare dataset enables the estimation of wholly and partially alcohol-attributable mortality and morbidity, and in 2019 it estimated that within the population of Ireland the overall disease burden of alcohol use represented more than 62,000 years of full health lost (calculated through DALYs). Alcohol use disorders and alcohol-related cancers represented the top causes of alcohol-attributable DALYs.

Alcohol use is associated with sexual violence, and in 2022, almost one-half of patients treated in SATUs had consumed more than six standard drinks prior to the sexual violence incident and one in every five patients was concerned that drugs and/or alcohol had been used by the perpetrator to facilitate the sexual assault. A report raising important concerns regarding the role of alcohol in sexual violence among students in higher education found that female students who reported hazardous drinking were more than twice as likely to have experienced sexual violence. The study highlighted the prevalence of sexual violence among students when the victim was too drunk or out of it to stop what was happening. Research on sexual assault is limited to the victims and their alcohol use at the time of the assault, but it is important to clarify that this does not suggest any responsibility on the part of the victim. More research is needed to understand the perpetrator, their use of alcohol and other drugs, and how it relates to their committing assault.

Alcohol-related harm from one's own drinking was more likely to be reported by males when examining data from the 2019–20 NDAS, and accidentally hurting oneself and harms to health were the most common harms reported. Harms from others' drinking were also examined and harm to family, or being a passenger with a drunk driver were the most common harms reported as a result of someone else's drinking.

Living in a household where a parent is dependent on alcohol is considered an ACE, and the harms experienced as a result can persist into adulthood. A study found that mental health professionals have inadequate resources to meet the needs of their service users who have experienced such ACEs. Current global estimates are that almost 1 in every 10 pregnant women consumes alcohol during pregnancy and that there are 19.8 cases of FASD per 1,000 of the population in the WHO European region, but that the rate is substantially higher in Ireland (47.5 per 1,000 of the population) due to per capita alcohol use levels. The WHO advises that alcohol should be avoided at all stages of pregnancy, and yet, a number of studies examined in this report found that alcohol advice provided during pregnancy is limited.

It is difficult to put a price on alcohol harm in Ireland, but it is extensive and expensive: a report published in 2010 estimated that alcohol harms cost in the region of EUR 3.7 billion in Ireland in 2007 [113]. A systematic review published in 2021 estimated the costs of alcohol-related harm in high income countries to be 2.6% of the GDP. In Ireland this is the equivalent of approximately EUR 12 billion [238]. In its pre-budget submission, Alcohol Action Ireland called for the 'polluter pays' principle to be established in Ireland and for a social responsibility levy of 1% to be placed on alcohol sales in the on-trade and 2% in the off-trade in order to address the consequences of alcohol use in Ireland [114].

# 08

# Alcohol use and mental health

Alcohol use, particularly hazardous drinking and dependency, and mental health are closely connected, and drinking can impact on an individual's well-being. It is common for people to drink to try to relieve the symptoms of poor mental health, but drinking can also lead to poor mental health. Alcohol is a depressogen; it causes chemical changes in the brain and can lead to anger, depression, or anxiety. It also affects the brain by slowing down the processing of information, making it more difficult to make logical decisions [38,115]. Alcohol use has long been linked with poor mental health, including both self-harm and suicide. Globally, suicide was the third leading alcohol-related cause of death among those aged 15–49 years according to the 2019 GBD study [85]. This study estimated that 27% of suicides and self-harm incidents are attributable to alcohol [6]. Reducing alcohol use is recognised by the WHO as an important element in preventing suicide [116].

## 8.1 Suicide, self-harm, and alcohol use in Ireland

Suicide in Ireland, particularly among young males, remains an important public health issue. In 2019, there were 524 deaths from suicide in Ireland, of which 78% (408 deaths) were males and 22% (116 deaths) were females [117]. In 2017, the standardised suicide rate among 28 European Union (EU) countries was 10.1 per 100,000 of the population, 11.0 in Ireland. In 2019, suicide was the leading cause of death among young males aged under 25 years and the third leading cause of death among females aged under 25 years in Ireland [118]. Ireland has the sixth highest suicide rate among young people aged 15–19 years in 29 European countries [118].

In 2008, the Suicide Support and Information System (SSIS) was established and piloted in the Co Cork region to collect information on risk factors associated with suicide and deaths classified as open verdicts. The SSIS identified cases of suicide and probable suicide using coroners' records, interviews with family members, and surveys of healthcare professionals.

In order to identify factors associated with alcohol use in cases of suicide and self-harm, a study used SSIS data to examine 307 cases of suicide that had occurred in Co Cork between 2008 and 2012 [119]. Toxicology was available for 298 of the 307 cases of suicide examined, and in 44% of those cases (n=141), alcohol was detected in the toxicology. Age was the only statistically significant association with alcohol involvement in suicide; those aged under 55 years were more likely to have been drinking prior to their death. About one-half (50.8%) of those aged under 25 years and 48.0% of those aged 25–54 years had consumed alcohol before their death. When examined by sex, alcohol was more commonly present in the toxicology reports of males, but this finding was not statistically significant (Figure 37).

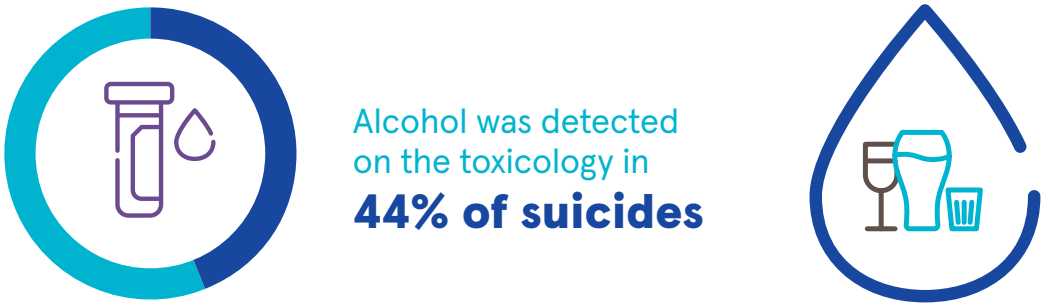
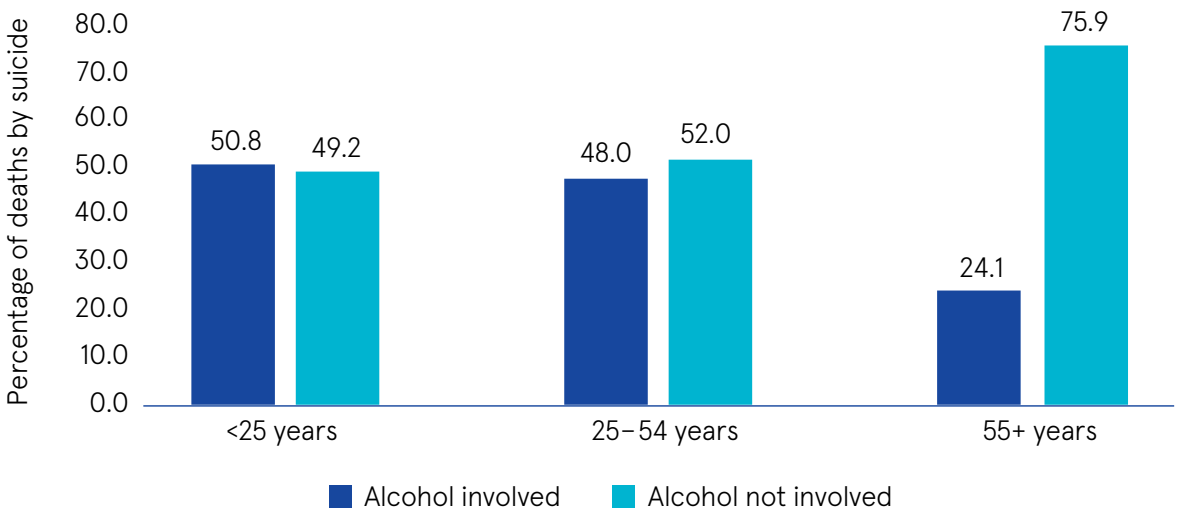



Figure 37 Alcohol involvement in cases of suicide, by age group, 2008–2012




Source: Larkin et al., 2017 [120]

Where the information was available (n=173), a history of alcohol or other drug abuse was noted in 61% (n=105) of the suicide cases in the study. Those with a history of substance abuse were more likely to have alcohol present in their toxicology report than those with no substance abuse history. Research elsewhere confirming a higher risk and greater incidence of suicide among individuals with problematic alcohol use, with the risk increasing with the frequency of alcohol consumption and quantity of alcohol consumed [120,121,122]. This research highlights the importance of monitoring alcohol use among suicidal individuals and also of screening for suicidal ideation and suicide attempts among heavy alcohol users.

The Irish Probable Suicide Deaths Study (IPSDS) (involving the HSE National Office for Suicide Prevention (NOSP), Irish coroners, and the HRB) was established under *Connecting for Life: Ireland's National Strategy to Reduce Suicide 2015–2020* in order to improve surveillance and evaluation and to provide high-quality research relating to suicide [123,124]. The study

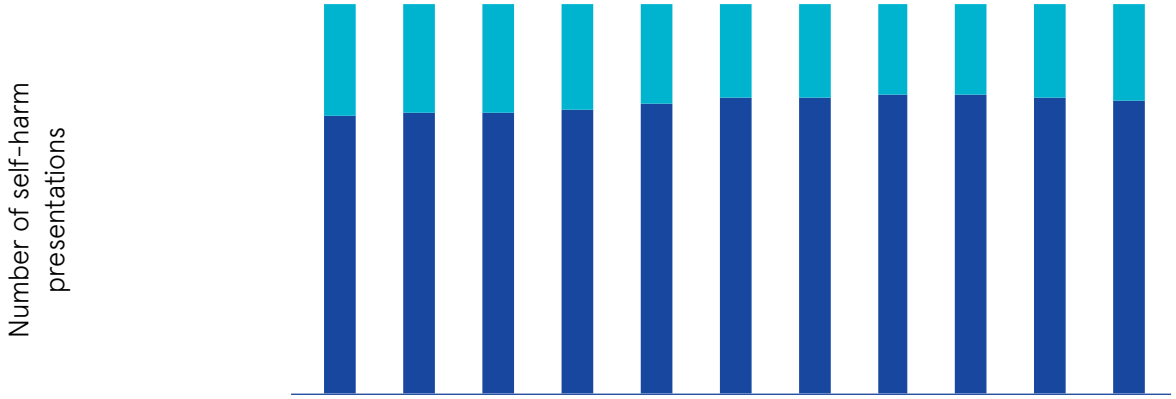
used coroners' data to describe in detail the characteristics of 2,349 people who died by 'probable suicide'[8] in Ireland during the period from 2015 to 2018. The current legal test for a coroner to classify a verdict of suicide requires evidence that the self-killing and intention are proved 'beyond a reasonable doubt'. The IPSDS includes such deaths, but it also includes deaths that are 'more likely than not' to have been a suicide death according to the balance of probabilities.

The IPSDS indicated that 783 people (33%) in the cohort being studied had a lifetime history of substance use, and of these, 319 people had a history of only alcohol dependency (41% of those with a lifetime substance use history or 14% of all probable suicides).

The National Self-Harm Registry Ireland (NSHRI) is a national system of population monitoring for the occurrence of hospital-treated self-harm which was established by the National Suicide Research Foundation. Since 2006, the NSHRI has collected data on all persons presenting to general and paediatric hospital EDs in the Republic of Ireland due to self-harm. All methods of intentional self-harm are included where it is clear that the self-harm was intentionally inflicted, and all individuals who are alive on admission to hospital following a self-harm act are included.

In 2020, there were 11,932 episodes of self-harm in Ireland recorded by the NSHRI, more of which involved females (56.6%) than males (43.4%) [125]. One in every three self-harm presentations in 2020 (3,873; 33%) was alcohol related, an increase from 31% in 2019 but a decrease from 39% in 2010 (Figure 38).

Figure 38 Number of self-harm presentations to EDs in Ireland, 2010–2020



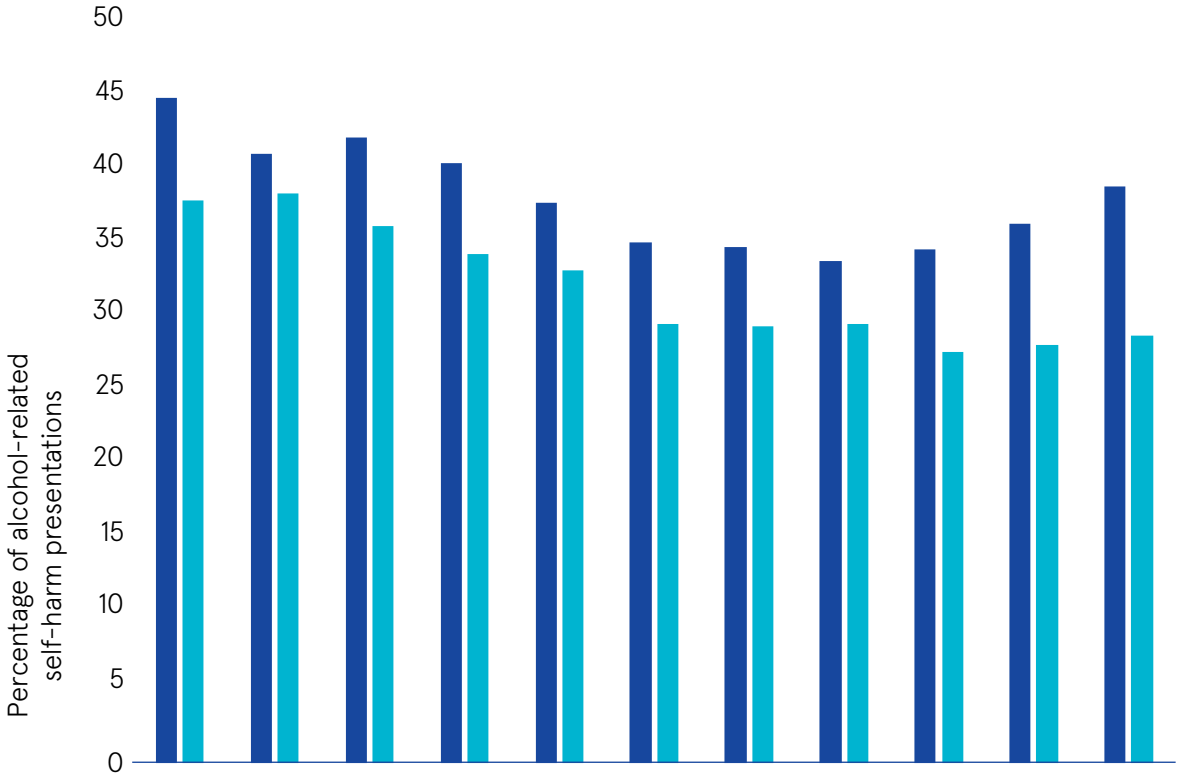

| | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Alcohol-related self-harm presentations | 4,858 | 4,773 | 4,610 | 4,037 | 3,860 | 3,515 | 3,572 | 3,571 | 3,792 | 3,886 | 3,873 |
| All self-harm presentations | 12,337 | 12,216 | 12,010 | 11,061 | 11,126 | 11,189 | 11,445 | 11,620 | 12,588 | 12,465 | 11,932 |

Source: Joyce et al., 2022 [126]

[8] 'Probable suicide' includes deaths with a coroner's suicide verdict and deaths that are more likely than not, based on the weight of evidence, to have been a suicide.

As in previous years, alcohol was more common in male presentations of self-harm (38%) than in female presentations (28%) in 2020 (Figure 39).

Figure 39 Alcohol-related self-harm presentations as a percentage of all self-harm presentations to EDs in Ireland, by sex, 2010–2020




| | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Males | 44.3 | 40.4 | 41.6 | 39.8 | 37.1 | 34.4 | 34.2 | 33.1 | 33.9 | 35.7 | 38.2 |
| Females | 37.3 | 37.8 | 35.6 | 33.7 | 32.6 | 28.9 | 28.7 | 28.9 | 27.0 | 27.5 | 28.1 |

Source: Joyce et al., 2022 [126]

Of those who presented to EDs for alcohol-related self-harm in 2020, 50.5% were discharged following treatment in the ED; 22.6% were admitted to a general ward in the treating hospital; 4.5% were admitted for psychiatric inpatient treatment; 1.5% were admitted to the intensive care unit; 4.1% were transferred to another hospital or psychiatric unit/ hospital; 14.4% left the ED before a care recommendation could be made; and 1.1% of presentations refused to be admitted for general or psychiatric care [126].

A study *Alcohol involvement in suicide and self-harm* examined 8,145 cases of self-harm ED presentations in Co Cork between 2007 and 2013 using data from the NSHRI [120]. Case notes for the patients established whether alcohol had been used before or at the time of the self-harm act. The median age of these presentations was 30 years, and males represented 52% of cases. Alcohol was involved in 21% of the self-harm presentations,

although the study authors noted an under-recording of alcohol use in case notes [120]. Alcohol involvement was more common in male presentations (22%) than female presentations (19%); almost one-quarter (23%) of self-harm cases aged 55 years and over had alcohol involvement, and alcohol involvement was also more likely among males in this age group (29%). Among females, those aged 35–44 years (23%) and 45–54 years (23%) were most likely to have alcohol involvement. Alcohol was more likely to be involved in self-harm presentations involving self-poisoning or drug overdose (25%) than other self-harm methods. Alcohol-related self-harm cases were more common at weekends (25%) and between the hours of 6.00 pm and 8.00 am (25%), highlighting the importance of increased numbers of specialised healthcare staff being available at these times [120].

A further study *Physical and mental illness comorbidity among individuals with frequent self-harm episodes* reviewed files and interviewed patients who attended EDs with frequent self-harm injuries across three general hospitals in Ireland and found that the majority (89.6%) had a history of mental or behavioural disorders, and the most common psychiatric diagnosis was AUD (51.1%) [126]. The study found that males and those with AUD were at increased risk of highly lethal self-harm methods and highlighted the prevalence of both physical and mental comorbidities among those who self-harm frequently.

A study *Self-harm in Irish prisons 2019: Third report from the Self-Harm Assessment and Data Analysis (SADA) Project* examined self-harm prevalence in prisons in Ireland. The study found that in 2019, 3% of the prison population self-harmed, and that self-poisoning with alcohol was among the most common methods [127]. Poor mental health and substance use were found to be the main contributory factors in self-harm incidents, and among the prison population in Ireland, the prevalence of substance use disorders (50.9%) and AUD (28.3%) were higher compared with the general population [128].

## 8.2 Summary: Alcohol use and mental health

Suicide is a leading cause of death globally, particularly among young people and 27% of suicides and self-harm incidents are alcohol-related [85,129]. A regional Irish study found that alcohol was present in the toxicology reports of 44% of suicide cases. Those with a history of alcohol or other drug misuse were at higher risk of suicide. In 2020, there were nearly 12,000 episodes of self-harm presentations recorded in Irish hospitals, and one-third involved alcohol. Alcohol-related self-harm hospital presentations were more common among males and were found to be more common at weekends and at night, highlighting the importance of the availability of specialised healthcare staff at these times.

Research indicates that suicide rates decrease during times of crisis such as during natural disasters, wars, or pandemics, but they increase again in the aftermath of such events [130,131]. The COVID-19 pandemic certainly contributed to poor mental health globally, and it is still too early to judge whether there has been an increase in suicides in its aftermath. Suicide data from the Central Statistics Office (CSO) indicates that there were 390 suicides in Ireland in 2019 and 465 in 2020 [118]. It is important that population-level policies continue to be introduced in order to reduce overall alcohol use.

# 09

# Alcohol-related crime in Ireland

Alcohol use is often associated with crime, as intoxication is frequently a risk factor for violence and antisocial behaviour [132]. Drinking alcohol lowers inhibitions, impairs a person's judgement, and increases the risk of aggressive behaviours [133]. Alcohol-related crime impacts not only on those directly affected, but also on the wider community, shaping perceptions of safety and security [134]. The HRB alcohol overviews in 2009 *Social consequences of harmful use of alcohol in Ireland* and 2016 *Alcohol in Ireland: consumption, harm, cost and policy response* featured detailed information about alcohol-related crimes in Ireland; that information is updated in this chapter using Police Using Leading Systems Effectively (PULSE) data [135,136].

## 9.1 An Garda Síochána's PULSE system

The analysis presented in this chapter relates to data from An Garda Síochána's PULSE system, a central reporting database for An Garda Síochána that records details of crime incidents. The database categorises crime into various incidents and types, and therefore the information in this chapter is aggregated crime data published by the CSO.

The recorded crime offences statistics published by the CSO are classified as 'Under Reservation', meaning that the quality of the statistics prior to 2023 did not meet the standards required of official statistics published by the CSO and reflecting the fact that there are data quality issues in the underlying sources used to compile these statistics. Therefore, data prior to 2023 in the time series may still be subject to some of the legacy data quality issues, and those statistics should therefore be interpreted with caution. The 'Under Reservation' designation has been lifted for the full series, and any PULSE data going forward will not carry the 'Under Reservation' proviso. The CSO advises that the published data provide users with the best information currently available but that revisions are still likely.

The analysis in this chapter includes crimes in which alcohol was definitely involved (for example, drink-driving offences), as well as crimes that commonly involve alcohol as a contributory factor (e.g. assaults and public order offences). The PULSE system does not explicitly record whether an assault is alcohol-related or not, but research shows that alcohol plays a major role in these incidents especially nighttime incidents at weekends involving young males [137,138]. The CSO provided the majority of the statistics in this section and are supplemented with information publicly available from the CSO website [139].

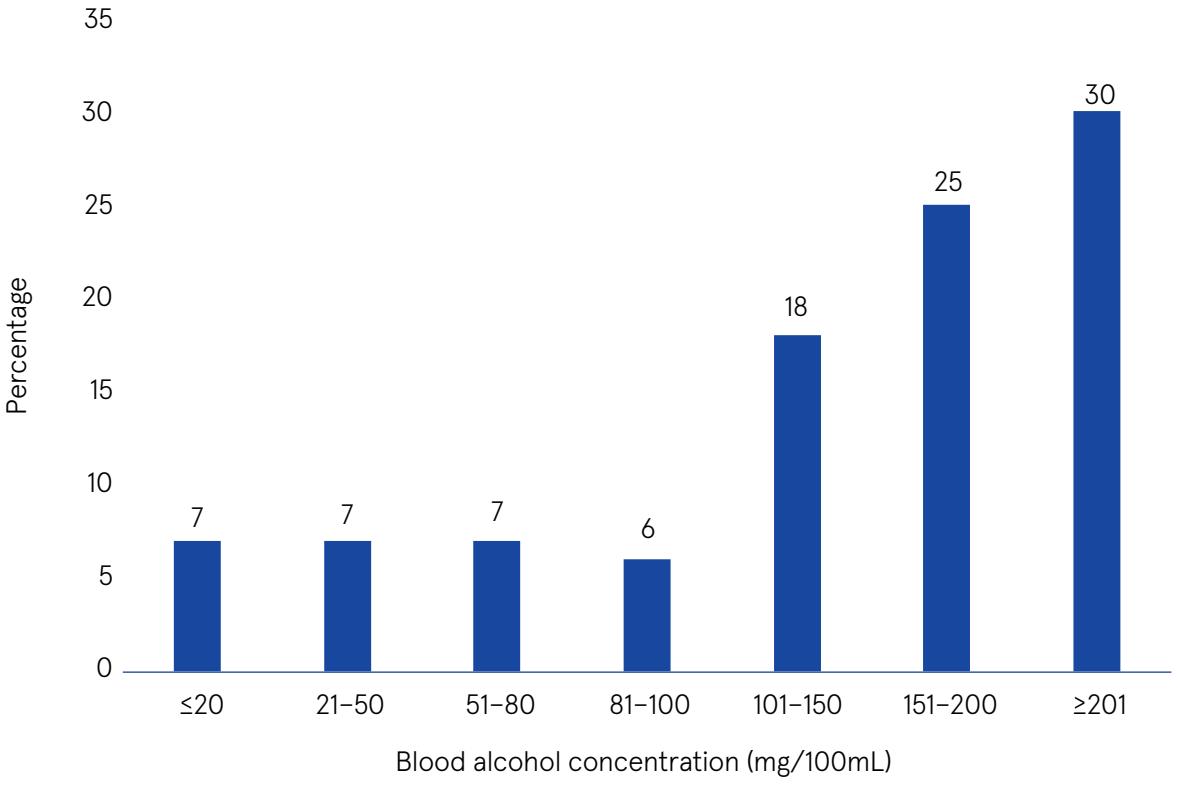
It is important to note that the PULSE system is an operational database, and its main function is to record Garda activity. A crime incident is recorded on PULSE if a member of An Garda Síochána determines that, on the balance of probabilities, a criminal offence defined by law has taken place. A decrease or increase in the number of offences recorded does not necessarily reflect a decrease or increase in the level of these behaviours; rather, this may be a consequence of changing Garda priorities or the targeting of particular places or activities or the reduction in the number of Gardaí.

When interpreting PULSE statistics, note that the data show the number of recorded incidents; these incidents may not have resulted in arrests and/or charges for a number of reasons. Also note that crime detection numbers and rates are published at two different time intervals (9 months after the end of the reference year and 19 months after the end of the reference year, respectively); this allows time for crime investigations to proceed. Thus, the data for 2022-2023 are not fully comparable with those from earlier years. Note too that these figures do not account for population change in the time period.

### 9.1.1 Drink-driving incidents

The legal blood alcohol limit for driving in Ireland is 50 milligrams (mg) of alcohol per 100 millilitres (mL) of blood, or 20 mg/100 mL for learner, novice, or professional drivers. The 2022 annual report from the Medical Bureau of Road Safety indicated that they received 5,622 blood and urine specimens for analysis in 2022 [140]. The median blood alcohol level in these specimens (excluding specimens with no trace of alcohol) was 160 mg/100 mL, and the highest blood alcohol level found was 415 mg/100 mL [141]. Figure 40 indicates that 30% of the samples that the Medical Bureau of Road Safety received for analysis in 2022 had a blood alcohol concentration of more than 200 mg/100 mL, this level means that these drivers were at least four times over the legal blood alcohol limit to drive.

Figure 40 Percentage of positive blood alcohol levels analysed by the Medical Bureau of Road Safety, by blood alcohol concentration, 2022



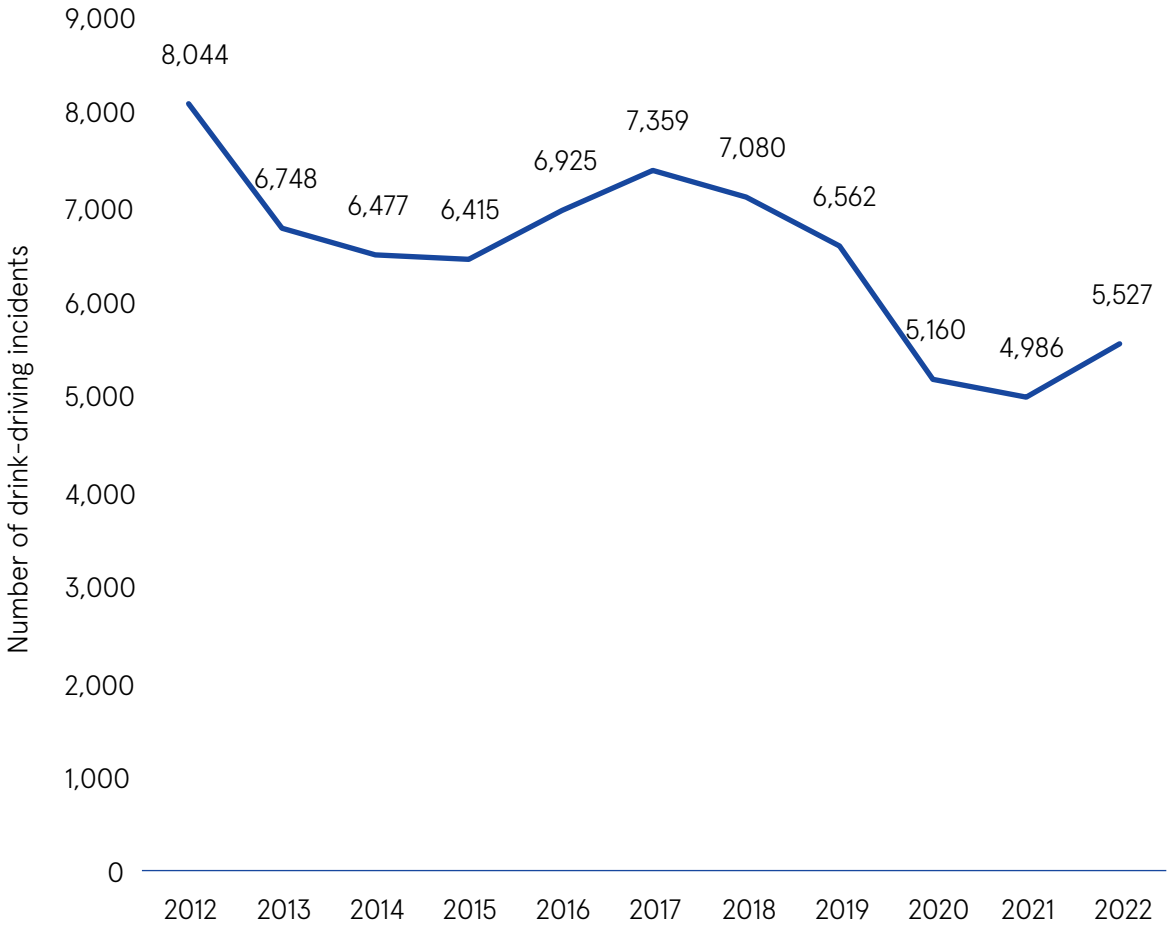

Source: Medical Bureau of Road Safety, 2023 [141]

In the 2019–20 NDAS, 6.0% of respondents reported having been a passenger with a drunk driver (8.5% of males and 3.6% of females); this was most commonly reported among those aged 15–24 years (11.5%) and those aged 25–34 years (8.9%) [34].

According to the PULSE data available from the CSO, there were 5,527 recorded incidents of drink-driving (driving or being in charge of a vehicle while over the legal blood alcohol limit) in 2022, a 31.3% decrease since 2012 (Figure 41). A decrease in the number of drink-driving incidents was reported during the COVID-19 pandemic (this would have been expected in 2020–21 as movement restrictions were still in place due to the pandemic), and 2022 saw an increase in drink-driving from the 2021 figures.

The Garda divisions with the most recorded crimes for drink-driving in 2022 were Galway, Dublin Metropolitan Region – Western, and Cavan/Monaghan, but variation between Garda divisions may be explained by differing Garda practices in different regions, or by the availability of public transport [141].

Figure 41 Number of recorded crime incidents for driving/being in charge of a vehicle while over the legal blood alcohol limit, 2012–2022




Source: Central Statistics Office, 2023 [140]

There were
**5,527 incidents of drink-driving recorded**
on PULSE in 2022

## 9.1.2 Assault, disorderly conduct, public order, and other social code incidents

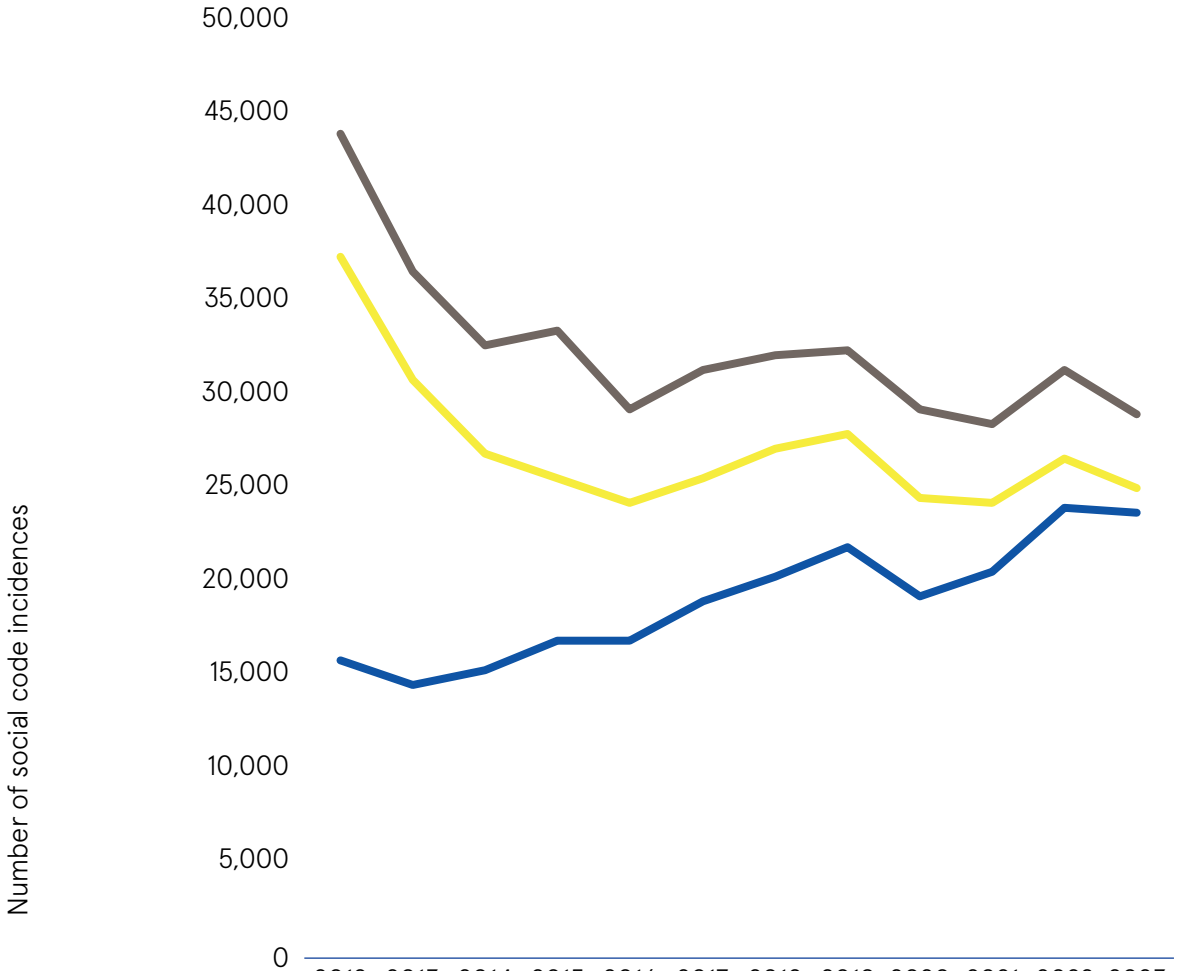
Figure 42 presents the trends in the number of incidents of disorderly conduct, assault,[9] and public order offences that were recorded on PULSE between 2012 and 2022. Not all of these incidents involved alcohol, but they are included in the data for this chapter as evidence indicates that alcohol is associated with between 30% and 65% of these types of crimes [142].

There has been a decrease in the number of disorderly conduct and public order incidents recorded on PULSE in the 11-year period from 2012 to 2023, although the number of assault incidents has increased. Assault offences and public order offences were among the most commonly recorded offences resulting in referrals to the Probation Service in 2021; 16.6% of all referrals were for assault, and 9.1% of all referrals were for public order offences [143].

