

# Support for evidence-based alcohol policy in Ireland: results from the Community Action on Alcohol Pilot Project

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**Abstract** In Ireland, the Public Health (Alcohol) Bill proposes introducing minimum unit pricing, health labelling, and advertising restrictions to tackle excessive consumption. The aim of this research was to examine the level of support for evidence-based alcohol control policy among the Irish population. We conducted a household survey using quota sampling in three pilot sites in Southern Ireland. Consumption, attitude, and behaviour questions were taken from previously validated instruments. In total, 1075 individuals completed the questionnaire. Hazardous alcohol consumption was reported by 51.1% of the population, 31.5% of women, and 69.8% of men. The majority of individuals (>50%) supported alcohol policy measures. These individuals are more likely to be low-risk drinkers, older individuals, and report alcohol-related issues in their local area. In the context of Ireland's Public Health (Alcohol) Bill, this research signals support for evidence-based strategies including minimum unit pricing and a reduction and separation of alcohol sales outlets.

**Keywords** Alcohol · Policy support · Ireland · Public health

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## Introduction

Since the beginning of recorded history, alcohol has been deeply embedded in society [1]. Today, it represents an integral part of modern culture and is generally consumed for enjoyment, relaxation, and reasons of sociability [2]. Alcohol is a sedative drug that alters the way one feels. It is a psychoactive substance with dependence-producing properties [3]. The use of alcohol at excessive levels causes a large social and economic burden to societies [4, 5].

According to the World Health Organisation (WHO), hazardous alcohol consumption (HAC) can be defined as a “pattern of alcohol consumption that increases the risk of harmful consequences for the user or others” [6]. This pattern of consumption includes individuals who “consume enough alcohol to be at risk of adverse consequences but do not meet criteria for alcohol abuse or dependence” [7]. It is estimated that each year 3.3 million individuals die from an alcohol-related disease globally, which includes second-hand effects such as consumption during pregnancy and motor vehicle accidents after alcohol consumption [8]. This makes alcohol the world’s third largest risk factor for disease burden, representing almost 6% of all deaths [8]. It is associated with a number of serious social and developmental issues including violence, child neglect and abuse, absenteeism in the workplace, unintended or unprotected sex, and financial problems [8–14].

Europeans have higher per capita alcohol consumption than other regions in the world. Specifically, alcohol plays a complex role in Irish society [15]. Currently, Ireland has one of the highest levels of alcohol consumption in the European Union (EU) [16]. In 2010, the EU Barometer report on Attitudes towards Alcohol highlights that Irish people drink on fewer occasions but drink more heavily on those occasions when compared to their counterparts [17]. Specifically, over half of Irish adults report HAC, costing the state an estimated €3.7 billion annually [18].

Throughout the past 20 years, national policies have taken into account the importance of tackling excessive alcohol consumption [15, 19–22], including establishment of “an integrated national alcohol policy based upon public health principles” [23]. However, no policy structure “for managing alcohol issues had previously been established in Ireland” [23]. In response to the National Substance Misuse Strategy [15], the Irish Government launched the Public Health (Alcohol) Bill on 8 December, 2015. This bill proposes the introduction of a multi-component, evidence-based strategy to tackle this national public health issue. Measures include the introduction of minimum unit pricing, health labelling, advertising restrictions, and structural separation [23, 24]. The Bill has been met with lobbying from the alcohol industry and intense media recognition [25–28].

Internationally, support for evidence-based alcohol policy has varied. Previous research recognises that “public support for policies to reduce alcohol consumption and harms generally has an inverse association with policy effectiveness: policies with greatest evidence for effectiveness, such as pricing and availability, are



often the least popular” [29]. A recent review, however, highlights that social support to evidence-based alcohol policy has fluctuated [30]. It also signals a decline in support with progressive economic liberalisation [31]. Conflicting messages which focus on a) industry misrepresentation of evidence, and b) public health campaigns coupled with long-held myths retain strong levels of support despite being ineffective [32]. As support for evidence-based alcohol policy remains in a constant state of flux and support for the public health alcohol bill has yet to be determined, the aim of this research was to examine the level of support for evidence-based alcohol control policy among the Irish population.

