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Alcohol Policy and Young People

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1. Introduction

The WHO European Alcohol Action Plan 2000-2005 has as its aim to prevent and reduce the harm done by alcohol throughout the European Region. The WHO aim, is reflected in Member States individual alcohol strategies or action plans, including Ireland's National Alcohol Policy. The central issues addressed in this paper, are what constitutes an effective policy response to reducing alcohol related harm among young people, how has Ireland acted since the 1990s and what of the challenges.

There can be no more excuses. The scientific body of knowledge has never been more comprehensive, in terms of its quality, the strength of evidence and its robustness across cultures, as to which strategies work and how to make them work to prevent and reduce alcohol related problems. In Ireland, we have learned that ignoring the problem and in some instances adding to the problem has carried an enormous human, social and economic cost to Irish society over the last decade. However, there have been some recent positive signs of progress on the alcohol issue.

2. Young people

Young people have a right to grow up in a society where they are protected from pressures to drink and from the harm done by alcohol, declared the World Health Organisation and all European Member States agreed in 2001[1]. Young peoples' attitude and drinking behaviour is shaped, to a large extent, by the society they live in. In Ireland, young people recognise the powerful influence of the 'drinking culture' on their lives. Dáil na nÓg (National Children Parliament), recently criticised adults for creating and passing on to their generation the problems related to alcohol. As noted by Donegal Youth Council "*we inherit our drinking culture, we celebrate if we win and we celebrate if we lose, any excuse! Even if there's no excuse we still drink alcohol"*. Therefore re-shaping the attitudes and behaviours of the adult society is necessary in order to provide a safer social climate for young people to lead healthy and productive lives.

Alcohol and Young People

Young people and alcohol, a phrase, often used to implying that alcohol is a problem for young people only, especially those under age, and that the rest of adult society has no problem with alcohol, which belies the facts and figures. However the focus of this paper is young people, which can be divided into three main groups, young adults (18-30 years), teenagers (15-17 years) and children (under 15) when discussing alcohol.

Young adults (18-29 years) tend to drink large amounts of alcohol when they drink and overall are heavy consumers of alcohol, although there is wide variation across

[a] The views expressed in this paper are personal.

cultures. Drinking among adults, from available comparable data (ECAS), show that men drink more than women and binge drinking is 3 to 4 times more common among men than women in the ECAS countries[2] (Table 1). Binge drinking is higher in the north of Europe and lower in the south. The highest frequency of binge drinking is among young adults (18-29 yrs). Young adults also have the highest total alcohol consumption in Finland, Sweden, UK and Ireland[3] for both men and women, while in France, Germany and Italy total consumption peaks in the middle to older age groups. The consequences of such drinking patterns have been also reported. One of the clear findings was that the total amount of alcohol consumed was an import predictor of alcohol related social problems.

Table 2: Drinking Patterns among adults in EU countries

Country	Binge per 100 drinking occasions	Reported Total consumption (pure alcohol)	Reported Total consumption 18-29 age group
MEN			
Finland	29	7.0	8.2
France	9	7.5	6.1
Germany	14	5.3	4.3
Italy	13	7.1	6.4
Sweden	33	5.3	7.5
UK	40	13.1	16.0
Ireland*	58	14.3	17.9
WOMEN			
Finland	17	2.4	2.9
France	5	2.2	1.8
Germany	7	2.4	3.2
Italy	11	3.5	2.5
Sweden	18	1.7	1.9
UK	22	5.1	7.9
Ireland*	30	4.8	9.1

