

National Alcohol Harm Reduction Strategy - Consultation Document

Richard Bryant-Jefferies

GP Liaison Alcohol Counsellor

*Author of 'Counselling the Person Beyond the Alcohol Problem' and
'Problem Drinking: A Person-Centred Dialogue)*

The strategy uses the words 'alcohol misuse' to refer to 'problematic drinking'. Yet alcohol does not have to be misused for problematic effects to occur. Someone emotionally distraught may lash out having drunk very little, causing themselves and others severe problems. They have not set out to misuse alcohol, they have simply had a few drinks but a situation has provoked them to lose control. The disinhibiting effect of alcohol after only 1 or 2 units makes all alcohol use potentially a misuse if it leads to some problematic effect. The question needs to be asked as well, 'why are we such an alcohol-centred society'? Why is alcohol seen by increasing number of people, particularly younger people, as the only way to really enjoy themselves?

Another fact that is missing from this Consultation is any real recognition of the human tragedy associated with alcohol misuse. The young person using alcohol to escape from the blight of violence or sexual abuse in the home or the bullying at school; the student who drinks themselves into a state of dependence and who struggles to come to terms with failing their course. The young woman for whom alcohol misuse is normal given her own early life experience who is struggling with three young children; the young man who drinks and drives his car into the bus queue, and who spends his life drinking to try and forget. The man or woman who in middle age has lost everything due to drink, and is living in a hostel but has to be on the streets during the daytime, nowhere else to go, no money and only the street drinking friends to be with. The person whose 20 years of alcohol use has led to stomach ulcers and oesophageal varices and is petrified of relapsing. The person whose memory has been so badly affected by alcohol use that he lives in a narrow band of time – today and yesterday but with little memory of previous weeks and months. The older man whose wife has died and he faces a long and lonely retirement, drinking to lose the long hours of the day and night. The woman found alone in her house in a pool of blood following a heavy alcohol related bleed.

Responses to the questions/points raised in the Consultation Document:

1. Government should be involved as quite simply there are too many conflicting interests and a national lead is required to ensure that an integrated and robust response is made to this problem. The causes and effects of alcohol use cuts across all areas of ministerial responsibility. Political will is required

to drive forward the agenda of reducing alcohol related harm and producing greater health and wellbeing among problematic drinkers.

2. Alcohol misuse is always individual responsibility, however, taking a responsible position requires information and political direction. It must be noted, too, that where an addictive and mood-altering drug is concerned (ie alcohol) then there will be times when an individual's judgement is impaired and they may find it difficult to resist alcohol use. This use may stem from addictive effect, or simply in order to deal with traumatic experiences and memories from which alcohol brings an irresistible relief.
3. Information and education are crucially important here, and political direction at both national and local level. The increased availability of alcohol can only encourage higher use and makes it increasingly difficult for those seeking to abstain or cut back. Yes, everyone has the right to make a free choice to drink, but with that choice comes responsibility. The same must equally be true for those who produce alcohol and deal in alcohol (off-licences, supermarkets and public-houses).
4. Consumers: Need to be informed of the likely risks and consequences of regular alcohol consumption. Voluntary groups: Need training in responding to people with alcohol problems. Commercial interests: Need to be disciplined in order not to exploit the addictive and mood-altering nature of alcohol in order to further their market share. Others: Everyone is affected by the sale and consumption of alcohol because it impacts on costs to society (workplace, health care, criminal justice), it can leave people physically, emotionally and mentally damaged (users and those who are affected by their behaviour) and it can.
5. Respect for the person who is the drinker. Recognition that no-one sets out to develop an alcohol problem, it happens as a result of individual choice often linked to an urge to 'feel good' or 'better', or not to be different. Services must be integrated. There is too much fragmentation and competition. Services must demonstrate effectiveness which requires 'effectiveness' to be defined which will not simply be about the amount of alcohol consumed but as much about the effects of alcohol use and changes that occur in the person of the drinker as they resolve issues that frequently underlie problematic drinking. Sustainability of change must be to the fore. Quick fix changes that last over short periods of time are not cost-effective.
6. Any alcohol use that leads to a problematic effect could be defined as misuse. Many people self-medicate on alcohol because they find it helps them better than prescribed medication. This must be acknowledged. There are times when alcohol use is an effective anaesthetic that helps people deal with

trauma, however, it can at best be a short term emotional anaesthetic, it is not a long term solution.