## Method

### The National Community Action on Alcohol Pilot Project

A key recommendation of the National Substance Misuse Strategy in Ireland is to promote the development of a coordinated approach to prevention and education interventions in relation to alcohol and drugs. Community mobilisation is identified in the Strategy as an approach which has been successful in bringing stakeholders together to develop alcohol and drug policies aimed at tackling substance misuse. Following endorsement by Government of the measures contained in the National Substance Misuse Strategy, the remit of Drugs Task Forces expanded from recreational drug use only to include alcohol in 2014. Drug and Alcohol Task Forces examine the extent of drug and alcohol issues in a local area and co-ordinate a response at a community level. As coordinating structures, the Task Forces have an important role in supporting the implementation of the National Substance Misuse Strategy, across a range of measures.

The National Community Action on Alcohol Pilot Project began in January 2015. The project is delivered nationally by the Alcohol Forum in partnership with the Drug Programmes and Policy Unit, Department of Health, and the Health and Wellbeing Division of the Health Service Executive. The project sought to reduce alcohol-related harm by supporting Drug and Alcohol Task Forces to adopt a ‘community mobilisation’ approach. The project fits into a national and international policy context that promotes community mobilisation approaches to address alcohol-related harms: the National Substance Misuse Strategy [15], The Healthy Ireland Framework (2013–2025), and the World Health Organisation Strategy on Alcohol (2010). In the south of Ireland, the Cork Local Drug and Alcohol Taskforce, and the Southern Regional Drug and Alcohol Taskforce have been tasked with implementation of the project.

### Pilot Sites

In southern Ireland, the three pilot sites are located across the Cork and Kerry regions. Pilot site selection is based on previous criteria outlined in community mobilisation processes [33]. These include (a) community size (population > 5000),



(b) location in the region, and, (c) resources available within each community. The Cork and Kerry Alcohol Strategy Group picked one predominantly urban site in a large city. The other two areas are towns on opposite points in the strategies region. Both the Southern Regional Drug and Alcohol Taskforce and the Cork Local Drug and Alcohol Taskforce collaborate regularly with each of the three sites. Each site has access to meeting spaces, community workers, and steering group members.

### **Household Sampling**

A marketing research company completed a cross-sectional, household survey of individuals living in the three sample sites in advance of project implementation on behalf of the co-authors. They selected 30 sampling points in each area (i.e. 90 sampling points in total) with sampling points representative of the population of each ward. Researchers selected a random starting address within each sampling point. Pairs of interviewers received points, assigned on a logical geographic basis to minimise the potential of interviewers attempting to sample the same households. Interviewers commenced work at that starting address, and proceeded to select further households using a random walk procedure.

Interviewers then completed interviews to meet quotas for age (18–35, 35–54, and 55+), gender, and working status. Quotas based on the Irish Census 2011, sourced from the small area statistics reflected the profile of each ward in terms of age, gender, and working status.

### **Data Collection**

The Clinical Research Ethics Committee for Cork Teaching Hospitals granted ethical approval for this project. The household survey comprised 35 questions. Questions focused on drinking patterns, drinking context, attitudes, and harm. The Alcohol Use Disorders Identification Test [6], a set of 10 questions investigated a person's alcohol use. The World Health Organisation tested the tool for sensitivity and specificity. It has been employed also in previous national research [34]. Hazardous Alcohol Consumption is defined as a total AUDIT score of 8 or more among males and females. Questions on context, attitude, and harm are based on previous national and international research.

### **Data Analysis**

We used IBM SPSS Statistics Version 22 to analyse data. Trained researchers coded, entered, and cleaned data. Data were then weighted for age and gender in line with population figures from Census 2011. We undertook descriptive and univariate analysis to investigate the impacts of consumption, gender, and age on drinking context, attitude, and related harm.



## Results

Among the overall sample of 1075 individuals, over half were women (51.3%). The majority of individuals (84.3%) reported attaining their Junior Certificate qualification or higher while over 40% reported being currently employed. Over half of the population were either married or cohabiting.