In the 2019–20 NDAS, 4.5% of all respondents reported experiencing assault in the previous year as a result of others' drinking (6.4% of males and 2.7% of females) [34]. Drinkers classified as having an AUD were more likely to report experiencing assault (17.2%) compared with non-drinkers (3.2%).

[9] 'Assault' includes all PULSE assault incidents recorded as 'attempts/threats to murder, assaults, harassments and related offences'.

Figure 42 Trends in the number of social code incidents (assault, disorderly conduct, and public order offences) where alcohol is likely to be a factor, 2012–2023



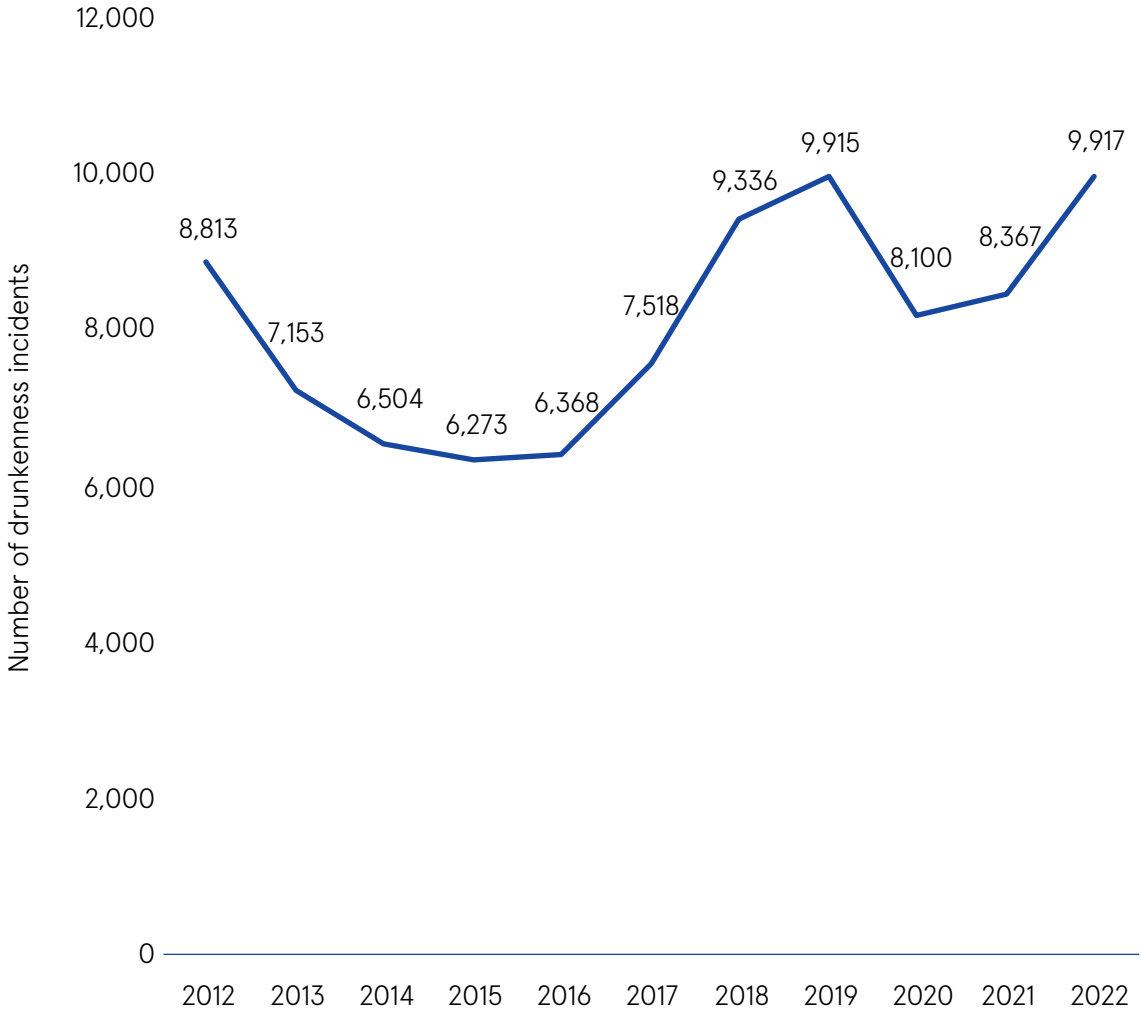

| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Public order and other social code offences | 43,785 | 36,394 | 32,604 | 33,252 | 29,201 | 31,178 | 31,964 | 32,389 | 29,028 | 28,390 | 31,283 | 28,822 |
| Disorderly conduct | 37,320 | 30,808 | 26,792 | 25,487 | 24,086 | 25,338 | 26,938 | 27,955 | 24,491 | 24,130 | 26,635 | 24,880 |
| Assault | 15,708 | 14,366 | 15,170 | 16,916 | 16,725 | 18,993 | 20,187 | 21,839 | 19,069 | 20,359 | 23,857 | 23,718 |

Source: Central Statistics Office, 2023 [140]

### 9.1.2.1 Public order and other social code offences: Alcohol specific

We obtained specific data for the years 2012–2022 on the number of recorded incidents categorised on PULSE under 'Public Order and Other Social Code' from the CSO. 'Drunkenness' is one such category and a 12.5% increase was noted in the number of incidents for drunkenness, from 8,813 incidents in 2012 to 9,917 in 2022 (Figure 43). The data suggest decreased crime during the pandemic and rapidly returning afterwards to pre-Covid levels.

Figure 43 Drunkenness incidents by year reported, 2012–2022

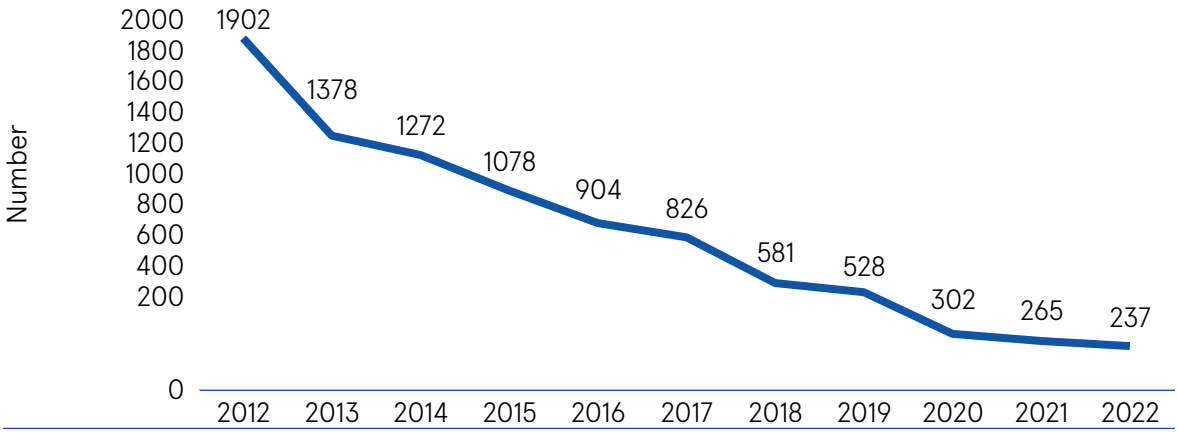



Source: Central Statistics Office, 2023 [140]

Other incidents categorised as public order and other social code offences include the sale or the provision of alcohol to minors (aged under 18 years); both crimes have a very low number of recorded incidents and have decreased substantially since 2012 (Table 19). There were just 26 incidents of the purchase or consumption of alcohol by those aged under 18 years in 2022. In 2022, there were less than 5 recorded incidents of registered clubs/special restaurant offences, and 41 incidents of air rage – disruptive or drunken behaviour on aircraft (air navigation transport – other offences).

Liquor licensing incidents include minors (those aged under 18 years) consuming alcohol in a licenced premises, the sale of alcohol without a valid licence, and breach of alcohol sales hours. A decline in the number of recorded liquor licensing incidents was noted between 2012 (n=1,902) to 2022 (n=237).

Figure 43a Number of recorded liquor licensing incidents recorded on PULSE, 2012–2022




Source: CSO, 2023

Table 19 Specified recorded crime incidents categorised as public order and other social code incidents, by year reported, 2012–2022

| 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Provision of intoxicating liquor to those aged under 18 years** | | | | | | | | | | |
| 99 | 50 | 24 | 23 | 25 | 30 | 10 | 18 | 10 | 8 | 9 |
| **Sale of intoxicating liquor to those aged under 18 years** | | | | | | | | | | |
| 128 | 112 | 61 | 71 | 70 | 77 | 63 | 48 | 26 | 51 | 38 |
| **Purchase or consumption of alcohol by those aged under 18 years** | | | | | | | | | | |
| 524 | 323 | 267 | 233 | 255 | 197 | 112 | 90 | 50 | 27 | 26 |
| **Registered clubs/special restaurant offences[a]** | | | | | | | | | | |
| 10 | ~ | 8 | ~ | ~ | ~ | ~ | ~ | ~ | ~ | ~ |
| **Air navigation transport – other offences[b]** | | | | | | | | | | |
| 19 | 19 | 19 | 29 | 20 | 29 | 38 | 22 | 10 | 10 | 41 |

Source: Central Statistics Office, 2023 [140]

[a] 'Registered clubs/special restaurant offences' refers to incidents as per the Intoxicating Liquor Act, 1988, including premises selling alcohol without a valid liquor licence or outside the trading hours permitted.

[b] 'Air navigation transport – other offences' refers to air rage – disruptive or drunken behaviour on aircraft.

~ denotes five cases or fewer

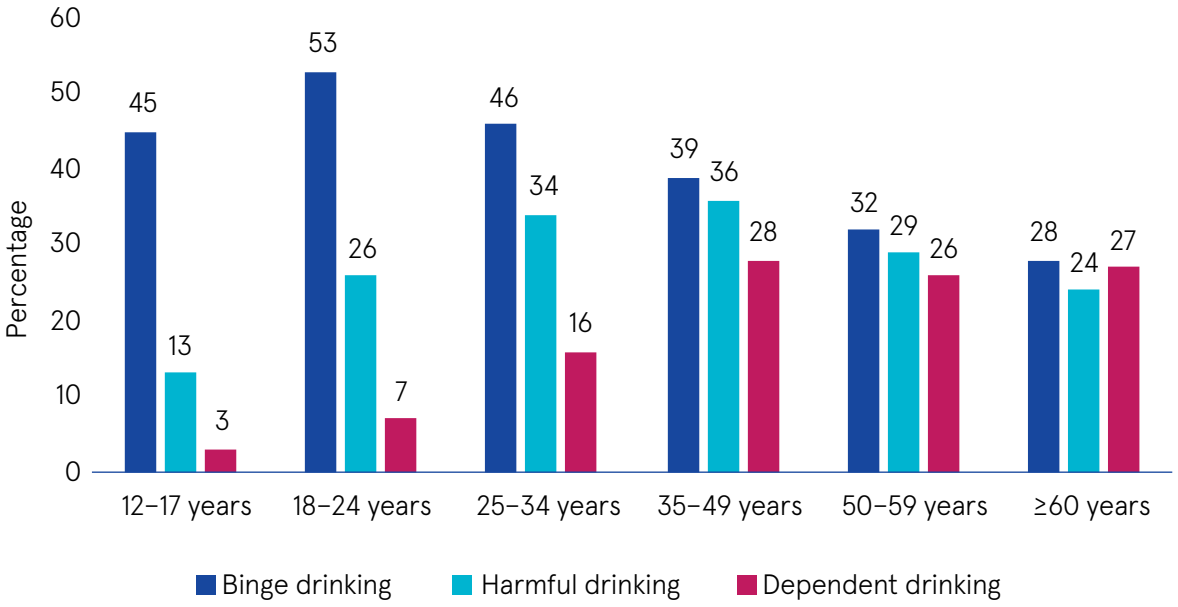
## 9.1.3 Alcohol and the Probation Services

### 9.1.3.1 Alcohol use among those on probation supervision

Alcohol and other drug use among those on probation supervision was examined in a report *Informing & Supporting Change: Drug and Alcohol Misuse among People on Probation Supervision in Ireland* and found alcohol misuse[10] was common, as was the link between alcohol use and the crime committed [144]. Probation officers completed surveys in 2019 with 3,096 clients on probation supervision and found that the majority of clients (81%) reported misusing alcohol and/or other drugs in their lifetime; 64% of the sample reported any alcohol misuse in their lifetime, 50% of whom reported combined alcohol and drug misuse and 14% of whom reported only alcohol misuse in their lifetime.

Among clients who reported lifetime alcohol misuse, alcohol dependence was reported by 20% of male Probation Service clients and 19% of female clients. Binge drinking was more likely to be reported by males (56%) than females (36%), as was harmful drinking (38% of males and 27% of females). Binge drinking was most common among the younger age groups (53% in the 18–24 years age group and 45% of those in the 12–17 years age group), and harmful alcohol use (36%) and alcohol dependency (28%) were more commonly reported among those aged 35–49 years (Figure 44).

Figure 44 Type of problem alcohol use among Probation Service clients, by age group, 2019



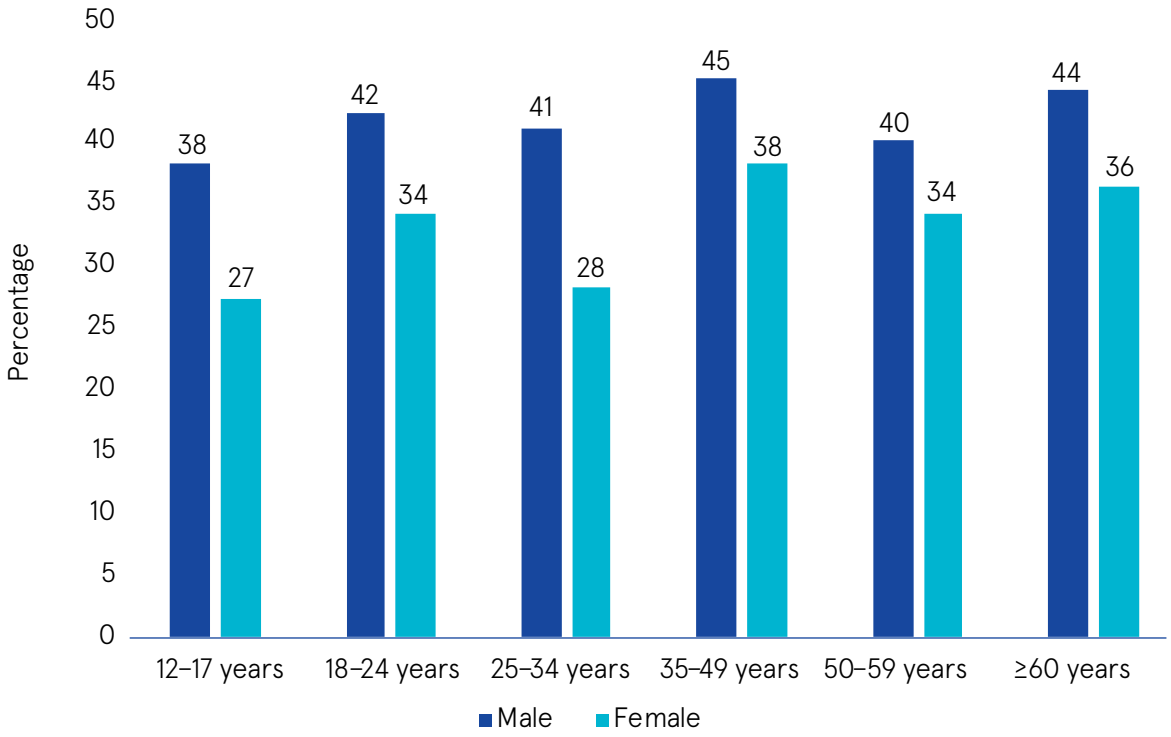

Source: Rooney, 2021 [145]

[10] Note that as per the Probation Service report, *Informing & Supporting Change: Drug and Alcohol Misuse among People on Probation Supervision in Ireland*, the terms 'alcohol misuse' and 'problematic alcohol use' refer to binge drinking, harmful drinking, or dependent drinking (binge drinking refers to the consumption of six or more standard drinks on one occasion).

### 9.1.3.2 Alcohol connected to the offending crime

The Probation Service survey examined if clients' drug and/or alcohol use was linked to the offence committed and found that alcohol use was connected to the offending crime for 42% of male Probation Service clients and 32% of female clients. Alcohol-related offending was most common among those aged 35–49 years (45% of males and 38% of females) (Figure 45).

Figure 45 Alcohol use linked to the offence committed by Probation Service clients, by age group and sex, 2019




Source: Rooney, 2021 [145]

The link between alcohol use and the offence committed was also determined by the drinking type of the Probation Service client. Of those who reported being binge drinkers, 61% committed an alcohol-related offence, this was 50% of harmful drinkers (50%) or 35% of dependent drinkers, indicating that binge drinking is particularly associated with criminal behaviour.

### 9.1.3.3 Service engagement for alcohol use and Probation Service interventions

Engagement with services for alcohol use was low among Probation Service clients with alcohol misuse issues; 16% of these clients engaged with a medical intervention for their alcohol use (most commonly general practitioner and outpatient services engagement) and 25% engaged with community support services (most commonly counselling/psychotherapy, Alcoholics Anonymous, and outreach).

Where an offender was not already engaged with support services for their alcohol misuse, probation officers commonly referred their clients to appropriate services in order to address their alcohol use issues. The most common referrals were for the motivational interviewing/SAOR (Support, Ask and assess, Offer assistance, and Refer) model (51%), to community-based addiction services run by the Health Service Executive (26%), and other community-based support services (26%).

## 9.2 Summary: Alcohol-related crime in Ireland

Alcohol use and crime are inextricably linked, and although the majority of the population drink without committing a crime, alcohol use, especially large amounts in short periods of time, can result in antisocial behaviour and/or crime. It is not always possible to tell the exact number of crimes caused due to alcohol use but studies have estimated that between 30% and 65% of assaults, disorderly conduct, public order, and other social code incidents are associated with alcohol-use.

In 2022, there were 5,527 drink-driving incidents recorded on the PULSE system and under the category of public order and other social code incidents, incidents of 'drunkenness' were back to pre-pandemic levels at 9,917 incidents. There were just 26 incidents of purchasing or consumption of alcohol by those aged under 18 years and 237 liquor licensing incidents. Although trends are presented in the figures, note that due to data quality issues and changing priorities and resources for An Garda Síochána, trends should be interpreted with this in mind.

The PULSE system does not routinely collate alcohol-related crimes. However, the Police Service of Northern Ireland (PSNI) indicate specifically if a crime involves alcohol. By doing so, their annual statistics indicate that alcohol-related crimes constitute 20% of all crimes recorded in Northern Ireland [239].

Examination of cases referred to the Probation Service reveals how many of these clients have a history of substance use problems, and the link between the crime for which they were referred to the Probation Service and their substance use was evident.

# 10

# Alcohol and gambling

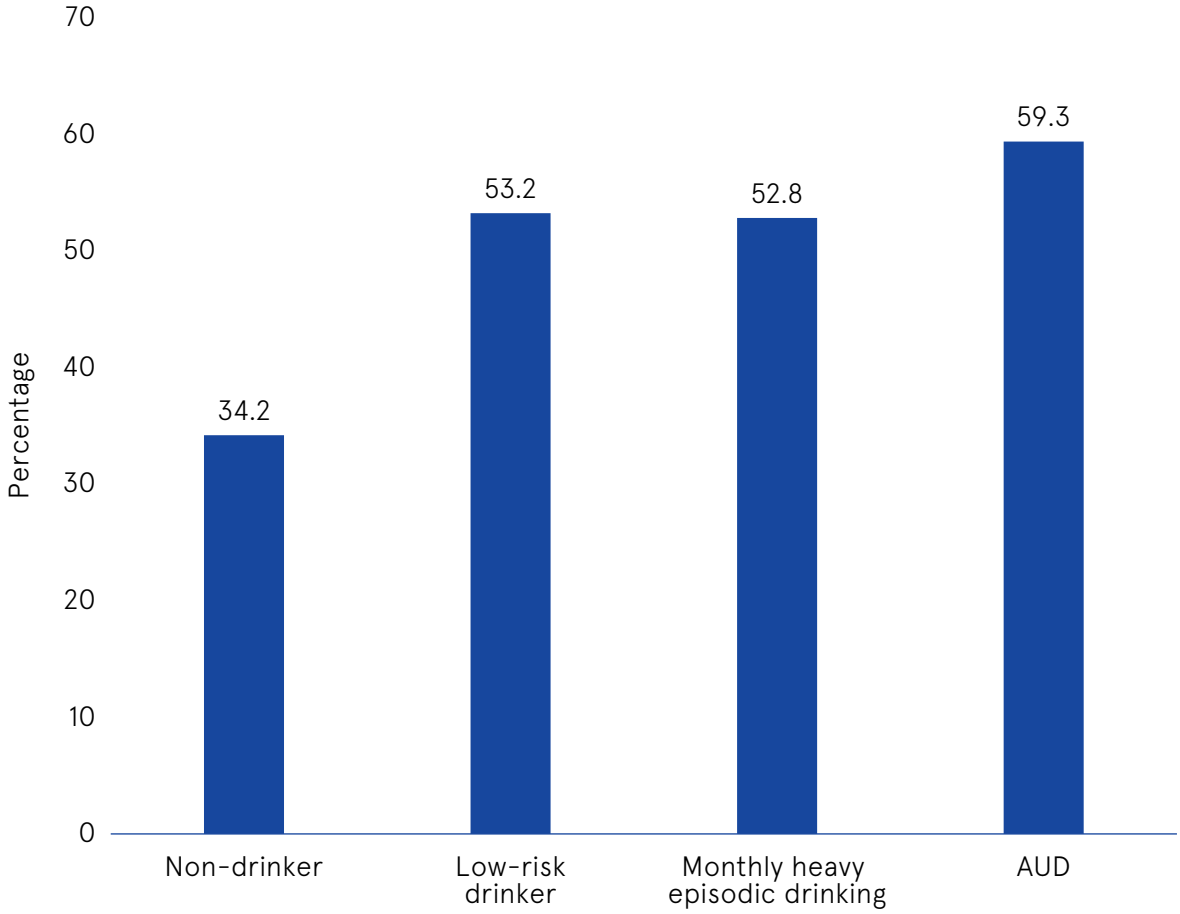
Gambling is a widely practised activity in Ireland, and almost one-half (49%) of NDAS respondents in 2019–20 aged 15 years and over reported gambling in the previous year, including lottery [145]. The NDAS examined the prevalence of problem gambling (as measured by a standard screening tool, the Problem Gambling Severity Index (PGSI), identifying common signs and consequences of problematic gambling. The survey also used an adapted version of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* in order to identify problem gambling [146]. Gambling disorder is recognised as a behavioural addiction disorder alongside alcohol and other drug addictive disorders, and these are commonly now examined together due to their shared aetiologies [53,147].

Problem gambling can have a negative effect on the individual's psychological, physical, and social well-being, as well as adverse effects on their mental health and finances [148]. Gambling-related harms can extend into relationship difficulties, employment absenteeism, and job loss, and have been associated with stigma, shame, and an increased risk of self-harm and suicide [148]. The secrecy that often surrounds problem gambling can result in a reluctance to seek treatment or to only seek treatment when the gambling is at a crisis point [149]. Problem gambling is often accompanied by alcohol and other substance use disorders [148], and the NDAS in 2019–20 examined this association.

Gambling behaviour was described in the HRB report *Gambling in the Republic of Ireland* as non-problematic gambling (an individual gambles but with no negative consequences); low-risk gambling (an individual experiences a low level of problems with few or no identified negative consequences); moderate-risk gambling (an individual experiences a moderate level of problems leading to some negative consequences); and problem gambling (an individual experiences negative consequences and a possible loss of control) [146]. The NDAS indicated that 0.3% of the adult population are problem gamblers [146]; however, a 2023 study by the Economic and Social Research Institute using data collected anonymously found a much higher prevalence of problem gambling, estimated at 3.3% of the adult population, or 1 in every 30 adults in Ireland [150].

We examined the prevalence of gambling and alcohol use using data from the 2019–20 NDAS. The findings indicated that drinkers were more likely to report gambling in the previous year (53.0%–59.3%) compared with non-drinkers (34.2%) (Figure 46).

Figure 46 Prevalence of gambling in the previous year, by drinker type, 2019–20

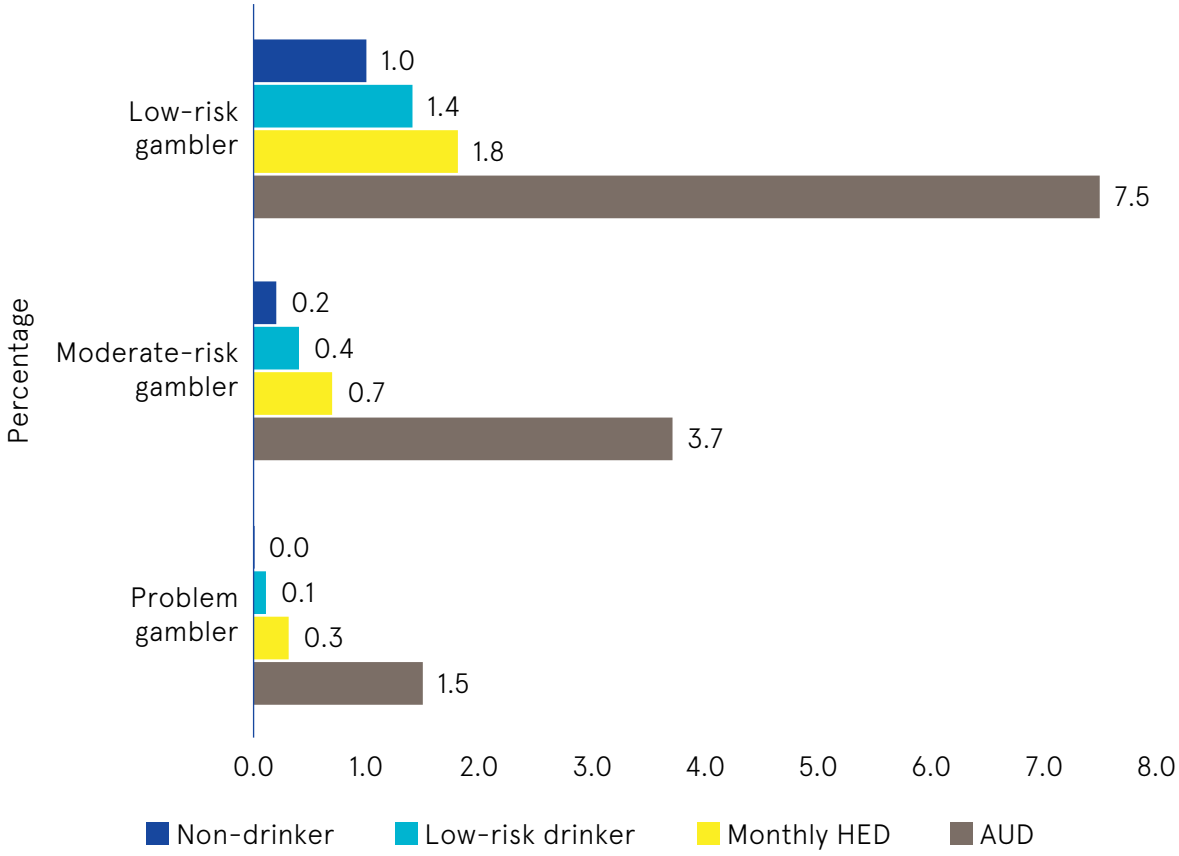



Source: Mongan et al., 2022 [146]

Drinkers who reported monthly heavy episodic drinking (HED) were more likely than low-risk drinkers[11] to meet the criteria for at-risk (low-risk and moderate-risk) and problem gambling. Those who met the criteria for AUD were most likely to meet the criteria for at-risk gambling (11.2%) or problem gambling (1.5%) (Figure 47).

[11] Those who had consumed alcohol in the previous year but did not engage in regular HED or meet the criteria for AUD.

Figure 47 Prevalence of problem gambling in the previous year, by drinker type, 2019–20




Source: Mongan et al., 2022 [146]

A study using NDTRS data examined cases receiving treatment for problem gambling and found that almost one-half (47.3%) of cases who received treatment for problem gambling reported problem use of at least one other substance, most commonly alcohol; 85.6% of those reporting additional problem drug use indicated that alcohol was the substance requiring treatment [151].

Those with alcohol use disorder were most likely to be

**at-risk gamblers or problem gamblers**

# 10.1 Summary: Alcohol and gambling

Gambling is a widely practised activity in Ireland, but the extent of problem gambling is difficult to quantify due to the secrecy, shame, and stigma surrounding gambling harm. The 2019–20 NDAS, in addition to collecting data on drug and alcohol use prevalence, also asked respondents about gambling (including problem gambling). The NDAS found that 0.3% of the population of Ireland are potentially problem gamblers, but this is considerably lower than that found in a study published in 2023, which estimated that 3.3% of the population are problem gamblers, 10 times higher than the proportion estimated by the NDAS.

The 2019–20 NDAS found that drinkers were more likely to gamble compared with non-drinkers, and when examined by drinker type, those who reported monthly HED and those with possible AUD were more likely to be at-risk or problem gamblers. Those receiving treatment for problem gambling were commonly also simultaneously seeking treatment for problem alcohol use.

# 11

# Alcohol-related mortality in Ireland

Data on alcohol-related deaths in Ireland are collected by the National Drug-Related Deaths Index (NDRDI). The Global Burden of Disease (GBD) study is also used to provide a picture of alcohol-related mortality and disability.

The latest data from both the NDRDI and the GBD study do not include deaths during or after the COVID-19 pandemic, but mortality data from other countries indicate that alcohol-related deaths increased during this period. For example, a study examining mortality data for England and Wales, Northern Ireland, Scotland, and the United States of America (USA) between 2001 and 2021 found that alcohol-related deaths increased in all countries between 2019 and 2021, particularly in the USA, but also in England and Wales [152]. As per capita alcohol use declined in Ireland during the pandemic period, it will be important to examine Irish data when available to verify if deaths increased as per the UK and USA, or whether a decline will be noted to reflect this decrease.

An Irish study estimating alcohol-related deaths during the period from 2000 to 2004 calculated that alcohol-attributable fractions based on prevalence survey data matched with meta-analyses of the disease/injury risk association [153]. The study estimated that 6,584 deaths during this period were caused by alcohol use, equating to 4.4% of all deaths between 2000 and 2004. Partially alcohol-attributable conditions accounted for 83% of alcohol-attributable deaths, and the other 17% of those deaths were caused by wholly alcohol-attributable conditions. Most alcohol-attributable deaths were caused by chronic conditions (69%) and acute conditions (31%). The study concluded that alcohol-attributable deaths were most common among moderate drinkers, and as such, population-level interventions are likely to have the greatest impact on reducing alcohol-related deaths.

## 11.1 GBD study: Alcohol-related deaths

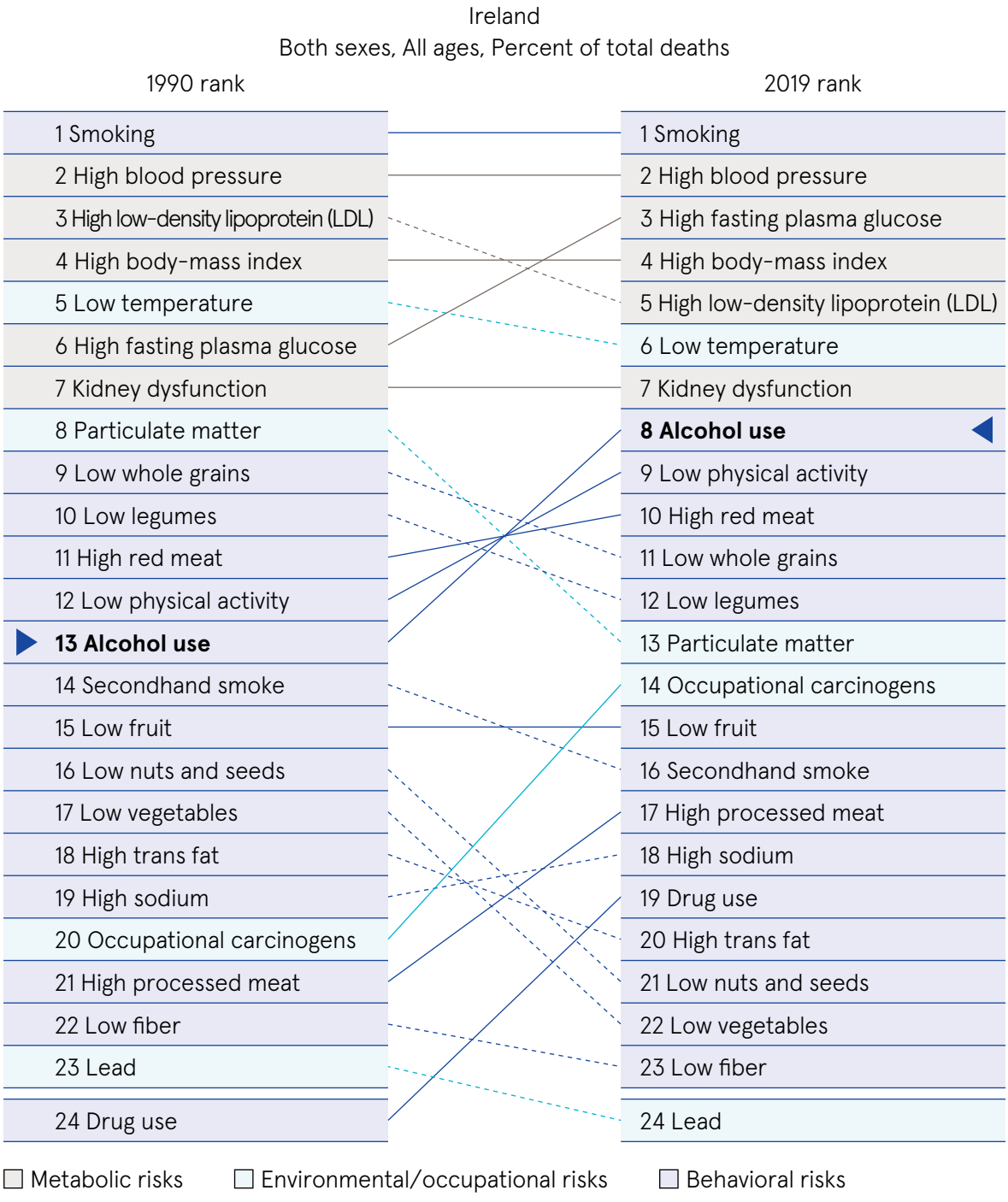
The GBD study quantifies health loss from hundreds of diseases, injuries, and risk factors by combining the prevalence of a given disease or risk factor and the relative harm it causes. It can be used to measure alcohol-related harm, including deaths, and considers a wide range of variables in order to calculate the mortality associated with alcohol use. GBD data are available to view online on an interactive visualisation hub, allowing users to explore the specific causes of alcohol-related deaths in further detail [154].

Alcohol use is the

**8th leading cause of all deaths in Ireland**

In 1990, the GBD ranked alcohol use as the 13th leading cause of all deaths among the population of Ireland (all ages, both sexes); in 2019, alcohol use had risen to the 8th leading cause of death (Figure 48) [7].