7. Drinking patterns that are of the nature of 'drinking to get drunk' are always likely to be problematic, particularly in public settings, but also in the home where we know alcohol use is strongly associated with domestic violence. Alcohol use above safe drinking limits should be highlighted by all health, social and criminal justice professionals, brief interventions offered and referral on to specialist services made where appropriate. Young people and alcohol needs addressing as patterns of high drinking are being established which, as well as causing problems in the short term, are likely to create longer term problems as well, particularly those related to health. Most drinking patterns can be changed if the drinker is offered an appropriately supportive, facilitative and accessible environment. Too often services and society mirror the psychological 'all or nothing' dynamics of alcohol use. Research is needed not only into the interventions given, but also the style of intervention and the qualitative aspect of the client-professional relationship. So many alcohol problems have their roots in relational traumas of one kind or another, in inability to express feelings or to feel a sense of belonging. As in any setting, the quality and nature of the working relationship is crucial to successful outcome. In terms of prevention Governments should be targetting schools and young people (using people who will have credibility to the children and young people), work place settings through alcohol awareness programmes, and through suppliers (warnings on bottles/cans, unit ratings on bottles/cans, increased monitoring of licencees, increased training of all health, social and criminal justice professionals and those who, in their professional life, come into contact with people who may have or be at risk of developing a problematic drinking pattern. Commuters using trains are also requiring targetting as this form of travel offers the time and opportunity for an alcohol habit to develop or be exacerbated.
8. Wider availability and increasing disposable income seem to be linked to higher alcohol use. There is also increasing emphasis on alcohol use within the fashion industry, in advertising and in many popular television series (the soaps, for instance). Alcohol use is frequently connected with loss and/or stress. With changing work patterns (no longer a 'job for life' culture) comes increased uncertainty, stress and risk of alcohol use. With more relationship breaks ups comes a wider prevalence of a sense of loss and a heightened risk of alcohol use. It is likely that the spread of higher education means more heavy drinking, and this can be both problematic at the time, and among those who establish a career within the same academic setting. An area that comes up time and again among clients is the sense that there is little in the way of social opportunity that is not in some way linked to alcohol. Every social setting it seems has a bar these days. Non-alcohol establishments could be subsidised in order to kick-start a counter-culture to the norm of alcohol use as a pre-requisite to a social experience.

9. Many ethnic groups are using alcohol but are not accessing services that may not appear acceptable or accepting. Language can be a problem. There is a need for greater outreach into the diverse communities of England. Much emphasis is placed on urban alcohol problems, and frequently alcohol services are sited in these areas (although frequently underresourced). However, alcohol use is also a huge problem in rural settings where there can be difficulties in accessing services due to poor public transport or simply the effect of being alcohol-affected. Service provision within rural communities, centred in GP Practices, seems to be an important step forward. We must also focus on older drinkers where we can expect increased prevalence of alcohol problems due to increasing numbers of early onset drinkers and an ageing population. Single men, often those following divorce, often do not receive priority treatment as they are not living with children or pregnant. Resources need to be targeted to this group.

10. Alcohol offers many people a social outlet and setting. Socialising is an important aspect of human nature. For many people alcohol helps them disinhibit in order to engage with people. This is fine but wouldn't it be better if the reasons for their inhibition be explored and resolved therapeutically? Alcohol can be a way for a person to engage with feelings and release them. Whilst this can have problematic effects it can be argued that this process is psychologically healthy. However, wouldn't it be better if people could be encouraged to engage with their feelings and find alternative ways to release pent up stress that is more constructive? Alcohol can be a therapeutic bridge, enabling a person to engage with aspects of their fragmented selves. Wouldn't it be better, though, if people were generally more aware of their fragmentation and of the benefit of greater self-awareness and self-understanding? Alcohol is often associated with rituals and these are an important feature of a healthy society. Most indigenous peoples have strong ritualism within their cultures, allowing them to mark, celebrate and cope with major events either in the individual's or the community's life. Does a little alcohol make us all healthy? Or is it simply that those who drink in moderation live life generally in moderation which in itself promotes greater health and well-being? Or does alcohol help us to live out something of our need to experience risk, which may also have psychological benefits.

11. There is not a clear English drinking culture, it varies. Pub drinking to get drunk is one aspect of the English style of drinking. Alcohol on its own rather than as an accompaniment to some other activity is also strongly present. The drinking to get drunk aspect is certainly a feature of many young people, but not exclusively so. In Surrey drinking encompasses many styles: heavy drinking by young people, street drinking, commuter drinking, business drinking, coping with loss drinking, self-medication using alcohol, binge drinking to suppress or release feelings.