In terms of alcohol consumption, over half the population reported hazardous alcohol consumption as measured using the Alcohol Use Disorders Identification Test for Consumption (51.1%). Over one-third of the population noted binge drinking monthly or less (37.3%). Almost 10% reported drinking to intoxication at least weekly. For demographic results, see Table 1.

Support for evidence-based alcohol policy varied across sociodemographic and alcohol consumption categories. Surveyors asked individuals whether they agreed or disagreed with the following public policy measures: random police check points to target drink driving, banning alcohol advertising directed at young people, banning alcohol sales to under 18s, banning price promotions, reducing the number of outlets selling alcohol, introducing minimum unit pricing, and selling alcohol in separate premises to other products. The majority of individuals (> 50%) supported population-based approaches including minimum unit pricing, separate premises, and reducing the number of outlets. Figure 1 highlights the levels of support.

Women are more likely to support minimum unit pricing (66.0% vs. 58.6%;  $p < 0.05$ ), a reduction in outlets (56.6% vs. 46.8%;  $p < 0.01$ ) selling alcohol, a ban on price promotion (70.5% vs. 62.8%;  $p < 0.05$ ), and separate sales premises for alcohol (56.0% vs. 47.2%;  $p < 0.05$ ) when compared to men. However, we noted no significant difference in gender support in relation to other policy measures. Those aged 18–24 were less likely to support a ban on advertising which targeted young people (55.7%) compared to those aged over 65 (86.1%). Younger age groups were less likely than older age groups to support separate premises sales, minimum unit pricing, and a reduction in the number of outlets selling alcohol. Those who completed a primary level of education only were more likely to support evidence-based alcohol policy. In relation to minimum unit pricing, 71.2% of those who reported completing their primary education supported this policy measure compared to 57.3% of those who completed some tertiary level of education ( $p < 0.01$ ). Similarly, 60.9% of individuals who had completed some level of primary education supported a separate sales outlet for alcohol compared to 43.8% of those who had completed some level of tertiary education. In terms of employment, those who were currently unemployed were more likely to support a reduction in sales outlets, separate sales outlets, and the introduction of minimum unit pricing. Those who reported being single were less likely to support each of the evidence-based alcohol policies except for random drink driving checks compared to those who were married/cohabiting or separated/divorced. See Table 2 for results on policy support in relation to sociodemographic information.

Those who reported 'low-risk' alcohol consumption were more likely to support evidence-based alcohol policy compared to those who report hazardous,



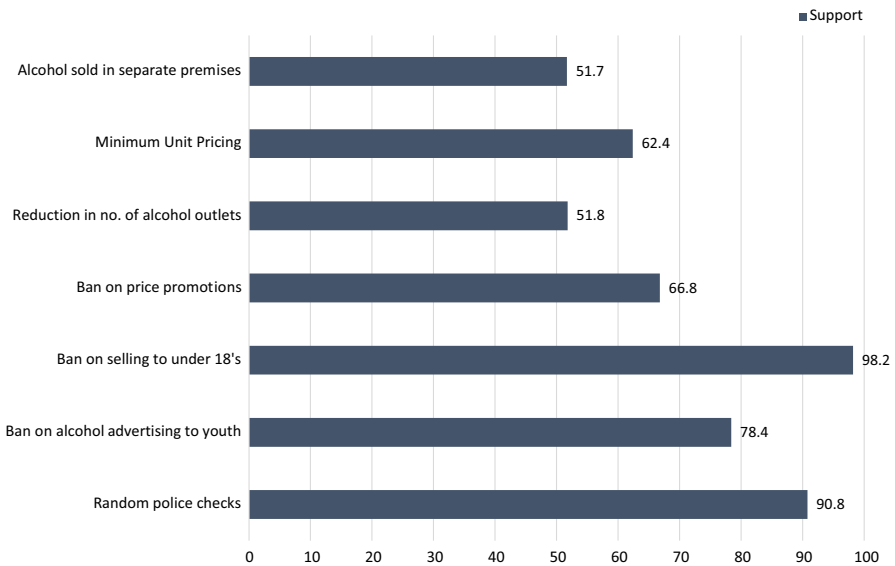
**Table 1** Demographic information for the overall sample population