*Source: ECAS survey[2] ;*Irish survey using ECAS questions[3]*

Teenagers and children tend to follow similar drinking patterns to adults, although at a lesser magnitude. The international survey data (HBSC[4], ESPAD[5]) show that children do experiment with alcohol at very early ages, some regularly consume alcohol and a proportion are involved in high risk drinking (binge drinking and drunkenness). For the most part, alcohol use and abuse increases with age and is higher among boys than girls with wide variation between countries. The critical age for accelerated alcohol use and abuse is between 13 and 15 years of age in many countries. At 16 years, about one in four boys in 9 of the EU countries are regular binge drinkers. (Table 2). For girls, one in five are regular binge drinkers in 6 of the EU Member States at age 16 years. Binge drinking was defined as 5 or more drinks per drinking occasion. Given that alcohol use poses serious risks for children and teenagers still developing and maturing, the main focus is to keep children alcohol-free. Some factors, identified in the HBSC survey, associated with staying alcohol-free were spending fewer evenings with friends, liking school and less inclined to be truant from school. For girls, being able to communicate well with their father was important. There was also a strong line between not smoking and not drinking. The consequences of alcohol use by teenagers, reported in ESPAD, include a range of problems affecting their performance at school, being in accidents, difficulties in relationships with others, unwanted sexual experiences, fights and trouble with the police.

Table 1: Drinking patterns among children (11, 13 years) and teenagers (16 years) in the Enlarged European Union

	HBSC 1998 At 11 years drunk twice or more often		HBSC 1998 At 13 years drunk twice or more often		ESPAD 1999 At 16 years Drunk 10 times or more during last year		ESPAS 1999 At 16 years Binge drinking 3 times or more during last 30 days	
Country	Boys %	Girls %	Boys %	Girls %	Boys %	Girls %	Boys %	Girls %
Austria	4	2	13	7				
Belgium**	6	1	11	6				
Cyprus					4	0	18	6
Czech Rep.	6	2	14	6	19	9	25	11
Denmark	6	3	25	21	43	35	37	22
Estonia	2	1	15	4	15	7	18	12
Finland	4	1	16	18	29	28	21	15
France*	1	0.4	8	5	6	1	16	7
Germany*	2	0.3	10	7				
Greece	5	1	9	5	4	1	13	5
Hungary	3	1	9	4	9	2	18	8
Ireland	7	1	15	8	28	25	32	32
Italy					4	1	na	na
Latvia	4	0.4	15	8	11	6	19	9
Lithuania	6	1	15	6	15	5	12	5
Malta					5	3	25	18
Poland	4	1	14	6	13	5	41	23
Portugal	4	1	10	5	6	1	10	5
Slovakia	16	8	23	13	9	5	12	7
Slovenia					14	9	29	19
Sweden	1	0.3	8	6	21	16	22	13
UK*	9	3	25	22	30	26	33	27

* HBSC data for France and Germany represents regions. UK data is for England ** Belgium (Flemish); Spain, Netherlands, and Luxembourg were not involved in the surveys.
Sources: WHO-HBSC, 2000[4]*; ESPAD 1999 Report*[5].

3. Effective alcohol policy – A Review

The research evidence is very clear on a number of key issues. Firstly, not all alcohol policy measures are equally effective. Secondly, policy measures that influence and change the physical, social and cultural environment around alcohol are more effective in preventing and reducing alcohol related harm, than measures targeted at the individual drinker. Thirdly, policies exclusively targeted at young people, while ignoring the wider adult population, are doomed to failure. Fourthly, while education programmes can influence beliefs and attitudes about alcohol, the overwhelming weight of the international evidence, across several contexts and settings including schools, colleges and communities, concludes that educational strategies show little or no effect in reducing alcohol consumption or related harm[6].

The most recent global review of alcohol policy, supported by WHO, clearly shows that the 'best value' for an effective alcohol policy response should combine measures targeted at the general population (taxes, controlling access to alcohol, RBT, Lower BAC), at high-risk groups (minimum age, enforcement of on-premise alcohol laws, community mobilisation) and at high-risk drinkers (brief intervention)[6]. Table 3

summarises Babor et al evaluation ratings for 30 different strategies, assessed for their effectiveness in preventing and reducing alcohol related problems.