Figure 48 Leading causes of death among the population of Ireland, showing where alcohol use ranks for all ages and both sexes, 1990 and 2019




Source: Global Burden of Disease, 2023 [7]

In 2019, GBD researchers estimated that 1,543 deaths in Ireland were attributable to alcohol, representing 4.8% of all deaths [6]. More alcohol-related deaths in 2019 were males (1,104; 71.5%) than females (439; 28.5%), and the total estimated number of alcohol-related deaths in 2019 represents an average of 4 deaths per day in Ireland due to alcohol. In 2019, the GBD study indicated that cirrhosis and other chronic liver diseases due to alcohol use was the most common cause of wholly alcohol-attributable deaths (179 deaths) in Ireland (Table 20).

Table 20 Causes of wholly alcohol-attributable deaths in Ireland in 2019

| | Number of deaths | 95% uncertainty interval (UI) | Rate per 100,000 of the population (95% UI) |
|---|---|---|---|
| Liver cancer due to alcohol use | 95 | 70–123 | 1.94 (1.42–2.50) |
| Alcoholic cardiomyopathy | 49 | 32–68 | 1.00 (0.66–1.38) |
| Cirrhosis and other chronic liver diseases due to alcohol use | 179 | 144–213 | 3.64 (2.93–4.34) |
| Alcohol use disorders | 95 | 78–106 | 1.93 (1.60–2.16) |

Source: Global Burden of Disease, 2023 [155]

Neoplasms were estimated to be the most common cause of partially alcohol-attributable deaths in 2019 (n=635), followed by digestive diseases (n=306) (Table 21).

Table 21 Causes of partially alcohol-attributable deaths in Ireland in 2019

| Causes of partially alcohol-attributable deaths | Number of deaths | 95% UI |
|---|---|---|
| Neoplasms | 635 | 534–735 |
| Digestive diseases | 306 | 240–371 |
| Cardiovascular diseases | 162 | −24–370 |
| Respiratory infections and tuberculosis | 146 | 71–224 |
| Self-harm and interpersonal violence | 123 | 70–179 |
| Substance use disorders | 95 | 78–106 |
| Unintentional injuries | 39 | 18–67 |
| Transport injuries | 21 | 12–30 |
| Neurological disorders | 19 | 14–24 |

Source: Global Burden of Disease, 2023 [155]

# 11.2 The National Drug-Related Deaths Index

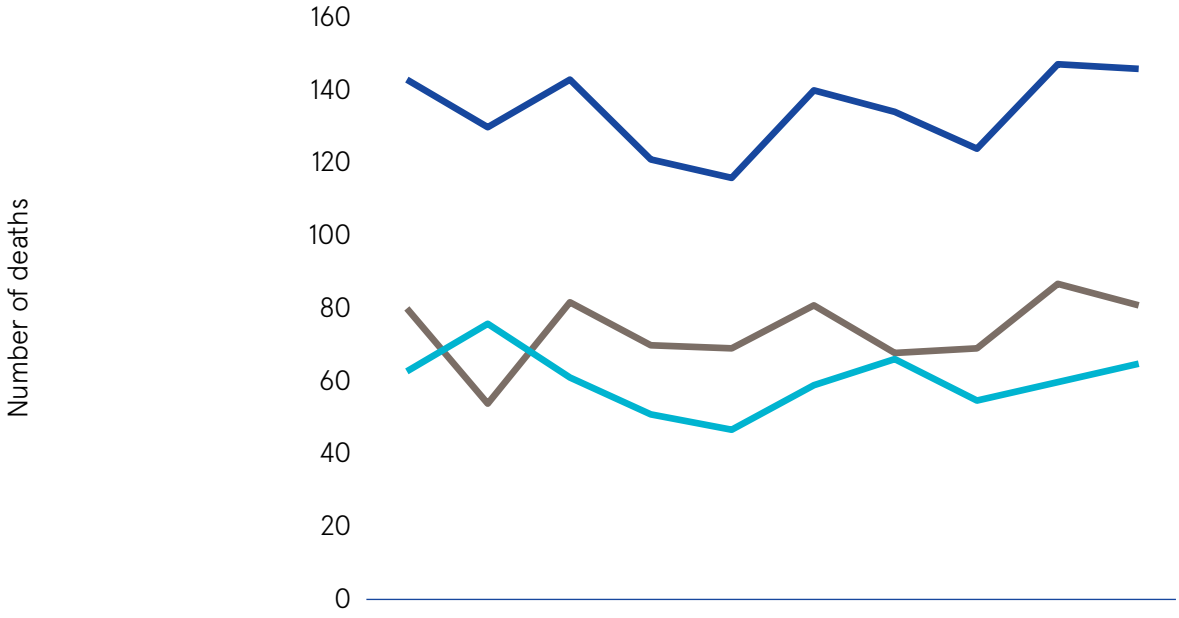
The NDRDI is a census of drug- and alcohol-related poisoning deaths (deaths due to the toxic effects of one or more substances on the body), and of deaths among people who used drugs and/or people who were alcohol dependent in Ireland. The NDRDI does not record all deaths that are partially attributable to alcohol, or all deaths where the term 'alcohol misuse' or 'alcohol abuse' is recorded in the data sources, and so the data are an underestimate of alcohol-related mortality in Ireland. A detailed description of the criteria for which a death is registered on the NDRDI as alcohol related is outlined in the 2021 HRB alcohol overview *Alcohol consumption, alcohol-related harm and alcohol policy in Ireland,* along with detailed information about alcohol-related deaths [30]. More up-to-date data from the NDRDI are limited because the NDRDI collects data from closed coroners' files, which means it has to report data in arrears. This has been exacerbated since the last HRB alcohol overview was published because of limited access to coroners' offices due to the COVID-19 public health restrictions. Limited preliminary data were released by the HRB in June 2023, and these are presented in this chapter. Further detailed data from the NDRDI are expected to be published in 2024.

In the previous HRB alcohol overview published in 2021, the most recently available data related to 2017, when 1,094 alcohol-related deaths were recorded by the NDRDI (75% male and 25% female) [30]. In 2017, alcohol-related deaths were more common among those aged 50–64 years (38% of alcohol-related deaths) than among other age groups. That report provides detailed information regarding these deaths and will be updated in the next HRB overview.

The provisional data from the NDRDI indicate that in 2020, there were 409 poisoning deaths where drugs and/or alcohol were implicated. Of these deaths, 1 in 5 (81 deaths; 19.8%) were poisoning deaths where alcohol was implicated (as part of polydrug use) [155]. This was a decrease from 2019, when there were 87 poisoning deaths in which alcohol was implicated as part of a polydrug death (this was the peak of such deaths since 2011) (Figure 49).

In addition to the poisoning deaths where alcohol was implicated as part of a polydrug death, there were 65 alcohol-only poisoning deaths in 2020 [156]. A peak in the number of alcohol-only poisoning deaths was evident in 2012, when there were 76 such deaths (Figure 49). The number of alcohol-only poisoning deaths increased between 2019 (60 deaths) and 2020 (65 deaths). Note that these are the number of deaths recorded and do not consider population changes during the period.

Figure 49 Number of alcohol-related poisoning deaths, 2011–2020




| | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|---|---|---|---|---|
| Alcohol implicated (as part of a polydrug death) | 80 | 54 | 82 | 70 | 69 | 81 | 68 | 69 | 87 | 81 |
| Alcohol-only poisoning deaths | 63 | 76 | 61 | 51 | 47 | 59 | 66 | 55 | 60 | 65 |
| Total alcohol poisoning deaths | 143 | 130 | 143 | 121 | 116 | 140 | 134 | 124 | 147 | 146 |

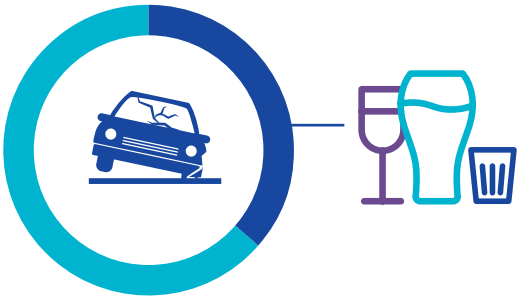
Source: Health Research Board, 2023 [156]

## 11.3 Alcohol and fatal road traffic collisions

The NDRDI collects detailed information on fatal road traffic collisions (RTCs) on behalf of the Road Safety Authority (RSA). In 2020, the RSA published a report on the number of fatal RTCs that had occurred during the period from 2013 to 2017 [156]. During this period, there were 705 road user fatalities, 600 of which had a toxicology reading available. More than one-third (36.5%; 219) of road user fatalities for which a toxicology reading was available had a positive toxicology[12] for alcohol. Of the 219 road user fatalities with a positive toxicology for alcohol, 61.6% were drivers,[13] 22.4% were pedestrians, 12.8% were passengers, and 2.3% were cyclists. The majority of road user fatalities were male (86.3%), and those aged 25–34 years represented the age group with the largest share of road user fatalities (27.4%), followed by those aged 15–24 years (26.0%).

[12] A positive toxicology refers to a case where the deceased had a blood alcohol concentration of >20 g of alcohol per 100 mL of blood (or equivalent in urine).

[13] 'Driver' refers to the driver of the vehicle (i.e. a car, van, tractor, truck, etc.).



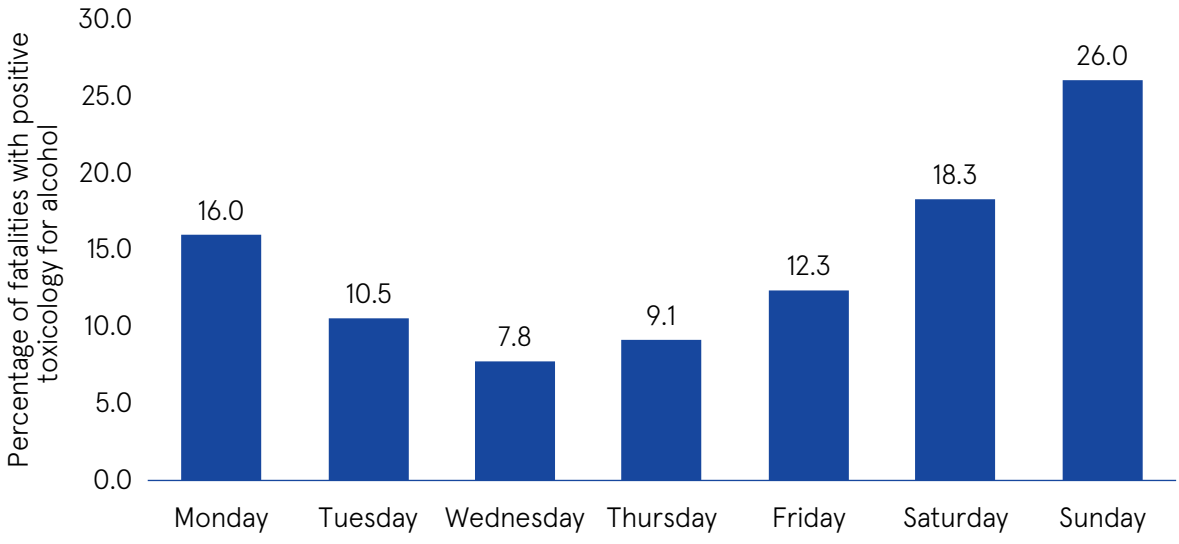
**More than one-third (36.5%) of road user fatalities**
had been drinking prior to the incident

## 11.3.1 Road user fatalities with positive alcohol toxicology

Among fatalities with a positive toxicology for alcohol, 22.8% had a blood alcohol concentration (BAC) of between 151 and 200 milligrams (mg) per 100 millilitres (mL) of blood, which placed them two to three times over the legal blood alcohol limit to drive, and 21.6% had a BAC of 201–250 mg/100 mL,[14] three to four times over the legal limit to drive.

Fatal collisions involving alcohol most commonly took place between 12.00 am and 3.00 am (27.9%), on Saturdays (18.3%) or Sundays (26.0%), and during the month of July (11.4%) (Figure 50).

Figure 50 Percentage of fatalities with positive toxicology for alcohol by day of the week, 2013–2017



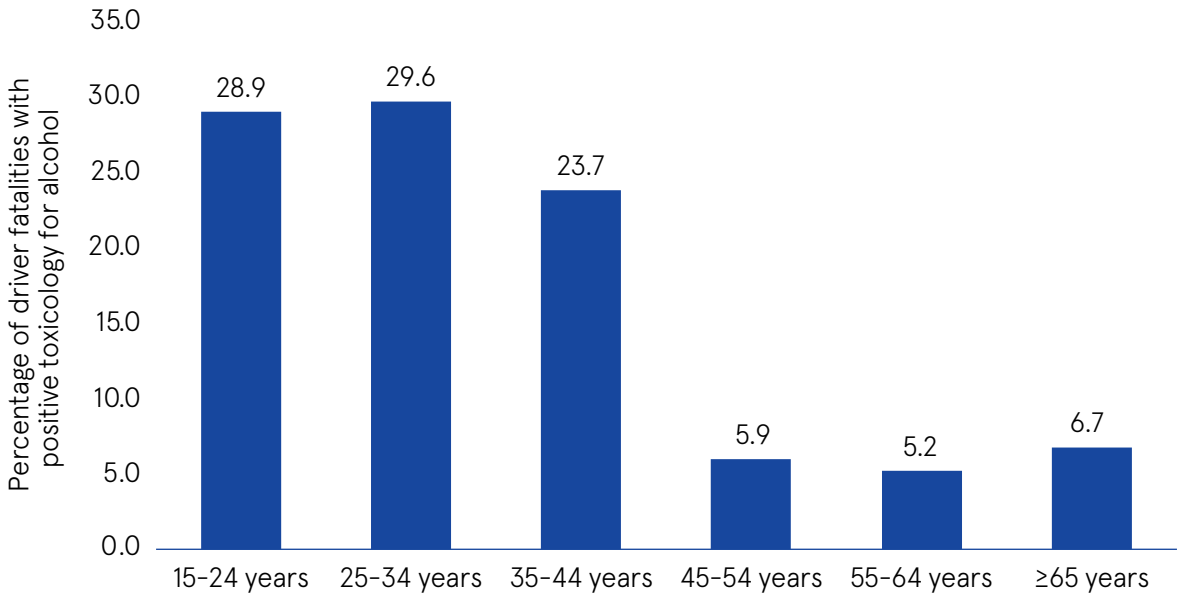

Source: Road Safety Authority, 2020 [157]

[14] The legal limit for driving in Ireland is 50 mg of alcohol per 100 mL of blood, or 20 mg per 100 mL for learner, novice, or professional drivers.

## 11.3.2 Driver fatalities with positive alcohol toxicology

Of the 379 drivers with a toxicology result available, 135 (35.6%) had a positive toxicology for alcohol; the majority of the driver fatalities were male (91.9%), and 29.6% of driver fatalities were aged 25–34 years (Figure 51) [157].

Figure 51 Percentage of driver fatalities with positive toxicology for alcohol, by age group, 2013–2017




Source: Road Safety Authority, 2020 [157]

Of the driver fatalities between 2013 and 2017 with a positive toxicology for alcohol, 22.2% had a BAC of 201–250 mg/100 mL of blood. There were nine driver fatalities in this period that were at least five times over the legal limit to drive, with a BAC in excess of 300 mg/100 mL (Table 22).

Table 22 BAC of driver fatalities with a positive toxicology for alcohol, 2013–2017

| BAC (mg/100 mL) | Number of driver fatalities | Percentage of driver fatalities |
|---|---|---|
| ≤50 | 6 | 4.4% |
| 51–100 | 14 | 10.4% |
| 101–200 | 51 | 37.8% |
| 201–300 | 55 | 40.7% |
| ≥301 | 9 | 6.7% |
| Total | 135 | 100.0% |

Source: Road Safety Authority, 2020 [157]

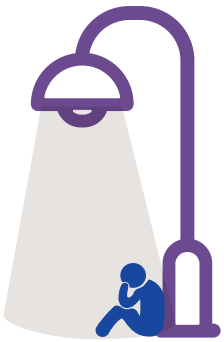
Where this information was available (n=105), more than one-half (54.3%) of drivers with a positive toxicology for alcohol were not wearing a seatbelt. Where the information was available for a record of the actions of the driver prior to the fatal collision (n=120), 50.0% had lost control of the vehicle, 44.2% went to the wrong side of the road, 32.5% exceeded a safe speed, and 29.2% failed to negotiate a bend [157].

Of the fatal RTCs where the driver had a positive toxicology for alcohol, 23.0% occurred during the period between 12.00 am and 3.00 am and 22.2% occurred between 9.00 pm and 12.00 am. Such incidents were most commonly reported on a Sunday (28.9%), and more than one-third (34.1%) occurred during the summer months of June, July, and August. Most fatal RTCs in which the driver had a positive toxicology for alcohol occurred on roads considered to be rural roads and where the speed limit is 80 kilometres (km) per hour or higher.

## 11.4 Alcohol-related deaths among people who were homeless

Substance use is common among those experiencing homelessness, with alcohol and other drugs implicated in 58.7% of deaths among homeless individuals in Dublin between 2011 and 2015 [157]. A study in Ireland that examined the deaths of 84 people who were categorised as homeless at the time of their death in 2019, extracted data from closed coroners' files [158]. Of those who died, 92.9% had a history of substance use: 47.6% used drugs only, 22.6% used drugs and alcohol, and 22.6% used alcohol only. Alcohol was implicated in 32.6% of poisoning deaths among those experiencing homelessness. Of non-poisoning deaths, 57.9% had a history of alcohol dependency. Of those who died due to a medical cause of death[15], 13.2% were alcohol related. The study also highlighted the high prevalence of mental health issues and medical conditions among this vulnerable population, along with substance use.

[15] Medical causes of death are those where a medical condition was listed as the cause of death including cerebral event; haemorrhage; infection(s) such as pancreatitis, meningitis, gastritis, or tuberculosis; respiratory disease such as asthma, chronic obstructive pulmonary disease, emphysema, bronchitis; or respiratory infection such as pneumonia, abscess of the lung, pneumonitis due to solids or liquids.



**Alcohol was implicated in 32.6% of poisoning deaths among those experiencing homelessness.**

Of non-poisoning deaths, 57.9% had a history of alcohol dependency.

Of those who died due to a medical cause of death, 13.2% were alcohol related.

## 11.5 Summary: Alcohol-related mortality in Ireland

The main sources of information on alcohol-related mortality are the NDRDI and the GBD study. As the NDRDI does not include partially alcohol-attributable conditions, it indicates that on average, three people die every day in Ireland as a direct result of alcohol. The GBD study includes partially alcohol-attributable deaths and estimates that there are at least four deaths per day in Ireland due to alcohol.

The GBD study ranked alcohol use as the eighth leading cause of death among the population in Ireland in 2019, with cirrhosis and other chronic liver diseases due to alcohol use causing the most wholly alcohol-attributable deaths, followed by AUD and liver cancer due to alcohol use. Partially alcohol-attributable deaths in 2019 were most commonly neoplasms, digestive diseases, and cardiovascular diseases. There has been a delay in obtaining up-to-date data from the NDRDI, primarily as a consequence of the COVID-19 pandemic, but provisional data indicate that there were 146 alcohol poisoning deaths in Ireland in 2020.

The data available from the RSA and NDRDI conclude that more than one-third of fatal RTCs between 2013 and 2017 involved the road user having a positive toxicology for alcohol. Among driver fatalities with a positive toxicology for alcohol, the drivers were typically male, aged under 45 years. The fatal RTCs were more likely to take place over the weekend, during the night or in the early hours of the morning, and on country roads.

# 12

# Alcohol treatment

Treatment for problem alcohol use in Ireland is provided by statutory and non-statutory services, including general hospitals, psychiatric hospitals, community-based services, and residential centres. Most treatment for problem alcohol use takes place in outpatient facilities. Treatment options for problem alcohol use include medication, psychiatric treatment, brief intervention, counselling (including cognitive behavioural therapy), medication-free therapy, family therapy, complementary therapy, pharmacotherapy and life skills training. The NDTRS and the NPIRS are the main sources of information on treatment for alcohol use in Ireland.

## 12.1 National Drug Treatment Reporting System

The NDTRS is an epidemiological database on treated problem drug and alcohol use in Ireland. It is coordinated by the National Health Information Systems Unit of the HRB on behalf of the Department of Health. For the purposes of the NDTRS, 'treatment' is broadly defined as any activity that aims to ameliorate the psychological, medical, or social state of individuals who seek help for their alcohol and other drug use. A record is completed for each client who is treated for alcohol and/or other drug use (whether they are being treated for the first time or have been previously treated), and data are collected on annual episodes of treatment rather than on the number of individuals being treated. This means that the same person could be counted more than once in a reporting year if they had more than one treatment episode in that year. More detailed information on the methodology used for the NDTRS can be found in NDTRS publications [159,160].

In 2022, data was reported to the NDTRS by 90.4% of publicly funded services known to provide alcohol treatment (excluding GPs). In addition, the NDTRS only receives counselling data from the Irish Prison Service. The data presented in this chapter therefore likely underestimate the true extent of alcohol use treatment in Ireland [161]. Nonetheless, the NDTRS is recognised as a comprehensive measure of treatment demand. Data presented in this overview are based on the latest alcohol treatment bulletin from the NDTRS, which covers alcohol treatment data for the 8-year period from 2015 to 2022, as well as on data requested from NDTRS staff and data from interactive tables available from the HRB National Drugs Library.

### 12.1.1 Treatment for alcohol as the main problem drug

Annual rates for the incidence (number of new cases) and prevalence (all cases) of treated problem alcohol use were calculated per 100,000 of the population aged 15–64 years based on census figures from the Central Statistics Office (Table 23) [162]. Incidence decreased from 109.1 cases per 100,000 in 2015 to 92.6 cases in 2022. Prevalence also decreased, from 234.8 cases per 100,000 in 2015 to 209.4 cases per 100,000 in 2022.

Table 23 Incidence and prevalence of treated problem alcohol use per 100,000 of the population aged 15–64 years, 2015–2022

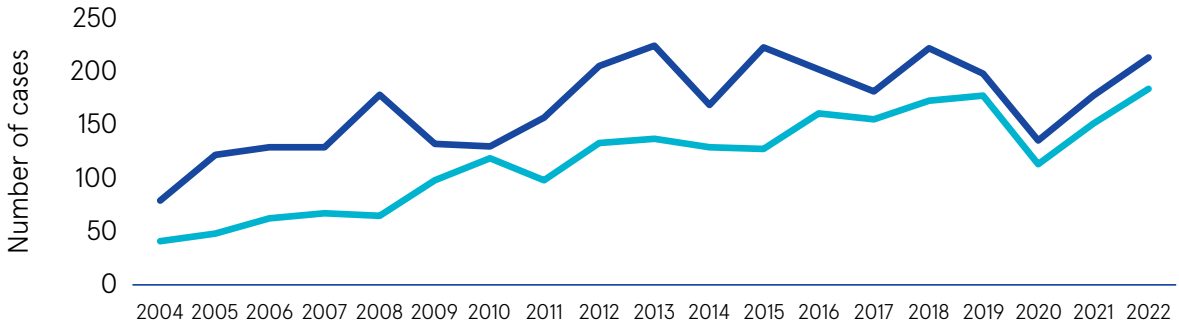
| | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|---|---|
| Rate of new cases per 100,000 of the population (incidence) | 109.1 | 112.0 | 105.7 | 95.4 | 96.7 | 73.0 | 86.8 | 92.6 |
| Rate of all cases per 100,000 of the population (prevalence) | 234.8 | 232.8 | 222.3 | 219.9 | 221.7 | 170.4 | 198.3 | 209.4 |

Source: Condron et al., 2023 [162]

Table 24 includes trends in the number of cases attending treatment for alcohol use from 2015 to 2022 by treatment status. Between 2015 and 2022, 57,725 cases were treated for alcohol as the main problem drug. The number of cases treated decreased by 2.6% from 2015 (7,618 cases) to 2022 (7,421 cases). The number of new cases (i.e. not known to have previously received treatment) also decreased during this time, from 3,553 cases in 2015 to 3,278 cases in 2022.

Reductions in cases presenting for treatment may reflect a true decrease but may also reflect reduced levels of participation or under-reporting to the NDTRS, or it may be a combination of both of these factors. Due to the COVID-19 pandemic and the associated restrictions, many service providers were impacted both in the treatment they could provide their clients and in terms of submitting data to the NDTRS. This also contributed to a decrease in treatment figures during this period. During the pandemic, a decline in the number of cases seeking treatment for alcohol use may also be due to avoiding treatment services, reduced capacity and closure of treatment services, and/or reduced alcohol use.

Figure 52 Number of cases aged 65 years and over reported to the NDTRS entering treatment for alcohol as the main problem drug, 2004 – 2022, by sex




| | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Male | 79 | 122 | 129 | 129 | 178 | 132 | 130 | 157 | 205 | 224 | 169 | 223 | 202 | 181 | 222 | 198 | 135 | 177 | 213 |
| Female | 41 | 48 | 62 | 67 | 65 | 98 | 119 | 98 | 133 | 137 | 129 | 127 | 161 | 155 | 173 | 177 | 113 | 151 | 184 |

Source: National Drug Treatment Reporting System (NDTRS), 2023

Figure 52 illustrates the number of cases aged 65 years and over who entered treatment for alcohol as their main problem substance between 2004 and 2022. The data indicate that there has been a substantial increase in the number of older people accessing treatment for their alcohol use during this period, particularly among older women which has seen a 349% increase since 2004, albeit from a low base. This may reflect greater societal awareness about alcohol dependency which may encourage olde people to seek help, where in the past they may have felt stigmatised. It may reflect the higher alcohol use among 'baby boomer' generation who are now reaching retirement age, or it may be as a result of increased screening and improved treatment options.


**A growing number of older people aged 65+ years accessing treatment for alcohol use**

## 12.1.2 Characteristics of cases entering treatment for alcohol as the main problem drug

Table 24 presents the characteristics of cases entering treatment for alcohol as their main problem drug between 2015 and 2022. In 2022, 61.5% of treatment cases were men. The median age of all cases in treatment in 2022 was 42 years; 43.6% of cases were aged 35–49 years and 1.0% were aged under 18 years. Among new cases (those that had never been treated for alcohol use before), 1 in 20 reported being homeless at the time of treatment entry, compared to 1 in 10 of those who had been previously treated, with 1 in 10 such cases reporting being homeless when they entered treatment. The proportion of cases that were unemployed decreased between 2015 (55.3%) and 2022 (47.6%), as did the number of cases that were early school leavers.

The highest number of cases treated for alcohol use in 2022 resided in Community Healthcare Organisation (CHO) 9 (Dublin North, Dublin North Central, and Dublin North West) (16.1%), followed by CHO 5 (South Tipperary, Carlow/Kilkenny, Waterford, and Wexford) (15.2%). When examined at county level, the highest number of cases treated for alcohol use in 2022 resided in counties Dublin (30.1%), Cork (9.4%), and Donegal (6.3%), although it should be noted that poor levels of participation in the NDTRS by alcohol services in some areas may affect this geographic analysis [142].

Table 24 Characteristics of cases entering treatment for alcohol use, 2015–2022

| | 2015 | | 2016 | | 2017 | | 2018 |
|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n |
| **All cases with alcohol as the main problem drug** | **7,618** | **–** | **7,643** | **–** | **7,350** | **–** | **7,464** |
| Median age (interquartile range) | 41 years (21–64 years) | – | 41 years (21–64 years) | – | 41 years (21–64 years) | – | 41 years (21–65 years) |
| Aged under 18 years | 103 | 1.4 | 124 | 1.6 | 112 | 1.5 | 114 |
| Male | 4,961 | 65.1 | 4,884 | 63.9 | 4,769 | 64.9 | 4,812 |
| Homeless | 572 | 7.5 | 613 | 8.0 | 620 | 8.4 | 713 |
| Traveller | 141 | 1.9 | 161 | 2.1 | 118 | 1.6 | 145 |
| Education ceased before the age of 16 years | 1,965 | 25.8 | 1,808 | 23.7 | 1,726 | 23.5 | 1,727 |
| Employed | 1,724 | 22.6 | 1,889 | 24.7 | 2,056 | 28.0 | 2,067 |
| Unemployed | 4,215 | 55.3 | 4,110 | 53.8 | 3,827 | 52.1 | 3,783 |
| Retired/unable to work | 925 | 12.1 | 964 | 12.6 | 887 | 12.1 | 958 |
| **New cases** | **3,553** | **–** | **3,678** | **–** | **3,500** | **–** | **3,230** |
| Median age (interquartile range) | 39 years (20–64 years) | – | 40 years (20–64 years) | – | 40 years(19–64 years) | – | 39 years (20–65 years) |
| Aged under 18 years | 83 | 2.3 | 87 | 2.4 | 90 | 2.6 | 87 |
| Male | 2,279 | 64.1 | 2,290 | 62.3 | 2,234 | 63.8 | 2,087 |
| Homeless | 148 | 4.2 | 160 | 4.4 | 166 | 4.7 | 191 |
| Traveller | 60 | 1.7 | 78 | 2.1 | 50 | 1.4 | 59 |
| Education ceased before the age of 16 years | 815 | 22.9 | 768 | 20.9 | 768 | 21.9 | 639 |
| Employed | 1,014 | 28.5 | 1,176 | 32.0 | 1,209 | 34.5 | 1,165 |
| Unemployed | 1,725 | 48.6 | 1,690 | 45.9 | 1,587 | 45.3 | 1,417 |
| Retired/unable to work | 384 | 10.8 | 404 | 11.0 | 367 | 10.5 | 354 |

| | 2019 | | 2020 | | 2021 | | 2022 | |
|---|---|---|---|---|---|---|---|---|
| % | n | % | n | % | n | % | n | % |
| – | **7,546** | – | **5,824** | – | **6,859** | – | **7,421** | – |
| – | 41 years (22–64 years) | – | 41 years (21–64 years) | – | 42 years (22–64 years) | – | 42 years (23–65 years) | – |
| 1.5 | 107 | 1.4 | 99 | 1.7 | 109 | 1.6 | 76 | 1.0 |
| 64.5 | 4,835 | 64.1 | 3,604 | 61.9 | 4,297 | 62.6 | 4,565 | 61.5 |
| 9.6 | 654 | 8.7 | 494 | 8.5 | 567 | 8.3 | 567 | 7.6 |
| 1.9 | 178 | 2.4 | 121 | 2.1 | 167 | 2.4 | 186 | 2.5 |
| 23.1 | 1,739 | 23.0 | 1,235 | 21.2 | 1,422 | 20.7 | 1,382 | 18.6 |
| 27.7 | 2,125 | 28.2 | 1,639 | 28.1 | 2,111 | 30.8 | 2,526 | 34.0 |
| 50.7 | 3,731 | 49.4 | 2,865 | 49.2 | 3,345 | 48.8 | 3,534 | 47.6 |
| 12.8 | 1,004 | 13.3 | 848 | 14.6 | 931 | 13.6 | 926 | 12.5 |
| – | **3,296** | – | **2,490** | – | **3,026** | – | **3278** | – |
| – | 40 years (19–64 years) | – | 40 years (19–65 years) | – | 40 years (20–65 years) | – | 41 years (21–65 years) | – |
| 2.7 | 83 | 2.5 | 82 | 3.3 | 90 | 3.0 | 67 | 2.0 |
| 64.6 | 2,080 | 63.1 | 1,498 | 60.2 | 1,841 | 60.8 | 2,010 | 61.3 |
| 5.9 | 207 | 6.3 | 149 | 6.0 | 165 | 5.5 | 166 | 5.1 |
| 1.8 | 73 | 2.2 | 46 | 1.8 | 70 | 2.3 | 85 | 2.6 |
| 19.8 | 716 | 21.7 | 464 | 18.6 | 568 | 18.8 | 519 | 15.8 |
| 36.1 | 1,116 | 33.9 | 890 | 35.7 | 1,106 | 36.5 | 1,379 | 42.1 |
| 43.9 | 1,458 | 44.2 | 1,069 | 42.9 | 1,301 | 43.0 | 1,324 | 40.4 |
| 11.0 | 390 | 11.8 | 278 | 11.2 | 358 | 11.8 | 353 | 10.8 |

| | 2015 | | 2016 | | 2017 | | 2018 |
|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n |
| **Previously treated cases** | **3,948** | **–** | **3,783** | **–** | **3,652** | **–** | **3,705** |
| Median age (interquartile range) | 42 years (23–64 years) | – | 43 years (24–64 years) | – | 43 years (24–64 years) | – | 42 years (23–65 years) |
| Aged under 18 years | 19 | 0.5 | 20 | 0.5 | 17 | 0.5 | 20 |
| Male | 2,599 | 65.8 | 2,480 | 65.6 | 2,394 | 65.6 | 2,382 |
| Homeless | 405 | 10.3 | 433 | 11.4 | 432 | 11.8 | 473 |
| Traveller | 77 | 2.0 | 70 | 1.9 | 62 | 1.7 | 67 |
| Education ceased before the age of 16 years | 1,124 | 28.5 | 1,003 | 26.5 | 912 | 25.0 | 957 |
| Employed | 688 | 17.4 | 674 | 17.8 | 804 | 22.0 | 778 |
| Unemployed | 2,423 | 61.4 | 2,331 | 61.6 | 2,145 | 58.7 | 2,109 |
| Retired/unable to work | 527 | 13.3 | 540 | 14.3 | 498 | 13.6 | 535 |
| **Cases with treatment status unknown** | **117** | **–** | **182** | **–** | **198** | **–** | **529** |
| **Cases with alcohol as an additional problem drug[a]** | **2,079** | **21.4** | **1,969** | **20.5** | **1,951** | **21.0** | **2,093** |
| **Total cases treated for alcohol (as the main or additional problem drug)** | **9,697** | **–** | **9,612** | **–** | **9,301** | **–** | **9,557** |

[a] The percentage figures displayed in this row are the percentage of the total number of alcohol treatment cases in each year where alcohol was the secondary drug being treated.

Source: Condron et al., 2023 [162]

| | 2019 | | 2020 | | 2021 | | 2022 | |
|---|---|---|---|---|---|---|---|---|
| % | n | % | n | % | n | % | n | % |
| – | **3,400** | – | **3,170** | – | **3,596** | – | **3,868** | – |
| – | 42 years (24–65 years) | – | 43 years (25–64 years) | – | 43 years (25–64 years) | – | 43 years (26–65 years) | – |
| 0.5 | 15 | 0.4 | 13 | 0.4 | 18 | 0.5 | 9 | 0.2 |
| 64.3 | 2,249 | 66.1 | 1,997 | 63.0 | 2,285 | 63.5 | 2,383 | 61.6 |
| 12.8 | 378 | 11.1 | 325 | 10.3 | 369 | 10.3 | 360 | 9.3 |
| 1.8 | 81 | 2.4 | 68 | 2.1 | 83 | 2.3 | 93 | 2.4 |
| 25.8 | 847 | 24.9 | 734 | 23.2 | 798 | 22.2 | 792 | 20.5 |
| 21.0 | 744 | 21.9 | 726 | 22.9 | 946 | 26.3 | 1,067 | 27.6 |
| 56.9 | 1,914 | 56.3 | 1,709 | 53.9 | 1,920 | 53.4 | 2,078 | 53.7 |
| 14.4 | 502 | 14.8 | 538 | 17.0 | 542 | 15.1 | 545 | 14.1 |
| – | **850** | – | **164** | – | **237** | – | **275** | – |
| **21.9** | **2,252** | **23.0** | **2,033** | **25.9** | **2,270** | **24.9** | **2,469** | **25.0** |
| – | **9,798** | – | **7,857** | – | **6,859** | – | **9,890** | – |

The median age for new cases receiving treatment was 42 years in 2022 and the median age of first alcohol use was 16 years, indicating a delay in seeking treatment or a delay in developing problem alcohol use. Almost two-thirds (65.3%) of all cases receiving treatment for their alcohol use in 2022 were classified as alcohol dependent, 18.1% were classified as harmful drinkers, and 12.2% were classified as hazardous drinkers. Of those who consumed alcohol in the month prior to entering treatment, females consumed a median of 15 standard drinks (interquartile range: 5–30) on a typical drinking occasion and males consumed a median of 20 standard drinks (interquartile range: 6–37) on a typical drinking occasion.