	<i>N</i>	%
<b>Gender</b>		
Male	524	48.7
Female	551	51.3
<b>Age</b>		
18–24	112	10.4
25–34	207	19.3
35–44	189	17.6
45–54	215	20.0
55–64	140	13.0
65+	212	19.7
<b>Education</b>		
Some primary	5	0.5
Primary	154	14.3
Junior certificate	260	24.2
Leaving certificate	282	26.2
Diploma	199	18.5
Primary degree	91	8.5
Postgraduate degree	74	6.9
Refusal	10	0.9
<b>Marital status</b>		
Single	316	29.4
Cohabiting	120	11.2
Married	462	43.0
Separated	64	6.0
Divorced	29	2.7
Widowed	83	7.7
Refusal	1	0.1
<b>Employment</b>		
Self-employed	40	3.7
Working for pay	410	38.1
Involuntarily unemployed	152	14.1
Student	57	5.3
Retired	194	18.0
Illness	40	3.7
Parental/pregnancy leave	4	0.4
Homemaker	153	14.2
Voluntarily unemployed for other reasons	23	2.1
Refused	2	0.2
<b>AUDIT-C</b>		
Non-hazardous	381	48.9
Hazardous	398	51.1



**Table 1** (continued)

	<i>N</i>	%
<b>Binge drinking</b>		
Never	226	29.2
Less than monthly	259	33.5
Monthly	128	16.6
Weekly	145	18.8
Daily/almost daily	15	1.9
<b>Drinking to intoxication</b>		
Weekly	71	9.4
Less than weekly	687	90.6

**Fig. 1** Support for evidence-based alcohol policy

or alcohol-dependent consumption patterns. In relation to minimum unit pricing, over 60% of low-risk drinkers supported its implementation compared to almost 30% of individuals who reported being alcohol dependent. Almost 50% of low-risk drinkers supported a reduction in the number of outlets selling alcohol compared to less than 20% of individuals who reported being alcohol dependent. Similarly, individuals who refrained from binge drinking were more likely to support public policy measures than people who reported binge drinking. Finally, individuals who reported drinking less than weekly were more likely to support public policy measures compared to those who reported drinking to intoxication weekly or less. See Table 3 for results of policy support in relation to alcohol consumption.