3.1 Controlling the physical availability of alcohol, be it the hours and days of sale, the number and type of alcohol outlets or certain restrictions on access to alcohol, is effective in reducing alcohol consumption and related problems. Setting a minimum age for the purchase of alcohol is one of the most effective measures in limiting access of alcohol to young people. In North America, increasing the minimum age from 18 to 21 years reduced drink driving, car crashes and traffic fatalities among young people[7,8]. The majority of European countries set 18 years as the legal age for alcohol purchase[9]. In Denmark, after the introduction of a minimum 15 age limit for alcohol purchase in 1998, a 36% drop in alcohol consumption among teenagers and a 17% drop in older students were reported[10]. As with all alcohol laws, the critical factor for effectiveness is enforcement with a credible deterrent. Government stores selling alcohol off-premise, remove the pressure to maximise profit as in the private sector, can limit alcohol consumption and related problems[11,12]. Such stores mainly operate in the US, Canada and in the Nordic countries. Making alcohol more available increases the likelihood that those under the legal age of purchase can access alcohol more easily and can result in increased youth drinking[13]. There is evidence to suggest that making drinks available, with a lower alcohol content, offers the possibility of reducing intoxication[6].

3.2 The **price of alcohol** influences frequent and heavy drinkers as well as children and young adults, which means when the price of alcohol increases, alcohol consumption tends to decrease[14]. Over the past thirty years in the UK, the decline in the relative cost of alcohol has corresponded to an increase in alcohol consumption[15]. Increasing alcohol taxes is a key instrument in the mix of effective policy measures. Raising alcohol taxes can also lead to a reduction in a host of alcohol related problems such as drinking and driving, death from liver cirrhosis, injuries, alcohol related violence and other crimes[14,6]. In the UK, it is estimated that a 10% increase in alcohol taxes could reduce alcohol related mortality between 7% and 37%[15].

3.3 Modifying the drinking context mainly focuses on preventing and limiting harm in the social drinking environment (licensed premises) by holding servers legally liable for serving to drunken persons, active enforcement of alcohol laws, better trained staff in responsible serving practices and effective management of potential problem behaviours among customers. There is a substantial body of scientific evidence from the USA, Australia, New Zealand, and Finland that a community policy approach is effective. That is institutions, organisations and groups within a community working together to change policies and practices to reduce alcohol related problems. However, sustaining the gains beyond the initial time scale of the project remains a challenge. Community mobilization approaches have been successful in reducing high risk drinking[16,17], violence in and around licensed premises[18,19], alcohol related injuries[20,17] and drink driving[21,22,23]. The community mobilisation approach has also been effective in addressing underage drinking[24]. While alcohol free alternatives (AFA) have not been shown to be effective as a single strategy in reducing underage drinking, AFA have been considered useful when combined with a community policy approach such as limiting alcohol availability through licensing laws, use of bye-laws for restricting drinking in public places and enhanced law enforcement.

3.4 Regulating alcohol promotion: Alcohol marketing is sophisticated in its methods, exceptionally well funded and powerful in its impact on young people including young adults, adolescents and those who have not yet tried alcohol[25,26]. Alcohol marketing places alcohol as a defining feature of youth culture, linking alcohol with social and sexual success. Alcohol marketing also undermines efforts to communicate health promotion messages to young people. While there is some evidence that bans on alcohol advertising decrease alcohol consumption[27], the other promotional activities, often using the largest part of the marketing budget, also need to be regulated[26]. Such activities include sponsorship, product placement and special alcohol promotions, which especially appeal to young males, the groups mostly likely to be high risk and heavy drinkers[6].

3.5 Drink driving countermeasures are considered one of the great success stories in reducing alcohol related problems and have *produced population-wide long term problem reductions of between 5% and 30%*[6]. The measures of proven high effectiveness are random breath testing and lower BAC (blood alcohol concentration). High visibility road checks act both as a deterrent and law enforcement, increasing compliance and reducing drink-driving offences. An immediate suspension from driving and a license disqualification are also effective measures in preventing and reducing alcohol related harm and should form part of an overall policy strategy. Given that young people tend to be inexperienced in driving and have high numbers of risky drinkers, a lower BAC limit near zero has shown to be very effective in reducing injuries, crashes and young drivers with a positive BAC[24,25,26]. Graduated licensing for novice drivers (night curfews, delayed access to full license) have also been effective in reducing drinking and driving among young people[6].

