PHARG
Public Health Alcohol Research Group

Monitoring and Evaluating the Public Health (Alcohol) Act 2018: A report from the Public Health Alcohol Research Group 2020-2022

REPORT TO THE MINISTER FOR HEALTH

June 2023

About this report

This report was compiled by Prof. Niamh Fitzgerald, Dr. Nathan Critchlow, and Colin Angus on behalf of the Public Health Alcohol Research Group (PHARG). It was approved by PHARG via email on 21st June 2023.

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List of acronyms

ABV	Alcohol-by-Volume
ED	Emergency Departments
EHS	Environmental Health Service
EHO	Environmental Health Office / Officers
ESPAD	European School Survey Project on Alcohol and Other Drugs
HBSC	Health Behaviours in School-aged Children
HRB	Health Research Board
IPH	Institute of Public Health
ISMH	Institute for Social Marketing and Health, University of Stirling
MESAS	Monitoring and Evaluating Scotland's Alcohol Strategy
NDAS	National Drug and Alcohol Survey
PHAA	Public Health (Alcohol) Act 2018
PHARG	Public Health Alcohol Research Group
MUP	Minimum Unit Pricing
SSA	Society for the Study of Addiction
TD	Teachta Dála
UK	United Kingdom
WHO	World Health Organization

Summary Briefing for Minister, Public Health Alcohol Research Group, June 2023

The Public Health (Alcohol) Act 2018 – hereafter 'PHAA' or 'the Act' – includes world-leading policy measures that are aligned with World Health Organization (WHO) recommendations and, once again, put Ireland at the forefront of public health policy. Robust monitoring and evaluation of the PHAA measures is vital both domestically and internationally and is overseen by the Public Health Alcohol Research Group (PHARG), established by then Minister for Health Simon Harris TD in December 2019.

PHARG Activity Report: Since 2020, with a total budget spend of €39,912, PHARG has:

- Established a framework for monitoring and evaluating key elements of the Act (Appendix A) and prepared advice on how to move forward.
- Made recommendations to support the implementation of minimum unit pricing (a floor price for alcohol meaning that alcohol cannot legally be sold more cheaply than the price set, which, in Ireland, is currently €0.10 per gram of alcohol); and
- Facilitated and advised on several key elements of data collection, including cross-border purchasing and awareness of health information related to alcohol.

Recommendations for PHARG: In the coming five years, PHARG should:

P1 Make recommendations for priority data collection to monitor and evaluate the impact of the Act, both overall and separately for individual PHAA measures.

P2 Work with the Department of Health, and other relevant authorities, to improve the availability and quality of data for evaluating whether the Act has achieved its policy objectives and to ensure that the 'expert research' specified in the Act can be taken account of by the Minister when making regulations, including:

- √ Establishing robust data collection systems in key services (e.g., emergency services; Environmental Health Service, Health Research Board, Social Inclusion services, An Garda Síochána etc.);
- √ Supporting the retention or integration of key outcomes and indicators in/into existing cross-sectional and longitudinal surveys (e.g., Healthy Ireland Survey, National Drug and Alcohol Survey), including for priority groups such as young people (e.g., HBSC, ESPAD etc);
- √ Purchasing robust data, where necessary (e.g., on alcohol sales/purchasing).

P3 Scope the cost and feasibility of priority studies, commissioning these studies directly as needed (subject to available budget), and looking to build capacity and expertise for independently funded studies where possible.

P4 Continue to map, track, and synthesise the findings of existing studies in Ireland on the key measures within the Act (pricing, advertising, labelling, structural separation) via a public portal.

P5 Analyse new data as it emerges from relevant surveys in the field.

P6 Ensure the perspectives of those with lived/living experience of alcohol-related hams are appropriately and meaningfully considered in monitoring and evaluation of the Act.

Challenges: Several strategic challenges must be addressed to enable effective monitoring and evaluation of the Act going forward. These include:

- Limited known expert public health research capacity in Ireland in the methods relevant to monitoring and evaluating the PHAA measures, which is reflected in membership of the PHARG.
- Proposed changes to alcohol licensing legislation through the Sale of Alcohol Bill (2022). If enacted, PHARG will need to account for any concurrent impact of the Bill on the availability and consumption of alcohol, as this may have important implications for robustly monitoring and evaluating the Act.
- Uncertainty and delays in funding for the work of PHARG and implementation of the Act more generally, which impeded the effective conduct of the group; the requirements set out in the Act will necessitate a much higher level of investment in future, in line with other countries.
- Significant capacity challenges for the chair, members, civil servants, and data collection that arose due to COVID-19 (now largely resolved).

Recommendations to the Minister: To address these challenges:

M1 Re-establish PHARG for a five-year period with a rolling annual budget of approximately €50,000 for core work (see Section 4), and a separate, more substantial, budget for commissioning relevant studies to be agreed annually in line with needs. The terms of reference for the group should be updated for the next phase of PHARG.

M2 Review the leadership and membership of PHARG in consultation with the outgoing chair and the Institute of Public Health (PHARG secretariat) to limit membership primarily to individuals with a remit specifically relevant to monitoring and evaluating the Act, rather than alcohol policy more generally, such as academic experts with requisite skills in natural experiment evaluation and public health policy evaluation (based in Ireland or abroad) and key officials in the Department of Health.

M3 Give consideration to reporting route for PHARG to the Department of Health and ensure that the PHARG chair is kept briefed of developments in relation to the commencement and implementation of PHAA measures. Ensure that PHARG has the opportunity to advise the Minister for Health on the implications of any proposed implementation timetable for the effective monitoring and evaluation of the Act.

M4 Ensure that the relevant authorities within the Health Service Executive (including Environmental Health, National Ambulance Service, Acute Services, Social Inclusion, Alcohol Programme) and other relevant services (e.g., An Garda Síochána; Tusla; Inland Revenue etc.) are tasked with working closely with PHARG to establish, with adequate resourcing, routine robust data collection on the harms of alcohol, related usage of public services, and compliance with the Act. Such data collection should be built into existing routine data sources where possible, with PHARG providing expert support to establish or refine and maximise the analytic potential of these data systems.

M5 Invest a ring-fenced €20,000 annually to continue the work of the UK-Ireland Alcohol Research Network (ACORN) – hosted by IPH – to grow capacity for alcohol and public health policy research in Ireland going forward, with the PHARG chair having discretion to co-opt ACORN members with relevant expertise or studies to PHARG working groups.

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Background

1. Background

The Public Health (Alcohol) Act 2018 – hereafter 'PHAA' or 'the Act' – was signed into law on 17th October 2018 [1]. For the first time, this legislation seeks to address the negative impacts of alcohol consumption on public health grounds. The Act contains a suite of measures designed to reduce alcohol consumption and limit the damage to the nation's health, society, and economy. The Act, in its broadest sense, intends to reduce alcohol consumption and related harms, which exist at high levels in Ireland [2,3]. The primary policy objectives of the Act are to [4]:

- Reduce alcohol consumption to 9.1 litres of pure alcohol per person per annum by 2020;
- Delay the initiation of alcohol consumption by children and young people;
- Reduce the harms caused by the misuse of alcohol;
- Ensure the supply and price of alcohol is regulated and controlled in order to minimise the possibility and incidence of alcohol related harm.

With the enactment and implementation of the Act, Ireland has become a world-leader in alcohol policy, delivering on two of the three key World Health Organization 'best buys' [5] by improving regulation of the affordability and marketing of alcohol. The third WHO best buy, restricting the availability of alcohol, is not addressed by the Act, but is the subject of the Sale of Alcohol Bill (2022) [6], which is discussed in Section 3.

Governments and public health bodies worldwide are looking to Ireland to put in place robust monitoring and evaluation for both individual PHAA measures and the Act as a whole. This will enable improved understanding of the most effective ways to reduce alcohol harms globally.