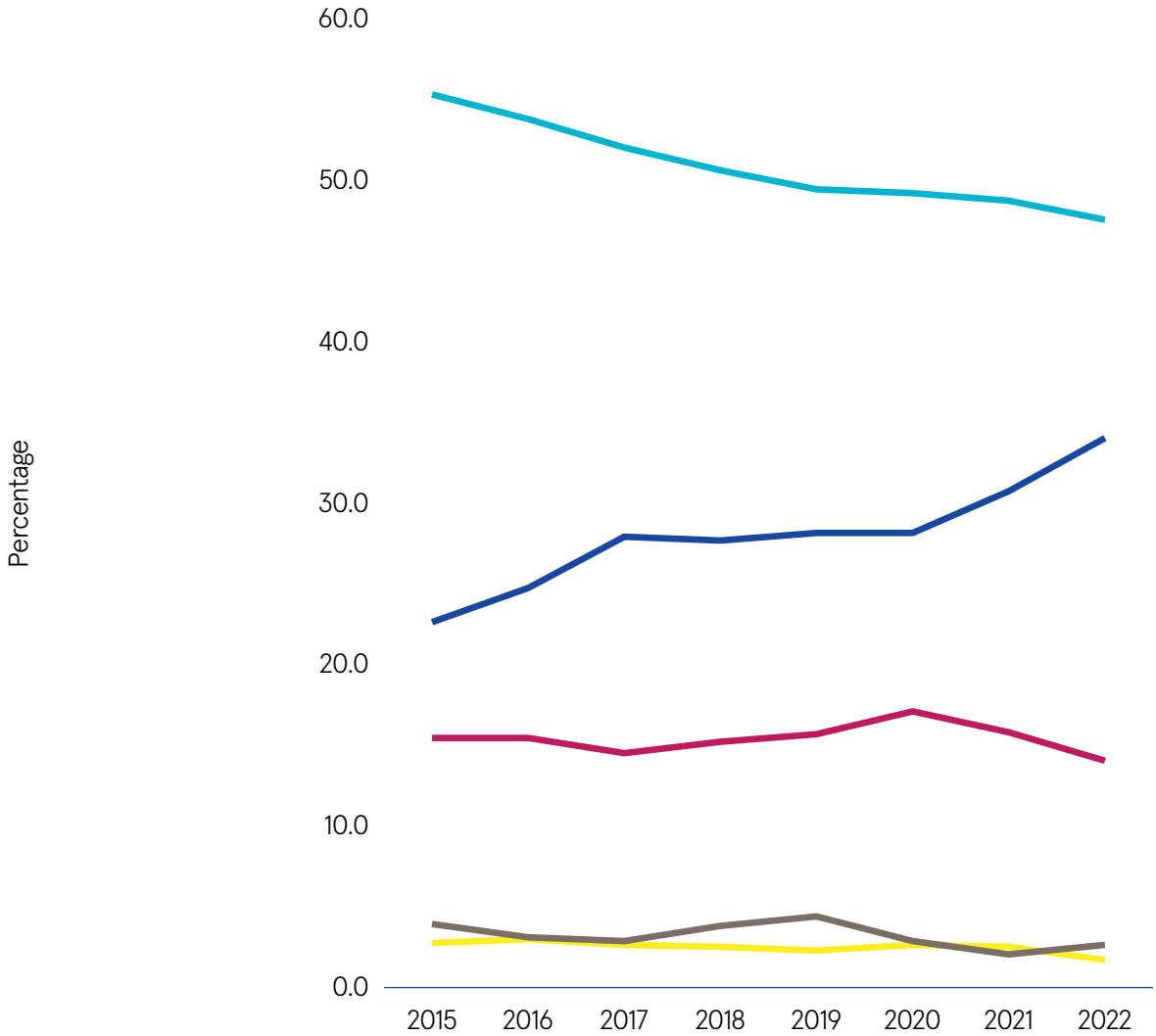
More than one-third (36.8%) of cases were living with children aged under 18 years; this was more common among males (57.8%) than females (42.2%). Almost one-half (48.9%) had children aged under 18 years but were not currently living with them; again, this was more common among males (60.5%) than females (33.1%). This may reflect how women with children may be reluctant to seek help for their alcohol use. Table 27 illustrates how 466 cases lived alone with children in 2022, more common among women receiving treatment. Males have typically accounted for two-thirds of cases receiving treatment for alcohol as the main problem drug when examining data from the NDTRS, and in 2022, males represented 61.5% of cases while females represented 38.5% of cases [162].

In 2020, Alcohol Action Ireland surveyed a number of alcohol treatment service providers in order to explore issues around the provision of treatment. Among the issues that arose from the study were barriers specific to women's ability to access treatment for their alcohol use. Practical issues (such as childcare) were mentioned, as well as a fear that many mothers have that their children will be taken away because of their alcohol problem. Women in particular may face additional obstacles to seeking treatment (such as domestic violence, lack of family support, pregnancy, and financial problems), but stigma was consistently reported as being a key barrier to women accessing treatment [163].

Such barriers facing women were reiterated in a study by Ivers *et al*., 2021 that interviewed women accessing treatment for substance use [164]. That study identified not only the barriers to accessing treatment due to being a parent, but also the additional barriers when an individual has a child with special needs. Many women accessing treatment reported experiencing trauma in their lives, and the authors recommended that liaising with other stakeholders, such as mental health services and maternity/children's services, is essential in order to fully support women in treatment. Gender-specific services tailored for women are required in order to encourage women to access treatment for alcohol use and to work towards reducing the stigma of women seeking treatment as well as clarifying and simplifying the pathway to treatment [165]. The potentially detrimental impacts that parental alcohol use can have on children can have lifelong effects, and treatment service providers can contribute to breaking the cycle of intergenerational substance use by helping to reduce or eliminate barriers to treatment [165].

Figure 53 displays the employment status of cases who received treatment for alcohol as their main problem drug between 2015 and 2022. The percentage of cases in regular employment has increased from 22.6% of cases in 2015 to 34.0% in 2022, and the number of unemployed cases has decreased from 55.3% to 47.6% in the same time period.

Figure 53 Cases receiving treatment for alcohol as the main problem drug, by employment status, 2015–2022




| | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|---|---|
| Regular employment | 22.6 | 24.7 | 28.0 | 27.7 | 28.2 | 28.1 | 30.8 | 34.0 |
| Unemployed | 55.3 | 53.8 | 52.1 | 50.7 | 49.4 | 49.2 | 48.8 | 47.6 |
| Retired/unable to work/at home | 15.4 | 15.4 | 14.5 | 15.2 | 15.7 | 17.1 | 15.8 | 14.0 |
| Student | 2.7 | 2.9 | 2.6 | 2.6 | 2.3 | 2.7 | 2.6 | 1.8 |
| Other/not known | 3.9 | 3.1 | 2.9 | 3.9 | 4.4 | 2.9 | 2.1 | 2.6 |

Source: National Drug Treatment Reporting System (NDTRS) data, 2023

Table 25 illustrates the employment status of cases entering treatment for alcohol as their main problem drug in 2022 compared with the employment status of the general population in Ireland as per the 2022 census. There are substantially higher rates of unemployment among cases receiving treatment for alcohol use (47.6% in 2022) compared with the general population (5.1%). The evidence indicates that unemployment is associated with treatment for alcohol use [166].

Table 25 Cases receiving treatment for alcohol as the main problem drug, by employment status, 2022

| | Total (NDTRS) | Total (census) | Male (NDTRS) | Male (census) | Female (NDTRS) | Female (census) |
|---|---|---|---|---|---|---|
| | % | % | % | % | % | % |
| In employment | 34.0 | 56.1 | 34.7 | 61.3 | 33.0 | 51.1 |
| Student | 1.8 | 11.1 | 1.5 | 10.9 | 2.1 | 11.2 |
| Retired/unable to work/at home | 14.0 | 27.1 | 11.9 | 21.5 | 17.3 | 32.4 |
| Unemployed | 47.6 | 5.1 | 49.5 | 5.8 | 44.7 | 4.5 |
| Other | 1.5 | 0.7 | 1.4 | 0.6 | 1.5 | 0.7 |
| Not known | 1.1 | – | 1.0 | – | 1.2 | – |

Source: National Drug Treatment Reporting System (NDTRS) data, 2023; Central Statistics Office, 2017, [167]

Among cases entering treatment for alcohol as their main problem substance in 2022, the highest level of education achieved by many was the Leaving Certificate (37.9%) (Table 26). Education levels varied by gender, with higher proportions of females attaining Leaving Certificates or third-level education compared with males. The percentage of cases accessing treatment for alcohol use who had completed third-level education (15.2% of males and 21.2% of females) is substantially lower than that of the general population (46.1% of males and 49.8% of females).

Table 26 Highest level of education completed among cases that received treatment for alcohol as their main problem drug, 2022

| | Total | | Male | | Female | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| Never went to school or completed primary school | 85 | 1.1 | 63 | 1.4 | 22 | 0.8 |
| Completed primary education | 673 | 9.1 | 493 | 10.8 | 180 | 6.3 |
| Completed Junior Certificate | 2,052 | 27.7 | 1,422 | 31.2 | 630 | 22.1 |
| Completed Leaving Certificate | 2,812 | 37.9 | 1,577 | 34.5 | 1,235 | 43.3 |
| Completed third-level education | 1,295 | 17.5 | 692 | 15.2 | 603 | 21.2 |
| Not known | 499 | 6.7 | 318 | 7.0 | 181 | 6.3 |
| **Total** | **7,416** | **100.0** | **4,565** | **100.0** | **2,851** | **100.0** |

Source: National Drug Treatment Reporting System (NDTRS) data, 2023

Note: Totals may differ from those given in other tables or figures due to missing data.

Table 27 describes the living arrangements of those entering treatment for alcohol as their main problem drug in 2022. Most cases lived with family members, with 21.7% living with children (with or without a partner). These children are likely to be at increased risk of experiencing harms associated with parental alcohol use.

Table 27 Cases receiving treatment for alcohol as the main problem drug, by living arrangements, 2022

| Living with | All | | Male | | Female | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| Alone | 2,068 | 27.9 | 1,319 | 28.9 | 749 | 26.3 |
| Parents/family | 1,842 | 24.8 | 1,302 | 28.5 | 540 | 19.0 |
| Friends | 182 | 2.5 | 130 | 2.8 | 52 | 1.8 |
| Partner (alone) | 850 | 11.5 | 482 | 10.6 | 368 | 12.9 |
| Partner & child(ren) | 1,140 | 15.4 | 637 | 14.0 | 503 | 17.7 |
| Alone with child(ren) | 466 | 6.3 | 50 | 1.1 | 416 | 14.6 |
| Other | 755 | 10.2 | 574 | 12.6 | 181 | 6.4 |
| Not known | 111 | 1.5 | 71 | 1.6 | 40 | 1.4 |
| **Total** | **7,414** | **100.0** | **4,565** | **100.0** | **2,849** | **100.0** |

Source: National Drug Treatment Reporting System (NDTRS) data, 2023

#### 12.1.2.1 Referral source of cases entering treatment for alcohol as the main problem drug

Almost one-half (47.2%) of cases self-referred, followed by being referred by a hospital or other medical source (13.3%), by a general practitioner (GP) (10.4%), by social services (9.6%), and by family or friends (8.7%).

#### 12.1.2.2 Type of alcohol treatment service provider

In 2022, 60.2% of cases receiving treatment for problem alcohol use were treated in outpatient facilities, 32.9% were treated in residential settings,[16] 4.7% were treated in low-threshold services, and 2.2% were treated in prison. The number of cases treated in prison between 2015 and 2022 has decreased from 2.7% of cases to 2.2%.

[16] Includes any service where the client stays overnight (e.g. inpatient detoxification, therapeutic communities, respite, and step-down).

The percentage of cases treated in prison for alcohol as their main problem drug is low considering that the evidence indicates that the prevalence of AUD is substantially higher in the prison population compared with the general population [168]. The WHO recommend best practices, interventions, and policies in the prison context and aims to reduce the harmful use of alcohol in prison settings by 10% by 2025 [169]. The NDTRS only receives counselling data from the Irish Prison Service. No medical data, e.g. detoxification or medication support, is received which may partly explain the discrepancy.

### 12.1.2.3 Waiting times for treatment for alcohol use

#### *12.1.2.3.1 Waiting times from referral to assessment*

The waiting time between referral and assessment was examined for those cases that entered treatment for alcohol as the main problem drug between 2015 and 2021. Although the median waiting time between referral and initial assessment has increased over the 7-year period from 2015 (5 days) to 2021 (8 days), assessment was provided quickly (Table 28).

Table 28 Mean and median waiting time from referral to assessment where alcohol was the main problem drug, 2015–2021

| Year entered treatment | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|---|---|
| Median waiting time (interquartile range) | 5 days (1–13 days) | 4 days (1–12 days) | 4 days (1–12 days) | 5 days (1–12 days) | 5 days (1–12 days) | 7 days (1–15 days) | 8 days (1–20 days) |
| Mean waiting time | 12.7 days | 11.8 days | 11.9 days | 12.6 days | 12.2 days | 15.3 days | 18.1 days |

Source: National Drug Treatment Reporting System (NDTRS) data, 2023

#### *12.1.2.3.2 Waiting times from referral to start of treatment*

The waiting time between referral and commencing treatment was assessed between 2015 and 2021. As with the time from referral to assessment, the length of time between referral and commencing treatment has also increased. The length of time varies by service type; for example, those waiting on a residential place may have to wait longer for a bed to become available. Nonetheless, in 2021 one-half of cases began treatment within 10 days of referral (Table 29).

Table 29 Mean and median waiting time from referral to start of treatment where alcohol was the main problem drug, 2015–2021

| Year entered treatment | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|---|---|
| Median waiting time (interquartile range) | 6 days (1–18 days) | 6 days (1–18 days) | 6 days (1–19 days) | 7 days (1–19 days) | 7 days (1–19 days) | 8 days (2–22 days) | 10 days (2–28 days) |
| Mean waiting time | 16.9 days | 19.4 days | 17.2 days | 16.7 days | 17.5 days | 20.8 days | 23.7 days |

Source: National Drug Treatment Reporting System (NDTRS) data, 2023

### 12.1.2.4 Polydrug use among cases receiving treatment for alcohol as the main problem drug

Almost one-quarter (24.2%) of cases receiving treatment for alcohol as their main problem drug in 2022 reported polydrug use. Cannabis and cocaine were the most common additional drugs reported. Although a decline in cannabis as an additional drug was recorded between 2015 (59.9%) and 2022 (49.4%), cocaine use increased from 32.5% in 2015 to 61.4% in 2022. Benzodiazepines (21.7%) and opioids (12.8%) were the third and fourth most common additional drugs reported in 2022.

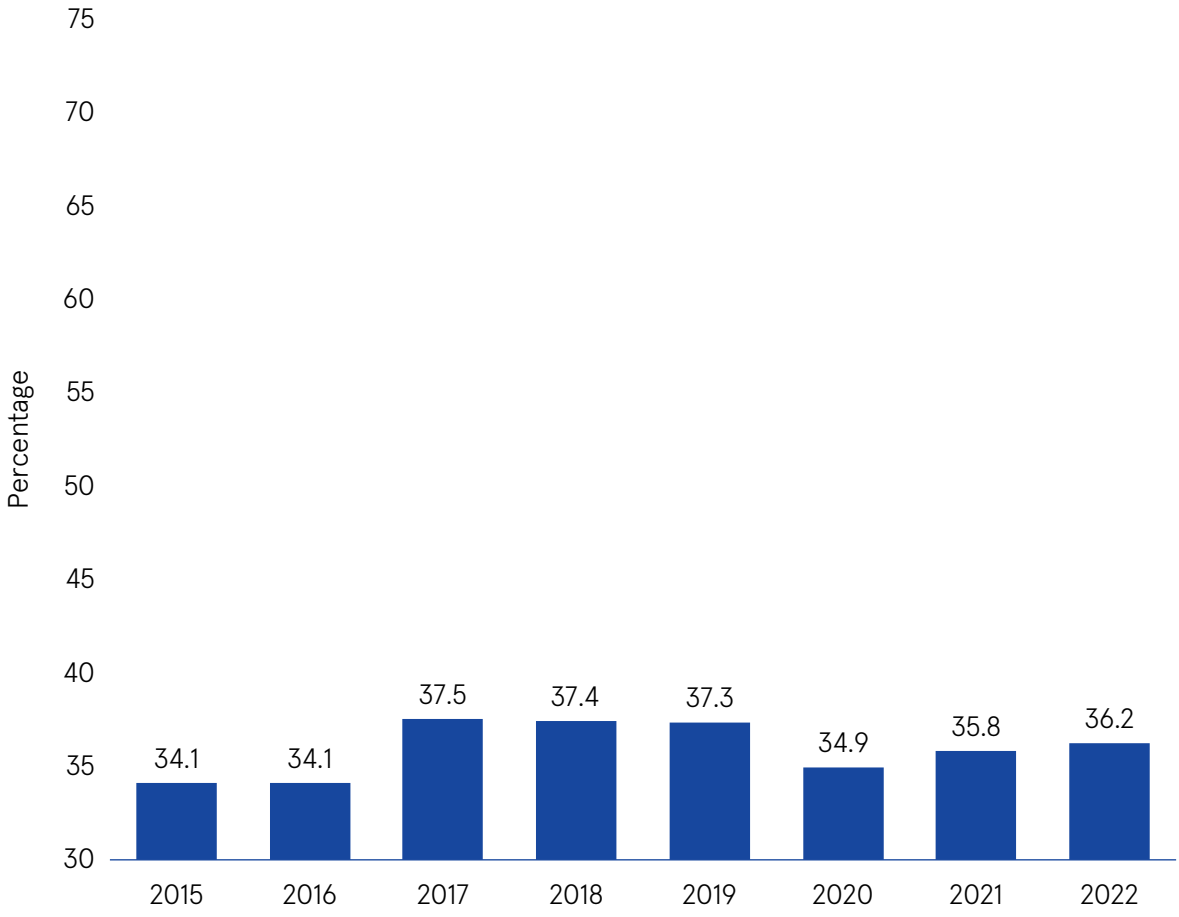
**Almost one-quarter (24.2%) of those receiving treatment for problem alcohol use in 2022 reported polydrug use.**

Cannabis and cocaine were the most common additional drugs reported.

### 12.1.2.5 Treatment cases where alcohol was an additional problem drug

In 2022, there were 12,009 cases treated for drugs other than alcohol as their main problem drug. Problem use of alcohol was common among this group, with 36.2% reporting problem use of alcohol alongside problem drug use [170]. The percentage of cases where alcohol was an additional problem drug among those receiving treatment for other drugs has decreased between 2019 (37.3%) and 2022 (36.2%) (Figure 54).

Figure 54 Percentage of cases receiving treatment for other drug use where alcohol was an additional problem drug, 2015–2022




Source: National Drug Treatment Reporting System (NDTRS) data, 2023

Between 2015 and 2021, there were 14,647 cases treated where alcohol was an additional problem drug. The majority were male, although the number of females has increased by 23.2% between 2015 and 2021 (Table 30). The largest proportion of cases during this period were aged 35–44 years (21.2%) and 20–24 years (19.3%). The overall percentage of cases aged 24 years and under reporting problem use of alcohol decreased between 2015 and 2021. However, the opposite trend was observed among those aged 25 years and over, whereby the overall percentage of cases in this age group reporting problem use of alcohol increased.

Table 30 Gender of cases where alcohol was an additional problem drug among those receiving treatment for other drug use, 2015–2021

| Year entered treatment | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | Total (n) | Percentage of total | Percentage change between 2015 and 2021 |
|---|---|---|---|---|---|---|---|---|---|---|
| Total | 2,079 | 1,969 | 1,951 | 2,093 | 2,252 | 2,033 | 2,270 | **14,647** | – | +9.2% |
| **Gender** | | | | | | | | | | |
| Male | 1,600 | 1,506 | 1,474 | 1,548 | 1,735 | 1,551 | 1,690 | **11,104** | 75.8% | +5.6% |
| Female | 469 | 459 | 468 | 542 | 511 | 480 | 578 | **3,507** | 23.9% | +23.2% |

Source: National Drug Treatment Reporting System (NDTRS) data, 2023

~ Denotes five cases or fewer.

Note that the total male and female cases do not add to the overall total due to missing values for gender

Of the cases that were treated for other drug use and where alcohol was an additional problem drug in 2021, the most common primary problem drug was cocaine (46.8% of cases with alcohol as an additional problem drug), followed by cannabis (21.0%) (Table 31). The main problem drug has changed since 2015, when cannabis (40.4%) was the most common primary problem drug with alcohol as a secondary problem drug. Cannabis remained the most common primary problem drug until 2018, when cocaine became the most common main problem drug. Table 31 indicates how the treatment for cocaine as the main problem drug has increased substantially since 2015. Cociane and alcohol are commonly used togther and the NDAS indicated that 85% of respondents who had ever used cocaine consumed alcohol on their first occasion of cocaine use [34]. The effects of mixing cocaine and alcohol together produces a toxic and dangerous substance called cocaethylene and the combination vastly increases the danger of suffering adverse effects that could cause death.

Table 31 Main problem drug for treated cases with alcohol as a secondary problem drug, 2015–2021

| | 2015 | | 2016 | | 2017 | | 2018 | | 2019 | | 2020 | | 2021 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % | n | % | n | % | n | % |
| Cocaine | 360 | 17.3 | 432 | 21.9 | 543 | 27.8 | 708 | 33.8 | 852 | 37.8 | 894 | 44.0 | 1,062 | 46.8 |
| Cannabis | 840 | 40.4 | 659 | 33.5 | 548 | 28.1 | 536 | 25.6 | 569 | 25.3 | 465 | 22.9 | 476 | 21.0 |
| Opiates | 490 | 23.6 | 522 | 26.5 | 501 | 25.7 | 490 | 23.4 | 436 | 19.4 | 338 | 16.6 | 380 | 16.7 |
| Benzodiazepines | 256 | 12.3 | 243 | 12.3 | 243 | 12.5 | 254 | 12.1 | 257 | 11.4 | 231 | 11.4 | 266 | 11.7 |
| All other drugs[a] | 105 | 5.1 | 87 | 4.4 | 79 | 4.0 | 65 | 3.1 | 75 | 3.3 | 58 | 2.9 | 57 | 2.5 |
| Other problems[b] | 28 | 1.3 | 26 | 1.3 | 37 | 1.9 | 40 | 1.9 | 63 | 2.8 | 47 | 2.3 | 29 | 1.3 |

Source: National Drug Treatment Reporting System (NDTRS) data, 2023

[a] Combines ecstasy, amphetamines, volatile inhalants, new psychoactive substances, Z-drugs, and other substances.

[b] Includes gambling, sex, pornography, gaming, and spending addiction.

## 12.1.3 Characteristics of cases entering and exiting treatment for alcohol as the main problem drug

The information presented in this section relates to immediate treatment outcomes for alcohol-related treatment in Ireland. In this section, an analysis is presented for a subset of the NDTRS data. Included are cases that entered treatment in the 7-year period between 1 January 2015 and 31 December 2021 and exited treatment between 1 January 2015 and 12 September 2023 for whom alcohol was the primary issue (n=47,947). Excluded from the analysis are a number of cases that were reported by the service provider as having exited treatment but for which the service provider was unable to provide details about the treatment outcome (n=1,587). Using this sample of cases that have exited treatment allows a greater understanding of the patterns, trends, and outcomes of treatment for cases receiving treatment for alcohol as their main problem substance.

### 12.1.3.1 Type of treatment intervention received

Brief intervention was the most frequent intervention provided to cases with alcohol as the primary problem substance. Among those entering treatment in 2021, 2,912 cases received brief intervention treatment and 2,493 cases received individual counselling (Table 32). There has been a 30.2% reduction in the number of cases receiving detoxification from alcohol between 2015 and 2021, from 1,529 cases in 2015 to 1,067 cases in 2021. With the exception of structured aftercare programmes, strengthening family programmes/structured family interventions, and multicomponent model interventions, there has been a decrease in the number of cases with alcohol as the main problem drug receiving all interventions in the time period examined. However, it should be noted that treatment service providers were hugely impacted by COVID-19 restrictions. Many closed for long periods and had limited capacity when they reopened; therefore, declines in treatment demand should be interpreted with this in mind.

Table 32 Number of cases with alcohol as the main problem drug, by type of intervention received for cases that exited treatment, 2015–2021[a, b]

| Intervention type | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|---|---|
| Brief intervention | 3,332 | 3,555 | 3,213 | 3,171 | 3,324 | 2,637 | 2,912 |
| Individual counselling | 3,276 | 3,465 | 3,435 | 3,403 | 3,475 | 2,541 | 2,493 |
| Group counselling | 1,417 | 1,676 | 1,775 | 1,630 | 1,790 | 985 | 643 |
| Individual education/ awareness programme | 686 | 551 | 526 | 849 | 883 | 483 | 528 |
| Group education/ awareness programme | 1,417 | 1,676 | 1,775 | 1,630 | 1,790 | 985 | 643 |
| Medication-free therapy | 2,189 | 2,175 | 2,050 | 2,017 | 1,899 | 1,112 | 1,464 |
| Complementary therapies | 843 | 762 | 833 | 713 | 632 | 383 | 322 |
| Social and/or occupational reintegration | 585 | 575 | 692 | 597 | 563 | 308 | 143 |
| Family therapy | 443 | 484 | 256 | 193 | 308 | 159 | 192 |

| Intervention type | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|---|---|
| Structured aftercare programme | 180 | 251 | 240 | 228 | 334 | 265 | 272 |
| Strengthening family programme/ structured family intervention | 6 | 10 | 210 | 213 | 184 | 123 | 168 |
| Psychiatric treatment | 113 | 108 | 121 | 46 | 115 | 94 | 89 |
| Multicomponent model | 13 | 12 | 30 | 61 | 50 | 93 | 158 |
| SAOR (Support, Ask and assess, Offer assistance, and Refer) | Not available | Not available | 0 | 0 | ~ | 8 | ~ |
| Detoxification from alcohol | 1,529 | 1,581 | 1,691 | 1,418 | 1,509 | 833 | 1,067 |
| Community detoxification | 23 | 22 | 47 | 39 | 43 | 57 | 34 |

Source: National Drug Treatment Reporting System (NDTRS) data, 2023

[a] Cases that commenced treatment between 2015 and 2021 and exited treatment between 2015 and 2023.

[b] A case may receive more than one treatment intervention during a treatment episode.

~ Denotes five cases or fewer.

### 12.1.3.2 Treatment duration

We examined the duration of treatment (length of time in days from the treatment start date to the end date). Included in this section are treatment cases which have both entered and exited treatment in the period 2015 to 2021. Cases that have not exited are excluded. Therefore, the totals included in this analysis and onwards differs from that shown previously. Overall, the median treatment duration was 64 days ($25^{th}$–$75^{th}$ percentile: 26–125 days). Treatment duration has increased between 2015 and 2021: among cases entering treatment in 2015, the median treatment duration was 58 days ($25^{th}$–$75^{th}$ percentile: 24–121 days), whereas among those entering treatment in 2021, the median treatment duration was 72 days ($25^{th}$–$75^{th}$ percentile: 29–131 days) (Table 33).

Table 33 Mean and median length of time from treatment start date to treatment end date for cases that exited treatment for alcohol as a main problem, 2015–2021

| Year entered treatment | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|---|---|
| Median treatment duration (interquartile range) | 58 days (24–120 days) | 60 days (25–121 days) | 57 days (22–110 days) | 59 days (23–112 days) | 64 days (26–115 days) | 80 days (29–171 days) | 72 days (29–131 days) |
| Mean treatment duration | 113 days | 112 days | 106 days | 111 days | 115 days | 134 days | 107 days |

Source: National Drug Treatment Reporting System (NDTRS) data, 2023

We also examined treatment duration by intervention type. The median length of time spent in treatment varied by intervention type, ranging from a median of 1 day (25$^{th}$–75$^{th}$ percentile: 1–32 days) for brief intervention treatment to a median of 103 days (25$^{th}$–75$^{th}$ percentile: 47–276 days) for structured aftercare programmes among those who entered treatment in 2015 (Table 34).

The intervention types most commonly used for alcohol treatment in 2021 were

**brief interventions and counselling**

Table 34 Mean and median length of time from intervention start date to intervention end date for cases that exited t

| Year entered treatment | 2015 | | 2016 | | 2017 | |
|---|---|---|---|---|---|---|
| | Mean (in days) | Median (interquartile range) (in days) | Mean (in days) | Median (interquartile range) (in days) | Mean (in days) | Median (interquartile range) (in days) |
| Brief intervention[c] | 38 | 1 (1–17) | 39 | 1 (1–27) | 33 | 1 (1–17) |
| Individual counselling | 119 | 46 (29–134) | 108 | 46 (29–121) | 103 | 41 (29–107) |
| Group counselling | 60 | 36 (29–68) | 70 | 38 (29–68) | 61 | 45 (29–70) |
| Individual education/ awareness programme | 89 | 31 (22–85) | 75 | 31 (19–71) | 79 | 34 (16–86) |
| Group education/awareness programme | 59 | 29 (22–64) | 54 | 29 (22–57) | 67 | 31 (25–64) |
| Medication-free therapy | 50 | 34 (29–72) | 52 | 36 (29–73) | 55 | 36 (29–74) |
| Complementary therapies | 55 | 38 (29–46) | 52 | 37 (29–46) | 53 | 39 (29–67) |
| Social and/or occupational reintegration | 70 | 66 (31–68) | 64 | 66 (42–68) | 65 | 67 (37–69) |
| Family therapy | 34 | 31 (29–36) | 36 | 31 (29–36) | 34 | 31 (15–36) |
| Structured aftercare programme | 132 | 97 (35–180) | 135 | 68 (29–197) | 256 | 170 (47–351) |
| Strengthening family programme/structured family intervention | 104 | 92 (69–137) | 66 | 34 (29–92) | 29 | 29 (29–29) |
| Psychiatric treatment | 50 | 29 (23–29) | 50 | 29 (29–29) | 43 | 36 (29–36) |
| Multicomponent model[d] | 517 | 213 (50–975) | 153 | 94 (22–211) | 205 | 62 (40–240) |
| SAOR[c] | Not available | Not available | Not available | Not available | – | – |
| Detoxification from alcohol | 13 | 7 (7–15) | 11 | 8 (7–14) | 9 | 7 (5–11) |
| Community detoxification | 174 | 70 (38–127) | 120 | 44 (24–88) | 16 | 10 (4–18) |

Source: National Drug Treatment Reporting System (NDTRS) data, 2023

[a] Cases that commenced treatment between 2015 and 2021 and exited treatment between 2015 and 2023.

[b] A case may receive more than one treatment intervention during a treatment episode.

[c] Typically an intervention of short duration (1–4 sessions).

[d] A client may receive more than one multicomponent model intervention in one treatment episode.

treatment for alcohol as a main problem drug, by intervention type, 2015–2021[a, b]

| 2018 | | 2019 | | 2020 | | 2021 | |
|---|---|---|---|---|---|---|---|
| Mean (in days) | Median (interquartile range) (in days) | Mean (in days) | Median (interquartile range) (in days) | Mean (in days) | Median (interquartile range) (in days) | Mean (in days) | Median (interquartile range) (in days) |
| 30 | 1 (1–10) | 36 | 1 (1–15) | 49 | 1 (1–43) | 37 | 1 (1–32) |
| 113 | 50 (29–114) | 108 | 46 (29–107) | 130 | 71 (30–168) | 107 | 64 (29–141) |
| 70 | 62 (29–78) | 65 | 60 (29–78) | 80 | 56 (29–80) | 68 | 31 (29–77) |
| 60 | 25 (14–72) | 71 | 31 (14–74) | 112 | 53 (29–144) | 86 | 57 (29–114) |
| 72 | 31 (23–76) | 68 | 31 (23–61) | 73 | 33 (26–72) | 68 | 36 (29–84) |
| 54 | 42 (29–74) | 55 | 53 (29–76) | 58 | 44 (29–78) | 55 | 48 (29–76) |
| 48 | 38 (29–41) | 46 | 37 (29–40) | 56 | 36 (29–40) | 51 | 29 (29–39) |
| 69 | 66 (44–70) | 72 | 67 (59–71) | 88 | 67 (51–81) | 97 | 79 (43–99) |
| 50 | 31 (1–36) | 34 | 31 (19–36) | 39 | 33 (31–36) | 36 | 31 (28–36) |
| 195 | 98 (42–257) | 207 | 138 (46–320) | 214 | 155 (55–301) | 182 | 103 (47–276) |
| 29 | 29 (29–29) | 28 | 29 (29–29) | 29 | 29 (29–29) | 30 | 29 (29–29) |
| 120 | 36 (36–36) | 71 | 36 (36–42) | 48 | 36 (36–36) | 35 | 36 (36–36) |
| 141 | 71 (36–206) | 139 | 104 (44–192) | 145 | 103 (30–200) | 115 | 65 (22–136) |
| – | – | 26 | 4 (1–52) | 42 | 19 (4–57) | 273 | 273 (7–539) |
| 7 | 7 (4–7) | 8 | 7 (4–8) | 10 | 7 (4–11) | 8 | 7 (5–9) |
| 8 | 1 (1–11) | 30 | 14 (8–27) | 37 | 11 (8–26) | 24 | 12 (9–19) |

### 12.1.3.3 Reason for treatment exit and condition on exit

Among those who exited treatment, the most common exit reason recorded in the NDTRS was that treatment had been completed (44.6% for treatment entrants in 2021), followed by cases who did not return for subsequent appointments (22.4% for treatment entrants in 2021) (Table 35). Proportions for each exit reason remained relatively stable across the 7-year reporting period.