**Table 2** Support for evidence-based alcohol policy in relation to sociodemographic information

	<i>N</i> (%)	Hazardous Drinking	Random driving check points	Ban alcohol advertising to youth	Ban on selling to under 18s	Ban on price promotions	Reduce no. of alcohol outlets	Support Minimum Unit Pricing	Separate premises sales
Total	1075								
Gender									
Male	524 (48.7)	278 (69.8)***	451 (89.7)	389 (78.0.4)	504 (97.7)	321 (62.8)*	239 (46.8)**	299 (58.6)*	241 (47.2)*
Female	551 (51.3)	120 (31.5)	495 (91.8)	407 (78.4)	538 (98.7)	380 (70.5)	299 (56.6)	349 (66.0)	300 (56.0)
Age									
18–24	112 (10.4)	75 (75.0)***	94 (88.7)	59 (55.7)***	105 (97.2)	43 (39.4)***	32 (30.2)***	50 (46.7)***	31 (29.2)***
25–34	207 (19.3)	102 (60.7)	179 (89.9)	142 (75.5)	199 (97.1)	111 (55.5)	73 (37.6)	102 (50.7)	86 (43.0)
35–44	189 (17.6)	65 (43.9)	162 (87.1)	144 (78.7)	185 (98.4)	108 (57.8)	90 (48.4)	96 (52.2)	77 (41.4)
45–54	215 (20.0)	73 (46.2)	193 (91.5)	160 (80.4)	211 (99.1)	153 (72.9)	130 (61.6)	142 (67.9)	123 (59.1)
55–64	140 (13.0)	44 (46.3)	124 (92.5)	117 (85.4)	138 (100)	112 (81.8)	77 (57.0)	100 (75.2)	82 (59.9)
65 +	212 (19.7)	39 (35.5)	194 (92.4)	174 (86.1)	204 (97.6)	174 (84.1)	136 (65.7)	158 (77.1)	142 (67.6)
Education									
Primary	159 (14.9)	44 (48.9)	144 (94.1)	132 (85.2)*	155 (98.1)	117 (76.5)	95 (61.3)*	109 (71.2)**	95 (60.9)**
Secondary	542 (50.9)	210 (54.0)	470 (90.0)	382 (75.3)	524 (98.5)	343 (64.4)	274 (52.7)	331 (63.4)	287 (54.2)
Tertiary	364 (34.2)	141 (48.1)	323 (90.5)	275 (79.9)	354 (98.1)	235 (66.2)	165 (46.5)	203 (57.3)	154 (43.8)
Employment									
Employed	450 (41.9)	194 (53.3)	405 (91.2)	330 (78.0)	442 (98.7)	281 (63.6)	193 (44.1)***	242 (55.4)***	191 (43.5)***
Unemployed	623 (58.1)	204 (49.4)	539 (90.4)	464 (78.6)	598 (97.9)	419 (69.1)	344 (57.4)	404 (67.3)	348 (57.4)
Marital status									
Single	316 (29.4)	168 (70.9)***	273 (89.5)	210 (70.0)***	300 (96.5)*	172 (56.0)***	127 (42.5)***	167 (55.1)**	123 (40.3)***
Married/cohabiting	582 (54.2)	185 (42.6)	517 (90.9)	445 (81.1)	572 (99.1)	400 (69.7)	304 (53.5)	359 (63.4)	315 (55.3)
Separated/divorced/ widowed	176 (16.4)	45 (42.1)	155 (92.8)	140 (84.8)	169 (98.3)	128 (76.2)	107 (62.6)	122 (72.2)	103 (60.2)

Statistical significance ( $\chi^2$ ): \* $p < 0.05$ , \*\* $p < 0.01$ , \*\*\* $p < 0.001$ 



**Table 3** Support for evidence-based alcohol policy in relation to alcohol consumption pattern

	Random driving check points	Ban alcohol advertising to youth	Ban on selling to under 18s	Ban on price promotions	Reduce no. of alcohol outlets	Support Minimum Unit Pricing	Separate premises sales
<b>AUDIT</b>							
Low risk	474 (91.9)*	397 (78.7)**	516 (98.5)*	340 (66.4)***	243 (47.7)**	306 (60.5)***	253 (49.3)***
Hazardous drinking	160 (87.4)	120 (68.2)	178 (95.7)	99 (52.9)	70 (38.7)	82 (43.9)	63 (34.4)
Harmful drinking	23 (82.1)	20 (64.5)	31 (100)	9 (27.3)	7 (22.6)	11 (34.4)	8 (25.0)
Alcohol dependent	18 (78.3)	14 (58.3)	25 (92.6)	10 (37.0)	5 (18.5)	8 (29.6)	9 (33.3)
<b>AUDIT-C</b>							
Non-hazardous	343 (92.7)*	294 (81.7)***	369 (97.9)	265 (72.2)***	189 (51.9)***	225 (62.2)***	187 (51.0)**
Hazardous	332 (87.4)	251 (68.2)	381 (97.4)	193 (49.2)	136 (35.4)	182 (46.7)	146 (37.6)
<b>Binge drinking</b>							
Never	205 (93.6)	186 (85.7)***	218 (97.8)	162 (75.0)***	119 (55.3)**	138 (64.5)**	120 (55.8)**
Less than monthly	233 (91.0)	177 (73.4)	254 (98.4)	159 (62.4)	105 (41.5)	136 (53.8)	111 (43.2)
Monthly	106 (88.3)	74 (63.2)	124 (97.6)	57 (44.9)	50 (41.0)	57 (46.3)	47 (37.6)
Weekly	117 (86.0)	95 (70.4)	136 (97.1)	70 (49.3)	44 (31.7)	68 (47.6)	50 (36.0)
Daily/almost daily	11 (78.6)	11 (73.3)	14 (93.3)	9 (60.0)	6 (40.0)	8 (57.1)	5 (33.3)
<b>Drinking to intoxication</b>							
Weekly	54 (81.8)*	42 (64.6)*	65 (95.6)	31 (45.6)*	15 (21.4)***	31 (45.6)*	23 (32.9)
Less than weekly	603 (90.5)	493 (96.3)	666 (97.9)	417 (62.1)	303 (46.0)	368 (55.4)	303 (45.6)