Then Minister for Health, Simon Harris TD, established the Public Health Alcohol Research Group (PHARG) for a three-year period from January 2020 to provide insight into monitoring and evaluation of the Act. The PHARG's terms of reference, and the key roles of the group, are outlined in Appendix B. The group comprises officials from Government departments in Ireland, as well as international experts from the United Kingdom (UK), including parties involved in monitoring of similar regulatory measures in Scotland.

Table 1: Membership of the Public Health Alcohol Research Group (PHARG) 2020-2022. Roles/ postholders may have changed, but are listed as correct at the time of service to PHARG

Member name and title	Role	Organisation
Prof. Joe Barry (Chair)	Professor of Public Health Medicine	Trinity College Dublin
Dr. Sheila Gilheaney	Chief Executive Officer	Alcohol Action Ireland
Dr. Helen McAvoy	Director of Policy	Institute of Public Health
Marion Rackard	Project Manager	HSE Alcohol and Mental Health and Wellbeing Programmes
Dr. Aisling Sheehan	National Lead	HSE Alcohol and Mental Health and Wellbeing Programmes
Anne Doyle	Research Officer	Evidence Centre, Health Research Board
Dr. Pat Kenny	Senior Lecturer	College of Business, Technological University Dublin
Colin Angus	Senior Research Fellow	Sheffield Alcohol Research Group, University of Sheffield
Prof. Niamh Fitzgerald	Professor of Alcohol Policy/ Director	Institute for Social Marketing and Health (ISMH), University of Stirling
Clare Beeston	Public Health Intelligence Principal – Evaluation	Public Health Scotland
Dr. Stephen Weir	Senior Lecturer	Institute of Public Administration
Dr. Geoffrey Shannon	Special Rapporteur on Child Protection	
Gerry Kenny	Tax Policy Division	Department of Finance
Kieran Culhane	Senior Statistician	Central Statistics Office
Paul Brosnan	Higher Executive Officer	Health and Wellbeing Programme Department of Health
Paula Leonard	National Lead	Irish Community Action on Alcohol Network (ICAAN)
Dr. Fiona Mansergh	Assistant Principal	Health and Wellbeing Programme Department of Health
Siobhan McNamara	Higher Executive Officer	Tobacco and Alcohol Control Unit Department of Health

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PHARG Activity Report and Future Priorities

2. PHARG Activity Report and Future Priorities

In early 2021, PHARG developed an ambitious work plan consisting of four aspects:

- Develop an overarching intervention logic model (see definition below).
- Use the intervention logic model to define a monitoring and evaluation framework.
- In light of the monitoring and evaluation framework, review the adequacy of current data sources in Ireland and internationally (as appropriate).
- In light of the intervention logic model and the monitoring and evaluation framework, identify gaps in existing data sources in Ireland and the research needed to fully monitor the progress of the Act and evaluate its impact.

The work of PHARG must be informed by robust methods and evidence. A logic model is a graphic or table which represents or describes the theory of how an intervention, such as a policy measure, produces outcomes. It outlines, in a simplified way, a hypothesis or 'theory of change' about how an intervention works and what indicators could be monitored or studied to determine effectiveness. Defining these 'outcome pathways', and the related data requirements, is a pre-requisite to robust monitoring and evaluation, though it does not in itself demonstrate the impact of a policy.

It was the initial plan of PHARG to develop an overarching logic model for the Act as a whole. Less than three months after PHARG was established, however, the COVID-19 pandemic led to considerable disruption to the group's work. In the first instance, the COVID-19 restrictions caused unprecedented changes in alcohol retail and consumer behaviour, quite separate from any changes that could be directly attributable to the Act. Secondly, the capacity of civil service officials and the PHARG Chair to participate in PHARG-related activities was compromised due to the diversion of attention to the pandemic response and recovery. Thirdly, statutory health information systems and data collection systems were disrupted, including the cancellation or deferment of surveys relevant to the measurement of alcohol-related harms across the health, social care and justice systems. Finally, COVID-19 meant it was difficult for many researchers to begin any meaningful collection of evaluation data due to practical challenges (e.g., restrictions on travel and social distancing etc.) and because attention was diverted towards urgent COVID-19 research projects.

PHARG wrote to the Minister for Health, Stephen Donnelly TD, on 10th November 2020 seeking to update him on the work of PHARG, in light of the significant impact of the pandemic on alcohol consumption and related harms.

Following a review and proposal by PHARG members Fitzgerald and Angus, the workplan was revisited, revised, and specified in greater detail in 2021, amid continuing pandemic-related pressures. The amended plan focused on progressing individual logic models for minimum unit pricing, advertising, and (if possible) for structural separation and labelling, before considering any overarching logic model or evaluation framework. This pragmatic approach was taken in line with limitations on available capacity and expertise in conducting natural experiment research and public health/alcohol policy evaluation among PHARG members. The specialist nature of the expertise required for this work led

to a reliance on a small number of PHARG members who formed a subgroup to oversee the logic model work (Barry; Fitzgerald; Angus; McAvoy; Sheehan; and Doyle), who co-opted Dr. Nathan Critchlow (University of Stirling) to lead work on advertising and labelling. It was further agreed, where necessary, that additional expertise outside of the PHARG group would be drawn upon to help take the work forward.

In light of this new approach, the following sections are structured according to the broad policy areas in the Act: pricing (2.1); advertising, marketing and sponsorship (2.2); health information and warnings (2.3); and structural separation (2.4). In each section, we summarise the activity of PHARG and its members, and provide a summary of key recommendations. Following this, we present a brief section outlining the most recent preliminary work on an overarching logic model and evaluation framework for the Act as a whole (2.5).

Each of the below sections also include key recommendations for data collection based on the work to date. We note, however, that these recommendations are not exhaustive, nor are the outcomes, indicators, and potential data requirements outlined in Appendix A. A central part of PHARG's future work will be to further scrutinise the feasibility and importance of these data sources and, in turn, support the development and implementation of appropriately designed and robust studies to evaluate and monitor the Act and its measures. Moreover, while each of the identified outcomes and indicators provide meaningful contribution to monitoring and evaluating the Act, it is unlikely that resources will be available to capture all those listed. Therefore, another important function of PHARG going forward will be to provide expert advice on prioritising monitoring and evaluation activities, in line with the recommendations in the report, and ensuring cost-effective use of any available resources.

Key Points

- PHARG's activity in 2020-22 has centred on developing logic models for the PHAA measures to identify the key data sources needed to enable robust monitoring and evaluation of the Act.
- The key outcomes, indicators, and potential data requirements outlined in Appendix A – Tables A1 to A5 – are a pre-requisite for effectively monitoring and evaluating the Act through appropriately designed and robust studies.

2.1 Minimum Unit Pricing and Restrictions on Price Promotions

An expert workshop was arranged in August 2021 with representation from evaluators of minimum unit pricing (MUP) in Wales and Scotland to discuss the potential pathways to impact. This informed a logic model and report by Fitzgerald and Angus which mapped out potential outcomes of the policy, impacts, indicators of impact, and data sources for each indicator. The report and its recommendations were informed by emerging data from the evaluation of MUP in Scotland [7] including studies examining the impact of MUP in the retail sector [8-10], among homeless populations [11,12], and with current and dependent drinkers [13,14]. The report was used to facilitate discussion about the availability of

existing data in Ireland and the key gaps for evaluating MUP. The resultant document highlighted several areas of action for the evaluation and implementation of MUP in Ireland that were deemed to be of high urgency. The most important recommendations from this report were provided to the Minister for Health as follows (see below).