Table 35 Treatment exit reason among cases that exited treatment for whom alcohol was the main problem substance, 2015–2021

| | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|---|---|
| | n (%) | n (%) | n (%) | n (%) | n (%) | n (%) | n (%) |
| Treatment completed | 3,255 (45.2) | 3,255 (45.3) | 3,242 (46.5) | 3,281 (45.3) | 3,267 (44.7) | 2,525 (45.2) | 2,872 (44.6) |
| Transferred/referred to treatment in another drug/ alcohol service | 451 (6.3) | 504 (7.0) | 483 (6.9) | 485 (6.7) | 499 (6.8) | 496 (8.9) | 601 (9.3) |
| Client declined further treatment | 1,238 (17.2) | 1,341 (18.6) | 1,295 (18.6) | 1,353 (18.7) | 1,385 (18.9) | 909 (16.3) | 1,114 (17.3) |
| Client did not return for appointments (no show/did not attend) | 1,716 (23.8) | 1,610 (22.4) | 1,576 (22.6) | 1,641 (22.7) | 1,662 (22.7) | 1,231 (22.1) | 1,445 (22.4) |
| Premature exit from treatment for non-compliance | 178 (2.5) | 186 (2.6) | 152 (2.2) | 144 (2.0) | 145 (2.0) | 89 (1.6) | 102 (1.6) |
| Released from prison but not linked to other treatment service | 26 (0.4) | 12 (0.2) | 11 (0.2) | 32 (0.4) | 48 (0.7) | 39 (0.7) | 33 (0.5) |
| Died | 25 (0.3) | 26 (0.4) | 24 (0.3) | 33 (0.5) | 29 (0.4) | 34 (0.6) | 28 (0.4) |
| Sentenced to prison | 33 (0.5) | 29 (0.4) | 25 (0.4) | 26 (0.4) | 33 (0.5) | 28 (0.5) | 23 (0.4) |
| Other | 14 (0.2) | 0 (0.0) | ~ | ~ | ~ | 0 (0.0) | 0 (0.0) |
| Medical or mental health reasons | 20 (0.3) | 53 (0.7) | 47 (0.7) | 80 (1.1) | 63 (0.9) | 44 (0.8) | 66 (1.0) |
| No longer lives in the area | 52 (0.7) | 41 (0.6) | 38 (0.5) | 43 (0.6) | 39 (0.5) | 40 (0.7) | 52 (0.8) |
| Prison-to-prison transfer | 44 (0.6) | 24 (0.3) | 9 (0.1) | 21 (0.3) | 38 (0.5) | 31 (0.6) | 40 (0.6) |
| Unable to attend due to work/ study commitments | 9 (0.1) | ~ | 7 (0.1) | 12 (0.2) | 24 (0.3) | 36 (0.6) | 41 (0.6) |
| Not known | ~ | ~ | ~ | 8 (0.1) | 10 (0.1) | 43 (0.8) | 9 (0.1) |
| **Total cases exiting treatment** | 7,201 | 7,191 | 6,975 | 7,239 | 7,315 | 5,582 | 6,444 |

Source: National Drug Treatment Reporting System (NDTRS) data, 2023

~ Denotes five cases or fewer.

At the point of treatment exit, the treatment practitioner recorded their client's condition on exit. Several conditions may be recorded where applicable. The majority of clients exiting treatment were abstaining from alcohol upon treatment exit, followed by clients who had reduced their alcohol use (Table 36).


**Over one-half of those who entered treatment for alcohol use were abstaining from alcohol when exiting treatment (54%)**

Table 36 Condition on treatment exit for cases who exited treatment and who had alcohol as the main problem drug, 2016–2021[a]

| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|---|
| Drug free | 246 (3.4%) | 539 (7.7%) | 730 (10.1%) | 865 (11.8%) | 695 (12.5%) | 776 (12.0%) |
| No change in drug use | 130 (1.8%) | 187 (2.7%) | 211 (2.9%) | 180 (2.5%) | 197 (3.5%) | 130 (2.0%) |
| Increased drug use | 16 (0.2%) | 14 (0.2%) | 22 (0.3%) | 17 (0.2%) | 27 (0.5%) | 16 (0.2%) |
| Reduced drug use | 193 (2.7%) | 238 (3.4%) | 227 (3.1%) | 260 (3.6%) | 297 (5.3%) | 193 (3.0%) |
| Abstaining from alcohol | 3,485 (48.5%) | 3,861 (55.4%) | 4,014 (55.4%) | 2,973 (40.6%) | 3,406 (61.0%) | 3,485 (54.1%) |
| No change in alcohol use | 593 (8.2%) | 719 (10.3%) | 848 (11.7%) | 510 (7.0%) | 619 (11.1%) | 593 (9.2%) |
| Increased alcohol use | 72 (1.0% ) | 65 (0.9%) | 78 (1.1%) | 72 (1.0%) | 94 (1.7%) | 72 (1.1%) |
| Reduced alcohol use | 919 (12.8%) | 989 (14.2%) | 1,028 (14.2%) | 923 (12.6%) | 1,091 (19.5%) | 919 (14.3%) |
| Substantially reached priority goals of care plan | 466 (6.5%) | 363 (5.2%) | 362 (5.0%) | 321 (4.4%) | 396 (7.1%) | 466 (7.2%) |
| Engaging with care plan | 537 (7.5%) | 445 (6.4%) | 637 (8.8%) | 711 (9.7%) | 768 (13.8%) | 537 (8.3%) |
| Disengaged from care plan | 285 (4.0%) | 277 (4.0%) | 359 (5.0%) | 317 (4.3%) | 307 (5.5%) | 285 (4.4%) |
| Care plan gaps and blocks identified | 170 (2.4%) | 193 (2.8%) | 204 (2.8%) | 104 (1.4%) | 164 (2.9%) | 170 (2.6%) |
| Engaging with other services (e.g. housing, education) | 199 (2.8%) | 226 (3.2%) | 244 (3.4%) | 191 (2.6%) | 185 (3.3%) | 199 (3.1%) |

| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|---|
| Engaging in other therapeutic services (e.g. self-help groups, Alcoholics Anonymous) | 575 (8.0%) | 639 (9.2%) | 758 (10.5%) | 584 (8.0%) | 646 (11.6%) | 575 (8.9%) |
| Engaging in other unstructured aftercare | 78 (1.1%) | 68 (1.0%) | 96 (1.3%) | 56 (0.8%) | 61 (1.1%) | 78 (1.2%) |
| Other | 17 (0.2%) | 7 (0.1%) | 12 (0.2%) | 8 (0.1%) | 16 (0.3%) | 17 (0.3%) |
| **Total cases exiting treatment** | 7,191 | 6,975 | 7,239 | 7,315 | 5,582 | 6,444 |

Source: National Drug Treatment Reporting System (NDTRS) data, 2023

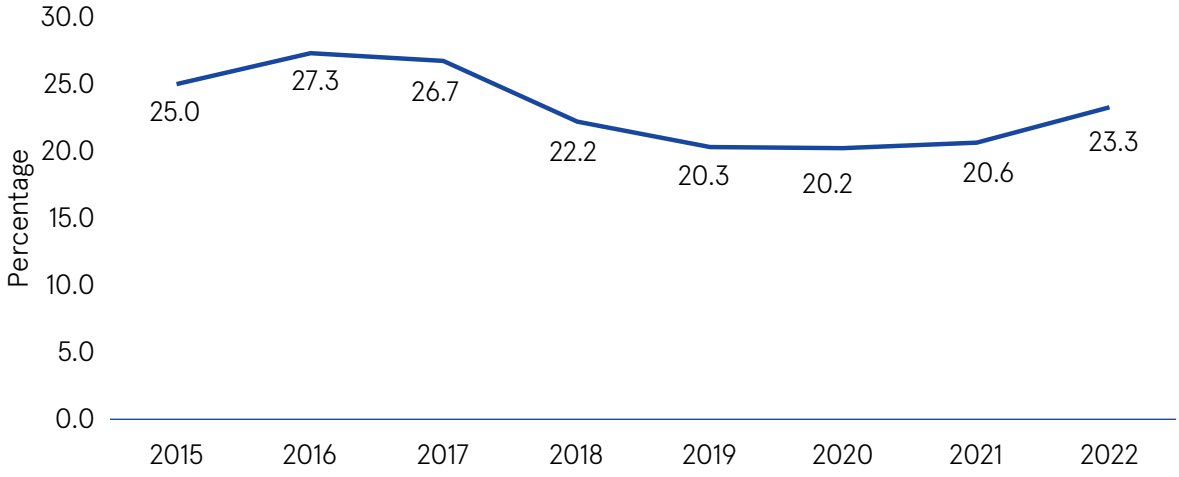
[a] Each case can have multiple conditions on exit.

### 12.1.3.4 Involvement of family or significant others in treatment

Alcohol problems affect not only those using alcohol, but also their family members and often their friends and colleagues [171]. The NDTRS captures information about family members or significant others who are involved in treatment delivery. Among cases who exited treatment, 85.5% of treatment cases had indicated whether a family member or significant other was involved in their treatment. Collectively for the period from 2015 to 2022, 27.3% of cases indicated that they had the support of another person in their treatment.

Figure 55 indicates the proportion of cases where a significant other was involved in the client's treatment between 2015 and 2022. The proportion of cases decreased from 25.0% in 2015 to 20.6% in 2021 but increased again to 23.3% in 2022.

Figure 55 Percentage of cases that received treatment for alcohol as their main problem drug where family members or significant others were involved in their treatment, 2015–2022[a]



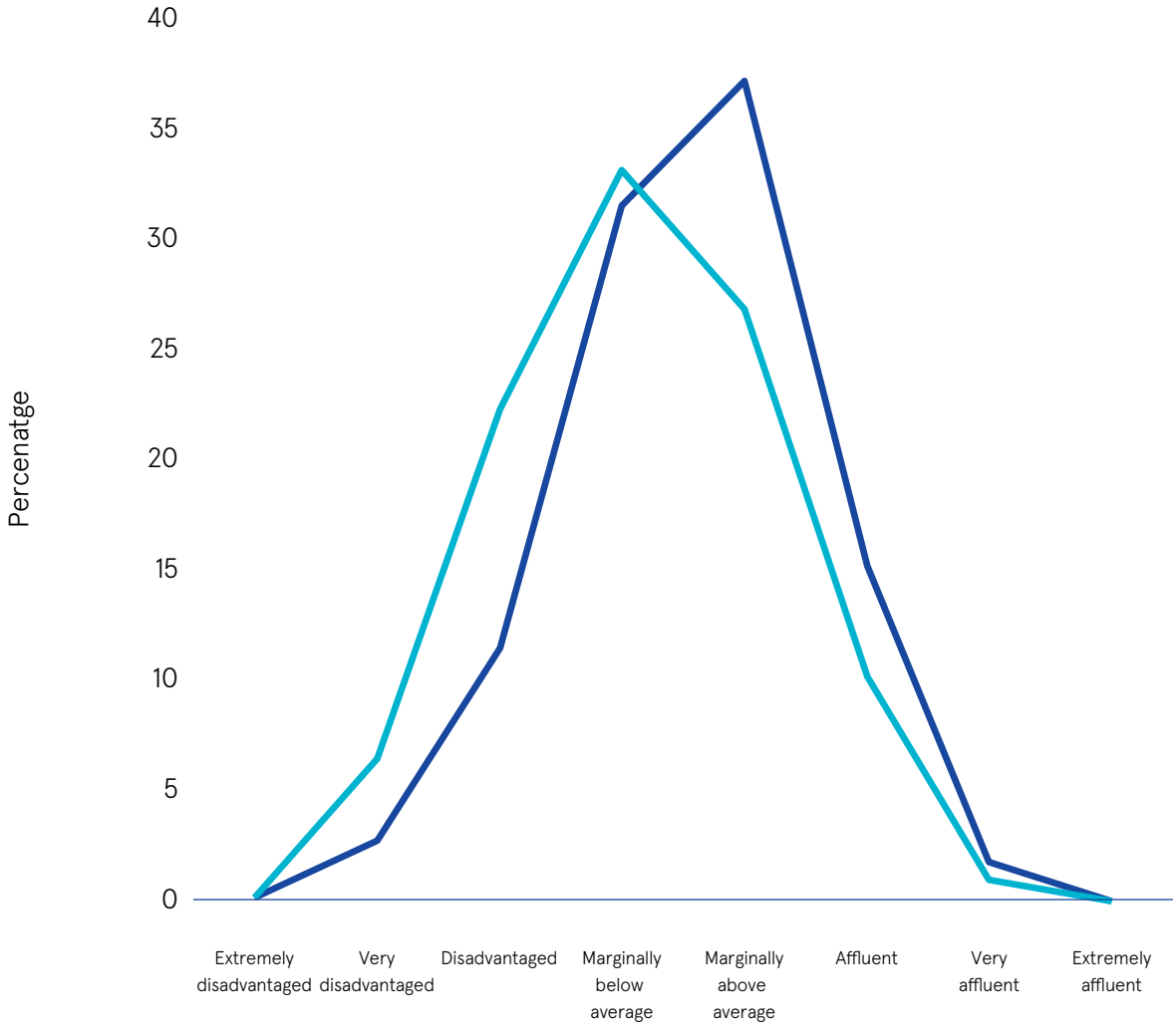

Source: National Drug Treatment Reporting System (NDTRS) data, 2023

[a] Cases that commenced treatment between 2015 and 2022 and exited treatment between 2015 and 2023.

## 12.1.4 Treatment for alcohol use and area of deprivation

A study using data from the NDTRS together with area of deprivation data as determined by the Pobal HP Deprivation Index examined treatment episodes from 2019 to 2021, inclusive [37,172]. Figure 56 illustrates the percentage of the population of Ireland that lives within each of the deprivation bands as well as the percentage of cases that received treatment for alcohol as their main problem drug by deprivation band. The data show that those in more disadvantaged areas are over-represented in terms of the number of cases receiving alcohol treatment. For example, despite 2.8% of the population living in very disadvantaged areas, 6.5% of cases who received treatment for alcohol use were from disadvantaged areas.

Figure 56 Area of deprivation for the general population of Ireland and for treatment episodes where alcohol was the main problem drug, 2019–2021




| | Extremely disadvantaged | Very disadvantaged | Disadvantaged | Marginally below average | Marginally above average | Affluent | Very affluent | Extremely affluent |
|---|---|---|---|---|---|---|---|---|
| Population (%) | 0.09 | 2.81 | 11.45 | 31.52 | 37.1 | 15.24 | 1.75 | 0.05 |
| Alcohol (%) | 0.11 | 6.53 | 22.23 | 33.19 | 26.8 | 10.13 | 0.99 | 0.03 |

Source: Collins et al., 2023 [159]

Those in more
**disadvantaged areas**
are over-represented in alcohol treatment.

## 12.2 Psychiatric hospital/unit admissions for alcohol-related disorders

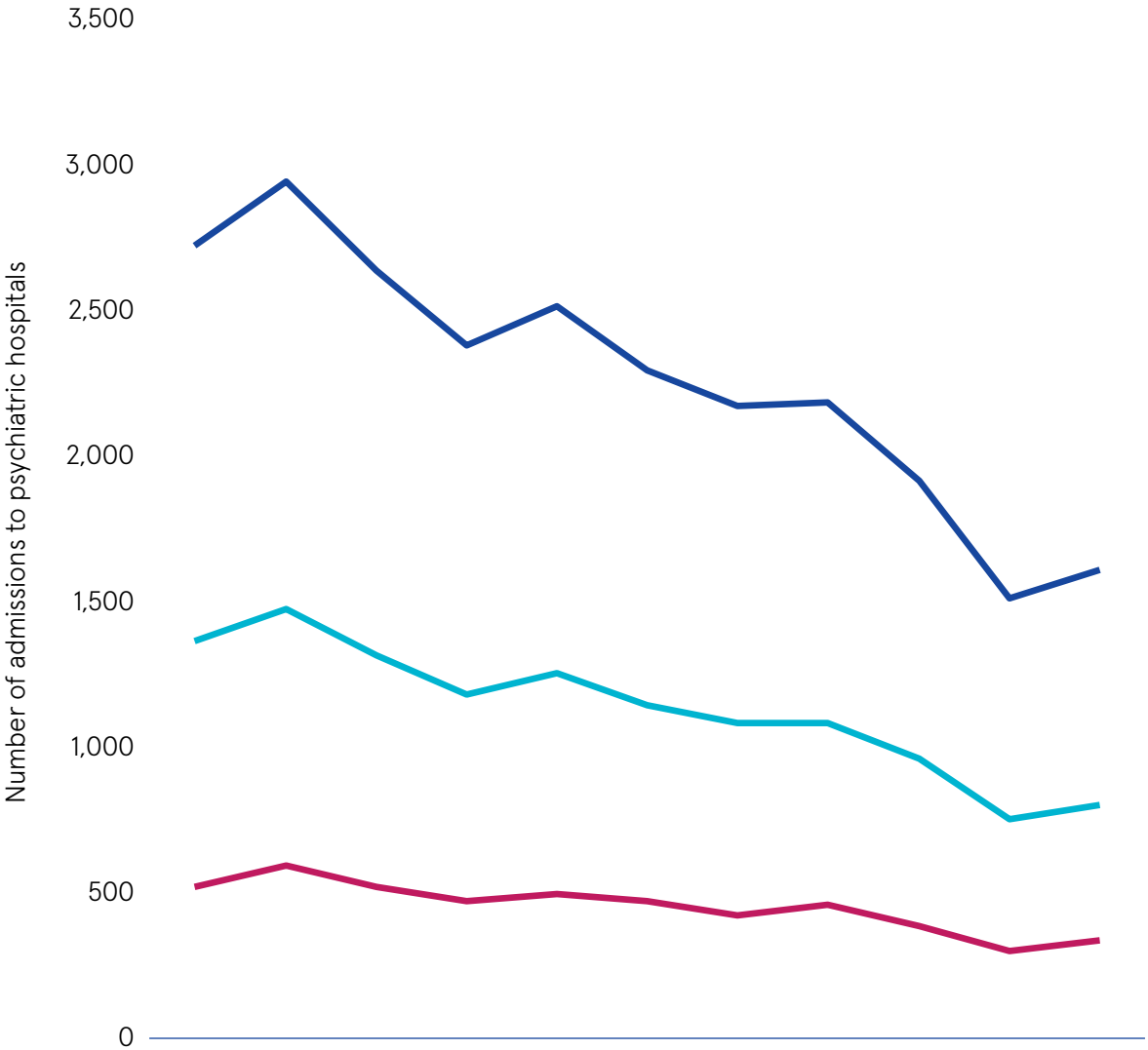
Prior to the publication of the 2006 mental health strategy, *A Vision for Change: Report of the Expert Group on Mental Health Policy,* individuals with AUD were commonly treated in psychiatric units, but as the strategy recommended treatment in community settings, the number of people with alcohol-related disorders receiving treatment in psychiatric units and hospitals has decreased substantially [173]. Despite this decrease, there remains a large group of individuals whose alcohol use requires inpatient treatment in psychiatric hospitals and units.

The NPIRS, managed by the HRB, records all admissions to, and discharges from, inpatient psychiatric services in Ireland, including psychiatric hospitals, general hospital psychiatric units, private hospitals, children's centres, and the Central Mental Hospital. Each admission and discharge represents one episode or event, and not an individual patient; while a single individual may have several admissions in any given year, each one is recorded as a separate event. Diagnoses are categorised in accordance with the WHO's ICD-10 categories, and alcohol-related disorders are those recorded as F10, representing disorders related to or resulting from abuse or misuse of alcohol [86].

The total number of admissions to psychiatric hospitals with an alcohol-related diagnosis decreased between 2012 and 2022, from 1,361 to 806 (Figure 57). As well as the recommendation for community-based treatment, another recommendation in *A Vision for Change* that contributed to the decrease in psychiatric admissions for those with alcohol-related disorders was the recommendation that those with alcohol-related disorders without a mental health diagnosis should not be treated in psychiatric facilities. A reversal of this recommendation was made in the 2020 policy document *Sharing the Vision: A Mental Health*

*Policy for Everyone*, which states that individuals with coexisting mental health difficulties and addiction to either alcohol or drugs should not be prevented from accessing mental health services [174].

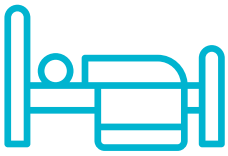
Figure 57 Number of admissions to psychiatric hospitals with an alcohol-related diagnosis, by sex, 2012–2022




| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Total | 1,361 | 1,470 | 1,318 | 1,188 | 1,260 | 1,147 | 1,086 | 1,090 | 958 | 758 | 806 |
| Males | 843 | 869 | 796 | 713 | 764 | 679 | 660 | 635 | 567 | 462 | 471 |
| Females | 518 | 601 | 522 | 475 | 496 | 468 | 426 | 455 | 391 | 296 | 335 |

Source: Daly and Lynn, 2023 [175]

Among the cases that entered psychiatric facilities due to alcohol-related disorders in 2022, 58.4% were males and 41.6% were females; that ratio has remained fairly consistent in the 10 years of data from the NPIRS [176].



**2.5% of psychiatric inpatient bed days**

were for alcohol-related disorders in 2022

## 12.2.1 Psychiatric admissions for alcohol-related disorders

There were 15,790 admissions to Irish psychiatric units and hospitals in 2022, 806 (5.1%) of which had a diagnosis of an alcohol-related disorder [176]. The highest percentage of alcohol-related psychiatric admissions was in the 35–44 years age group (25.3%), followed by the 45–54 years age group (19.5%) (Table 37).

Table 37 Psychiatric admissions for alcohol-related disorders, by age group, 2022

| Age group | n | % |
|---|---|---|
| 18–19 years | 9 | 1.1 |
| 20–24 years | 54 | 6.7 |
| 25–34 years | 143 | 17.7 |
| 35–44 years | 204 | 25.3 |
| 45–54 years | 157 | 19.5 |
| 55–64 years | 136 | 16.9 |
| 65–74 years | 83 | 10.3 |
| ≥75 years | 20 | 2.5 |
| **Total** | **806** | **100.0** |

Source: Daly and Lynn, 2023 [176]

Where an individual's occupation was known, non-manual skilled occupations had the highest percentage of alcohol-related admissions (13.8%), followed by lower professional occupations (11.3%), manual skilled occupations (7.6%), employer and manager occupations (7.6%), and higher professional occupations (7.1%).

Among admissions for alcohol-related disorders in 2022, 263 (32.6%) were first-time admissions and 543 (67.4%) were readmissions. The legal status of the patient on admission indicated that most admissions for alcohol-related disorders were voluntary admissions. There were 21 admissions with alcohol-related disorders in 2022 indicated as having no fixed abode (16 males and 5 females), representing 2.6% of all admissions in 2022.

More than one-half (50.2%; n=405) of all alcohol-related disorder admissions in 2022 were to acute units in general hospitals, 44.9% (n=362) were to independent/private and private charitable centres, and 4.8% (n=39) were to psychiatric hospitals/continuing care units. Of first-time admissions for alcohol-related disorders (n=263), 60.1% were to acute units in general hospitals, 36.5% were to independent/private and private charitable centres, and 3.4% were to psychiatric hospitals/continuing care units.

Where the referral source was known, 17.0% of all alcohol-related admissions in 2022 were referred by the emergency department or the assessment unit attached to a general hospital, 8.1% were referred by the justice system (Garda/prison/courts), 5.8% were self-referrals, 5.5% were referred by a GP or an out-of-hours GP/primary care service, 2.7% were referred by another hospital (psychiatric or general hospital), 2.5% were referred by an outpatient clinic or day hospital/day centre, and 1.4% were referred by a Community Mental Health Team or sector team. The remainder (57%) were referred by family or friends, another psychiatric hospital or unit, another hospital (not specified whether it was a psychiatric hospital or not), a community residence or residential home or nursing home, a consultant, or another service.

### 12.2.2 Psychiatric discharges for alcohol-related disorders

There were 15,593 discharges (including deaths) from Irish psychiatric units and hospitals in 2022. Of these, 1,092 (7%) discharges had a primary discharge diagnosis of an alcohol-related disorder. Of those discharges, more than one-third (35.3%) were discharged within 1 week, 19.9% were discharged after between 1 and 2 weeks, 17.5% were discharged after between 2 and 4 weeks, and 0.9% were discharged after 3 months or longer. The average length of stay for those with a primary discharge diagnosis of alcohol-related disorders in 2022 was 33.5 days (median: 11 days).

Co Leitrim had the highest rate of admissions for alcohol-related disorders, at 46.8 per 100,000 of the population, followed by Co Donegal (at 42.7 per 100,000 of the population) and Co Sligo (at 35.1 per 100,000 of the population) [142]. Co Kilkenny had the lowest rate of admissions for alcohol-related disorders, at 6.0 per 100,000 of the population. First-time admissions for alcohol-related disorders were also highest in Co Leitrim, at 15.6 per 100,000 of the population, followed by Co Donegal (at 15.1 per 100,000 of the population) and Co Clare (at 11.8 per 100,000 of the population).

### 12.2.3 Psychiatric inpatient bed days for alcohol-related disorders

The number of bed days used in 2022 for alcohol-related disorders was 18,409, representing 2.5% of the total number of psychiatric inpatient bed days. This included all admissions and all discharges in 2022, as well as all patients who were still resident in psychiatric facilities on 31 December 2022.

## 12.3 Pharmacotherapeutics for alcohol-related conditions

The number of alcohol-related prescription items and the costs of these prescriptions are obtained from the HSE Primary Care Reimbursement Service (PCRS) register, which contains data on medicines dispensed to those with full eligibility for the General Medical Services (GMS) scheme. Means testing is carried out in order to determine an individual's eligibility for the GMS scheme, and as such, more socially deprived cohorts are over-represented. Those aged 70 years and over are also eligible for the GMS scheme (if their gross income is not more than EUR 550 per week for a single person or not more than EUR 1,050 per week for a couple), and so the older population is also over-represented. The GMS scheme does not include private prescriptions (i.e. prescriptions where the patient is not eligible for free or subsidised schemes) or prescriptions dispensed in hospitals. However, the majority of pharmaceutical expenditure comes from PCRS GMS pharmacy claims, and in 2015, almost 40% of the population of Ireland was covered by the GMS scheme [177].

We obtained aggregate-level pharmacy claims data on alcohol-related prescription items from the PCRS. The medications listed in Table 38 are based on PCRS claims data from community pharmacists and only include items reimbursed by the PCRS. The data do not capture items dispensed outside of community drug schemes where the prescription is paid for privately, and do not include claims which are under the Drugs Payment Scheme monthly threshold amount. It is important to note that the PCRS does not capture data in relation to diagnoses or indications for the medicines reimbursed, and therefore the information presented here should be interpreted with caution. The medications listed in Table 38 are approved for the treatment of AUD or alcohol withdrawal, but it is not definitively known if that is what they were prescribed for in all instances.

Table 38 Number of patients and number of prescriptions for alcohol-related medications dispensed through the PC

| | | 2012 | 2013 |
|---|---|---|---|
| Disulfiram (Antabuse) | Number of prescriptions | 6,783 | 6,266 |
| | Number of patients | 1,637 | 1,598 |
| Naltrexone hydrochloride (Revia and Vivitrol) | Number of prescriptions | ~ | 30 |
| | Number of patients | ~ | 10 |
| Acamprosate (Campral) | Number of prescriptions | 2,404 | 2,232 |
| | Number of patients | 502 | 469 |
| Chlordiazepoxide (Librium) | Number of prescriptions | 40,976 | 36,582 |
| | Number of patients | 13,060 | 12,193 |
| Naltrexone hydrochloride (Ethylex) | Number of prescriptions | – | – |
| | Number of patients | – | – |
| Nalmefene (Selincro) | Number of prescriptions | – | – |
| | Number of patients | – | – |

Source: Primary Care Reimbursement Service (PCRS), 2023

~ Denotes five cases or fewer

CRS scheme, 2012–2022

| 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|---|---|
| 5,292 | 5,226 | 5,020 | 4,873 | 4,842 | 5,070 | 4,786 | 4,668 | 4,635 |
| 1,401 | 1,372 | 1,310 | 1,200 | 1,215 | 1,220 | 1,047 | 1,025 | 1,043 |
| 57 | 71 | 136 | 137 | 595 | 1,129 | 1,180 | 1,285 | 1,257 |
| 16 | 24 | 37 | 44 | 191 | 280 | 258 | 247 | 218 |
| 2,044 | 2,047 | 2,238 | 2,304 | 2,132 | 2,033 | 2,204 | 2,263 | 2,221 |
| 456 | 460 | 508 | 515 | 491 | 454 | 473 | 465 | 496 |
| 32,766 | 30,874 | 30,714 | 29,044 | 27,494 | 27,767 | 26,212 | 25,946 | 23,831 |
| 11,299 | 10,886 | 10,885 | 10,328 | 9,989 | 10,183 | 9,309 | 9,369 | 8,738 |
| – | – | – | – | – | – | 14 | 88 | 113 |
| – | – | – | – | – | – | 12 | 24 | 26 |
| – | 1,778 | 1,580 | 1,095 | 786 | 886 | 666 | 691 | 770 |
| – | 982 | 686 | 457 | 314 | 310 | 214 | 218 | 280 |

Scientific evidence has shown that medications can improve an individual's chances of success in reducing alcohol use or achieving sobriety and, as a result, improving their health and reducing their risk of alcohol-related harms when combined with other treatment, including detoxification or rehabilitation and behavioural therapy such as counselling, cognitive behavioural therapy, and/or self-help groups [178].

The use of medications for the treatment of AUD is associated with reductions in cravings, drinking volume, and number of drinking days, as well as with increases in the rate of abstinence, with varying degrees of success [179,180,181,182]. In Europe, the European Medicines Agency has approved a number of drugs for the treatment of alcohol-related conditions, including the following:

- Disulfiram (commonly known by the brand name Antabuse) works by blocking the alcohol metabolism pathway, producing unpleasant symptoms when an individual who is taking disulfiram consumes alcohol, such as nausea, vomiting, abdominal pain, diarrhoea, and more.
- Acamprosate (sold under the brand name Campral) works by restoring the natural balance of chemicals in the brain. Acamprosate is taken with the purpose of maintaining abstinence from alcohol as opposed to reducing alcohol use.
- Naltrexone hydrochloride (also known by its brand names Revia and Vivitrol) contains anticraving agents. It is used to treat AUD and is an opioid antagonist that reduces the rewarding effects of alcohol and cravings for alcohol. Naltrexone hydrochloride can be used by people who are still drinking alcohol with the goal of reducing the frequency and duration of drinking. Ethylex contains naltrexone hydrochloride and is also used to treat alcohol dependence and to support abstinence.
- Chlordiazepoxide (trade name Librium) is a benzodiazepine that is used to treat anxiety disorders, but it can also be used to treat symptoms of alcohol withdrawal.
- Nalmefene (sold under the brand name Selincro, among others) is an opiod antagonist that is used for the reduction of alcohol consumption in patients with alcohol dependence who have a high drinking risk level but who do not have physical withdrawal symptoms and do not require immediate detoxification.

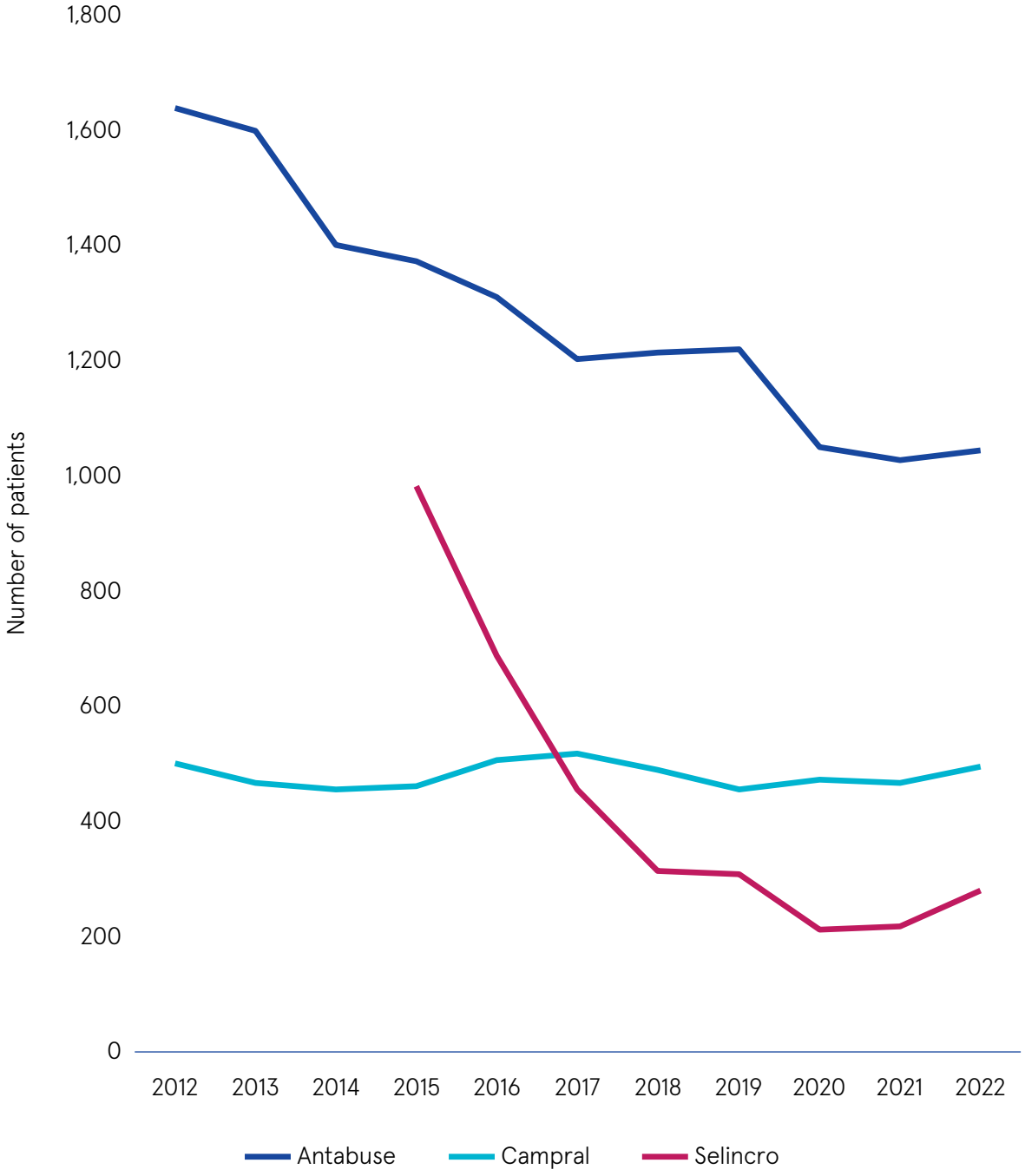
Of these alcohol-related prescription items, Librium was the most frequently prescribed, with the PCRS indicating that 8,738 people who were eligible under the GMS scheme were prescribed Librium in 2022 (a decrease from 13,060 people in 2012). However, as outlined earlier, Librium is a benzodiazepine and is not exclusively prescribed for alcohol use. In 2022, naltrexone hydrochloride was prescribed to 218 patients; however, caution should be taken when considering the number of patients prescribed naltrexone hydrochloride, as it is also prescribed for opioid dependence withdrawal symptoms. When used to treat AUD, it reduces cravings for alcohol and helps patients to maintain their sobriety.

The main drugs prescribed in Ireland for the treatment of alcohol dependence are acamprosate (Campral), disulfiram (Antabuse), and nalmefene (Selincro). Naltrexone hydrochloride is also prescribed for alcohol dependence, but it is important to note that it can also be used to treat other drug dependence). Of these drugs, disulfiram (Antabuse) was the most prescribed, with 1,043 patients being prescribed this medication in 2022, a 36.3% decrease since 2012 (n=1,637) (Figure 58).

The number of patients prescribed acamprosate (Campral) has remained fairly consistent between 2012 (n=502) and 2022 (n=496). Nalmefene (Selincro) was approved in Ireland as a treatment for alcohol use in 2014, and the following year, 982 patients who were eligible under the GMS scheme were prescribed Selincro. Its prescribing to patients has declined by 71.5%, from 982 patients in 2015 to 280 patients in 2022.

In 2022, 2,221 prescriptions for acamprosate (Campral) were dispensed, 7.6% lower than the number dispensed in 2012. There were 4,635 prescriptions for disulfiram (Antabuse) dispensed in 2022, 31.7% lower than in 2012. In 2022, there were 770 prescriptions for nalmefene (Selincro) dispensed, 56.7% lower than in 2015 when it was first introduced.

Figure 58 Number of patients prescribed Antabuse, Campral, and Selincro, 2012–2022




Source: Primary Care Reimbursement Service (PCRS), 2023

Overall, the number of patients prescribed alcohol-related medications, as recorded on the PCRS register, has declined by 29.0% in the 11-year period from 2012 (n=15,202) to 2022 (n=10,801).