Statistical significance ( $\chi^2$ ): \* $p < 0.05$ , \*\* $p < 0.01$ , \*\*\* $p < 0.001$



Individuals who reported second-hand impacts of alcohol use were more likely to support evidence-based alcohol policy compared to individuals who did not report harm from other people drinking. Individuals who perceived societal issues in their local area (within a 15 min walk from their home) were more likely to support evidence-based alcohol policy than individuals who did not perceive local alcohol issues. Significant differences were noted in relation to a reduction in the number of alcohol outlets, a support for the introduction of minimum unit pricing, and separate alcohol sales premises among individuals who reported teenagers drinking on the street, adults drinking in public, underage drinking, public drunkenness, alcohol-related violence, and drink driving in their local area. See Table 4 for results on policy support in relation to societal issues.

## Discussion

This paper outlines the level of support for public health policy among the general population in Ireland. It signals substantial public support for evidence-based public health alcohol policy with individuals reporting more support for government intervention such as the Public Health (Alcohol) Bill.

### Sociodemographic

The current research suggests support for restriction of supply, access, and availability in an effort to combat excessive alcohol use among the general population. The majority of the population (>98%) believe in strictly enforcing the illegal selling of alcohol to people under the age of 18. The majority of individuals (>50%) across the region support both implementation of minimum unit pricing (62.4%) and selling of alcohol in premises separate from food and other household products (51.7%). Similar to recent research carried out in England, Scotland, and Australia, women, older aged individuals, and low-risk drinkers are more likely to support alcohol policy [30, 35, 36]. This level of support signals the recognition of the Irish population at a community level for their government to tackle this persistent public health issue nationally [23]. Even though support is predominant, as the policy becomes more restrictive we note a reduction in public support. This complements recent research in the United Kingdom which noted that “support was strongest for policies increasing law enforcement and providing health information/treatment services and more divided for pricing and availability pricing policies” [35]. Finally, it highlights the high levels of awareness among the Irish community in relation to effective, evidence-based policy to tackle excessive alcohol use across the country [37, 38].

### Alcohol Consumption

Those who reported excessive alcohol use were less likely to support evidence-based alcohol policy in the current research. Furthermore, almost 60% of participants reported that “individuals are responsible enough to protect themselves from