- There is a need for ongoing transparency and clarity on all aspects of the enforcement and compliance system for minimum unit pricing (MUP) and for appropriate data to be collected and made available to us (PHARG) by those responsible for monitoring compliance.
- Retailers need guidance and support to understand and be able to properly implement MUP[1].
- There should be a public communication campaign around the introduction of MUP explaining the operation of and rationale for the policy, to support smooth implementation and acceptance, and to encourage compliance.
- Data should be collected before and after the introduction of MUP on purchasing of alcohol in Northern Ireland for consumption in Ireland.
- Support should be made available to vulnerable drinkers who may be most affected by MUP, and an assessment of the impact of MUP on these groups should be undertaken within drug and alcohol and other relevant services (e.g. homeless services).
- Efforts to routinely and systematically capture the health and social impacts of problematic alcohol use and the impact of the MUP initiative on the level of health service usage should be strengthened across all public services, especially in acute hospital and emergency department settings.

In response to these recommendations, PHARG provided advice to member Sheehan who worked within the HSE to support communication with alcohol service providers around how the introduction of MUP may affect their client group. The National HSE Alcohol, Mental Health and Wellbeing Programme, and National Social Inclusion Office also commenced work in relation to this prior to the introduction of MUP. The University of Stirling also sought and received funding from the Institute of Public Health (PHARG Secretariat) to put in place a pre-MUP survey of alcohol purchasing in Northern Ireland. The Institute of Public Health have since also awarded funding to the University of Stirling to repeat this assessment one-year post-MUP, the results of which will be published as soon as possible following peer review.

The summary of priority actions was provided, as worded above, to Minister for Health Stephen Donnelly TD in an update letter from PHARG on January 20th 2022 which sought a meeting to discuss the matters raised. Further correspondence was received from Minister of State Feighan's office on 2nd March 2022 which indicated that he would hope to facilitate a meeting with PHARG when the group had a product to share.

A summary of the outcomes, indicators, and potential data requirements identified in the full logic model for monitoring and evaluating MUP are outlined in Appendix A, Table A1 and Table A2. There remain several important outstanding monitoring and evaluation priorities for MUP which should be progressed by PHARG going forward, most notably those shown in Box 1.

1. Guidance was published in December 2021 and is available at: https://www.gov.iepdf/?file=https://assets.gov.ie/206477/b77611ba-d074-4ece-8be2dab68594141f.pdf

Data on alcohol-related attendances at hospitals before and after the introduction of MUP has already been gathered [15,16]. These studies were not designed to robustly evaluate the impact of MUP but will help to inform the design and refinement of the routine data collection protocols needed for this purpose in future and for evaluation of the Act as a whole, across Ireland.

Box 1: Recommendations for PHARG 2023-2028

a) Examine the feasibility of, and if feasible commission, a time series analysis study of the impact of MUP on alcohol sales in Ireland, preferably using a control country without a comparable MUP policy (i.e., England, region of England, or Northern Ireland).

b) Examine the feasibility of, and if feasible commission, a study of the impact of MUP on alcohol-related hospital admissions using routine data sources collected before and after the introduction of MUP.

c) Complete and report the analysis of consumer survey data on cross-border purchasing of alcohol in Northern Ireland.

d) Examine the potential for and make recommendations to the Minister for Health on how routine and robust data collection on alcohol in selected EDs could be established to track the impact of alcohol on ED attendances, and (if possible) ambulance services, over time, and to ensure that any future changes in the level of alcohol taxation or MUP, and forthcoming changes to late night retailing of alcohol, can be evaluated.

e) Examine the feasibility of, and if feasible commission, regular assessment of the affordability of alcohol to inform the rate at which the MUP is set by the Minister for Health.

2.2 Alcohol Advertising, Marketing, and Sponsorship

PHARG has carried out three activities in respect of the PHAA measures on marketing. The first is development of a logic model by Dr. Nathan Critchlow to inform monitoring and evaluation. Dr. Critchlow was identified by PHARG to lead on this as he is conducting a series of studies, funded through a fellowship from the Society of the Study of Addiction (SSA) and support from the IPH, to examine the impact of the PHAA restrictions on advertising [17]. The logic model developed by Critchlow was refined in two stages: first through consultation with another expert in marketing research, Martine Stead (then-Deputy Director of ISMH, University of Stirling) and then through a presentation to the PHARG sub-group. The resultant logic model, summarised in Appendix A Table A3, identifies the key outcomes, indicators, and potential data requirements for monitoring and evaluating the restrictions, including those needed prior the remaining restrictions commencing (e.g., broadcast watershed).

The second activity is that PHARG has been scoping options for examining how the advertising and marketing restrictions which have already commenced (in November 2019 and November 2021) have impacted on exposure among children and young people. Unlike with adults [17], no specific baseline data was collected among children and young people before these restrictions commenced, which creates a challenge for monitoring and evaluation. In response, Critchlow and PHARG member Doyle (HRB) have been

reviewing alternative options. The first option reviewed was to use a 2015 survey of alcohol marketing awareness among adolescents, conducted by NUI, as a de facto baseline [18]. Members Doyle and Critchlow only obtained access to the original survey instrument from this prior assessment in January 2023. As such, the extent to which this may provide a viable baseline for follow-up is yet to be assessed.

The second option considered was to collect data using the European School Survey Project on Alcohol and Other Drugs (ESPAD), which has been used to look at awareness of alcohol marketing among young people in France [19]. Although any data collected in Ireland would only be cross-sectional, some degree of impact could be inferred if awareness among young people in Ireland was compared to other countries similar in size and profile to Ireland, including those with/without similar advertising restrictions. While this remains a potentially viable option, a key challenge identified by Critchlow and Doyle is that cross cultural comparison would only be possible if at least some other countries involved in the ESPAD programme also agreed to include the same questions on alcohol advertising awareness. To date, it is unclear to what extent this will be possible, if at all.

The third activity was contribution to the letter sent to the Minister for Health Donnelly TD on 20th January 2022. In it, PHARG noted that alcohol companies may be using brand-sharing to continue promotional activity where advertising for regular strength products is no longer permitted [e.g., 20]. This includes, for example, advertising for products with zero-strength alcohol-by-volume (ABV) on public transport and during the recent European Rugby Champions Cup but using similar brand iconography to the regular strength product (e.g., brand names, logos, and fonts). To what extent brand sharing advertising is legally compatible with the Act is yet to be clearly established, but it does have the potential to undermine the impact of the PHAA restrictions. In the January 2022 letter, PHARG requested an opportunity to discuss these concerns with the Ministers.

In addition to the following recommendations, it is vital that routine, regular, and robust data collection is done by the relevant authorities responsible for ensuring compliance with these measures (see overarching recommendations for the Minister in Section 4).

Box 1: Recommendations for PHARG 2023-2028, continued

f) Ensure that existing adult consumer surveys examining how the PHAA advertising restrictions impact on marketing awareness – to date co-funded by the IPH and SSA – continue to be funded to generate longer-term evaluation data for existing restrictions and new evaluation data for forthcoming restrictions.

g) Examine the feasibility of, and if feasible commission, analysis of alcohol advertising data in Ireland (e.g., volume/expenditure), preferably covering restricted and unrestricted advertising activities and related non-alcoholic offerings (e.g., zero-ABV products).

h) Continue to examine the feasibility of, and if feasible commission, youth survey data to examine awareness of, and engagement with, alcohol marketing, including before and after the forthcoming restrictions (e.g., broadcast watershed).

2.3 Health Information and Warnings

PHARG has carried out three activities in respect of plans to introduce mandatory health information and warnings on alcohol packaging, in alcohol advertising, and in licensed premises. The first is that Dr. Critchlow has reviewed the outcomes, indicators, and potential data required to monitor and evaluate this measure, principally by reviewing peer reviewed literature in relation to two similar real-world interventions: health warnings on tobacco packaging [e.g., 21-24] and health warnings on alcohol packaging in a Canadian province [25-27]. The resultant basic logic model is summarised in Appendix A Table A4.