**8,738 patients were prescribed Librium in 2022,**
a medication used to treat the symptoms of withdrawal from alcohol

The costs associated with prescriptions dispensed and reimbursed through the PCRS scheme are listed in Table 39. Each medication dose is displayed separately, as opposed to in Table 38, which displays medication doses combined (e.g. chlordiazepoxide (Librium) 5 milligrams (mg) and chlordiazepoxide (Librium) 10 mg are merged). In 2022, the ingredient costs were highest for Campral, and were lowest for Ethylex. The total prescription cost for the dispensed medications listed in 2022 was EUR 478,299.72, with Librium 10 mg representing the costliest of the medications dispensed, as Librium was the medication most commonly prescribed to patients.

The majority of ingredient costs decreased between 2012 and 2022, with the exception of naltrexone hydrochloride, which saw a substantial cost increase. The total ingredient cost for alcohol-related items prescribed in 2022 was EUR 298,946.42. This is 1% lower than in 2021 and 7.6% higher than in 2012. Note that ingredient costs do not account for inflation.

Table 39 Ingredient cost and total cost of alcohol-related medications dispensed through the PCRS scheme, 2012–2022

| | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|---|
| **Antabuse tablets – 400 mg** | | | | | |
| Ingredients cost (EUR) | 62,833.33 | 58,159.93 | 49,449.77 | 48,203.05 | 46,891.40 |
| Total cost (EUR) | 106,066.49 | 101,940.07 | 88,047.40 | 88,609.73 | 87,781.45 |
| **Naltrexone hydrochloride tablets – 50 mg** | | | | | |
| Ingredients cost (EUR) | 241.44 | 1,754.75 | 2,836.89 | 3,679.77 | 5,861.36 |
| Total cost (EUR) | 264.71 | 1,918.99 | 3,119.21 | 4,070.25 | 6,777.17 |
| **Campral tablets** | | | | | |
| Ingredients cost (EUR) | 97,392.81 | 93,327.69 | 87,528.38 | 83,621.38 | 88,507.99 |
| Total cost (EUR) | 114,572.59 | 110,245.52 | 103,763.39 | 99,061.04 | 104,267.57 |
| **Librium capsules – 5 mg** | | | | | |
| Ingredients cost (EUR) | 22,863.38 | 21,872.57 | 20,704.63 | 19,886.31 | 19,807.86 |
| Total cost (EUR) | 79,056.52 | 77,759.22 | 74,533.30 | 72,901.57 | 74,261.67 |
| **Librium capsules – 10 mg** | | | | | |
| Ingredients cost (EUR) | 94,474.83 | 81,688.43 | 72,331.35 | 66,744.39 | 66,103.75 |
| Total cost (EUR) | 254,119.76 | 225,064.36 | 201,311.39 | 189,321.22 | 187,235.08 |
| **Ethylex film-coated tablets – 50 mg** | | | | | |
| Ingredients cost (EUR) | – | – | – | – | – |
| Total cost (EUR) | – | – | – | – | – |
| **Selincro film-coated tablets – 18 mg (pack size 14)** | | | | | |
| Ingredients cost (EUR) | – | – | – | 37,339.16 | 33,605.39 |
| Total cost (EUR) | – | – | – | 40,064.70 | 36,828.02 |
| **Selincro film-coated tablets – 18 mg (pack size 28)** | | | | | |
| Ingredients cost (EUR) | – | – | – | 130,075.88 | 119,824.57 |
| Total cost (EUR) | – | – | – | 136,505.23 | 126,724.22 |

Source: Primary Care Reimbursement Service (PCRS)

| 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|
| 45,527.77 | 44,284.32 | 44,243.44 | 41,948.68 | 40,098.43 | 38,649.92 |
| 82,853.89 | 82,916.85 | 80,395.08 | 74,077.68 | 71,909.25 | 68,871.92 |
| 5,322.42 | 29,554.94 | 60,416.09 | 61,373.21 | 66,588.03 | 62,580.64 |
| 6,205.41 | 33,298.75 | 66,542.95 | 67,517.76 | 73,646.75 | 68,708.10 |
| 77,073.35 | 68,423.78 | 61,884.46 | 68,274.84 | 65,310.11 | 64,927.53 |
| 95,432.41 | 83,073.71 | 75,414.58 | 83,288.35 | 79,534.72 | 78,819.64 |
| 18,552.64 | 16,905.85 | 18,333.26 | 17,120.33 | 17,927.54 | 16,495.86 |
| 69,818.92 | 63,978.99 | 68,173.39 | 65,926.82 | 68,991.77 | 62,577.32 |
| 60,836.38 | 56,311.63 | 53,893.52 | 49,249.77 | 46,614.15 | 42,927.93 |
| 170,881.34 | 158,127.34 | 153,362.38 | 140,999.94 | 138,159.11 | 120,747.70 |
| – | – | – | 256.89 | 1,317.05 | 1,867.63 |
| – | – | – | 331.70 | 1,900.60 | 2,500.28 |
| 22,923.40 | 14,662.70 | 15,342.92 | 11,261.90 | 7,913.27 | 7,832.35 |
| 25,105.08 | 15,550.02 | 16,400.62 | 12,051.02 | 8,355.77 | 8,303.78 |
| 80,458.17 | 56,996.73 | 66,799.35 | 51,572.89 | 56,313.62 | 63,664.56 |
| 85,654.84 | 60,345.30 | 70,733.72 | 54,517.41 | 59,530.79 | 67,770.98 |

# 12.4 Summary: Alcohol treatment

We used data from the NDTRS in order to examine the prevalence of treatment for alcohol use in Ireland. In the period from 2015 to 2022, there has been a 10.8% decrease in the rate per 100,000 of the population of cases treated for alcohol as the main problem drug. The majority (61.5%) of treatment cases in 2022 were males, and the median age of all cases in treatment in 2022 was 42 years. The most common type of intervention received in 2022 for alcohol use was brief intervention treatment, followed by individual counselling. Over one-half of cases were abstaining from alcohol when exiting treatment (54.1%).

The NPIRS indicated that there were 806 cases of people admitted to psychiatric hospitals with an alcohol-related diagnosis in 2022, and that the majority (58.4%) were males.

Data from the HSE PCRS register indicate that in 2022, 8,738 patients were prescribed chlordiazepoxide (Librium), 496 patients were prescribed acamprosate (Campral), and 1,043 patients were prescribed disulfiram (Antabuse). Overall, the number of patients prescribed alcohol-related medications has declined by 29.0% in the 11-year period from 2012 to 2022.

# 13

# Alcohol policy in Ireland

The HRB overview published in 2016 *Alcohol in Ireland: consumption, harm, cost and policy response* provides a detailed history of alcohol policy in Ireland and was updated in the 2021 HRB overview *Alcohol consumption, alcohol-related harm and alcohol policy in Ireland* to reflect the enactment of the Public Health (Alcohol) Act 2018. Since the publication of the last HRB alcohol overview in 2021, many components of the Public Health (Alcohol) Act 2018 have been commenced. This legislation is based on recommendations made by the National Substance Misuse Strategy Steering Group [183]. The Steering Group was established in 2009 to address alcohol-related harm in Ireland and to make policy recommendations to the Irish Government.

# 13.1 The Public Health (Alcohol) Act 2018

The passing of the Public Health (Alcohol) Act 2018 placed Ireland at the forefront of those countries taking legislative action to address alcohol-related harms and sees alcohol being treated as a public health issue [25]. Although it was a lengthy process to get the legislation passed due to considerable opposition from those with a vested interest in alcohol sales, the measures included in the Act are based on WHO 'best-buy' recommendations (i.e. the most effective measures recommended to tackle alcohol use and associated problems in the population), including alcohol price, availability, and marketing [50,61]. There is a particular emphasis in the legislation on reducing harm to young people and children, who are most vulnerable to the negative consequences of alcohol consumption.

## 13.1.1 Minimum unit pricing

Section 11 of the Act, addressing minimum unit pricing (MUP) on alcohol products, was made a legal obligation on 4 January 2022 and sets a minimum price of 10 cent per gram of alcohol or EUR 1 per standard drink. MUP differs from a tax increase as it is compulsory and enforces prices whereas the cost of tax increases can be either absorbed by the industry, distributed unevenly across alcoholic products or passed on to non-alcoholic products. MUP targets the heaviest drinkers and those with the lowest incomes, as they are most likely to buy the cheapest alcohol and are most affected by alcohol-related harms [184,185]. The affordability of alcohol is recognised by the WHO as one of the leading contributors to alcohol use and related harms, and MUP is thus considered a WHO 'best-buy' recommendation. The third edition of *Alcohol: No Ordinary Commodity* updated and critically reviewed the scientific evidence of global alcohol control policies; unsurprisingly, it considers policies that increase the affordability of alcohol to be harmful and ineffective at reducing alcohol use and harms, whereas it classifies MUP as a 'good practice', meaning that it is considered a good investment but that it is less effective than best practices such as tax increases [76].

Ireland is one of few countries globally to introduce MUP, along with the Northern Territory in Australia, Scotland, and Wales. Evidence on the impact of MUP is slowly emerging from other jurisdictions, but as it was so recently introduced in Ireland, it is too early to estimate its effect in reducing alcohol-related harms here. As such, we rely on evidence from Scotland as MUP was introduced there in 2018.

In the first year following the introduction of MUP in Scotland, there was an overall decrease in alcohol sales volumes, evidence of price increases in the off-trade sector for all alcohol products, and a decrease in the sale of larger multipacks and larger container sizes, although there was limited evidence of the withdrawal of products or the introduction of new products, or of MUP affecting concentrations of alcohol by volume [186]. Specifically, off-trade sales in Scotland were 4% lower than they would have been in the absence of MUP [187]. Five years after the introduction of MUP in Scotland, off-trade sales remained 3% lower than they were pre-MUP [188]. Weekly alcohol consumption decreased both in the off-trade and on-trade, and this decrease was more evident among women (compared with men), among older people, and among those living in more affluent areas [189]. Heavy drinkers saw the largest reduction in alcohol use, although an increase in alcohol use was noted in the 5% of men who were the heaviest drinkers, and MUP was not associated with a reduction in alcohol use among younger men or men living in more deprived areas.

A study by Anderson et al. (2021) examining the impact of MUP in both Scotland and Wales found reductions in alcohol sales in households that had previously bought the most alcohol, but MUP had not affected the alcohol spending of those who usually purchased smaller amounts of alcohol or of those with lower incomes [190]. Another study (by Dimova *et al*., 2022) examining the impact of MUP on service providers supporting clients experiencing homelessness in Scotland found that although they expected adverse effects among their clients as a result of the introduction of MUP, these did not materialise to the degree anticipated, and the majority of service providers acknowledged the need for such a policy [191]. However, although not quantified, the service providers noted a number of adverse impacts, including an increase in hospital admissions for alcohol withdrawal symptoms; a small minority reported an increase in the number of clients accessing food banks, which may have been as a result of prioritising alcohol over food or the increased financial strain [192].

A Scottish study (by Francesconi and James, 2022) examined the impact that MUP had on fatal road traffic collisions and accidents involving drink drivers in the months before and after the introduction of MUP [193]. The results indicated that there was no change in the number of incidents in Scotland compared with the rest of Britain (where MUP was not in place at the time), implying that the policy did not affect such accidents. In two other studies, there was no clear evidence that MUP caused wider negative consequences, such as increased criminality, illicit substance use, or acute withdrawal [193,194], although one of these studies found no evidence of a beneficial impact of MUP within EDs [195]. Fears of an increase in cross-border alcohol purchasing were unfounded, as time series analyses indicated that although some cross-border purchasing did occur following the introduction of MUP in Scotland, it had not happened to the extent some had predicted and was unlikely to affect population-level consumption statistics [195].

MUP in Scotland has a 6-year sunset clause, meaning that MUP could be abolished in 2024 unless the Scottish Parliament votes for it to continue. A report commissioned by the Scottish Government to assist its decision-making regarding whether MUP should continue was produced by Public Health Scotland and published in *The Lancet* in 2023 [189]. The report sought to determine whether MUP had contributed to reducing alcohol-related health and social harms and whether some people or businesses were more affected by MUP (either positively or negatively) than others. The findings indicated that MUP reduced

wholly alcohol-attributable deaths and hospitalisations and that such decreases were greatest among men and those living in the most deprived areas of Scotland. No consistent evidence was found to indicate that MUP reduced alcohol-related ambulance call-outs, ED presentations, prescribing of medication to treat alcohol dependence, alcohol-related crime, or illicit drug use. The report found that MUP impacted on the price of ciders and spirits and that sales of these products subsequently decreased, but overall, there was no consistent evidence that the alcohol industry financially gained or lost as a result of MUP. Importantly, an evaluation of the impact of MUP on alcohol-attributable deaths and hospital admissions in Scotland estimated that wholly alcohol attributable deaths decreased by 13.4% and reduced wholly alcohol attributable hospital admissions by 4.1% [189].

A systematic review of the literature examining MUP modelling studies and natural studies found that the number of hospitalisations due to alcohol decreased due to the introduction of MUP and that those living in areas of higher deprivation were most likely to experience a reduction in alcohol-related hospitalisations [196]. In the Northern Territory of Australia, where MUP was introduced in 2018, an examination of wastewater samples found that per capita alcohol use initially declined considerably after the introduction of MUP, but after a period of 15 months, per capita alcohol use had increased again to pre-MUP levels [197].

None of the adverse consequences reported outweigh the benefits, and overall public health researchers have concluded that MUP is an effective alcohol policy option for reducing alcohol sales and use (specifically from the off-trade sector), and as a WHO 'best-buy' recommendation, MUP is recommended for countries with high levels of per capita alcohol use and related harms. However, the evidence shows that MUP is most effective in combination with a suite of other recommendations that complement each other (as per the Public Health (Alcohol) Act 2018) and when it is adjusted in line with inflation.

### 13.1.2 Health warning labels on alcohol products

Section 12 of the Public Health (Alcohol) Act 2018 requires that all alcohol products to be sold in Ireland display health warning labels. The Minister for Health, Stephen Donnelly, signed Section 12 into law in May 2023, aligning alcohol products with other food and beverage products that already contain health information and, where appropriate, health warnings. In order to allow businesses sufficient time to prepare for this change, a 3-year lead-in time was granted, and from May 2026, all alcohol products will be legally required to display:

- A warning informing the consumer of the danger of alcohol use
- A warning outlining the danger of alcohol use when pregnant
- A warning informing the consumer of the direct link between alcohol consumption and fatal cancers
- The quantity in grams of alcohol contained in the container
- The calorie content in the container, and
- Details of an independent website providing public health information in relation to alcohol use.

The law also requires that similar health information be made available for customers in licenced premises.

By 2026,

**Ireland will have the most comprehensive health warning labels**

on alcohol products in the world

Until the passage of this legislation, labelling on alcohol products has been determined by the alcohol industry, and evidence suggests that existing labels are not effective at communicating the health risks or the content of the product. For example, a 2016 study in the UK examining alcohol labelling found that current labelling did not meet the standards set out in the alcohol industry's pledge, (this pledge consists of three required elements: the number of units in the drink; the Chief Medical Officer's daily guidelines for lower-risk consumption; and a warning about the risks of drinking while pregnant, either in the form of text or as a logo showing the silhouette of a pregnant woman holding a wine glass with a line struck across it). Two further optional elements are: a reference to the Drinkaware website and a 'Responsibility statement' (e.g. 'please drink responsibly'), as the font and logos appeared in a smaller size than on other products with labelling outlining their health effects [198].

Health labelling on alcohol products is a WHO-recommended intervention for reducing alcohol-related harms by providing consumers with information regarding the harms related to alcohol. Ireland leads the world in the introduction of such labelling, as although warning labels are already present in a number of countries (including Australia, Brazil, Canada, Colombia, France, Mexico, the Russian Federation, South Africa, South Korea, Taiwan, Thailand, and the USA), none are as comprehensive as Irish labelling [199]. Health warning labels on alcohol products are recommended as a good practice for reducing alcohol use and related harms [76]. The use of QR codes is often suggested as an alternative to explicit health warning labels, allowing the purchaser to scan their alcohol product with their smartphone and read information about the content and potential health effects of the product. However, research has found that the use of QR codes to obtain such information is not effective, with just 0.1% of a sample of 7,079 customers scanning the code [200].

Health warning labels ensure that consumers have accurate information regarding the calorie content and the strength of alcohol products and are informed of the health risks associated with alcohol. However, findings from 2016 the Healthy Ireland Survey demonstrate that public knowledge of the link between cancer and alcohol in Ireland is low. Just one-quarter of Irish women are aware of the direct link between alcohol and breast cancer, despite this being the most common type of cancer among women in Ireland [201,202].

There was significant opposition and mounting pressure on the Irish Government to block the introduction of alcohol labelling, particularly from the alcohol industry. This was unsurprising considering the resistance that the Northern Territories Alcohol Labels Study in Canada experienced in 2017 when attempting to pilot an alcohol labelling study [203]. For that study, the statement "Alcohol can cause cancer" was added to warning labels on alcohol products at a liquor store in Whitehorse, Yukon, Canada next to existing federally mandated warnings about drinking while pregnant or drink-driving. The study planned to run for 8 months but was stopped after only a few weeks following strong alcohol industry lobbying. Spirits Canada, Beer Canada, and the Canadian Vintners Association (now Wine Growers Canada) threatened legal action against the Yukon Government, arguing that it had no legislative authority to add the labels and would be liable for defamation, damages for lost sales, and packaging trademark and copyright infringement because the labels had been added without the consent of the alcohol manufacturers. The study resumed with non-cancer warning labels (drinking guidelines and standard drink content). Alcohol sales continued to decline during an 8-month period of rotating alcohol warnings.

Previous research examining the effectiveness of health warning labels has found that such messages increase knowledge of the health-related risks associated with alcohol use, are effective in communicating information about low-risk alcohol guidelines, and motivate changes in alcohol use behaviours, particularly among women [204,205,206,207,208,209]. For example, a UK study by Blackwell *et al*. (2016) alcohol industry labelling could be improved and that including additional information about the number of standard drinks and the low-risk guidelines for alcohol use is vital for increasing drinkers' knowledge [205]. Another UK study (by Pechey et al., 2020) found that, among a representative sample of the UK population (N=5,528), the use of both images and text health warning labels resulted in the greatest likelihood of behavioural change among respondents (although this was least popular) [207]. A large study by Winstock et al. (2020) involving 75,969 current drinker respondents from 29 countries (including 306 respondents from the Republic of Ireland) found that women and high-risk drinkers were more likely to reduce their alcohol intake as a result of health warning labels [208]. A study by Jongenelis *et al*. (2018) involving heavy drinkers found that such labels were likely to result in positive behavioural changes in drinking patterns and that they heightened drinkers' awareness of the cancer risk associated with alcohol use [210]. An Australian study by Miller et al. (2016) also found that health warnings on alcohol products were successful in communicating the link between alcohol use and cancer risk [206].

The 2023 Healthy Ireland Survey found that 53% of drinkers reported never seeing heath messaging and information on alcohol packaging and 14% of drinkers often or always do [35]. Of those who do notice heath messaging and information, just 7% reported looking closely or reading this information. Respondents were also asked if they see or hear health warning messages when looking at alcohol advertising and 19% of drinkers reported often or always

seeing or hearing health messages, while 41% of drinkers never do. Of those who see/hear messages, just 9% said they pay close attention to this information in advertising and just 7% reported seeking out information on the effects of alcohol use. This evidence is important baseline information to repeat after labelling have been implemented to examine any changes in engagement with health warning labels.

The evidence indicates that health warning labels similar to those that will be mandatory on alcohol products in the Republic of Ireland beginning in 2026 have been proven to raise awareness of what alcohol products contain. Not only will drinkers be informed of the calorie content and the amount of alcohol in grams in the alcohol product, but, crucially, they will be made aware of the cancer risk and the risk of harm if drinking when pregnant. With the evidence indicating that without such labelling, awareness to date is low, the introduction of this labelling has the potential to reduce hazardous drinking among the population of Ireland and to reduce alcohol-related harms. Public support is high for labelling and other jurisdictions are watching with interest how Ireland fares from their introduction.

### 13.1.3 Restrictions on the sale and supply of alcohol products

As the sale and promotion of alcohol is a commercial determinant of health, the alcohol industry has a direct impact on the health of the population [210]. The measures included in the Public Health (Alcohol) Act 2018 attempt to counteract such activity, and restricting the sale and availability of alcohol is fundamental to the Act in order to prevent children and young people's alcohol use. Section 23 of the Act, commenced in November 2018, prohibits the sale or supply of alcohol at a reduced price or free of charge to a certain group, at a reduced price when an individual is already purchasing a certain quantity or another service (e.g. 'buy one, get one free' or 'free drink with a service' promotions), or during a limited time period (3 days or fewer) (e.g. happy hours), or the promotion of an event that is likely to encourage people to drink in a hazardous manner (e.g. 'bottomless brunches', where a dining experience offers unlimited alcohol; or the award of or use of bonus or loyalty card points for alcohol purchases).

The main objective of Section 23 of the Public Health (Alcohol) Act 2018 is to restrict the sale and supply of alcohol by reducing the affordability and availability of alcohol, which is particularly aimed at young people but ultimately aims to reduce alcohol use at a population level.

### 13.1.4 Structural separation

Since November 2020, under Section 22 of the Public Health (Alcohol) Act 2018, visibility of alcohol products (and their advertising) is limited in certain licenced premises, such as supermarkets, grocery stores and garage forecourts. Alcohol products must be separated from other goods, and depending on the size of the store, alcohol in such premises must be either: stored in an area separated by a physical barrier not less than 1.2 metres high and through which alcohol and advertisements for alcohol are not visible; stored in one or more closed storage units or cabinets on the shop floor in which the products are not visible up to a minimum height of 1.5 metres; or stored in no more than three adjacent open storage units in the premises, each 1.0 metre wide and 2.2 metres high [211].

Structural separation aims to discourage shoppers from purchasing alcohol as part of everyday household grocery shopping and to recognise that alcohol is 'no ordinary commodity' [76]. Alcohol is commonly purchased in supermarkets, and therefore structural separation is a very important part of the Public Health (Alcohol) Act 2018. Research has shown that alcohol displays and advertising within supermarkets, particularly end-of-aisle displays (products placed at the end of an aisle, giving the product and brand a competitive advantage), are very persuasive to shoppers and encourage alcohol sales and consumption [212]. Access to alcohol and the advertising of alcohol is now more controlled, resulting in alcohol being less likely to be on display near grocery products and less visible to children. Limiting its physical availability is considered a best practice in reducing population-level alcohol use and thus reducing alcohol-related harms [76].

There has been little research on the effectiveness of structural separation to date, and what research has been done relies on observational studies that cannot control for contextual and historical factors. However, experimental research assessing the impact of alcohol-related cues on drinking behaviours has been carried out. For example, until 2017, alcohol laws in the state of Utah, USA, required a barrier between the customer and the area where drinks were prepared. The main intent of this barrier (colloquially referred to as the 'Zion curtain' in reference to the prominence of the Mormon Church in Utah) was to prevent patrons from watching their drinks being poured, as the law recognised that this was an alcohol-related cue that could result in hazardous drinking [213]. Cue-reactivity research indicates that alcohol-related cues (often studied using pictures of drinks and people drinking, or using virtual reality methods) affect heavy drinkers and those with alcohol dependency. Such research provides the evidence that preventing exposure to alcohol-related images and sights is a good practice for protecting vulnerable individuals who are more affected by alcohol-related cues.

### 13.1.5 Alcohol advertising

Because children and young people are particularly susceptible to alcohol advertising, it is important that they are protected as much as possible from alcohol marketing and advertising [214]. Research indicates that exposure to alcohol marketing is a key influencer on children's decision to drink and is associated with early alcohol use initiation and hazardous drinking [215,215,216]. The Public Health (Alcohol) Act 2018 contains a number of components that restrict alcohol advertising, with a particular emphasis on protecting young people.

A report examining alcohol marketing restrictions that have been incorporated into alcohol policies in seven European countries (Estonia, Finland, France, Ireland, Lithuania, Norway, and Sweden) found that such policies receive public support, particularly in relation to preventing children and young people's exposure to alcohol marketing [217].

As sections 13 and 19 of the Public Health (Alcohol) Act 2018 are based on recommendations made in 2012, the online advertising and marketing of alcohol is not properly considered. In 2012, the online presence of alcohol marketing and advertising was nowhere near as prolific as it is now; consequently, the advertising sections of the Act do not go far enough to reduce children's exposure to online alcohol advertising.

#### 13.1.5.1 Advertising in print media

Section 18 of the Public Health (Alcohol) Act 2018 has not yet been commenced but applies to alcohol advertising in print media such as newspapers and magazines. Under this section of the Act, when commenced, print media will be restricted to a maximum of 20% of the advertising space containing alcohol advertising, alcohol advertisement content will be restricted to specific information about the nature of the product, and advertisements will include health warnings about alcohol use. Alcohol advertising in print media must not be aimed at children, and where a publication or a page of a publication is aimed at children or is likely to be read by children, or where 20% or more of the publication's readership comprises children, alcohol advertising will be prohibited. Alcohol advertising will not be permitted on the front or back cover of a publication or any wrapper, envelope, or other covering of a publication.

There is strong evidence indicating that children are highly influenced by advertising, as they are not yet capable of identifying the difference between marketing messages and factual information [218]. Cue-reactivity studies examining brain activity during exposure to alcohol images have found that when heavy alcohol users are exposed to alcohol imagery, their brain activity shows an increase in alcohol cravings [219]. As well as heavy drinkers, those in recovery from a history of alcohol dependence are prone to attentional bias, i.e. they are likely to focus on certain elements (such as the pleasurable effects of alcohol) while ignoring others (the low-risk guidelines or health warnings). In the case of alcohol marketing, these vulnerable groups are more likely to have their attention drawn to alcohol-related messages and images, and thus alcohol marketing can be a stimulus for relapse among those in recovery [220].

#### 13.1.5.1 Advertising during sporting events

Under Section 15 of the Public Health (Alcohol) Act 2018, alcohol advertising during sporting events is prohibited, including alcohol-branded clothing or the advertising of alcohol in or on a sports area (a pitch, court, track, etc.). Research has shown that since the commencement of Section 15 (November 2021), alcohol branding is still evident in sporting areas, albeit using the zero-alcohol alternatives or 'alibi marketing' (using identifying features of the brand without specifically advertising alcohol) [220,221]. An examination of rugby matches in Ireland following the commencement of Section 15 of the Act found that alcohol brand references remained clearly visible in or on the sporting area. In 14 matches played during the 2021–22 European Rugby Champions Cup, 481 alcohol brand references were noted, either through the use of zero-alcohol alternatives or through using well-known alcohol branding logos [222].

An examination of the frequency and nature of alcohol marketing during televised broadcasts of the 2020 Six Nations Championship tournament was carried out in order to highlight the extent of alcohol marketing during popular sporting events prior to the implementation of Section 15 of the Act [221]. Content analysis of four matches (two played in Ireland, one played in Scotland, and one played in France) was undertaken. The study found that alcohol marketing was most frequent in the match played in Scotland, with an average of 5 alcohol references per broadcast minute (for a total of 961 alcohol references, or 1 alcohol reference every 12 seconds). The two matches played in Ireland closely followed, with an average of 4 references per minute (for a total of 754 alcohol messages in one game, or 1 reference every 16 seconds and 690 alcohol messages in the other, or 1 reference every 15 seconds), while for the match played in France, there was 1 alcohol reference per minute (for a total of 193 alcohol references). The study provided clear evidence of the need for legislation to curtail alcohol advertising during sporting events, but also highlighted how alcohol marketing is permitted in prominent locations that are not restricted by Section 15 controls (for example, pitch-side advertising and advertising placed around the stadium structure), meaning that alcohol marketing is still very visible during sporting events.

#### 13.1.5.3 Sponsorship

Section 16 of the Public Health (Alcohol) Act 2018 prohibits alcohol sponsorship of an event where the majority of those taking part are children, or of an event aimed specifically at children. Section 16 also prohibits alcohol sponsorship of motorsports. Sections 15 and 16 were legally enforced in November 2021.

#### 13.1.5.4 Advertising on children's clothing

From November 2019, alcohol-branded children's clothing – including children's clothing with alcohol logos, emblems, brand names, or trademarks – is prohibited from sale under Section 17 of the Public Health (Alcohol) Act 2018. A study commissioned by Alcohol Action Ireland in 2015 found that 61% of a sample of adolescents aged 13–17 years reported owning alcohol-branded merchandise, and that this was especially prominent among boys [217]. The study concluded that children who reported owning alcohol-branded merchandise were more likely to drink alcohol, engage in binge drinking, and report having been drunk.

#### 13.1.5.5 Advertising in cinemas

Under Section 20 of the Act, only films with an over 18 certification have been permitted to show advertisements for alcohol products since November 2019.

#### 13.1.5.6 Advertising in certain places

Since November 2019, Section 14 of the Act has prohibited the advertising of alcohol products in parks and open public spaces; on public transport vehicles and in train or bus stations and at bus or Luas stops; and within 200 metres of the perimeter of a school, playground, or a child services location.

Concerns have been raised about the presence of alibi alcohol advertising in the vicinity of public transport in Ireland since the implementation of Section 14 [222]. It is suggested that circumventing the legislation in this manner undermines the Act and exposes people to alcohol-related marketing, as even if this marketing is not explicitly advertising an alcohol product, the brand is synonymous with the full-strength product.

A study examining marketing awareness at two different time points after the implementation of the advertising restrictions but before they were commenced and again after the restrictions became mandatory found that respondents' recollection of seeing alcohol marketing in the previous month decreased from 94.1% to 93.8% between the two waves of the study [223]. The percentage of respondents who recalled alcohol marketing on public transport decreased from 65% in Wave 1 to 55% in Wave 2, awareness of marketing through posters and billboards decreased from 77% to 69% between waves, and awareness of alcohol marketing in the cinema decreased from 37% to 27% between waves. No change was observed in participants' recollection of seeing alcohol marketing on catch-up or streaming services, social media, special price offers, and branded merchandise.

#### 13.1.5.7 Content of advertisements

Not yet commenced is Section 13 of the Public Health (Alcohol) Act 2018, which makes provision for restrictions on all forms of alcohol advertising. Once commenced, this section of the Act will make it mandatory for all alcohol advertisements to adhere to the inclusion of certain information, including cancer health warnings. Commencement of Section 13 is awaiting conclusion of the Food Safety Authority of Ireland's consultation and assessment of regulations at European Union level.

One study examined whether consumer protection messages in alcohol advertising present on Twitter (now known as X) in Ireland provided the consumer with warnings about alcohol use and/or signposted public health information about alcohol [224]. Of the 554 tweets examined, none provided information about the link between alcohol consumption and fatal cancers, and 0.5% provided a warning related to drinking during pregnancy. Voluntary and self-regulated consumer protection messages were observed in 36.3% of the tweets, 72.9% had no link to a public health website, and 20.6% provided a link to an alcohol-industry-funded website. When Section 13 of the Public Health (Alcohol) Act 2018 is commenced, alcohol marketing on the X platform and all internet marketing will be required to provide consumers with impartial information about alcohol and alcohol-related harms.

#### 13.1.5.8 Broadcast watershed

In November 2023 Section 19 of the Act was implemented, which will see advertising watershed restrictions banning alcohol advertising on television between the hours of 3.00 am and 9.00 pm, and on the radio between 12.00 am and 10.00 am and between 3.00 pm and 12.00 am on weekdays. The provision will come into operation on 10 January 2025.

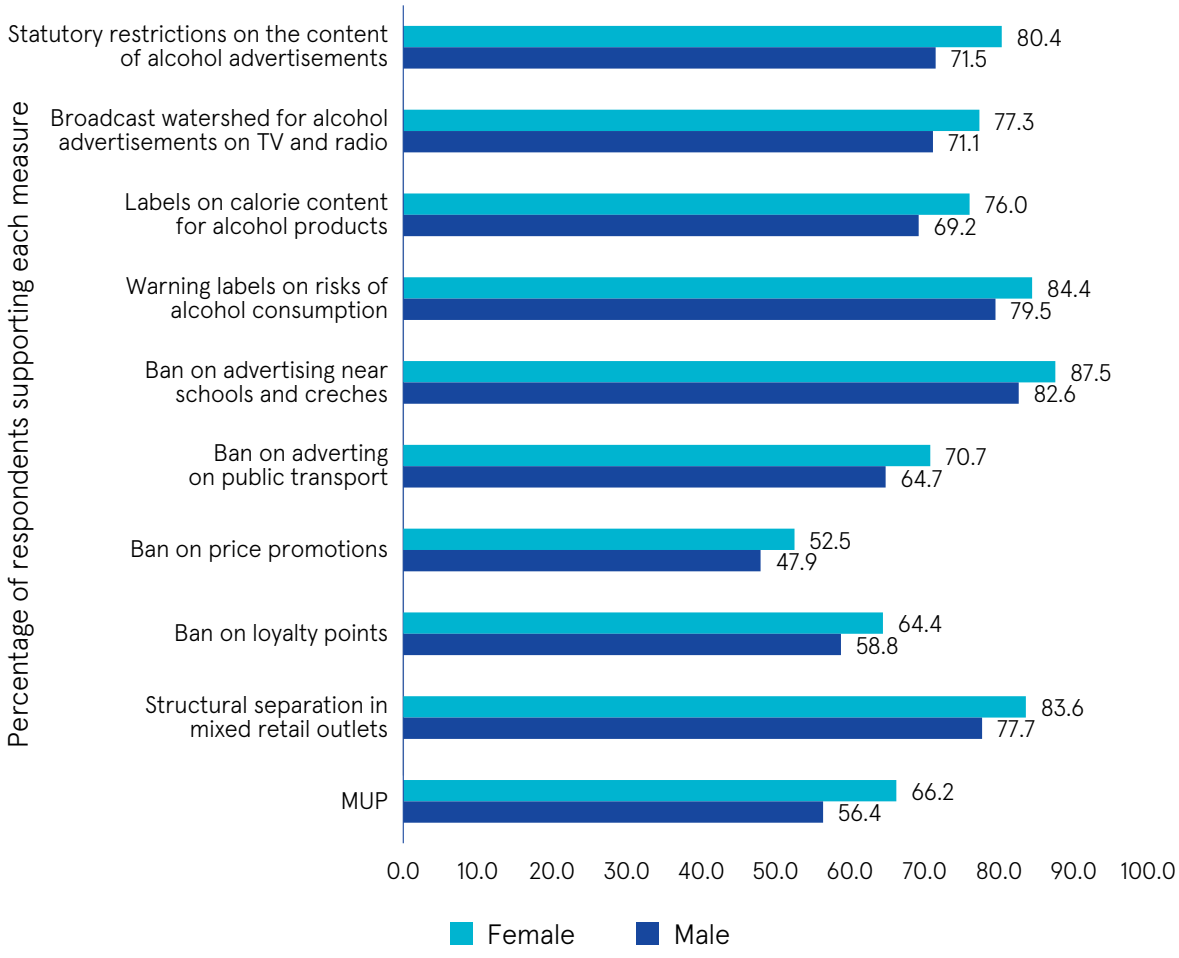
## 13.1.6 Review of operation of Sections 13–20

Section 21 of the Public Health (Alcohol) Act 2018 also makes provision for the review of Sections 13–20 no later than 3 years after their commencement.