**Table 4** Support for evidence-based alcohol policy in relation to harm to others and social issues

	Random driving check points	Ban alcohol advertising to youth	Ban on selling to under 18s	Ban on price promotions youth	Reduce no. of alcohol outlets	Support mini- mum unit pricing	Separate premises sales
<b>Teenagers drinking on the street</b>							
Problem	606 (91.7%)	527 (81.1%)*	669 (98.5%)	451 (66.9)	377 (56.7)***	440 (66.3)**	384 (57.4)***
Not a problem	284 (88.2%)	231 (74.0%)	316 (97.2%)	212 (66.3)	133 (42.0)	170 (53.5)	126 (39.0)
<b>Adults drinking in public</b>							
Problem	336 (91.8%)	302 (84.1%)***	369 (98.7%)	273 (73.4)**	234 (63.6)***	260 (71.4)***	229 (61.9)***
Not a problem	542 (89.4%)	440 (74.5%)	605 (97.7%)	379 (61.8)	265 (43.9)	344 (56.6)	272 (44.5)
<b>Underage drinking</b>							
Problem	684 (91.0%)	587 (79.6%)	755 (98.1%)	511 (66.6)	420 (55.7)***	496 (65.7)***	417 (54.9)***
Not a problem	199 (89.2%)	160 (74.1%)	221 (98.2%)	145 (65.9)	90 (40.7)	114 (52.3)	92 (41.3)
<b>Public drunkenness</b>							
Problem	466 (89.8%)	406 (79.5%)	526 (98.7%)	361 (68.4)	307 (58.9)***	355 (68.5)***	312 (59.5)***
Not a problem	419 (91.3%)	343 (76.9%)	454 (97.6%)	297 (64.3)	195 (43.0)	256 (55.8)	196 (42.5)
<b>Alcohol-related violence</b>							
Problem	476 (90.0%)	410 (78.5%)	534 (98.3%)	361 (66.9)	308 (57.8)***	353 (66.5)**	308 (57.4)***
Not a problem	364 (90.1%)	299 (76.9%)	398 (97.8%)	259 (64.4)	176 (44.4)	229 (57.1)	176 (43.5)
<b>Drink driving</b>							
Problem	365 (90.3%)	314 (78.7%)	408 (98.3%)	292 (70.5)*	234 (57.2)***	270 (66.7)**	239 (58.2)***
Not a problem	327 (89.1%)	267 (75.4%)	365 (98.1%)	223 (61.1)	150 (41.8)	204 (55.9)	154 (42.0)

Statistical significance ( $\chi^2$ ): \* $p < 0.05$ , \*\* $p < 0.01$ , \*\*\* $p < 0.001$



alcohol related harm”. This complements previous research by Li et al. which noted that heavy alcohol users were among those with the lowest support for evidence-based alcohol policy in Scotland and England [35]. Discourse on alcohol education and prevention is framed in many forms. The alcohol industry framed their latest campaign as individuals, families, and culture being the cause of alcohol-related harm. They downplay or ignore “the role of industry in shaping that drinking culture” [28]. Meanwhile, public health advocates oppose “policy moves that are not supported by evidence” [4]. These conflicting messages may impact both myths and support surrounding national health policy.

## **Societal Impacts**

A previous report highlights the impact of alcohol on society in Ireland [39]. Recent findings by Chisholm et al. note that evidence-based alcohol policy measures are a cost-effective public health response to the burden of alcohol use [40]. The current research signals that those who perceive local issues in their community due to excessive alcohol use are more likely to support policy measures targeting consumption. In addition, research shows that many issues associated with excessive alcohol use occur within the community. These impact community members, and community members often respond, both formally and informally [41]. However, an evidence-based policy framework nationally is required to support communities tackling this endemic issue [4].

## **Advocacy, Media and Lobbying**

The introduction of the Public Health (Alcohol) Bill will, for the first time, ensure that alcohol is addressed as a ‘public health issue’ by the state [42]. Much dialogue on the Public Health (Alcohol) Bill is noted in Ireland since the Bill was launched in 2015. While the proposed legislation has generated support from public health advocates, efforts face significant opposition from industry and the general population. Considering this, substantial discussion and debate across Irish media is occurring [26, 43–45]. Although considerable delays in policy implementation persist, this delay has facilitated public discourse and debate and may underpin the current level of public support for evidence-based alcohol policy.

## **Strengths and Limitations**

This research employed a robust sampling strategy to gain a representative cross-section of each local community in the south of Ireland. Applying a household sampling strategy used in previous similar research studies, the questionnaire focuses on consumption, attitude, supply and prevention of alcohol use, and related harm. Demographic information in relation to gender were similar to national and local statistics [46].

It is important to note that participants may have given socially desirable responses considering face-to-face administration of the questionnaires [47].



## Conclusion

Globally, alcohol consumption and related harm continue to be a significant public health issue. The current research provides further evidence of public support for evidence-based alcohol policy measures, in particular those included in the current Public Health (Alcohol) Bill. In addition, it provides public health practitioners with the framework to encourage public support of future public health policy measures. As excessive alcohol consumption continues to cause harm to the user and others around them, implementation of evidence-based policy measures will facilitate the reduction of excessive consumption and alcohol-related harm.

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