The second activity undertaken by PHARG has been to identify opportunities to capture or access this information through existing data sources. It was identified through PHARG member Sheehan that some relevant data is already collected in existing surveys, such as the Ask About Alcohol survey (e.g., knowledge of health effects of alcohol and where consumers access health information about alcohol). PHARG member Doyle and Dr. Critchlow also developed questions for the next wave of the Healthy Ireland Survey (currently in the field, publication expected in Q4, 2023) to gather baseline data concerning: (i) awareness of, and engagement with, health messages, health warnings, and health-related product information (on packaging and in advertising) and; (ii) where consumers currently access health information about alcohol. It is intended these measures will be repeated once the requirements for health information and warnings become mandatory.

The third activity was a letter to the Minister for Health in January 2022. In this iteration of PHARG, it was identified that there is currently an absence of evidence about the impact of health warnings for alcohol on consumers in Ireland. This includes, as far as PHARG is aware, little robust evidence evaluating how the labels submitted by the Irish Government to the European Commission may impact among various consumer groups, including key groups such as young people. Therefore, in our letter to the Minister for Health in January 2022, PHARG requested an opportunity to discuss appropriate evidence-based input to the wording and design of these labels. In this letter, PHARG noted our understanding that draft labels were being prepared, and requested that these be made available for evaluation and expert input prior to being finalised, to maximise their potential for reducing alcohol-related harm. This offer was not taken up by the Minister for Health as to do so would have been sharing draft law.

In addition to the following recommendations, it is vital that routine, regular, and robust data collection is undertaken by the relevant authorities responsible for ensuring compliance with these measures (see overarching recommendations for the Minister in Section 4 overleaf).

Box 1: Recommendations for PHARG 2023-2028, continued

i) Lead/contribute to/commission analysis of the Healthy Ireland data relating to awareness of, and engagement with, health messages, health warnings, and health-related product information on packaging and in advertising, and ensure suitable questions continue to be included in future waves once the PHAA measures have commenced.

j) Design and commission pre-implementation research to test the impact of the planned health information and warning designs through qualitative consumer focus groups and experimental designs.

k) Support existing surveys (e.g., Healthy Ireland, Ask About Alcohol, Health Behaviours in School Aged Children, ESPAD, National Drug and Alcohol Survey etc) to monitor key indicators such as knowledge of the health conditions linked to alcohol, age of initiation, and/or knowledge of the health characteristics of alcoholic drinks (e.g., grams of alcohol/calories contained etc.), including after the PHAA measures have commenced.

2.4 Structural Separation

The main activity in relation to structural separation was an expert workshop facilitated by Fitzgerald in September 2021 with PHARG member McAvoy. This involved colleagues from ISMH (Douglas Eadie, Martine Stead, Dr. Nathan Critchlow) who have been involved in previous evaluations of retailer-based interventions, for example evaluating the introduction of a ban on point-of-sale displays of tobacco products [28], placement of unhealthy foods at checkouts [29,30], and implementation of MUP in small retailers [8,9]. The resultant basic logic model, summarised in Appendix A Table A5, identifies the key priorities which should be progressed by PHARG going forward, which are outlined below.

In addition to the following recommendations, it is vital that routine, regular and robust data collection is undertaken by the relevant authorities responsible for ensuring compliance with these measures (see overarching recommendations for the Minister in Section 4).

Box 1: Recommendations for PHARG 2023-2028, continued

l) Examine the feasibility of, and if feasible commission, research to assess the compliance/quality of implementation in diverse mixed retailers (supermarkets, convenience stores, forecourts etc.) and barriers to successful implementation.

m) Examine the feasibility of, and if feasible commission, research to examine whether the degree of compliance/quality of implementation in diverse mixed retailers is associated with exposure to, and perceived visibility of, alcohol branding in retailers among young people and adults from local communities.

n) Examine the feasibility of, and if feasible commission, research with adults and young people to examine exposure to, perceived visibility of, and salience of alcohol products and branding (including co-branded no and low-alcohol products) in diverse mixed retailers, preferably in comparison with a jurisdiction without structural separation (e.g., England or region of England).

2.5 Cross-cutting Data Requirements and Overarching Evidence Needs

In addition to the data requirements specific to the individual measures, outlined above, there are several aspects of monitoring and evaluating which are relevant to all individual PHAA measures and are needed to understand the combined impact of the Act as a whole. As such, there are some cross-cutting actions that PHARG should take going forward which will greatly assist with monitoring and evaluation.

To this end, key members of the logic model subgroup have identified a series of outcomes, indicators, and potential data sources that sit within an overarching framework for monitoring and evaluating the Act as a whole, shown in Appendix A Table A1. Defining these data requirements in logic models is a prerequisite to evaluating a policy and has, therefore, been PHARG's initial focus. It is essential to note, however, that the effectiveness of a policy measure cannot be properly evaluated simply by looking at trends in data. Rather, having the right data enables studies to be designed using that data, ideally alongside data from neighbouring or comparable countries or regions where the policy has not been introduced or is different. These 'natural experiment' studies are highly diverse in design, but often draw on a combination of quantitative and qualitative methods (such as time series analysis or regression analysis using primary or secondary data, documentation analysis, and interview or focus group data) to understand if and how changes in outcomes of interest can be causally attributed to the policy [31]. Going forward there will be a need for PHARG to enable such studies to be designed and delivered, and in so doing, to identify the priority data requirements for monitoring and evaluating the impact of the Act.

For many of the measures in the Act, an important part of monitoring and evaluation will be assessment of the extent to which the measures have been implemented and complied with as intended. In most cases, such data should be gathered by the authorised officers who have responsibility for ensuring compliance with the Act. It is therefore important that

PHARG works closely with the Department of Health, and with the Environmental Health Service and any other relevant authorities, to establish systems of routine and robust data collection on compliance with, and the quality of implementation of, the measures in the Act. Effective use of existing routine data systems, for both monitoring compliance and examining other relevant outcomes and indicators, is congruent with the recent Public Service Data Strategy, 2019 to 2023 [32].

In considering these overarching and cross-cutting data requirements we have also taken account of two other important aspects of monitoring and evaluating the Act:

- The primary policy objectives of the Act – outlined in Section 1 – of reducing consumption, delaying the initiation of consumption, reducing alcohol-related harms and regulating the supply and price of alcohol [4].
- The types of expert research specified in several sections of Act [1] – including 11 (MUP), 12 (labelling) and 13 (content of adverts) – which should be considered by the Minister in making regulations under the Act. See example text for Section 11 in Box 2.

Box 2: Public Health (Alcohol) Act 2018, Section 11, subsection (5) [1]

When making an order under subsection (3), the Minister shall take into account any expert research available to him or her on the effectiveness of the introduction of the minimum price per gram of alcohol for the purposes of this Act, and shall have regard to:

(a) the rate of alcohol consumption,

(b) patterns of alcohol consumption,

(c) health-related risks caused by alcohol consumption,

(d) data from health services relating to alcohol related presentations at health facilities,

(e) other societal harm caused by alcohol consumption,

(f) the price and affordability of alcohol products, and

(g) such other matters he or she considers appropriate.

It is important to recognise that evaluation of the PHAA and its measures may not be restricted to the work of PHARG members or partner organisations. While there appears to be limited capacity and expertise in alcohol policy evaluation in Ireland, as a high-profile policy, the PHAA may be subject to studies led by independent academics or conducted as part of postgraduate studies. It is essential that PHARG retains an overview of all relevant research, performing a similar role in this respect to that of the MESAS team (Monitoring and Evaluating Scotland's Alcohol Strategy) in Public Health Scotland. MESAS maintain a website that describes and summarises the findings of relevant studies of MUP as they emerge – explaining in lay terms what each new study means, what it adds to what was already known, and what further studies are relevant to understanding the impact of the policy going forward [7].