3.6 The purpose of **early intervention** is to detect high risk drinking and harmful drinking in individuals before or shortly after the early signs of alcohol related problems. Effective screening tools have been developed to match high risk and harmful drinking patterns with appropriate interventions[31]. Brief intervention, typically consisting of one to three sessions involving counselling and education, has been shown to reduce high risk and harmful drinking and related problems[6]. Brief intervention is delivered in a variety of health care settings, with primary care and emergency room the most common. It is recommended that screening and brief intervention on alcohol issues should be routine in all aspects of health service delivery for an integrated system[31].

3.7 The health promotion literature has recognised for over two decades that **information and education** does not change complex health behaviours and that creating a supportive environment with healthy public policies is essential for sustained behaviour change[32,33,34]. The alcohol research literature also concurs that education is not effective in reducing alcohol related harm, but can be useful in increasing understanding and in building life skills. Therefore, education should not be the lead policy measure, but rather an integral part of an overall strategy. The mistaken over-reliance on education as the key solution to underage drinking has diverted attention and delayed more effective strategies being implemented. Media advertising, warning labels and information at point of sale outlets are also useful in creating awareness. The use of warning labels on alcohol products in the USA increased awareness of the potential risks of alcohol use, among the target groups, in the areas specified on the labels – pregnancy, driving a car or operating machinery.

Recall was also good for warning messages as in media advertisements, and on signs at point-of-sale[35,36]. The value of media campaigns lie in creating greater awareness of alcohol issues and in providing a forum for public debate and support for policy changes[37].

3.8 Alcohol Policy and Young People: In summary, priority should be given to implementing the following effective policies in an integrated way, to reduce harm among young people.

- Regulating availability, through minimum age, alcohol taxes, government monopoly of off-license sales, alcohol control enforcement, seller liability
- Modifying the drinking context by community mobilisation targeting high risk drinking, violence, drinking driving and underage drinking and promoting low strength alcoholic beverage.
- Drink driving countermeasures by graduated license for novice drinkers, lower BAC for young drinkers, random breath testing and license disqualification,
- Regulating alcohol promotion by restricting sport sponsorship, high-risk promotional activities and volume of alcohol advertising.
- Early intervention by screening and brief intervention across health and social welfare services,
- Creating greater awareness and support for effective alcohol policies across society. Providing education as a supporting strategy rather than a lead strategy and link it to drug education.

4. Ireland and Alcohol – A Profile

4.1 Social and cultural environment: Irish society has experienced major changes over the last decade with rapid economic growth, increased employment opportunities attracting many young adults back home, more young people with part-time jobs, heightened interest in recreational, leisure and sporting activities and changing attitudes to lifestyle issues. The link of alcohol use with all forms of leisure, sport and entertainment, gives a clear message to young people – 'to have enjoyment and to make friends you need alcohol'. Against this backdrop, the rise in alcohol consumption has been dramatic and the rise in harm alarming.

4.2 Consumption and harm: We in Ireland are now amongst the highest consumers of alcohol in the world. Between 1990 and 2002, alcohol consumption per capita increased by **41%,** the highest rate of increase in Europe[38]. Alcohol harm is visible on our streets, in our courts, hospitals, workplaces, schools and homes. The vast majority of alcohol harm occurs among the adult population. Alcohol related mortality increased significantly during the same time period. The number of people who died (rate per 100,000) from alcohol abuse/dependency increased by a factor of four, cirrhosis doubled and alcohol poisoning almost doubled. High profile cases involving alcohol and violence have grabbed media headlines, but are only the tip of the iceberg. Since 1996, public order offences increased by 247%, assaults by 82% and drink driving offences by 125%[39]. One in four attending the hospital emergency room are alcohol related.

4.3 Drinking Patterns and harm: A recent study showed that adults in Ireland had the highest reported consumption per drinker, the highest level of binge drinking and experienced more harm than other European countries[3]. Binge drinking is the norm

among Irish men, in that out of every 100 drinking occasions, 58 end up in binge drinking for men and 30 for women. Binge drinking is defined as drinking at least one bottle of wine, or 7 measures of spirits or 4 pints of beer or more during one drinking occasion (75/80 grams of pure alcohol). The harm experienced as a result of their drinking had personal (regrets, fights, accidents), economic (work) and social (friendship and home-life) consequences. Young Irish men (18-29 age group) reported the highest consumption of alcohol, had more binge drinkers and experienced more harm (fights, accidents, work) than any other group in the population.