12. All the factor highlighted are pertinent to the development of problematic drinking, however, there seems little in the way of education reaching people concerning the dangers of alcohol use. Fashion and marketing are key factors for younger people. Family background has a role in influencing whether a person develops a problematic drinking habit.
13. For some people, it will reduce their intake, but we are increasingly a risk-taking society so it is likely that more people are likely to be attracted to another form of risk-taking.
14. Harmful drinking is, quite simply, a style of drinking that is causing, or is likely to cause, harm. Harm may be defined by a variety of factors, for instance, quantity, effect on others, impact on employment, impact on finances.
15. Alcohol clearly has enormous health costs. It can adversely affect all parts of the body.
16. Impact on GP workload – a great many consultations are for alcohol related problems; impact on A&E; impact on surgical wards (falls, accidents); impact on general medical wards (ulcers and other internal damage from alcohol use); impact on mental health services – many of their patients have alcohol problems.
17. We have to extend prevention beyond health-care. It has to be centred in the schools and in the workplace, as well as in health care. All health and social care professionals should be able to recognise the symptoms of an alcohol problem, raise the issue in an appropriate and sensitive way and know who to refer the person on to for help.
18. Many people are missed. Brief interventions are a useful start, but often the alcohol use is itself symptomatic of something else, for instance, childhood sexual abuse. A brief intervention will not resolve this. There is a need to be able to identify where a brief intervention is appropriate, and this may be difficult as the patient may simply not want to disclose what is behind their alcohol use. Or they may simply be unaware of it, having dissociated in the past and therefore having no conscious memory of the cause.
19. The problem is that we do not know what does work. Rehabilitation units do not seem to publish outcome figures. Many services produce figures but they are short term. The difficulty is that there are many approaches, some more 'alcohol' centred, others more 'person' or 'patient' centred. Services are not geared up for everyone, the elderly in particular can find it difficult to access rehabilitation that is suitable for them. The way that people can be treated in rehabilitation can be demeaning and disrespectful, and this counter-therapeutic. For instance, clients who lapse should not immediately be thrown out, but facilities should be available to take them aside for a couple of days

and process what happened, giving them another chance. Putting people back out after a lapse can only lead to a return to alcohol use and is simply ridiculous. Primary Health Care Team members are the gateway to secondary services. They can offer a brief intervention. The health-care professional should be able to consult a specialist service for advice, information and support. Where further assessment and intervention is necessary, referral should be made to the specialist service. The client may require detoxification – resourcing and access to this must be available; the client may need residential rehabilitation, but this may not always be tailored to their needs (not everyone wants to work with an AA approach). A big difficulty in Surrey is answering the question ‘who actually does commission alcohol services?’ It is not a DAT responsibility, and the PCTs are struggling to keep on top of service provision. Guidance is needed. Complementary therapies have been shown to be effective, and this should be developed further. Anything that reduces the reliance on chemical solutions to chemical problems has to be worth looking into.

20. Community drug treatment has one factor that is crucial – the prescription, a carrot to keep people in touch with services. Alcohol services do not have any substitute prescribing options. Perhaps lower strength lagers should be prescribed to reduce the harm and encourage reduced-strength drinking. As with drugs, there is a problem with supply and availability. This has never been resolved on the drug side, except where substitute prescribing of injectables has undermined the dealers.
21. We come back to education, particularly in the work place. But also pub landlords must take responsibility for selling a substance that is having an adverse affect on their clientele. If alcohol is sold to someone and it is foreseeable that that person is likely to commit an assault, then surely there is some degree of culpability on the part of the provider of the substance – alcohol. Home-based incidents are more difficult, but perhaps there needs to be a national help-line specifically for young people and children to phone regarding alcohol related incidents in the home, and that such calls are followed up by alcohol specialists within social services.
22. Clearly, a number of mental health problems are caused by heavy alcohol use, and there are those who use alcohol to relieve symptoms of a mental health problem. Suicide is a very real problem, but often this is linked to the underlying trauma’s that the person has been unable to resolve or come to terms with, or stresses in their life and a sense of ‘what’s the point’ when looking to the future. Heavy drinkers who have a suicidal background and who experience a great deal of loss seem to be particularly at risk. Is it the alcohol as a chemical that induces suicidal ideation, or does it leave people more open to their depression and the sense of futility in living? One of the major problems lies in mental health diagnosis and the difficulty in pinning don whether the primary problem is the alcohol or mental health. However, for

a service to be truly 'patient-centred' this would be immaterial. With alcohol problems likely to increase it seems highly likely that there will be a need for more alcohol specialists to be attached to other services – mental health, primary health care, social service, criminal justice. The community-based alcohol service would employ these specialists but they would have a specific role within these other areas, leaving others to provide a core service for which would probably take the form of a day programme along with one-to-one therapeutic counselling where underlying trauma's need addressing.