Overarching Recommendations for PHARG 2023-2028

P1 Make recommendations for priority data collection to monitor and evaluate the impact of the Act, both overall and separately for individual PHAA measures.

P2 Work with the Department of Health, and other authorities, to improve the availability and quality of data for evaluating whether the Act has achieved its policy objectives and to ensure that the 'expert research' specified in the Act can be taken account of by the Minister for Health when making regulations, including:

- √ Establishing robust data collection systems in key services (e.g., emergency services; Environmental Health Service, Health Research Board, Social Inclusion services, An Garda Síochána etc.).
- √ Supporting the retention or integration of key outcomes and indicators in/into existing cross-sectional and longitudinal surveys (e.g., Healthy Ireland survey, NDAS), including for priority groups such as young people (e.g., HBSC, ESPAD etc).
- √ Purchasing robust data where necessary (e.g., on alcohol sales/purchasing).

P3 Scope out the cost and feasibility of priority studies, such as robust natural experiment evaluations, commissioning these directly as needed (subject to available budget), and looking to build capacity and expertise for independently funded studies where possible.

P4 Continue to map, track, and synthesise the findings of existing studies in Ireland on the key measures within the PHAA (pricing, advertising, labelling, structural separation) via a public portal.

P5 Analyse new data as it emerges from relevant surveys in the field.

P6 Ensure the perspectives of those with lived/living experience of alcohol-related hams are appropriately and meaningfully considered in monitoring and evaluation of the Act.

3

Strategic Challenges

3. Strategic Challenges

Several strategic challenges have been identified which also need to be addressed by the Department of Health to enable effective monitoring and evaluation of the Act going forward. Addressing these challenges would not only benefit alcohol policymaking but would further strengthen capacity in Ireland to deliver policy-relevant public health research more generally.

Limited expert capacity and resources: There exists limited expert capacity in Ireland in the methods most relevant to monitoring and evaluating the PHAA measures, including the type of natural experiment evaluations and policy studies mentioned above. As such, there was limited experience in this regard within the existing membership of PHARG. The group did include two academic experts based in the UK (Angus and Fitzgerald) who are internationally recognised for their expertise in the methods required for evaluating alcohol policy measures, however their capacity is limited, and neither is an expert on the evaluation of advertising or labelling regulations. Moreover, these academics served on PHARG on a voluntary basis and their capacity was necessarily limited by the lack of dedicated resources for PHARG. This capacity gap was addressed to some extent by co-opting Critchlow (a marketing expert) to the PHARG logic model subgroup, and by that subgroup's use of expert workshops to inform the work of PHARG. In future, PHARG would benefit from the bulk of members being policy evaluation experts, and membership should be restricted only to those with a remit for data collection or research for monitoring and evaluating the Act rather than alcohol policy more generally. This would ensure that PHARG can focus on its primary remit of enabling monitoring and evaluation with objectivity and rigour.

Little clarity on details and timing of implementation: There has been, and remains, limited clarity on the timetable and details of when and how key measures within the Act were/are to be implemented. There are many measures yet to be commenced (warnings on packaging, content restrictions on advertising, advertising broadcast watershed, print advertising restrictions etc.). This lack of clarity impedes the ability of PHARG to prioritise monitoring and evaluation activity and to ensure that adequate baseline data are collected for the evaluation of each measure.

Proposed liberalisation of alcohol availability: At the time of writing, the Department of Justice had recently published draft legislation for the Sale of Alcohol Bill (2022) [6]. These proposed reforms may lead to more widespread later opening hours for bars and nightclubs, allow on-trade premises to obtain licences without any need to purchase a surrendered licence, and allow cultural venues to obtain a licence to sell alcohol. If implemented, these changes will, over time, interact with the PHAA measures on affordability and marketing and, consequently, also have the potential to impact on the primary objectives of the Act (see Section 1). This has implications for robustly monitoring and evaluating the Act, as any studies would need to account for confounding influence of the Sale of Alcohol Bill on the key outcomes and indicators outlined.

4

Recommendations to the Minister for Health

4. Recommendations to the Minister for Health

To address these challenges, we make strategic recommendations to the Minister for Health, which are outlined in Box 3 overleaf.

Effective and robust evaluation of public policies takes time to be confident in the conclusions reached. A comparable programme in Scotland – Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS) – has been established since 2010 with research valued at over £2 million GBP and significant institutional infrastructure overseeing the programme at Public Health Scotland. Under this programme, over 20 studies are underway or completed into the impact of MUP [7]. This includes research commissioned directly by MESAS and studies funded by organisations separate to the MESAS programme. Research into MUP in Wales is also on-going [33], including a recent evaluation study commissioned at a cost of £350,000. To date, PHARG has made significant progress with very limited financial resources (€39,912) and member capacity. The next phase requires consistent funding and dedicated focus to ensure that PHARG can be a valued resource for public policy and ministerial decision-making, as is the case with programmes elsewhere and as is mandated in the Act. These matters are reflected in our first recommendation M1 below, though we do not specify a budget level for commissioning studies as those would need to be costed once fully designed. We anticipate the core budget would be needed to resource senior researcher input and support to:

- √ Manage and provide a secretariat to PHARG;
- √ Monitor and synthesise emerging relevant research;
- √ Make the synthesis publicly available;
- √ Scope out, design, cost, and commission relevant studies;
- √ Support the establishment of robust data collection systems or the purchasing of new data;
- √ Support the analysis and interpretation of survey data as it emerges.

Recommendations M2 to M4 seek to address some of the challenges identified in Section 3.

The final recommendation M6 refers to the UK-Ireland Alcohol Research Network (ACORN) (https://alcoholresearch-uk-irl.net/). This capacity building network for alcohol policy research was funded until June 2022 jointly by the Irish Research Council and Economic and Social Research Council in the UK, but this funding has now ended. Though somewhat hampered by the pandemic, this network had begun to build links and enable transfer of learning between UK-based academics and colleagues in Ireland interested in this area of work. This initiative included study visits, a capacity building research workshop, and several webinars, and it has already resulted in a new all-Ireland team receiving grant funding to conduct research on alcohol health labelling. It is an important vehicle for building local capacity for public health research which will be necessary for robust studies of the PHAA and its measures. It is important that increased capacity for alcohol research in Ireland is similarly met by more opportunities for researchers to obtain funding, thus leading to more Ireland-specific research and longer-term retention of those working in this field.

Box 3: PHARG Recommendations to the Minster for Health, 2023-2028

M1 Re-establish PHARG for a five-year period with a rolling annual budget of approximately €50,000 for core work (see Section 4), and a separate, more substantial, budget for commissioning relevant studies, to be agreed annually in line with needs. The terms of reference for the group should be updated for the next phase of PHARG.

M2 Review the leadership and membership of PHARG in consultation with the outgoing chair and the Institute of Public Health (PHARG secretariat) to limit membership primarily to individuals with a remit specifically relevant to monitoring and evaluating the Act, rather than alcohol policy more generally, such as academic experts with requisite skills in natural experiment evaluation and public health policy evaluation (based in Ireland or abroad) and key officials in the Department of Health.

M3 Give consideration to reporting route for PHARG to the Department of Health and ensure that the PHARG chair is kept briefed of developments in relation to the commencement and implementation of PHAA measures. Ensure that PHARG has the opportunity to advise the Minister for Health on the implications of any proposed implementation timetable for the effective monitoring and evaluation of the Act.