4.4 Youth drinking and harm: In 2002, fewer children under 15 years, reported experimenting with alcohol, drinking on a regular basis or getting drunk, in comparison to 1998[40]. However, for those 15-17 years there was no reported change in the overall pattern of drinking, where about half of the boys and girls were regular drinkers and drunkenness was prevalent. Among 16 year olds, one in three were regular binge drinkers and one in four reported being drunk ten or more times in the last year[5]. In 2002, alcopops was the most popular drink among girls while beer continued to be the most popular drink among boys[40]. The significant role alcohol contributes to harm among Irish young people such as unsafe sex, alcohol overdose, accidents, assaults, suicide and poor school performance has been previously documented[41]. A glimpse of the problems experienced by young people can be seen in the work of the Garda Juvenile Diversion Programme. Between 1997 and 2002, there was a 185% increase in juvenile alcohol related offences[42]. Of particular concern is the increase in '*intoxication in public places'* among teenagers, which increased from 550 offences in 1997 to 1,898 offences in 2002, an increase of 245%. However, the figure for the same offence, *intoxication in a public place*, among adults was 22,701 in 2002, up 194% since 1997.

5. Alcohol Marketing Practices

5.1 Sponsorship: By the early 1990's the drinks industry had developed sponsorship deals with many musical and cultural events around Ireland. The current high visibility alcohol sport sponsorships, in sports with the highest youth participation (gaelic football, rugby and soccer), began in 1994 with the Guinness All Ireland Hurling Championship and symbolised a major social shift in a community rich in tradition and culture. The GAA sponsorship deal was followed by the Heineken Cup (rugby) and the Carlsberg League (soccer). Sponsorship deals of this type give in-depth exposure through event naming, product placement, sport commentary and discussions of the sporting events and embed the alcohol product into the daily lives of people. Alcohol sports sponsorship, linking alcohol, masculinity and sport, attracts young males, the groups mostly likely to be high risk and heavy drinkers[6].

5.2 Alcohol products: The introduction of alcopops in 1995, with a strong sweet taste, disguising the taste of alcohol, attracted many young people into alcohol. The more recent new alcohol products with high alcohol content (shooter, shots) provide for a quick and easy 'fix' of alcohol for those who are interested in getting drunk fast. Drink combinations such as 'vodka and red bull' allow the drinker to consume large quantities of alcohol that the body otherwise could not normally tolerate, due to the stimulant affect of red bull. Alcohol promotions such as free alcohol, cheap alcohol

and strong alcohol encourage high risk drinking which contributes to increased risk of alcohol related problems.

5.3 Alcohol advertising: In Ireland, alcohol advertising is governed by voluntary codes or self-regulation. The codes of advertising all set down certain guidelines to protect young people. However, during the last decade alcohol advertising has increased in volume, as reflected in the advertising spend, from €25.8 million in 1996 to €43.2 million in 2002[43]. The greatest increase happened in spirits advertisements between 1996 and 2000, coinciding with the introduction to the market of the new spirits based alcopops - Television (+228%), Outdoors (+136%), Cinema (+116%) and press (83%) and radio (-62%). Alcohol advertising also extended its scope by advertising alcopops products on television, despite the voluntary code that spirits drinks would not be advertised on television. During this time period a new commercial television station came into operation. A study was undertaken in 2000 asking young people how they perceived alcohol advertisements and whether the advertisements were in compliance with the codes. The results suggested that alcohol advertisements did infringe the codes in a number of ways. These included linking of alcohol use with social or sexual success, depiction of immoderate drinking, use of characters that appear to be under 25 years, implying that alcohol had therapeutic effects or improved physical performance and alcohol advertisements targeted at young people[44]. In 2003 the Drinks Industry Group established a Central Copy Clearance company to vet alcohol advertising prior to launch to ensure compliance with the voluntary code. However, despite the CCC role, alcohol advertisements continue to breach the code, illustrating the deficiencies of the self-regulation system[45].