## 13.1.7 Public support for legislation to address alcohol use and related harms

Understanding public support for legislation assists those advocating for such measures to lobby for the outstanding measures in the Act to be implemented. One study targeted a sample of 1,069 residents of Ireland aged 18 years and over in order to examine the level of support for the policies included in the Public Health (Alcohol) Act 2018 [225]. The highest level of support was shown for alcohol advertising near schools and creches to be banned (85%) and for alcohol products to carry health warning labels (82%). The lowest level of support was shown for the ban on price promotions (50%) and for MUP (62%). Women were more likely than men to support all the measures (Figure 59).

Figure 59 Percentage of respondents showing support for alcohol policy measures, by sex




Source: Calnan *et al.*, 2023 [225]

The study also found that those who reported hazardous or harmful drinking patterns were less likely to support these components of the legislation compared with those who were low-risk drinkers, particularly in relation to banning price promotions (which was supported by 36% of those who reported hazardous or harmful drinking patterns compared with 65% of low-risk drinkers), implementing MUP (supported by 49% of hazardous or harmful drinkers compared with 75% of low-risk drinkers), and banning alcohol advertising on public transport (supported by 57% of hazardous or harmful drinkers compared with 80% of low-risk drinkers). The results of this study indicate that those in older age groups (65 years and over) and low-risk drinkers were more likely to support the measures contained in the Public Health (Alcohol) Act 2018. The findings of this study are particularly interesting when compared with previous research that has shown that the least popular measures to reduce alcohol use, such as reducing its availability and increasing pricing, are commonly the most effective [226]. The findings highlight the importance of raising awareness regarding the purpose and effectiveness of such policies in order to ensure their support.

### 13.1.8 Compliance with the legislation

Compliance with the legislation has been found to be good among retailers and industry with no person or organisation found guilty of an offence under the Public Health (Alcohol) Act 2018 following complaints made to the HSE of non-compliance as of June 2023 [227].

A Parliamentary Question (PQ) raised for Government response in May 2023 asked for the number of complaints made to the HSE in relation to breaches of the section 22, structural separation, since its enactment. The formal response provided from the HSE was that 31 complaints were made to the HSE in the first 2.5 years since commencement [228]. A further PQ requested the number of instances of alleged breaches of section 14 (advertising in certain places) and the response given was that five cases of alleged breaches of section 14 had been brought to the attention of the HSE Environmental Health Service for investigation [229]. In February 2023, a PQ requested a breakdown of the number of prosecutions brought under section 14 of the Act and the formal response was that no prosecutions had been taken to date (21 February 2023) [230].

## 13.2 The Sale of Alcohol Bill (2022)

The General Scheme of the Sale of Alcohol Bill (2022) was published by the Department of Justice in late 2022, partly in response to the economic impact of the COVID-19 pandemic on the night-time economy and in order to revive same. The Bill also aims to streamline the liquor licensing process, much of which is based on very outdated legislation [55].
The Minister for Justice has since proposed to separate the Bill to compise of two strands, one to be a shorter reform Bill, the Intoxicating Liquor Bill 2024, where extended opening hours are one of several features. The original Bill will focus on modernising the liquor licensing laws.

In relation to public health, however, many aspects of the Bill conflict with the Public Health (Alcohol) Act 2018, as it proposes to make alcohol more freely available, not only through additional venues being licenced to sell liquor but also through extended opening hours. To date, opening hours for licenced premises have been governed by the Intoxicating Liquor Act 2003; the current opening hours and the proposed opening hours as outlined in the Sale of Alcohol Bill (2022) are displayed in Table 40. The Bill makes extending opening hours a simplified process, and nightclubs will be permitted to stay open and serve alcohol until 5.00 am (currently they are permitted to stay open and serve alcohol until 2.30 am) [231].

Table 40 Current and proposed opening hours for licenced premises

| | Current opening hours | | Proposed opening hours | |
|---|---|---|---|---|
| | On-trade | Off-trade | On-trade | Off-trade |
| Monday to Thursday | 10.30 am to 11.30 pm | 10.30 am to 10.00 pm | 10.30 am to 12.30 am | 10.30 am to 10.00 pm |
| Friday and Saturday | 10.30 am to 12.30 am | 10.30 am to 10.00 pm | 10.30 am to 12.30 am | 10.30 am to 10.00 pm |
| Sunday and St Patrick's Day | 12.30 pm to 11.00 pm | 12.30 pm to 10.00 pm | 10.30 am to 11.00 pm | 10.30 am to 10.00 pm |
| Nightclubs | Closing time 2.30am | | Closing time 06.00am | |

Under the Sale of Alcohol Bill (2022), the extinguishment requirement would be abolished, which to date meant that anyone wishing to open a new pub or off-licence must first purchase a licence from an existing outlet. Those licences could then be transferred to another location in any part of the country, therefore maintaining a certain number of licences throughout the country. The enactment of the Bill is likely to result in many more venues (referred to as 'cultural amenities' in the Bill) applying for and being granted a liquor licence, thus increasing the availability of alcohol [232].

The Sale of Alcohol Bill (2022) strengthens the law around the distance sale of alcohol, whereby upon implementation, those delivering alcohol to a home or venue must confirm that the person receiving the alcohol is aged 18 years or over, but no further checks are required in order to ensure that they are the person who will be consuming the alcohol.

Public health advocates argue that the Bill undermines the Public Health (Alcohol) Act 2018, and many submissions were made during the Bill consultation process to highlight the dangers associated with increased alcohol availability and the risks this would pose to public health. A call for a health impact assessment has been made by public health advocates, to consider the findings elsewhere that indicate that extending opening hours and making alcohol more available is associated with increased alcohol-related harms [233,234].

# Summary: Alcohol policy in Ireland

The most significant legislation passed governing alcohol use in Ireland is the Public Health (Alcohol) Act 2018. This legislation is based on proven evidence of what works best at a population level for reducing alcohol use and related harms as recommended by the WHO. Despite the opposition to the legislation that significantly delayed its enactment, the evidence available shows that public support for the Act is high, and there is much interest globally on its impact on alcohol use in Ireland. The majority of the Act's components have been commenced between 2018 and 2023, and evidence is slowly emerging on their effectiveness. As much of the implementation of the various sections of the Act coincides with the COVID-19 pandemic, the effect of the legislation is not always clear, since the pandemic also caused drinking behaviours to change during this period. However, evidence from other jurisdictions with similar legislation is used to describe the rationale for, and the potential outcomes of enacting the various components of the Act.

MUP has been in place since 1 January 2022 in Ireland, but we primarily rely on evidence from Scotland as to its effectiveness, which to date has been overall positive. The evidence suggests that it is effective in targeting those from lower socioeconomic status groups and that it reduced alcohol-related deaths and hospitalisations. An Irish study found a significant reduction in alcohol-related ED presentations following the commencement of MUP however alcohol-related hospital admissions did not decrease. Ultimately, the most high-level, comprehensive and reliable data available about impacts of MUP show per capita alcohol consumption reduced, and wholly alcohol attributable deaths reduced in Scotland. Both trends were significantly different to England and Wales, and neither could have happened without the heaviest and most dependent drinkers reducing their consumption because they contribute the majority of total consumption and the majority of alcohol attributable deaths.

Health warning labels have received some of the most criticism and resistance from those with a vested interest in alcohol sales. Despite the opposition, health warning labels on alcohol products will be mandatory in Ireland from 2026, ensuring that drinkers are informed about the contents of the products as well as warning them about the risks associated with consuming alcohol. An intended consequence of the labels is the expectation that their introduction will improve self-reporting of alcohol consumption in population prevalence surveys. As the labels will detail the number of grams of alcohol within a container, drinkers will be better informed of how much alcohol they are drinking, which in turn will mean more accurate recollection when they are surveyed (to date, individuals' self-reported alcohol consumption is vastly underestimated).

Alcohol advertising is one of the most influential drivers of adolescent drinking, and children in particular are regularly exposed to alcohol marketing. The Public Health (Alcohol) Act 2018 intends to protect children as much as possible from this exposure, but a number of ambiguities exist that undermine the legislation, namely alcohol companies' ability to use 'alibi marketing' and advertise for zero-alcohol products. A further consideration is online alcohol advertising, which is overlooked in the legislation because when the recommendations for the content of the Act were being drawn up in 2012, no one could have foreseen how social media and online activity would be such a fundamental part of our lives, and especially in children's and adolescents' lives.

Taken in isolation, each section of the Public Health (Alcohol) Act 2018 is not a silver bullet solution to reducing alcohol-related harms, but they should be considered collectively. Furthermore, enforcing the Act is as crucial as implementation, and monitoring its effectiveness should be a priority.

There is concern that the Sale of Alcohol Bill (2022) threatens the Public Health (Alcohol) Act 2018, as it intends to make alcohol more freely available through extended opening hours and an expansion of the number of outlets selling alcohol. Although the Bill is welcomed for its proposed streamlining of liquor licensing laws, the WHO advises particular caution regarding increasing the availability of alcohol, as this is associated with increased alcohol-related harms.

# 14

# Conclusion

This overview presents the most recent information from a number of indicators measuring alcohol use among the population of Ireland and related social, criminal and health harms and treatment interventions that form part of the response to alcohol use. We live in an alcogenic environment where alcohol use is interlinked in many aspects of our lives and remains a problem in Ireland. Building an awareness and understanding of the harms caused by alcohol use will support policy makers, service providers, and law enforcement to respond effectively.

The data presented in this overview indicate there have been changes to alcohol use behaviours since the last overview published in 2021, primarily due to the COVID-19 pandemic but also potentially attributable to the legislation introduced, the Public Health (Alcohol) Act, 2018. Our per capita alcohol use ranks us at 16th out of 38 OECD countries and in contrast to a number of other OECD countries, per capita alcohol use here saw a more substantial decline during the COVID pandemic. There is a growing minority of people choosing not to drink and adolescents are delaying alcohol use, reasons to be cautiously optimistic that the legislation is effective and that as a nation we have become more aware that alcohol is 'no ordinary commodity'. However, it would be premature to fully attribute behavioural change to the legislation considering it is not fully implemented and considering the multiple competing events and economic effects relating to the pandemic.

Ireland still has a high level of per capita use (9.9 litres in 2023), still above the now outdated aim of the Department of Health for 2020 (9.1 litres). Many people in Ireland continue to drink alcohol in a manner that is risky to their health; over one-half of drinkers are classified as hazardous drinkers and one in every 5 are classified as having an alcohol use disorder. Heavy episodic drinking remains commonplace, particularly among young males (15–24 years). One-half of drinkers drink at least once a week, one-third drink multiple times per week, and drinking at home is now the norm. COVID undoubtedly had an impact on the nation's behaviours and not least, on our mental health as our lives were turned upside down and although alcohol use remained unchanged (or saw a decline) for the majority, it is the 13% who reported increasing their alcohol use that is cause for concern.

During the pandemic, off-licences were considered an 'essential' business and remained open. Alcohol availability, a key driver of alcohol use, is explored in this overview and indicates that alcohol is easily obtainable throughout the country and even more so in deprived areas. With 1 liquor licence for every 345 people in the country, and 73% of the population living within 300 metres of a premises selling alcohol, we are well served. And although there has been a decrease in the number of pubs nationally, they have quickly been replaced with off-licences, increasing by 95% between 2003 and 2021. This overview also examined alcohol affordability and it is clear that the price of alcohol, especially in the on-trade, has increased but much less so in the off-trade. The price increases are lesser compared to those seen in household utility bills and other food and drink products and in fact, is as affordable now as it was in 2003 when inflation is considered. Irish households spent 2.9 billion euro on off-trade alcohol in 2021 and ranked 8th out of 30 European countries for the percentage of household income spent on alcohol.

The consequences of alcohol use are outlined in this overview, including alcohol-related hospitalisations, alcohol-related deaths, the numbers receiving treatment for problem alcohol use, and alcohol-related crime. Alcohol use in Ireland places a sizeable burden on resources, not least in healthcare. Alcohol is responsible for at least three deaths every day, and for almost 19,000 wholly alcohol-attributable hospital discharges from acute Irish public hospitals in 2021. Although a decrease has been noted in alcohol-related hospitalisations when compared to 2001, rates of hospital discharges for alcohol-related liver disease per 100,000 of the population have increased by 80% since 2001, with 2021 seeing the highest ever recorded rates of alcohol-related liver disease although declining in 2022.

Alcohol use has long been intertwined in mental health problems and one in every three of those presenting to Irish hospitals in 2020 for self-harm had consumed alcohol prior or during the self-harm incident and a regional study found alcohol was listed on the toxicology report of 44% of suicide cases.

As well as health services, criminal justice services are impacted by alcohol use. Over 5,500 incidents of drink-driving and almost 10,000 incidents of drunkenness were recorded on the PULSE database in 2022. This large number of offences places considerable pressure on the scarce financial resources of the State, with major costs for the taxpayer in terms of the increased policing required. Demands on the criminal justice system, the ambulance service and on hospital emergency departments, and the expense of cleaning up city and town centres, have not been considered here. There is also a human cost: innocent victims of alcohol-related violence may sustain injuries, and public disorder contributes to people's fear of crime.

Almost 10,000 cases were treated for alcohol in 2022. There has been a decline in the numbers receiving treatment for alcohol use since 2015. The demographic of those seeking treatment for alcohol use has changed over time and the data show an increase in the number of cases in employment although there are substantially higher rates of unemployment among cases receiving treatment for alcohol use compared with the general population. Those living in more disadvantaged areas are more likely to receive alcohol treatment. Almost one-half of cases self-referred and just 10% were referred by their GP. The median waiting time between referral and assessment was 8 days for over one-half of cases. The waiting time between referral and commencing treatment has increased since 2015 and varies by service type. Overall, treatment began within 10 days of referral. The median treatment duration overall was 64 days, an increase between 2015 and 2021 but varies considerably by treatment type. Brief intervention and individual counselling were the most frequent interventions provided to cases with alcohol as the primary problem substance.

The Public Health (Alcohol) Act in 2018 is ground-breaking legislation that aims to tackle population-level alcohol use but with a particular focus on preventing children and young people from alcohol-related harms. Implementation of the final components of the Act prioritises the nation's health. We will continue to monitor the alcohol situation in Ireland through our overviews.

Although we have a wealth of information about alcohol use and related harms, there are still some important gaps in our knowledge base. We still rely on ad hoc studies to estimate the burden of alcohol in emergency department presentations. Those studies indicate a high prevalence of alcohol-related presentations, but we cannot definitively quantify this. We know too, from ad hoc studies in other jurisdictions, that alcohol-related ambulance callouts place a considerable burden on this service but with no routinely collected data in Ireland, again, we are unable to quantify that burden.

With our world-leading legislation to address alcohol use in this country, it is essential that we monitor its effectiveness and to do so, requires high-quality information systems that are accurate and complete, in order to comprehensively determine the impact of policy. To date we have relied heavily on evidence from other jurisdictions to determine how similiar legislation has been effective or not. Identifying gaps in our data as well as the continuation of a steering group to advise on best approaches to do this is warranted.

# Research gaps

This report has highlighted that we have multiple sources of information, from routine surveys, national information systems, administrative data and published literature about alcohol use in Ireland. There remains some important gaps in our knowledge base, namely the lack of data on numbers of emergency department presentations and ambulance callouts that are alcohol related. There are groups where there is limited or no information available or a lack of up-to-date information available, so we do not know the extent of alcohol use among these populations, for example, LGBTQI population, ethnic minorities including members of the Traveller community and those living in Ireland as asylum seekers or refugees.

It is difficult to quantify the involvement of alcohol in domestic violence and we have included information in this report about alcohol use among the victims of sexual assault, but what about the perpetrators? There is limited information about community mental health services and how alcohol use and mental health issues are often intertwined.

Alcohol use places a considerable burden on Irish society but the economic costs are relatively unknown. A report published in 2010 is still relied on to estimate the societal costs associated with problem alcohol use (EUR 3.7 billion or 1.9% of GDP). More recently, a systematic review and meta-analysis of available literature found that in high-income countries, the economic costs of alcohol use were estimated to be approximately 2.6% of the GDP. Government revenue raised from alcohol sales is significantly less. Given the evidence of the harm associated with alcohol use in Ireland, it is vital that a precise figure be determined to understand the financial burden alcohol use places on Irish society.

# 15

# Appendices

# Appendix 1 Alcohol-attributable conditions (HIPE)

| Acute conditions | | Chronic conditions | | Other chronic conditions | |
|---|---|---|---|---|---|
| ICD-10-AM code | Description | ICD-10-AM code | Description | ICD-10-AM code | Description |
| F10.0 | Mental and behavioural disorders due to use of alcohol, acute intoxication | E24.4 | Alcohol-induced pseudo-Cushing's syndrome | F10.1 | Mental and behavioural disorders due to use of alcohol, harmful use |
| T51.0 | Ethanol | G31.2 | Degeneration of nervous system due to alcohol | F10.2 | Mental and behavioural disorders due to use of alcohol, dependence syndrome |
| T51.1 | Methanol | G62.1 | Alcoholic polyneuropathy | F10.3 | Mental and behavioural disorders due to use of alcohol, withdrawal state |
| T51.2 | 2-Propanol | G72.1 | Alcoholic myopathy | F10.4 | Mental and behavioural disorders due to use of alcohol, withdrawal state with delirium |
| T51.3 | Fusel oil | I42.6 | Alcoholic cardiomyopathy | F10.5 | Mental and behavioural disorders due to use of alcohol, psychotic disorder |
| T51.8 | Other alcohols | K29.2 | Alcoholic gastritis | F10.6 | Mental and behavioural disorders due to use of alcohol, amnesic syndrome |
| T51.9 | Alcohol, unspecified | K70.0 | Alcoholic fatty liver | F10.7 | Mental and behavioural disorders due to use of alcohol, residual and late-onset psychotic disorder |

| Acute conditions | | Chronic conditions | | Other chronic conditions | |
|---|---|---|---|---|---|
| ICD-10-AM code | Description | ICD-10-AM code | Description | ICD-10-AM code | Description |
| X45 | Accidental poisoning by and exposure to alcohol | K70.1 | Alcoholic hepatitis | F10.8 | Mental and behavioural disorders due to use of alcohol, other mental and behavioural disorders |
| X65 | Intentional self-poisoning by and exposure to alcohol | K70.2 | Alcoholic fibrosis and sclerosis of liver | F10.9 | Mental and behavioural disorders due to use of alcohol, unspecified mental and behavioural disorder |
| Y15 | Poisoning by and exposure to alcohol, undetermined intent | K70.3 | Alcoholic cirrhosis of liver | Z50.2* | Alcohol rehabilitation |
| R78.0 | Finding of alcohol in blood | K70.4 | Alcoholic hepatic failure | Z71.4 | Alcohol abuse counselling and surveillance |
| Y90.0–Y90.9* | Evidence of alcohol involvement determined by blood alcohol level | K70.9 | Alcoholic liver disease, unspecified | Z72.1 | Problems related to lifestyle – alcohol |
| Y91.0*–Y91.9 | Evidence of alcohol involvement determined by level of intoxication | K86.0 | Alcohol-induced chronic pancreatitis | Z86.41 | Personal history of alcohol use disorder |
| | | K85.2 | Alcohol-induced acute pancreatitis | O35.4 | Maternal care for (suspected) damage to foetus from alcohol |
| | | | | I42.6 | Alcoholic cardiomyopathy |

*Following the change to the 10th edition of the ICD-10 AM for HIPE inpatient morbidity coding, the following codes were no longer used as of January 1st 2020:

Y90.9 Presence of alcohol in blood, level not specified

Y91.- Evidence of alcohol involvement determined by level of intoxication

Z50.2 Alcohol rehabilitation

# Appendix 2 ICD–10–AM codes for Hospital In-Patient Enquiry (HIPE) alcohol-related hospitalisations

| | Description |
|---|---|
| F10 | Mental and behavioural disorders due to use of alcohol |
| F10.0 | Mental and behavioural disorders due to use of alcohol, acute intoxication |
| F10.1 | Mental and behavioural disorders due to use of alcohol, harmful use |
| F10.2 | Mental and behavioural disorders due to use of alcohol, dependence syndrome |
| F10.3 | Mental and behavioural disorders due to use of alcohol, withdrawal state |
| F10.4 | Mental and behavioural disorders due to use of alcohol, withdrawal state with delirium |
| F10.5 | Mental and behavioural disorders due to use of alcohol, psychotic disorder |
| F10.6 | Mental and behavioural disorders due to use of alcohol, amnesic syndrome |
| F10.7 | Mental and behavioural disorders due to use of alcohol, residual and late-onset psychotic disorder |
| F10.8 | Mental and behavioural disorders due to use of alcohol, other mental and behavioural disorders |
| F10.9 | Mental and behavioural disorders due to use of alcohol, unspecified mental and behavioural disorder |
| G31.2 | Degeneration of nervous system due to alcohol |
| G62.1 | Alcoholic polyneuropathy |
| I42.6 | Alcoholic cardiomyopathy |
| K29.2 | Alcoholic gastritis |
| K29.20 | Alcoholic gastritis, without mention of haemorrhage |
| K29.21 | Alcoholic gastritis, with haemorrhage |
| K70 | Alcoholic liver disease |
| K70.0 | Alcoholic fatty liver |

| | Description |
|---|---|
| K70.1 | Alcoholic hepatitis |
| K70.2 | Alcoholic fibrosis and sclerosis of liver |
| K70.3 | Alcoholic cirrhosis of liver |
| K70.4 | Alcoholic hepatic failure |
| K70.9 | Alcoholic liver disease, unspecified |
| K86.0 | Alcohol-induced chronic pancreatitis |
| P04.3 | Fetus and newborn affected by maternal use of alcohol |
| Q86.0 | Fetal alcohol syndrome (dysmorphic) |
| T51 | Toxic effect of alcohol |
| T51.0 | Ethanol |
| T51.1 | Methanol |
| T51.2 | 2-Propanol |
| T51.3 | Fusel oil |
| T51.8 | Other alcohols |
| T51.9 | Alcohol, unspecified |
| X45 | Accidental poisoning by and exposure to alcohol |
| X65 | Intentional self-poisoning by and exposure to alcohol |
| Y15 | Poisoning by and exposure to alcohol, undetermined intent |

# References


1 WHO. WHO Alcohol Factsheet. https://www.who.int/news-room/fact-sheets/detail/alcohol#:~:text=Key%20facts,represents%205.3%25%20of%20all%20deaths. (accessed 22 Jun 2023).

2 Ipsos MRBI. THE 2019-20 Irish national drug and alcohol survey: technical report. Dublin: Health Research Board 2022. https://www.drugsandalcohol.ie/36492/

3 Ipsos MRBI. Healthy Ireland survey 2022: summary report. Dublin: Government of Ireland 2022. https://www.drugsandalcohol.ie/37636/

4 Doyle A, Sunday S, Galvin B, *et al*. Alcohol and other drug use among children and young people in Ireland: prevalence, risk and protective factors, consequences, responses, and policies. Dublin: Health Research Board 2022. https://www.drugsandalcohol.ie/36112/

5 North Dublin Regional Drug & Alcohol Task Force. 'Improving health outcomes by understanding the lived experiences of young people in North Dublin?: North Dublin risk and protective factors Planet Youth report 1. Dublin: Merlin Press 2022. https://www.drugsandalcohol.ie/36972/

6 Kabir Z, Gilheany S, McKinney E, *et al*. Global burden of disease: estimates of alcohol use and attributable burden in Ireland. What the data tell us and what we need to do to address the burden of alcohol. Dublin: Alcohol Action Ireland; UCC School of Public Health 2022. https://www.drugsandalcohol.ie/35733/

7 Global Burden of Disease (GBD). https://www.healthdata.org/gbd

8 Central Statistics Office. Population and Migration Estimates April 2022. Cork: Central Statistics Office 2022. https://www.cso.ie/en/releasesandpublications/ep/p-pme/populationandmigrationestimatesapril2022/

9 Central Statistics Office. Census 2016 Profile 3 - An Age Profile of Ireland. Cork: Central Statistics Office (CSO) 2017. https://www.cso.ie/en/csolatestnews/presspages/2017/census2016profile3-anageprofileofireland/

10 Central Statistic Office. CSO population 2022 Census. https://www.cso.ie/en/statistics/population/censusofpopulation2022/censusofpopulation2022-summaryresults/ (accessed 4 Jul 2023).

11 World Health Organization. Unrecorded alcohol: what the evidence tells us. Geneva: World Health Organization 2021. https://www.drugsandalcohol.ie/36053/

12 Manthey J, Braddick F, Lopez-Pelayo H, *et al*. Unrecorded alcohol use in 33 European countries: analyses of a comparative survey with 49,000 people who use alcohol. *International Journal of Drug Policy* 2023;**116**:104028. https://www.drugsandalcohol.ie/38718/

13 OECD data. Alcohol consumption. 2022. OECD (2023), Alcohol consumption (indicator). doi: 10.1787/e6895909-en (Accessed on 07 September 2023)

14 OECD. Health at a Glance 2021. 2021. doi:https://doi.org/https://doi.org/10.1787/ae3016b9-en

15 Doyle A. Decline in alcohol use among young people: potential consequences for public health policy, legislation, and discourse. *Drugnet Ireland* 2022;**Issue 82, Summer 2022**:10–3. https://www.drugsandalcohol.ie/37095/

16 Drinks Ireland. Irish beer market report 2022. Dublin: Drinks Ireland 2023. https://www.drugsandalcohol.ie/39113/

17 Drinks Ireland. Irish spirits market report 2022. Dublin: Drinks Ireland 2023. https://www.drugsandalcohol.ie/39449/

18 Griswold MG, Fullman N, Hawley C, *et al*. Alcohol use and burden for 195 countries and territories, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016. *The Lancet* 2018;**392**:1015–35.

19 Anderson BO, Berdzuli N, Ilbawi A, *et al*. Health and cancer risks associated with low levels of alcohol consumption. *The Lancet Public Health 2023*;**8**:e6–7. https://www.drugsandalcohol.ie/37891/

20 GBD 2020 Alcohol Collaborators. Population-level risks of alcohol consumption by amount, geography, age, sex, and year: a systematic analysis for the Global Burden of Disease Study 2020. *The Lancet* 2022;**400**. https://www.drugsandalcohol.ie/36626/

21 Furtwængler NA, de Visser RO. Lack of international consensus in low-risk drinking guidelines. *Drug and alcohol review* 2013;**32**:11–8.

22 World Health Organization. Global alcohol action plan 2022-2030 to strengthen implementation of the global strategy to reduce the harmful use of alcohol. First draft. Geneva: World Health Organization 2021. https://www.drugsandalcohol.ie/34429/

23 Mongan D, Long J. Standard drink measures in Europe. Peoples' understanding of standard drinks and their use in drinking guidelines, alcohol surveys and labelling. Lisbon: RARHA 2015. https://www.drugsandalcohol.ie/30419/

24 Office of the Attorney General. Public Health (Alcohol) Act. Dublin: Irish Statute Book 2018. https://www.drugsandalcohol.ie/33698/

25 Long J, Mongan D. Alcohol consumption in Ireland 2013: analysis of a national alcohol diary survey. Dublin: Health Research Board 2014. https://www.drugsandalcohol.ie/22138/

26 Paradis C, Butt P, Shield K, *et al*. Canada's guidance on alcohol and health: final report. Ottawa: Canadian Centre on Substance Use and Addiction 2023. https://www.drugsandalcohol.ie/37947/

27 Shield K, Paradis C, Butt P, *et al*. New perspectives on how to formulate alcohol drinking guidelines. *Addiction* 2023.

28 Health Service Executive. HSE Weekly low-risk alcohol guidelines. https://www2.hse.ie/wellbeing/alcohol/improve-your-health/weekly-low-risk-alcohol-guidelines.html (accessed 10 Oct 2022).

29 O'Dwyer C, Mongan D, Doyle A, *et al*. Alcohol consumption, alcohol-related harm and alcohol policy in Ireland. Dublin: Health Research Board 2021. https://www.drugsandalcohol.ie/33909/

30 European Commission K. National low-risk drinking recommendations (or drinking guidelines) and standard units. https://knowledge4policy.ec.europa.eu/health-promotion-knowledge-gateway/national-low-risk-drinking-recommendations-drinking-guidelines_en

31 Aalto M, Alho H, Halme JT, *et al*. AUDIT and its abbreviated versions in detecting heavy and binge drinking in a general population survey. *Drug and alcohol dependence* 2009;**103**:25–9.

32 Bradley KA, DeBenedetti AF, Volk RJ, *et al*. AUDIT-C as a brief screen for alcohol misuse in primary care. *Alcoholism: Clinical and Experimental Research* 2007;**31**:1208–17.

33 Mongan D, Millar S, Galvin B. The 2019–20 Irish National Drug and Alcohol Survey: main findings. Dublin: Health Research Board 2021. https://www.drugsandalcohol.ie/34287/

34 Ipsos B&A. Healthy Ireland survey 2023 - summary report. Dublin: Healthy Ireland, Department of Health 2023. https://www.drugsandalcohol.ie/39977/

35 Ipsos MRBI. Healthy Ireland survey 2018 summary of findings. Dublin: Government Publications 2018. https://www.drugsandalcohol.ie/29851/

36 Haase T, Pratschke J. The 2016 Pobal HP Deprivation Index. Dublin: Pobal, 2017. www.trutzhaase.eu (accessed 7 Sep 2022).

37 Carbia C, Garcia-Cabrerizo R, Cryan JF, *et al*. Associations between mental health, alcohol consumption and drinking motives during COVID-19-second lockdown in Ireland. *Alcohol and Alcoholism* 2022;**57**:211–8. https://www.drugsandalcohol.ie/35897/

38 Central Statistics Office. Social Impact of COVID-19 Survey April 2020. Central Statistics Office 2020. https://www.cso.ie/en/releasesandpublications/ep/p-covid19/covid-19informationhub/socialandwellbeing/socialimpactofcovid-19survey/

39 Department of Health. Healthy Ireland survey 2017 summary of findings. Dublin: Stationery Office 2017. https://www.drugsandalcohol.ie/28041/

40 Ipsos MRBI. Healthy Ireland Survey 2016: summary of findings. Dublin: Stationery Office 2016. https://www.drugsandalcohol.ie/26278/

41 Ipsos MRBI. Healthy Ireland survey 2021 summary of findings. Dublin: Department of Health 2021. https://www.drugsandalcohol.ie/35296/

42 Ipsos MRBI. Healthy Ireland survey 2021 summary of findings. Dublin: Department of Health 2021. https://www.drugsandalcohol.ie/35296/

43 Yap MB, Cheong TW, Zaravinos-Tsakos F, *et al*. Modifiable parenting factors associated with adolescent alcohol misuse: a systematic review and meta-analysis of longitudinal studies. *Addiction* 2017;**112**:1142–62.

44 Bryant L, MacKintosh AM, Bauld L. An exploration of the impact of non-dependent parental drinking on children. *Alcohol and alcoholism* 2020;**55**:121–7.

45 Rajkumar RP. COVID-19 and mental health: A review of the existing literature. *Asian journal of psychiatry* 2020;**52**:102066.

46 Reynolds CM, Purdy J, Rodriguez L, *et al*. Factors associated with changes in consumption among smokers and alcohol drinkers during the COVID-19 'lockdown' period. *European Journal of Public Health* 2021;**31**:1084–9. https://www.drugsandalcohol.ie/34071/

47 Troya MI, Joyce M, Khashan A, *et al*. Mental health following an initial period of COVID-19 restrictions: findings from a cross-sectional survey in the Republic of Ireland. *HRB Open Research* 2021;**4**:130. https://www.drugsandalcohol.ie/39461/

48 Ewing SWF, Sakhardande A, Blakemore S-J. The effect of alcohol consumption on the adolescent brain: A systematic review of MRI and fMRI studies of alcohol-using youth. *NeuroImage: Clinical* 2014;**5**:420–37.

49 World Health Organization. Global strategy to reduce the harmful use of alcohol. Geneva: World Health Organization 2010. https://www.drugsandalcohol.ie/14845/

50 National Advisory Committee on Drugs, Drug and Alcohol Information and Research Unit. Drug use in Ireland and Northern Ireland. Alcohol consumption and alcohol-related harm in Ireland 2010/2011 drug prevalence survey. Bulletin 7. Dublin: National Advisory Committee on Drugs & Public Health Information and Research Branch 2012. https://www.drugsandalcohol.ie/18439/

51 Western Region Drug and Alcohol Task Force, Planet Youth. Growing up in the West. The lives of our young people. Planet Youth county report Galway 2022. Galway: WRDATF 2023. https://www.drugsandalcohol.ie/38816/

52 The American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (DSM–5). The American Psychiatric Association. 2013.

53 World Health Organization. Tackling NCDs: 'best buys' and other recommended interventions for the prevention and control of noncommunicable diseases. Geneva: World Health Organization 2017. https://www.drugsandalcohol.ie/37100/

54 Ireland. Department of Justice. General Scheme: Sale of Alcohol Bill 2022. Dublin: Government of Ireland 2022. https://www.drugsandalcohol.ie/37347/

55 Revenue, Irish Tax and Customs. Revenue Irish Tax and Customs - Excise Licences. https://www.revenue.ie/en/corporate/information-about-revenue/statistics/excise/licences/excise-licences.aspx (accessed 19 Oct 2022).

56 Joint Committee on Justice. Report on pre-legislative scrutiny of the General Scheme of the Sale of Alcohol Bill 2022. Dublin: Joint Committee on Justice 2023. https://www.drugsandalcohol.ie/38312/

57 Open Street Map. openstreetmap.org. https://www.openstreetmap.org/ (accessed 6 Nov 2023).

58 GeoDirectory. GeoDirectory - address mapping. https://www.geodirectory.ie/

59 Doyle A, Houghton F. Alcohol availability and accessibility around schools in Ireland: an examination of liquor licences proximity. Irish Journal of Medical Science Published Online First: 7 September 2023. https://www.drugsandalcohol.ie/39528/

60 WHO Regional Office for Europe. Making the European region safer: developments in alcohol control policies, 2010–2019. Copenhagen: WHO Regional Office for Europe 2021. https://www.drugsandalcohol.ie/34060/

61 Freisthler B, Wernekinck U. Examining how the geographic availability of alcohol within residential neighborhoods, activity spaces, and destination nodes is related to alcohol use by parents of young children. *Drug and alcohol dependence* 2022;**233**:109352.

62 Heather N, Stockwell T. *The essential handbook of treatment and prevention of alcohol problems*. John Wiley & Sons 2004.

63 Chen M-J, Gruenewald PJ, Remer LG. Does alcohol outlet density affect youth access to alcohol? *Journal of Adolescent Health* 2009;**44**:582–9.

64 Azar D, White V, Coomber K, *et al*. The association between alcohol outlet density and alcohol use among urban and regional Australian adolescents. *Addiction* 2016;**111**:65–72.

65 Ross CS, Maple E, Siegel M, *et al*. The relationship between population-level exposure to alcohol advertising on television and brand-specific consumption among underage youth in the US. *Alcohol and Alcoholism* 2015;**50**:358–64.

66 Richardson E, Hill S, Mitchell R, *et al*. Is local alcohol outlet density related to alcohol-related morbidity and mortality in Scottish cities? *Health & place* 2015;**33**:172–80.

67 Zhu L, Gorman DM, Horel S. Alcohol Outlet Density and Violence: A Geospatial analysis. *Alcohol and Alcoholism* 2004;**39**:369–75. doi:10.1093/alcalc/agh062

68 Livingston M. A longitudinal analysis of alcohol outlet density and domestic violence. *Addiction* 2011;**106**:919–25.