M4 Ensure that the relevant authorities within the Health Service Executive (including Environmental Health, National Ambulance Service, Acute Services, Social Inclusion, Alcohol Programme) and other relevant services (e.g., An Garda Síochána; Tusla; Inland Revenue etc.) are tasked with working closely with PHARG to establish, with adequate resourcing, routine robust data collection on the harms of alcohol, related usage of public services, and compliance with the Act. Such data collection should be built into existing routine data sources where possible, with PHARG providing expert support to establish, or refine and maximise the analytic potential of such data systems.

M5 Invest a ring-fenced €20,000 annually to continue the work of the UK-Ireland Alcohol Research Network (ACORN) – hosted by IPH – to grow capacity for alcohol and public health policy research in Ireland going forward, with the PHARG chair having discretion to co-opt ACORN members with relevant expertise or studies to PHARG working groups.

5

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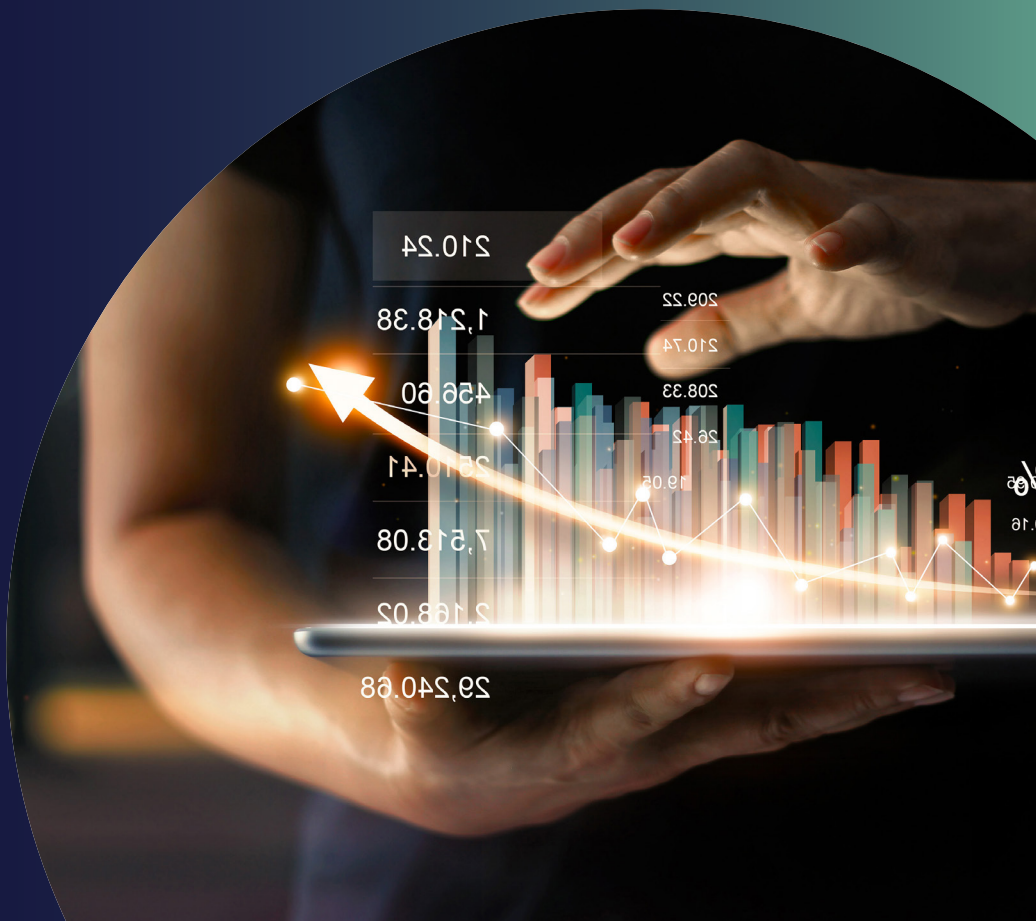
6

Appendices



Appendix A

Table A1 sets out the key outcomes, indicators, and potential data requirements to monitor and evaluate to the overall impact of the combined measures in the Act, thus examining to what extent it is meeting the primary policy objectives (see Section 1) [4]. Such data would not in itself constitute direct evaluation but, in the case of routine data from services or routine morbidity and mortality figures, should be analysed in specific and robust studies designed to evaluate the combined impact of the Act and its component measures. These studies should include evaluation of the relative contribution of the various PHAA measures in relation to changes in the overarching outcomes. Data requirements for the individual PHAA measures are set out in Tables A2-A5 below. Although not noted in every row, the diverse impact in different population subgroups, and the impact on health inequalities, should be considered in data collection and related studies wherever possible.

Table A1. Outcomes, indicators, and potential data requirements to monitor and evaluate the combined impact of all measures within the PHAA

Outcome	Key indicators	Potential data requirements
Alcohol use among general population	Per capita consumption, overall and among current drinkers.	Routine revenue data on litres of pure alcohol sold in Ireland.
	Prevalence of hazardous/harmful/ dependent use.	Repeat cross-sectional population-level surveys with the necessary power (i.e., sample size) for subgroup analysis.
Alcohol use among young people	Patterns of alcohol use (e.g., % of drinkers, frequency of drinking).	Repeat cross-sectional probability-based surveys with young people.
	Patterns of hazardous/harmful/ dependent alcohol use.	
	Age of initiation of alcohol consumption.	

Impact on harmful/ dependent drinkers	Demand for, and waiting times in, alcohol treatment services.	Routine data from specialist alcohol and addiction treatment services.
	Recovery rates from alcohol dependence, alcohol withdrawal rates, substitution to other substances or illicit alcohol, diversion of spend to/from alcohol.	Qualitative data from dependent drinkers, service providers, and frontline services.
Alcohol health harms and burden on health services	Alcohol-attributable deaths.	Routine mortality records.
	Alcohol-related burden on hospital capacity.	Routine data on alcohol-specific and alcohol-related hospital admissions.
	Alcohol-related burden on emergency health services.	Routine data on alcohol-related emergency department visits and ambulance callouts.
	Alcohol burden on primary healthcare system.	Routine data on visits to primary care by patients with alcohol use disorders
	Alcohol-attributable morbidity in different population groups and in the longer term.	Modelling future impact of changes in alcohol use, including impact on inequalities and for specific conditions (e.g., Foetal Alcohol Spectrum Disorder).
Harm to others	Experiences of harms from someone else's drinking.	Repeat cross-sectional population-level surveys.
	Alcohol-related crime.	Routine data from Garda Síochána and police and criminal justice system, including on violence.
	Alcohol-related traffic offences and accidents.	Routine data from Road Safety Authority and the Garda Síoch ána.

Economic impact	Alcohol-related economic burden (e.g., healthcare and criminal justice costs, alcohol-related workplace absence).	Repeat cross-sectional population-level surveys to capture rates of short- and long-term workplace absence.
		Routine data on illness benefit claims from Social Welfare Services.
		Cost estimates of hospital admissions and societal costs of crime, including direct impacts on victims and costs to the police and criminal justice system.
	Government revenue from alcohol sales or diverted spend.	Alcohol duty receipts; Value Added Tax receipts.
	Alcohol industry profitability and sector size.	Alcohol producer/retailer data (e.g., size of industry, number and type of licences, employment, revenue, profit etc.)
	Impact on other industries arising from spend diverted to or from alcohol.	Other industry data to be determined.
Public awareness, attitudes, and brand salience.	Awareness of, and support for, the Act and individual measures	Repeat cross-sectional population-level surveys. Qualitative research with adults and young people.
	Public attitudes towards alcohol (e.g., norms, expectancies, motives for consumption etc) and alcohol-related harms	
	Salience of alcohol products/brands among adults and youth (e.g., brand recognition, favoured brands etc).	