6. Irish Policy Responses

6.1 Alcohol availability: In Ireland alcohol is easy to access, as there are at least 13,000 outlets that sell alcohol. Since the 1980s, alcohol has become more available by increases in the number of exemptions (later opening) and in the number of outlets (restaurants and clubs, off-licenses). During the economic boom since 1994, there was no increase in alcohol taxes (excise duty), although alcohol prices did increase. In response to calls for longer opening hours, from the retail drinks and tourist sectors, a Dail Select Committee examined the issue in 1996. Despite the scientific evidence showing the increased risks of increasing availability presented to the Committee and outlined in the National Alcohol Policy[46], the Dail committee decided to recommend greater availability through longer opening hours and more exemptions, which was enacted in the Intoxicating Liquor Act 2000. The longer opening hours combined with no increases in alcohol taxes over a seven-year period and an annual economic growth rate of at least 10%, was akin to throwing petrol on an already burning fire. In contrast, the same legislation[47] introduced strong measures to curb underage drinking by imposing a ‘closure order’ for those convicted of selling alcohol to those underage. Illustrating the misperception that drinking in Ireland is a problem only for those underage.

The Minister of Justice, Equality and Law Reform, established the Commission on Liquor Licensing (CLL) in 2000 to consider reform of the licensing laws. Some of the CLL recommendations, if implemented will further increase availability such as

more off-licenses, more on-premises bars (café bar model) and distance sales[48] and pose a threat of increased alcohol problems.

6.2 Community approach in the college environment: A framework for the development of a college alcohol policy was developed in 2000 with the Heads of Colleges and the Student Union, in response to a growing concern about alcohol promotion practices on campus and related problems[49]. Five key areas were addressed, controlling marketing, promotions and sponsorship, limiting harm in the drinking environment, increasing awareness and education, encouraging alternatives and choice and providing campus support services. Each third level institution is encouraged to adopt the framework into policy to reflect the needs and aspirations of their own campus environment.

6.3 Information and education: A three-year alcohol awareness campaign (2001-2003) was implemented to raise awareness and create debate on alcohol issues and to highlight the necessity of a public health approach to reducing alcohol problems. A server training initiative was developed, in co-operation with the Drinks Industry, to establish policies and procedures in the retail drinks trade to reduce harm in the drinking environment. It is now administered by the training organisation (Failte Ireland) for the hospitality sector.

Youth participation in matters that affect them is a key goal of the National Children's Strategy in Ireland. Several initiatives have been developed, both in terms of structures and programmes, for active participation by young people. A Dáil na nÓg or National Children's Parliament has been established as a national forum where children can raise and debate issues of concern. At county level, the Donegal Youth Council is an example of youth democracy in action where young people elect young people to a junior council, mirroring that of the senior County Council. The Gaf in Galway, set up by the Western Health Board as a social health project, provides a safe space (alcohol and drug free) for young people can go to meet and hang out with friends, listen or partake in music as well as access information (The Gaf evaluation 2003). A similar café style service for young people is Elmo's Attic in Ennis. Both these centres are used by boys and girls 15 years and older and involve young people in the active management of the centres. Innovative programmes include Teenage Kicks, Bono Vox and the No Name Club. Bono Vox is a mentoring programme between University students and second level students, culminating in a play on alcohol issues co-written by the teenagers and performed by the drama students in the university. Teenage Kicks is an arts, education and health project, illustrating young people's perceptions of the impact of alcohol on themselves and their community through art and film. The No Name Club promotes alcohol-free social activities.

6.4 Strategic Task Force on Alcohol: The Strategic Task Force on Alcohol (STFA), set up by the Minister of Health in 2002, was asked to bring forward specific measures to Government, based on sound scientific evidence, to prevent and reduce alcohol related harm in Ireland. The STFA first Interim Report[41] recommended specific measures for action including an increase in alcohol taxes, the introduction of random breath testing, lower BAC, prohibition of service to drunk customers, restrictions on high risk sales promotions and reduced exposure of children to alcohol marketing.