69 Taylor N, Livingston M, Coomber K, *et al*. The combined impact of higher-risk on-license venue outlet density and trading hours on serious assaults in night-time entertainment precincts. *Drug and alcohol dependence* 2021;**223**:108720.

70 Rowland B, Toumbourou JW, Livingston M. The association of alcohol outlet density with illegal underage adolescent purchasing of alcohol. *Journal of Adolescent Health* 2015;**56**:146–52.

71 Martins JG, Guimarães MO, Jorge KO, *et al*. Binge drinking, alcohol outlet density and associated factors: a multilevel analysis among adolescents in Belo Horizonte, Minas Gerais State, Brazil. *Cadernos de Saúde Pública* 2019;**36**:e00052119.

72 Wang S, Chen Y, Huang J, *et al*. Spatial relationships between alcohol outlet densities and drunk driving crashes: an empirical study of Tianjin in China. *Journal of Safety Research* 2020;**74**:17–25.

73 Sherk A, Stockwell T, Chikritzhs T, *et al*. Alcohol consumption and the physical availability of take-away alcohol: systematic reviews and meta-analyses of the days and hours of sale and outlet density. *Journal of studies on alcohol and drugs* 2018;**79**:58–67.

74 World Health Organization. Tackling NCDs: 'best buys' and other recommended interventions for the prevention and control of noncommunicable diseases. Geneva: World Health Organization 2017. https://www.drugsandalcohol.ie/37100/

75 Babor TF, Casswell S, Graham K, *et al. Alcohol: no ordinary commodity: research and public policy.* Oxford University Press 2022. https://www.drugsandalcohol.ie/37638/

76 Manthey J, Jasilionis D, Jiang H, *et al*. The impact of alcohol taxation increase on all-cause mortality inequalities in Lithuania: an interrupted time series analysis. *BMC medicine* 2023;**21**:22.

77 EuroStat. Final consumption expenditure of households by consumption purpose - Alcoholic beverages. https://ec.europa.eu/eurostat/databrowser/view/NAMA_10_CO3_P3__custom_7561599/default/table?lang=en

78 Central Statistics Office. Household Budget Survey. CSO Household Budget Survey. 2016. https://data.cso.ie/product/HBS

79 Central Statistics Office. Standard Report on Methods and Quality for Household Budget Survey. Standard Report on Methods and Quality for Household Budget Surve. https://www.cso.ie/en/media/csoie/methods/householdbudgetsurvey/PR_500169_HBS_Quality_Report_v1.0.pdf

80 Central Statistics Office. Central Statistics Office Consumer Price Index. CSO CPI. https://data.cso.ie/table/CPM12 (accessed 30 Jun 2023).

81 Angus C. Analysis of changes in alcohol prices, taxation and affordability in the Republic of Ireland. Dublin: Alcohol Action Ireland 2023. https://www.drugsandalcohol.ie/39136/

82 Lehto J. The economics of alcohol. *Addiction* 1997;**92**:S55–9.

83 Stockwell T, Zhao J, Clay J, *et al*. Why do only some cohort studies find health benefits from low volume alcohol use? A systematic review and meta-analysis of study characteristics that may bias mortality risk estimates. *Journal of studies on alcohol and drugs* 2024;:jsad-23.

84 Murray CJL, Aravkin AY, Zheng P, *et al*. Global burden of 87 risk factors in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019. *The Lancet* 2020;**396**:1223–49. doi:10.1016/S0140-6736(20)30752-2

85 World Health Organization. World Health Organization ICD-10. 2019. https://icd.who.int/browse10/2019/en

86 Rehm J, Gmel Sr GE, Gmel G, *et al*. The relationship between different dimensions of alcohol use and the burden of disease—an update. *Addiction* 2017;**112**:968–1001.

87 Rehm J, Greenfield TK, Rogers JD. Average volume of alcohol consumption, patterns of drinking, and all-cause mortality: results from the US National Alcohol Survey. *American Journal of Epidemiology* 2001;**153**:64–71.

88 National Cancer Registry I. Modifiable risk factors and cancer in Ireland. Dublin: National Cancer Registry 2020. https://www.drugsandalcohol.ie/33135/

89 Shield KD, Soerjomataram I, Rehm J. Alcohol use and breast cancer: a critical review. *Alcoholism: Clinical and Experimental Research* 2016;**40**:1166–81.

90 McNicholl B, Goggin D, O'Donovan D. Alcohol-related presentations to emergency departments in Ireland: a descriptive prevalence study. *BMJ Open* 2018;**8**. https://www.drugsandalcohol.ie/29070/

91 Maharaj T, Fitzgerald N, Gilligan E, *et al*. Alcohol-related emergency department presentations and hospital admissions around the time of minimum unit pricing in Ireland. *Public Health* 2024;**227**:38–41. https://www.drugsandalcohol.ie/40186/

92 Healthcare Pricing Office, Health Service Executive. Activity of acute public hospitals in Ireland 2021 annual report. Dublin: Health Service Executive 2022. https://www.drugsandalcohol.ie/37578/

93 O'Dwyer C, Mongan D, Millar S, *et al*. Drinking patterns and the distribution of alcohol-related harms in Ireland: evidence for the prevention paradox. *BMC Public Health* 2019;**19**. https://www.drugsandalcohol.ie/31239/

94 Ireland. Department of Health,. Health in Ireland key trends 2022. Dublin: https://www.drugsandalcohol.ie/37620/

95 Armstrong PR, Ring E, MacNicholas R. A decade of rising alcoholic liver disease hospital admissions and deaths in Irish hospitals, 2007-2016: a retrospective cross-sectional analysis. *European Journal of Gastroenterology & Hepatology* 2022;**34**:671–7. https://www.drugsandalcohol.ie/35445/

96 Hope A, Gill A, Costello G, *et al*. Alcohol and injuries in the accident and emergency department: a national perspective. Dublin: Health Promotion Unit, Department of Health and Children 2005. https://www.drugsandalcohol.ie/6006/

97 Hannon MJ, Luke L. The burden of alcohol misuse on the emergency department. *Irish Medical Journal* 2006;**99**:118–20. https://www.drugsandalcohol.ie/6966/

98 Subramanian Y, Barrett J, Kim S, *et al*. A comparison of daytime and out of hour mental health presentations to Beaumont Hospital Emergency Department between 2018 and 2020. Irish Journal of Medical Science Published Online First: 2 January 2023. https://www.drugsandalcohol.ie/37862/

99 Eogan M. National Sexual Assault Treatment Unit (SATU) annual report 2022. Dublin: National Sexual Assault Treatment Unit 2023. https://www.drugsandalcohol.ie/39255/

100 Eogan M. National Sexual Assault Treatment Unit (SATU) annual report 2021. Dublin: National Sexual Assault Treatment Unit 2022. https://www.drugsandalcohol.ie/36786/

101 Scurich N. Introduction to this special issue: Underreporting of sexual abuse. *Behavioral Sciences & the Law* 2020;**38**:537–656.

102 Burke L, Dawson K, Flack WF, *et al*. Alcohol, drug use and experiences of sexual violence victimisation among first-year college students in Ireland. *Journal of Sexual Aggression* 2023;**Early online**. https://www.drugsandalcohol.ie/38997/

103 MacNeela P, Dawson K, O'Rourke T, *et al*. Surveys of experiences of sexual violence and harassment in higher education: reports and findings. Dublin: Higher Education Authority 2022. https://www.drugsandalcohol.ie/35563/

104 Felitti VJ, Anda RF, Nordenberg D, *et al*. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American journal of preventive medicine* 1998;**14**:245–58.

105 Alcohol Action Ireland. Silent Voices manifesto. Dublin: Alcohol Action Ireland 2019. https://www.drugsandalcohol.ie/31465/

106 Feeney M, Lambert S. Understanding the views of professionals of the impact of parental problem alcohol use on clients. Dublin: Alcohol Action Ireland 2022. https://www.drugsandalcohol.ie/37305/

107 Popova S, Charness ME, Burd L, *et al*. Fetal alcohol spectrum disorders. *Nature Reviews Disease Primers* 2023;**9**:11.

108 Popova S, Lange S, Probst C, *et al*. Global prevalence of alcohol use and binge drinking during pregnancy, and fetal alcohol spectrum disorder. *Biochemistry and Cell Biology* 2018;**96**:237–40.

109 Murphy M, McHugh S, O'Keeffe LM, *et al*. Preventive health counselling during antenatal care using the pregnancy risk assessment monitoring system (PRAMS) in Ireland. *BMC pregnancy and childbirth* 2020;**20**:1–10.

110 O'Keefe LM, Kearney PM, McCarthy FP, *et al*. Prevalence and predictors of alcohol use during pregnancy: findings from international multicentre cohort studies. *BMJ Open* 2015;**5**. https://www.drugsandalcohol.ie/24224/

111 Manca F, Lewsey J, Waterson R, *et al*. Estimating the burden of alcohol on ambulance callouts through development and validation of an algorithm using electronic patient records. *International journal of environmental research and public health* 2021;**18**:6363.

112 Martin N, Newbury-Birch D, Duckett J, *et al*. A retrospective analysis of the nature, extent and cost of alcohol-related emergency calls to the ambulance service in an English region. *Alcohol and alcoholism* 2012;**47**:191–7.

113 Byrne S. Costs to society of problem alcohol use in Ireland: a report for the Health Service Executive. 2010.

114 Alcohol Action Ireland. Alcohol Action Ireland pre-budget submission: 2024. Dublin: Alcohol Action Ireland 2023. https://www.drugsandalcohol.ie/36713/

115 Jane-Llopis E, Matytsina I. Mental health and alcohol, drugs and tobacco: a review of the comorbidity between mental disorders and the use of alcohol, tobacco and illicit drugs. *Drug and alcohol review* 2006;**25**:515–36.

116 World Health Organization. World health statistics 2021: monitoring health for the SDGs, sustainable development goals. Geneva: World Health Organization 2021. https://www.drugsandalcohol.ie/34223/

117 Central Statistics Office. Suicide Statistics 2019. https://www.cso.ie/en/releasesandpublications/ep/p-ss/suicidestatistics2019/

118 Eurostat. Suicide rate by age group. European Commision 2019. https://ec.europa.eu/eurostat/web/products-datasets/product?code=tps00202

119 Larkin C, Griffin E, Corcoran P, *et al*. Alcohol involvement in suicide and self-harm. *Crisis* 2017;**38**:413–22. https://www.drugsandalcohol.ie/28375/

120 Conner KR, Bagge CL. Suicidal behavior: links between alcohol use disorder and acute use of alcohol. *Alcohol Research: Current Reviews* 2019;**40**. https://www.drugsandalcohol.ie/32326/

121 Amiri S, Behnezhad S. Alcohol use and risk of suicide: a systematic review and Meta-analysis. *Journal of addictive diseases* 2020;**38**:200–13.

122 Isaacs JY, Smith MM, Sherry SB, *et al*. Alcohol use and death by suicide: A meta-analysis of 33 studies. *Suicide and Life-Threatening Behavior* 2022;**52**:600–14.

123 Ireland. Department of Health, Health Service Executive, National Office for Suicide Prevention. Connecting for life. Ireland's National Strategy to Reduce Suicide 2015-2020. Dublin: Department of Health 2015. https://www.drugsandalcohol.ie/24167/

124 Cox G, Munnelly A, Rochford S, *et al*. Irish probable suicide deaths study - IPSDS 2015-2018. Dublin: HSE National Office for Suicide Prevention 2022. https://www.drugsandalcohol.ie/37546/

125 Joyce M, Chakraborty S, O'Sullivan G, *et al*. National Self-Harm Registry Ireland annual report 2020. Cork: National Suicide Research Foundation 2022. https://www.drugsandalcohol.ie/37441/

126 Sadath A, Troya MI, Nicholson S, *et al*. Physical and mental illness comorbidity among individuals with frequent self-harm episodes: a mixed-methods study. *Frontiers in Psychiatry* 2023;**14**. https://www.drugsandalcohol.ie/38368/

127 National Suicide Research Foundation, Irish Prison Service. Self-harm in Irish prisons 2019: Third report from the Self-Harm Assessment and Data Analysis (SADA) project. Longford: Irish Prison Service 2021. https://www.drugsandalcohol.ie/34047/

128 Gulati G, Keating N, O'Neill A, *et al*. The prevalence of major mental illness, substance misuse and homelessness in Irish prisoners: systematic review and meta-analyses. *Irish Journal of Psychological Medicine* 2019;**36**:35–45. https://www.drugsandalcohol.ie/29009/

129 Arensman E, Scott V, De Leo D, *et al*. Suicide and suicide prevention from a global perspective. Crisis 2020.

130 Kõlves K, Kõlves KE, De Leo D. Natural disasters and suicidal behaviours: a systematic literature review. *Journal of affective disorders* 2013;**146**:1–14.

131 Wasserman D, Iosue M, Wuestefeld A, *et al*. Adaptation of evidence-based suicide prevention strategies during and after the COVID-19 pandemic. *World psychiatry* 2020;**19**:294–306.

132 Mongan D, Long J. Alcohol in Ireland: consumption, harm, cost and policy response. Dublin: Health Research Board 2016. https://www.drugsandalcohol.ie/25697/

133 Room R, Rossow I. The share of violence attributable to drinking. *Journal of Substance Use* 2001;**6**:218–28. doi:10.1080/146598901753325048

134 Klingemann H, Gmel G. *Mapping the social consequences of alcohol consumption*. Springer 2001.

135 Mongan D, Long J. Alcohol in Ireland: consumption, harm, cost and policy response. Dublin: Health Research Board 2016. https://www.drugsandalcohol.ie/25697/

136 Mongan D, Hope A, Nelson M, *et al*. Social consequences of harmful use of alcohol in Ireland. HRB Overview series 9. Dublin: Health Research Board 2009. https://www.drugsandalcohol.ie/12653/

137 University College Dublin. Institute of Criminology. Public order offences in Ireland: a report by the Institute of Criminology, Faculty of Law, University College Dublin for the National Crime Council. Dublin: Stationery Office 2003. https://www.drugsandalcohol.ie/5437/

138 O'Donnell I. Violence and social change in the Republic of Ireland. *International Journal of the Sociology of Law* 2005;**33**:101–17. https://www.drugsandalcohol.ie/12671/

139 CSO. CSO PULSE recorded crime statistics. https://data.cso.ie/product/rc

140 Medical Bureau of Road Safety. Medical Bureau of Road Safety annual report 2022. Dublin: Medical Bureau of Road Safety 2023. https://www.drugsandalcohol.ie/39589/

141 Doyle A. Regional alcohol-related harm - County level factsheet. Published Online First: 1 August 2023. https://www.drugsandalcohol.ie/39285/

142 Nepal S, Kypri K, Attia J, *et al*. Indicators for estimating trends in alcohol-related assault: Evaluation using police data from Queensland, Australia. *Injury prevention* 2019;**25**:444–7.

143 Probation Service. Probation Service annual report 2021. Dublin: Probation Service 2022. https://www.drugsandalcohol.ie/37013/

144 Rooney L. Informing & supporting change: drug and alcohol misuse among people on probation supervision in Ireland. Dublin: Probation Service 2021. https://www.drugsandalcohol.ie/35133/

145 Mongan D, Millar SR, Doyle A, *et al*. Gambling in the Republic of Ireland. Results from the 2019-20 National Drug and Alcohol Survey. Dublin: Health Research Board 2022. https://www.drugsandalcohol.ie/35305/

146 American Psychiatric Association. *Diagnostic and statistical manual of mental disorders : DSM-IV-TR*. American Psychiatric Publishing, Inc 2000.

147 Dowling NA, Cowlishaw S, Jackson AC, *et al*. Prevalence of psychiatric co-morbidity in treatment-seeking problem gamblers: A systematic review and meta-analysis. *Australian & New Zealand Journal of Psychiatry* 2015;**49**:519–39.

148 Columb D, O'Gara C. A national survey of online gambling behaviours. *Irish Journal of Psychological Medicine* 2018;**35**:311–9. https://www.drugsandalcohol.ie/28197/

149 Fulton C. Playing social roulette: the impact of gambling on individuals and society in Ireland. Dublin: Department of Social Protection 2015. https://www.drugsandalcohol.ie/24295/

150 O' Ceallaigh D, Timmons S, Robertson D, *et al*. Measures of problem gambling, gambling behaviours and perceptions of gambling in Ireland. Dublin: ESRI 2023. https://www.drugsandalcohol.ie/39671/

151 Condron I, Lyons S, Carew AM. Gambling in Ireland: profile of treatment episodes from a national treatment reporting system. *Irish Journal of Psychological Medicine* 2022;**Early online**:1–8. https://www.drugsandalcohol.ie/36419/

152 Angus C, Buckley C, Tilstra AM, *et al*. Increases in 'deaths of despair'during the COVID-19 pandemic in the United States and the United Kingdom. *Public health* 2023;**218**:92–6.

153 Martin J, Barry J, Goggin D, *et al*. Alcohol-attributable mortality in Ireland. *Alcohol and Alcoholism* 2010;**45**:379–86. https://www.drugsandalcohol.ie/13232/

154 Global Burden of Disease interactive Visualisation Hub. https://vizhub.healthdata.org/gbd-compare/ (accessed 4 Jul 2023).

155 Health Research Board. Health Research Board reports latest drug-related deaths figures. Published Online First: 24 June 2023. https://www.drugsandalcohol.ie/39036/

156 Road Safety Authority. Road deaths and alcohol 2013-2017. Dublin: Road Safety Authority 2020. https://www.drugsandalcohol.ie/33937/

157 Ivers J-HH, Zgaga L, O'Donoghue-Hynes B, *et al*. Five-year standardised mortality ratios in a cohort of homeless people in Dublin. *BMJ Open* 2019;**9**. https://www.drugsandalcohol.ie/30198/

158 Lynn E, Devin J, Craig S, *et al*. Deaths among people who were homeless at time of death in Ireland, 2019. Dublin: Health Research Board 2023. https://www.drugsandalcohol.ie/38793/

159 National Drug Treatment Reporting System. National Drug Treatment Reporting System 2012-2018 Alcohol data. Dublin: Health Research Board 2019.

160 O'Neill D, Carew AM, Lyons S. National Drug Treatment Reporting System 2014 – 2020 alcohol treatment data. Dublin: Health Research Board 2021. https://www.drugsandalcohol.ie/34164/

161 Condron I, Lyons S, Carew AM. National Drug Treatment Reporting System: 2022 alcohol treatment demand. Dublin: Health Research Board 2023. https://www.drugsandalcohol.ie/38799/

162 Central Statistics Office. Central Statistics Office, Population and Migration Estimates, April 2021. https://www.cso.ie/en/releasesandpublications/ep/p-pme/populationandmigrationestimatesapril2021/

163 Alcohol Action Ireland. Alcohol treatment services: a snapshot survey 2021. Dublin: Alcohol Action Ireland 2021. https://www.drugsandalcohol.ie/34359/

164 Ivers J-H, Giulini F, Paul G. Supporting women to access appropriate treatment study. Dublin: Trinity College Dublin 2021. https://www.drugsandalcohol.ie/34462/

165 McSweeney A, Lambert S. A thematic analysis of the roles and experiences of professionals in supporting individuals who require treatment for alcohol dependence. Cork: University College Cork 2022. https://www.drugsandalcohol.ie/36432/

166 Azagba S, Shan L, Qeadan F, *et al*. Unemployment rate, opioids misuse and other substance abuse: Quasi-experimental evidence from treatment admissions data. *BMC psychiatry* 2021;**21**:1–9.

167 Central Statistic Office. CSO. Census of Population 2016—Profile 11 Employment, Occupations and Industry; Central Statistics Office: Dublin, Ireland, 2016. Available online: https://www.cso.ie/en/releasesandpublications/ep/p-cp11eoi/cp11eoi/ioscs (accessed 26 Sep 2023).

168 MacAskill S, Parkes T, Brooks O, *et al*. Assessment of alcohol problems using AUDIT in a prison setting: more than an'aye or no'question. *BMC Public Health* 2011;**11**:1–12.

169 World Health Organization. Addressing the noncommunicable disease (NCD) burden in prisons in the WHO European Region: interventions and policy options. World Health Organization. Regional Office for Europe 2022.

170 O'Neill D, Lyons S, Carew AM. National Drug Treatment Reporting System: 2022 drug treatment demand. Dublin: Health Research Board 2023. https://www.drugsandalcohol.ie/38794/

171 Copello AG, Velleman RD, Templeton LJ. Family interventions in the treatment of alcohol and drug problems. *Drug and alcohol review* 2005;**24**:369–85.

172 Collins P, Carew AM, Craig S, *et al*. Analysis of the relationship between addiction treatment data and geographic deprivation in Ireland. *Drugnet Ireland* 2023;**Issue 84, Winter 2023, insert**:6–13. https://www.drugsandalcohol.ie/38474/

173 Expert Group on Mental Health Policy. A vision for change: report of the Expert Group on Mental Health Policy. Dublin: Stationery Office 2006. https://www.drugsandalcohol.ie/6154/

174 Department of Health. Sharing the vision: a mental health policy for everyone. Dublin: Government of Ireland 2020. https://www.drugsandalcohol.ie/32228/

175 Daly A, Lynn E. National Psychiatric Inpatient Reporting System (NPIRS) annual report on the activities of Irish psychiatric units and hospitals, 2022. Dublin: Health Research Board 2023. https://www.drugsandalcohol.ie/39109/

176 Daly A, Craig S. Annual report on the activities of Irish psychiatric units and hospitals 2021. Dublin: Health Research Board 2022. https://www.drugsandalcohol.ie/37218/

177 Sinnott S-J, Bennett K, Cahir C. Pharmacoepidemiology resources in Ireland—an

introduction to pharmacy claims data. *European journal of clinical pharmacology* 2017;**73**:1449–55.

178 Mason BJ, Heyser CJ. Alcohol use disorder: the role of medication in recovery. *Alcohol Research: Current Reviews* 2021;**41**.

179 Abraham AJ, Andrews CM, Harris SJ, *et al*. Availability of medications for the treatment of alcohol and opioid use disorder in the USA. *Neurotherapeutics* 2020;**17**:55–69.

180 Littleton J, Zieglgänsberger W. Pharmacological mechanisms of naltrexone and acamprosate in the prevention of relapse in alcohol dependence. *The American journal on addictions* 2003;**12**:s3–11.

181 Fitzgerald N, Angus K, Elders A, *et al*. Weak evidence on nalmefene creates dilemmas for clinicians and poses questions for regulators and researchers. *Addiction* 2016;**111**:1477–87.

182 Palpacuer C, Laviolle B, Boussageon R, *et al*. Risks and benefits of nalmefene in the treatment of adult alcohol dependence: a systematic literature review and meta-analysis of published and unpublished double-blind randomized controlled trials. *PLoS medicine* 2015;12:e1001924.

183 Department of Health. Steering Group Report on a National substance misuse strategy. Dublin: Department of Health 2012. https://www.drugsandalcohol.ie/16908/

184 WHO Regional Office for Europe. Alcohol pricing in the WHO European Region. Update report on the evidence and recommended policy actions. Copenhagan: World Health Organization 2020. https://www.drugsandalcohol.ie/32286/

185 World Health Organization Regional Office for Europe. No place for cheap alcohol: the potential value of minimum pricing for protecting lives. Copenhagen: World Health Organization Regional Office for Europe 2022. https://www.drugsandalcohol.ie/36494/

186 Ferguson K, Giles L, Beeston C. Evaluating the impact of MUP on alcohol products and prices. Edinburgh: Public Health Scotland 2022. https://www.drugsandalcohol.ie/37474/

187 Duffy JC, Snowdon C, Tovey M. The hangover. The cost of minimum alcohol pricing in Scotland. London: Institute of Economic Affairs 2022. https://www.drugsandalcohol.ie/36197/

188 Wyper GMA, Mackay DF, Fraser C, *et al*. Evaluating the impact of alcohol minimum unit pricing on deaths and hospitalisations in Scotland: a controlled interrupted time series study. *The Lancet* 2023;**401**:1361–70. https://www.drugsandalcohol.ie/38411/

189 Rehm J, O'Donnell A, Kaner EF, *et al*. Differential impact of minimum unit pricing on alcohol consumption between Scottish men and women: controlled interrupted time series analysis. *BMJ Open* 2022;**12**:e054161. https://www.drugsandalcohol.ie/36643/

190 Anderson P, O'Donnell A, Kaner E, *et al*. Impact of minimum unit pricing on alcohol purchases in Scotland and Wales: controlled interrupted time series analyses. *The Lancet Public Health* 2021;**6**:E557–65. https://www.drugsandalcohol.ie/34251/

191 Dimova ED, Strachan H, Johnsen S, *et al*. Alcohol minimum unit pricing and people experiencing homelessness: a qualitative study of stakeholders' perspectives and experiences. *Drug and Alcohol Review* 2022;**Early online**. https://www.drugsandalcohol.ie/37215/

192 Holmes J, Angus C, Boyd J, *et al*. Evaluating the impact of Minimum Unit Pricing in Scotland on people who are drinking at harmful levels. Edinburgh: Public Health Scotland 2022. https://www.drugsandalcohol.ie/36398/

193 Francesconi M, James J. Alcohol price floors and externalities: the case of fatal road crashes. *Journal of Policy Analysis and Management* 2022;**Early online**. https://www.drugsandalcohol.ie/37307/

194 So V, Millard AD, Katikireddi SV, *et al*. Intended and unintended consequences of the implementation of minimum unit pricing of alcohol in Scotland: a natural experiment. *Public Health Research* 2021;**9**. https://www.drugsandalcohol.ie/35025/

195 Chung Patterson H, Beeston C, McQueenie R, *et al*. Evaluating the impact of Minimum Unit Pricing (MUP) of alcohol in Scotland on cross-border purchasing. Edinburgh: Public Health Scotland 2022. https://www.drugsandalcohol.ie/35799/

196 Maharaj T, Angus C, Fitzgerald N, *et al*. Impact of minimum unit pricing on alcohol-related hospital outcomes: systematic review. *BMJ Open* 2023;**13**:e065220. https://www.drugsandalcohol.ie/38116/

197 O'Brien JW, Tscharke BJ, Bade R, *et al*. A wastewater-based assessment of the impact of a minimum unit price (MUP) on population alcohol consumption in the Northern Territory, Australia. *Addiction* 2022;**117**:243–9.

198 Petticrew M, Douglas N, Knai C, *et al*. Health information on alcoholic beverage containers: has the alcohol industry's pledge in England to improve labelling been met? *Addiction* 2016;**111**:51–5.

199 Doyle A. Public Health (Alcohol) (Labelling) Regulations 2023 signed into law. *Drugnet Ireland* 2023;**Issue 86, Summer 2023**:11–2. https://www.drugsandalcohol.ie/39492/

200 Rehm J, Ferreira-Borges C, Kokole D, *et al*. Assessing the impact of providing digital product information on the health risks of alcoholic beverages to the consumer at point of sale: A pilot study. *Drug and Alcohol Review* 2023.

201 Doyle A, O'Dwyer C, Mongan D, *et al*. Factors associated with public awareness of the relationship between alcohol use and breast cancer risk. BMC Public Health. 2022. https://www.drugsandalcohol.ie/37780/

202 O'Dwyer C, Mongan D. Public awareness of alcohol-related health conditions in Ireland: findings from the Healthy Ireland Survey. *Drugnet Ireland* 2019;**Issue 70, Summer 2019**:19–21. https://www.drugsandalcohol.ie/31013/

203 Vallance K, Stockwell T, Hammond D, *et al*. Testing the effectiveness of enhanced alcohol warning labels and modifications resulting from alcohol industry interference in Yukon, Canada: Protocol for a quasi-experimental study. *JMIR research protocols* 2020;**9**:e16320.

204 Blackwell AKM, Drax K, Attwood AS, *et al*. Informing drinkers: can current UK alcohol labels be improved? 2018;**192**:163–70. https://www.drugsandalcohol.ie/32527/

205 Miller ER, Ramsey IJ, Baratiny GY, *et al*. Message on a bottle: are alcohol warning labels about cancer appropriate? *BMC public health* 2016;**16**:1–10.

206 Pechey E, Clarke N, Mantzari E, *et al*. Image-and-text health warning labels on alcohol and food: Potential effectiveness and acceptability. *BMC Public Health* 2020;**20**:1–14.

207 Winstock AR, Holmes J, Ferris JA, *et al*. Perceptions of alcohol health warning labels in a large international cross-sectional survey of people who drink alcohol. *Alcohol and alcoholism* 2020;**55**:315–22.

208 Zhao J, Stockwell T, Vallance K, *et al*. The effects of alcohol warning labels on population alcohol consumption: an interrupted time series analysis of alcohol sales in Yukon, Canada. *Journal of studies on alcohol and drugs* 2020;**81**:225–37.

209 Jongenelis M, Pratt I, Slevin T, *et al*. Effectiveness of warning labels at increasing awareness of Alcohol-related cancer risk among heavy drinkers. 2018.

210 Maani N, Collin J, Friel S, *et al*. Bringing the commercial determinants of health out of the shadows: a review of how the commercial determinants are represented in conceptual frameworks. *European Journal of Public Health* 2020;**30**:660–4.

211 Doyle A. Most recent regulations of Public Health (Alcohol) Act 2018 implemented. *Drugnet Ireland* 2021;**Issue 77, Spring 2021**:15–7. https://www.drugsandalcohol.ie/34282/

212 Nakamura R, Pechey R, Suhrcke M, *et al*. Sales impact of displaying alcoholic and non-alcoholic beverages in end-of-aisle locations: an observational study. *Social Science & Medicine* 2014;**108**:68–73.

213 Robinson-Greene R. Alcohol Laws in Utah: Drunk with Power? *The Prindle Post* 2017.

214 Jernigan D, Noel J, Landon J, *et al*. Alcohol marketing and youth alcohol consumption: a systematic review of longitudinal studies published since 2008. *Addiction* 2017;**112**:7–20.

215 Sargent JD, Babor TF. The Relationship Between Exposure to Alcohol Marketing and Underage Drinking Is Causal. *Journal of Studies on Alcohol and Drugs, Supplement* 2020;:113–24. doi:10.15288/jsads.2020.s19.113

216 Fox CA, Kelly C, Molcho M. Alcohol marketing and young people's drinking behaviour in Ireland. Dublin: Alcohol Action Ireland 2015. https://www.drugsandalcohol.ie/24854/

217 Scobie G, Patterson C, Rendall G, *et al*. Review of alcohol marketing restrictions in seven European countries. Glasgow: Public Health Scotland 2022. https://www.drugsandalcohol.ie/36444/

218 Babor T, Caetano R, Casswell S, *et al. Alcohol: No Ordinary Commodity: Research and Public Policy*. 2nd ed. Oxford, UK: Oxford University Press 2010.

219 Babor TF, Jernigan D, Brookes C. The regulation of alcohol marketing: From research to public health policy. *Addiction* 2017;**112**:1–127.

220 Purves RI, Critchlow N. Alcohol marketing during the 2020 Six Nations Championship: a frequency analysis. Stirling: Scottish Health Action on Alcohol Problems; Institute of Alcohol Studies; and Alcohol Action Ireland 2021. https://www.drugsandalcohol.ie/34911/

221 Critchlow N, Moodie C, Houghton F. Brand sharing between alcoholic drinks and non-alcoholic offerings: a challenge to Ireland's restrictions on alcohol advertising. *Irish Journal of Medical Science* 2023;**192**:1975–7. https://www.drugsandalcohol.ie/37072/

222 Critchlow N, Purves RI. Alcohol branding during rugby union matches in Ireland after commencement of Sect.15 from the Public Health (Alcohol) Act: a frequency analysis of highlights from the European Rugby Champions Cup and Six Nations Championship. *Irish Journal of Medical Science* 2023;**Early online**. https://www.drugsandalcohol.ie/38429/

223 Critchlow N, Moodie C. Awareness of alcohol marketing one year after initial implementation of Ireland's Public Health (Alcohol) Act and during the COVID-19 pandemic. *Journal of Public Health* 2022;**44**:e537–47. https://www.drugsandalcohol.ie/34954/

224 Critchlow N, Moodie C. Consumer protection messages in alcohol marketing on Twitter in Ireland: a content analysis. *Drugs: Education Prevention and Policy* 2023;**30**:304–11. https://www.drugsandalcohol.ie/35588/

225 Calnan S, Millar S, Mongan D. Support for evidence-based alcohol policy in Ireland: results from a representative household survey. *European Journal of Public Health* 2023;**33**:323–30. https://www.drugsandalcohol.ie/38321/

226 Buykx P, Li J, de Matos EG, *et al*. Factors associated with public support for alcohol policy in England: a population-based survey. *The Lancet* 2016;**388**:S31.

227 Dáil Éireann debate. Question 695 – Health service executive. [alcohol] [25854/23]. (30 May 2023). 2023. https://www.drugsandalcohol.ie/40236/ (accessed 9 Feb 2024).

228 [Oireachtas] Dáil Éireann debate. Question 474 – Alcohol sales. [20709/23]. (03 May 2023). 2023. https://www.drugsandalcohol.ie/40228/ (accessed 9 Feb 2024).

229 [Oireachtas] Dáil Éireann debate. Question 173 – Alcohol sales. [10408/23]. 2023. https://www.drugsandalcohol.ie/40200/ (accessed 9 Feb 2024).

230 Dáil Éireann debate. Question 383 – Alcohol advertising. [5311/23]. 2023. https://www.drugsandalcohol.ie/40200/ (accessed 9 Feb 2024).

231 Office of the Attorney General. Intoxicating Liquor Act. 2008. https://www.irishstatutebook.ie/eli/2008/act/17/enacted/en/html

232 Babor TF. The Sale of Alcohol Bill (2022): an analysis of costs and benefits. Dublin: Alcohol Forum Ireland 2023. https://www.drugsandalcohol.ie/38742/

233 Rossow I, Norström T. The impact of small changes in bar closing hours on violence. The Norwegian experience from 18 cities. *Addiction* 2012;**107**:530–7.

234 Chikritzhs T, Stockwell T. The impact of later trading hours for hotels on levels of impaired driver road crashes and driver breath alcohol levels. *Addiction* 2006;**101**:1254–64.

235 Organisation for Economic Co-Operation and Development. (2021) Preventing harmful alcohol use. OECD Health Policy Studies Paris: OECD Publishing. https://www.drugsandalcohol.ie/34208/

236 Hope, A and Barry, J and Byrne, S (2018) The untold story: harms experienced in the Irish population due to others' drinking. Dublin: Health Service Executive. https://www.drugsandalcohol.ie/28839/

237 McCutchen, C., Hyland, P., Shevlin, M., & Cloitre, M. (2022). The occurrence and co-occurrence of ACEs and their relationship to mental health in the United States and Ireland. *Child Abuse & Neglect, 129*, 105681. https://www.sciencedirect.com/science/article/pii/S0145213422002010

238 Manthey, J and Hassan, SA and Carr, S and Kilian, C and Kuitunen-Paul, S and Rehm, J (2021) What are the economic costs to society attributable to alcohol use? A systematic review and modelling study. PharmacoEconomics, 39, pp. 809-822. https://doi.org/10.1007/s40273-021-01031-8.https://www.drugsandalcohol.ie/34203/

239 Northern Ireland Statistics and Research Agency (2023) Police Service of Northern Ireland. Trends in Police Recorded Crime in Northern Ireland 1998/99 to 2022/23 https://www.psni.police.uk/system/files/2023-11/456441561/Police%20Recorded%20Crime%20in%20Northern%20Ireland%201998-99%20to%202022-23.pdf