A2. Additional data requirements (beyond Table A1) for monitoring and evaluating controls on alcohol pricing and promotion.

Commencement of pricing controls began on 11th January 2021 with the Section 23 restrictions on some price promotions, such as multi-buy discounts, short-term price reductions, accrual or use of loyalty points in relation to alcohol sales, and promotion of alcohol in a manner likely to encourage harmful consumption[1]. Commencement continued on 4th January 2022 with Section 11, which made it a requirement for all alcohol sold in Ireland to have a minimum unit price of €0.10 per gram of alcohol contained. Table A2 sets out the key outcomes, indicators, and potential data requirements to monitor and evaluate these controls on alcohol pricing and promotion. These are in addition to the overall outcomes and indicators required to evaluate the impact of the Act, set out in Table A1.

Table A2. Outcomes, indicators, and potential data requirements to monitor and evaluate the controls on alcohol pricing and promotion

Outcome	Key indicators	Potential data requirements
Price changes and retailer compliance	Price of alcohol and price differentials within alcohol market.	Market research data from distributors and retailers, with sufficient granularity to examine sales price and price-per-gram for individual products. The potential of such data would be enhanced by further information on sales patterns, such as regionality, seasonality, and volume sales.
	Proportion of alcohol sold at compliant thresholds.	
	Complaints, investigations, enforcement actions, prosecutions, convictions, relating to compliance with the law.	Empirical data gathered systematically by EHS, supplemented with interviews to review the efficacy of monitoring and enforcement mechanisms.
		Routine data from the Courts Service of Ireland on convictions for non-compliance.

[1] Department of Health (2021) Public Health (Alcohol) act 2018 (Sale and Supply of Alcohol Products) Regulations 2020 (S.I. No. 4/2020): Guidance for industry. https://assets.gov.ie/118356/2b0f718c-70a1-4479-97f1-3e9d8217e422.pdf.

	Price-based incentives to purchase alcohol.	Primary observational data from retailers (on-trade/off-trade and online/offline).
		Market research data on sales of alcoholic products under price-based promotions.
Market and consumer purchasing changes	Trends in the availability of alcohol (e.g., products delisted or new entrants).	Market research data including from producers, distributors, retailers, with sufficient granularity to examine sales trends, purchasing trends, and characteristics for individual products. The potential of such data would be enhanced by further information on sales patterns, such as regionality, seasonality, and volume sales.
	Reformulation of products, such as reduced ABV, product size (millilitres), or pack size (e.g., containers in multipacks).	
	Trends in consumer purchasing of alcohol (e.g., volume, type of products purchased etc).	
	Trends in wider consumer purchasing (e.g., substitution of spending between alcohol and elsewhere)	Household or individual-level panel data (typically collected by market research companies) which records purchases of alcohol and other household items.
		Qualitative consumer research, including key populations (e.g., hazardous and harmful drinkers).
Consumer circumvention	Cross-border purchasing of alcohol.	Repeat cross-sectional consumer surveys of cross-border purchasing, supplemented with interviews with retailers in border regions. Store-level retail sales data from outlets in border regions and non-border regions as a control group.
	Purchasing of illicit alcohol.	Routine data from An Garda Síochána and police and criminal justice system.
		Repeat cross-sectional consumer surveys measuring purchasing sources.

A3. Additional data requirements (over and above Table A1 above) for monitoring and evaluating the controls on alcohol advertising and sponsorship

Commencement of the advertising controls began in November 2019, with restrictions on outdoor and public transport advertising (Section 14), children's branded clothing (Section 17), and cinema advertising (Section 20)[2]. Commencement continued in November 2021, with restrictions on some advertising during sport (Section 15) and sponsorship of certain sports and events (Section 16)[3]. Controls yet to commence include a requirement for alcohol advertising to only contain factual product information (Section 13), restrictions on print media advertising (Section 18), and a watershed on broadcast advertising (television/radio) (Section 19). Table A3 sets out the key outcomes, indicators, and potential data requirements to monitor and evaluate these controls on advertising and sponsorship. These are in addition to the overall outcomes and indicators required to evaluate the impact of the Act set out in Table A1.

Table A3. Outcomes, indicators, and potential data requirements to monitor and evaluate the controls on advertising and sponsorship

Outcome	Key indicators	Potential data requirements
Exposure to, and engagement with, alcohol marketing	Exposure to, awareness of, and engagement with alcohol marketing.	Repeat cross-sectional adult and youth consumer surveys.
		Qualitative research with adults and young people.
		Objective methods of exposure (e.g., wearable cameras, ecological momentary assessments)
		Observational audits paired with secondary data to estimate exposure (e.g., frequency of advertising on public transport matched with footfall data footfall or audits of television advertising paired with viewer statistics).

[2] Department of Health (2019) Public Health (Alcohol) Act 2018 (Number 24 of 2018) Guidance for Industry. https://assets.gov.ie/35498/05ce0af5d2084f7cb58daa89d5e7541a.pdf.

[3] Department of Health (2021) Public Health (Alcohol) Act 2018 (Number 24 of 2018) Guidance for Industry, Section 15 & 16. https://assets.gov.ie/202413/c815b0ae-3816-48f7-bec1-b25b290767c3.pdf

	Marketing expenditure, volume, and reach.	Alcohol advertising data, with sufficient granularity to examine trends for individual advertising activities and alcohol subsectors (including no- and low-alcohol products).
Appeal and influence of alcohol marketing	Marketing appeal, brand salience, perceived purchase/consumption intentions, and alcohol-related attitudes.	Repeat cross-sectional adult and youth consumer surveys.
		Qualitative research with adults and young people.
		Between-group factorial experiments.
Compliance and circumvention	Complaints, investigations, enforcement actions, prosecutions.	Data from EHOs, supplemented with interviews to review efficacy of existing monitoring and enforcement mechanisms.
Displacement of advertising spend	Marketing expenditure, volume, and reach.	Alcohol advertising data, with sufficient granularity to examine trends for individual advertising activities and alcohol subsectors (including no- and low-alcohol products).
Economic impact among industries affected by restrictions	Economic 'health' of advertising/ marketing industries and beneficiaries of alcohol marketing/ sponsorship revenue (e.g., industry size, employment, revenue, profit) including diverted corporate spend.	Data relating to the advertising/ marketing industry and other beneficiaries of alcohol marketing/ sponsorship revenue or diverted corporate spend, supplemented with expert testimony from representatives of these affected industries.

A4. Additional data requirements (over and above Table A1) for monitoring and evaluating measures relating to the display of health warnings on alcohol packaging, in licensed premises, and in alcohol advertising

Section 12 will make it a requirement for alcohol packaging and licensed premises to display health warnings about alcohol, health characteristics about the product (e.g., grams of alcohol), and information about an independent source of health advice about alcohol. This measure was signed into law by the Minister for Health in May 2023 and there will be a minimum three-year lead-in before the measure becomes mandatory[4], giving time to develop and implement studies to monitor and evaluate the changes. Section 13 will also make it a requirement for similar health warnings and information about an independent source of information about alcohol to appear in alcohol advertisements. Table A4 sets out the key outcomes, indicators, and potential data required to monitor and evaluate the health warning requirements. These are in addition to the overall outcomes and indicators required to evaluate the impact of the Act set out in Table A1.

Table A4. Outcomes, indicators, and potential data requirements to monitor and evaluate the health warnings on alcohol packaging

Outcome	Key indicators	Potential data requirements
Warning salience	Salience of warnings (e.g., noticing / reading).	Repeat cross-sectional surveys with adults and young people. Between group factorial experiments with adults and young people. Qualitative consumer research with adults and young people
Warning response	Behavioural and cognitive response to warnings (e.g., thinking about content, warning avoidance, foregoing drinking, thinking about reducing alcohol use, perceived believability).	
Salience of alcohol products/brands	Brand/product cognitions (e.g., perceived quality, taste, appeal, attractiveness, value, perceived harm).	