7. Signs of Progress:

7.1 Increased taxes: Excise duty was increased on cider and spirits by Government in December 2001 and 2002 respectively. Following the increases in excise duty, the alcohol sales figures for both cider and spirits significantly decreased, demonstrating that alcohol taxes can have an influence on alcohol consumption. In 2002, cider sales decreased by -11.3%, while wine and spirits increased and beer remained relatively stable. In 2003 following the tax increase on spirit products, spirits sales decreased by 20% while wine sales increased (+8%) and both beer (-2.5%) and cider (+1%) showed marginal changes[50].

7.2 Stronger laws: The Intoxicating Liquor Act 2003 includes measures to combat drunkenness and disorderly conduct, binge drinking and underage drinking. These include a ban on the supply of alcohol to drunken customers and 'closure order' if convicted; a ban on happy hours; reverting to the earlier closing time on Thursday night; restrictions on those under 18 year from bars after 9pm; a requirement for 18-21 year olds to carry age document and the provision for plain clothes gardai to enforce alcohol laws. The Road Traffic Act 2003 extended the grounds for requesting a breath test to detect alcohol. The Minister for Transport is committed to the introduction of random breath testing in the near future. The Minister for Health and Children received government approval to proceed with legislation to reduce the exposure of children to alcohol marketing. The proposed legislation will restrict where alcohol advertisements can be placed, limit content, ban drinks industry sponsorship of youth leisure activities and require a health warning on advertisements.

7.3 STFA 2004 Report: The STFA 2004 Report will bring forward a comprehensive list of new recommendations; to build capacity in communities and organisations to prevent and respond to alcohol related harm; to achieve the targets set out in the WHO Declaration on Alcohol and Young People; and for early intervention to reduce high risk and harmful drinking and related problems.

8. Challenges

8.1 Involvement of Young People: All young people have a right to be heard and participate when policies, services and programmes are being developed to meet their needs. Member States in the European Region made commitments at WHO and EU level to involve young people in the shaping of decisions that affect their lives. However, translating that commitment into tangible actions has not been very apparent across Europe.

8.2 Alcohol a global product, but no ordinary commodity: The European Union was developed to provide for a single market where goods can be sold without unnecessary barriers to trade. It has provided opportunities for economic growth and prosperity in all Member States, including Ireland. However, alcohol is no ordinary commodity and its harmful properties result in a wide range of problems, therefore the full suite of market rules do not and should not necessarily apply. The recent proposal on excise duty and the sale promotion directive illustrates the divergent views within the EU. Both measures would result in cheaper and more available alcohol, which is not in the best interest of public health and are unlikely to improve the well-being of European citizens. A better balance is needed at European level between public health

policy and other policy areas. European policies should complement and reinforce Member States strategies to reduce alcohol related harm.

8.3 Alcohol Industry: The alcohol industry exists to sell alcohol. Their aim, like all commercial businesses, is for a better bottom line not for better health for the citizens of Europe. Therefore, it is inevitable that effective public health measures will continue to be opposed by the drinks industry if they impact on profits. While the drinks industry says it is committed to reducing alcohol related harm, the continuing call by the industry for education as the lead strategy rings hollow given the research evidence, which shows that education is a supportive rather than a lead strategy. The Drinks Industry of Ireland rejected several of the recommendations in the STFA Interim Report (reduce overall consumption, increase taxes, lower BAC) despite the strong scientific evidence base for these recommendations[51]. One can only conclude that the alcohol industry is at best lukewarm on the public health approach

9. Conclusion

The myth that the Irish are a nation of drinkers, perhaps true 100 years ago, has become a self-fulfilling reality in the last decade. Lessons must be learned from Ireland's mistakes. Economic gains in one dimension of life can carry a social, economic and health loss in another dimension. We must ensure that the public understand and support the need for specific integrated actions, based on what works, in the interest of the common good of society. The reality is, that although alcohol in moderation is enjoyable, sociable and part of most cultures, there is also an inherent risk with its use as it is a toxic substance and a drug. We do a disservice to our young people in not facing that reality, i.e. that alcohol is no ordinary commodity. We have to adjust our attitudes, behaviours and environments to reflect that sobering reality.

To improve the quality of life of communities across the European Region and to ensure our most valuable asset -young people - are supported in leading healthy and productive lives, our starting point should be balanced pro health alcohol policies.

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