[4] Department of Health (2023). Ministers for Health bring into law the world's first comprehensive health labelling of alcohol products. gov.ie - Ministers for Health bring into law the world's first comprehensive health labelling of alcohol products (www.gov.ie)

Knowledge of health effects of alcohol	Recall, recognition, and believability of health conditions linked to alcohol.	Repeat cross-sectional surveys with adults and young people.
	Knowledge of health characteristics of alcohol products (e.g., grams of alcohol, calories etc).	
	Knowledge of, and use of, independent sources of health information about alcohol.	Repeat cross-sectional surveys with adults and young people.
		Data about engagement with independent sources of health information (e.g., website and application analytics).
Compliance and circumvention	Complaints, investigations, enforcement actions, prosecutions.	Data from EHOs, supplemented with interviews to review efficacy of monitoring and enforcement mechanisms.
	Presentation of warnings on packaging and licensed premises.	Primary observations of alcohol packaging and licenced premises.

A5. Additional data requirements (over and above Table A1) for monitoring and evaluating structural separation of alcohol products in off-trade mixed retailers

Section 22 requires the physical separation of alcohol products and associated advertising in mixed retail premises (e.g., convenience stores, supermarkets, forecourts) according to pre-defined options set out in the Act[5]. After a two-year lead-in period, structural separation became mandatory in November 2020. Table A5 sets out the outcomes, key indicators, and data requirements to monitor and evaluate to structural separation. These are in addition to the overall outcomes and indicators required to evaluate the impact of the Act set out in Table A1.

Table A5. Outcomes, indicators, and potential data requirements to monitor and evaluate the structural separation of alcohol products in off-trade mixed retailers

Outcome	Key indicators	Potential data requirements
Exposure to alcohol in off-trade retail settings	Exposure to, and perceived visibility of, alcohol and alcohol brands in small and large off-trade mixed retailers.	Repeat cross-sectional surveys with adult and young people, ideally with comparator data outside Ireland where structural separation does not apply. Qualitative consumer research with adults and young people.
Impulse purchasing	Frequency and volume of unplanned alcohol purchases in stores	Qualitative consumer research with adults.

[5] Department of Health (2019) Public Health (Alcohol) Act 2018 (Number 24 of 2018): Guidance for industry, Section 22. https://assets.gov.ie/34508/f07a44a819dc410682eb8dbb377b89cc.pdf.

Underage access to alcohol	Ease of underage purchase of alcohol.	Repeat cross-sectional surveys with those under the minimum legal purchasing age for alcohol.
		Qualitative research with those under the minimum legal purchasing age for alcohol.
Compliance, circumvention, and displacement	Complaints, investigations, enforcement actions, prosecutions.	Data from EHOs, supplemented with interviews to review efficacy of existing monitoring and enforcement mechanisms.
	Compliance and quality of implementation in small and large mixed off-trade retailers.	Primary observational audits of small and large retailers.
	Extent of displays of co-branded no- and low-alcohol products in affected retailers	
	Ease of implementation and facilitators and barriers to effective structural separation.	Qualitative research with small and large retailers to examine ease of implementation, maintenance, and perceived impact

Appendix B Terms of Reference

Public Health Alcohol Research Group: Terms of Reference

The Public Health (Alcohol) Act 2018 was signed into law on 17 October 2018. The primary policy objectives of the Public Health (Alcohol) Act 2018 are to:

- reduce alcohol consumption to 9.1 litres of pure alcohol per person per annum by 2020;
- delay the initiation of alcohol consumption by children and young people;
- reduce the harms caused by the misuse of alcohol;
- ensure the supply and price of alcohol is regulated and controlled in order to minimise the possibility and incidence of alcohol related harm.

1. The Act includes provisions for minimum unit pricing, structural separation, health labelling on products that contain alcohol, restrictions on the advertising and marketing of alcohol, the regulation of sports sponsorship and restrictions on certain promotional activities.

   The Public Health Alcohol Research Group (ARG) was established by the Department of Health to monitor the implementation of The Public Health Alcohol Act by identifying gaps in data and provide insights into where further research is needed.

   The key roles of the Public Health Alcohol Research Group (ARG):

1. Monitoring the progress and evaluating the impact of The Act.

2. Review existing data and research and consider its relevance to implementing The Act.

3. Identify gaps in existing data and research and examine how they might be filled.

4. Liaise with relevant organisations and stakeholders including other Government departments, international bodies and relevant organisations as required to review the adequacy of existing data.

5. Provide advice to the Department of Health on further research and action that may be required.

6. ARG members are required to disclose any relationships, conditions, or circumstances that present a potential conflict of interest in their role as an ARG member and the contributions they make. A register of ARG membership and Declarations of Interest will be maintained and updated annually. Separate guidance will be provided on this.

7. It is recognised that some members are representing their parent organisation, and in some cases that organisation may be a membership organisation. Circulation to members is permissible. ARG members and those in attendance should not circulate meeting papers or matters discussed during the course of meetings beyond that appropriate for the status of their membership unless agreed in advance with the Department of Health lead and the ARG Chair. ARG members and those in attendance must not make research outputs publically available before publication.

8. Overall, the key role and responsibility of the ARG is to monitor and evaluate the impact of The Act to the best of their ability.

APPENDIX A: Meetings

- Meeting will be chaired by a member of the ARG appointed by the Department of Health or a designated replacement.
- It is anticipated that the group will meet 3 times per year, although this may change according to the needs.
- Outside of meetings, ARG members may be asked to comment or advise on questions or issues relevant to their specific areas of expertise.
- Meetings will take place in The Institute of Public Health, 700 South Circular Road, Dublin 8 with teleconferencing and videoconferencing facilities available or via Zoom should the need arise.
- A minute of the meeting will be prepared by the secretariat of the group and will be circulated as soon as possible. Minutes will be approved at the next meeting.

APPENDIX B: Members
August 2020

The ARG Members as of (August 2020) are:

- Joe Barry (Chair) Professor of Public Health Medicine, Trinity College
- Sheila Gilheaney, CEO, Alcohol Action Ireland
- Helen McAvoy, Director of Policy, Institute of Public Health
- Marion Rackard, Project Manager, HSE Alcohol Programme
- Aisling Sheehan, National Lead, HSE Alcohol and Mental Health and Wellbeing Programmes at Health Service Executive
- Clare O'Dwyer, Research Officer, Evidence Centre, Health Research Board
- Pat Kenny, College of Business, Technological University Dublin
- Colin Angus, Senior Research Fellow, Sheffield Alcohol Research Group, University of Sheffield

- Niamh Fitzgerald, Senior Lecturer in Alcohol Studies, Institute for Social Marketing, University of Stirling
- Clare Beeston, Lead for the Evaluation at NHS Health Scotland
- Stephen Weir, Institute of Public Administration
- Geoffrey Shannon, Former special rapporteur on child protection
- Gerry Kenny, Tax Policy Division, Department of Finance
- Dan Kelleher, Indirect Taxes Policy & Legislation, Revenue Commissioners
- Kieran Culhane, Senior Statistician, CSO
- Denise Keogh, Tobacco and Alcohol Control Unit, Department of Health
- Paul Brosnan, Health and Wellbeing Programme, Department of Health
- Paula Leonard, Irish Community Action on Alcohol Network (ICAAN)
- Noelle Cotter, R&D and Health Analytics Section, Department of Health
- Fiona Mansergh, Health and Wellbeing Programme, Department of Health

PHARG

Public Health Alcohol Research Group

Contact PHARG:

Email: info@phargireland.org