23. A lot of alcohol related crime it seems is crime against the person, and therefore it needs to be given a high priority.
24. Certainly some of those who drink-drive do re-offend. Domestic violence can be strongly alcohol related. Violence in the streets and in bars and clubs is frequently alcohol related, people being left feeling particularly belligerent, perhaps, or disinhibited and unable to censor behaviours that might not occur other than under the influence of alcohol. There are many clients who get 'fighting drunk' but when they are sober are full of remorse and find it hard to understand what happens. It is likely to have it's roots in dissociated, unresolved anger.
25. Of course it is a reality. There are parts of Guildford that some people simply won't go to late in the evening, the area where many of the bars are concentrated. It may be uncomfortable for the brewing and distilling industries but the reality is that their products when consumed can lead to extreme behaviours that can put others at risk.
26. Take Guildford as an example. It is on a crossing of many railway lines. People can come in to town from Reading, Portsmouth, Woking, Dorking, and the southern side of London, with great ease. Whilst it is vital to have good transport links to get people home, it is also a problem where this very transport network brings in more drinkers. There is often a problem of concentration – a great many alcohol affected people in a relatively small area. Licensing of premises has got to be more strongly regulated and perhaps there should be a move to reduce the number of city-centre premises. Again, reduce supply and perhaps reduce demand. It would certainly reduce the concentration of people. Taxi ranks are a particular problematic area. Alcohol leaves people impatient. Initiatives (such as the SOS bus in Norwich) have sought to provide a mobile service for later night drinkers, an opportunity to offer advice and get people home. This could usefully be extended to many city centres, funded by the drinks industry as it is their patrons who will be using the bus service.
27. Rural drinking is generally much more social in the sense that the pub is often at the heart of a village community. This contrasts dramatically to down town bars which seem simply places to consume alcohol. Of course, there

- are problems associated with rural drinking, vandalism, health impact and all the usual problems that can arise, but perhaps it is more easily contained.
28. Anything that reduces scope for damage to people and property has to be helpful. But plastic drinking glasses are not going to take away violence, just reduce the potential harm although a plastic glass thrust forcefully into your face is still going to cause a mess. What about weapon searches before people enter into bars? Someone drinking with a knife in their pocket is much more dangerous than someone without it. The layout of bars is important. Often city centre bars have large open spaces for people to stand, this encourages heavier drinking but it also means more people can be packed in. This is not conducive to a safe drinking environment. Many rural drinking environments contain far more seating and are generally smaller. This should be looked into.
 29. Anything that encourages joint-working is important, however, the problem can be that different organisation may have different priorities depending on their professionalism. Clear and agreed protocols must be formulated and adhered to if joint-working is to be successful. What holds back alcohol services in SW Surrey/NE Hampshire from greater joint working is resourcing.
 30. Yes, but not exclusively so. The older generations who are doing the targeting have to put their house in order if their message is to have any credibility. All age groups can demonstrate anti-social behaviour. Elderly problematic drinking residents in sheltered accommodation can also cause problems for their neighbours, and with an increasing elderly population, and also more 'early-onset drinkers' within this group, elderly drinking will become an increasing problem in the years ahead.
 31. Yes, but extended opening hours would need a change of drinking culture to be successful. Currently too many people drink to get drunk and extending the opening hours will see them even more alcohol affected, doing more damage to themselves. Or at risk of doing damage to others, and likely after a few hours sleep to drive to work quite unaware that they are still way over the limit.
 32. Street drinkers will simply move to where there are no cameras. Better to provide wet houses where alcohol use is tolerated and monitored in order to get these people off the street and ensure quality and consistent healthcare is made available. Frequently, street drinkers are the victims of crime, set upon by others who see them as an easy target. Wet houses would also protect them. More people should be arrested for public drunkenness. What about having an alcohol blood limit for pedestrians who are alcohol affected?
 33. I think we have swung too far away from individual responsibilities. Those who choose to drink in a way that leads to criminal acts must take responsibility. Those who provide them with the substance after they have

already reached a point of drunkenness also need to be accountable. As a society we need initiative to hammer home the point that alcohol is a substance that needs to be treated with respect, that it is addictive and mood-altering. Yet government must take responsibility for initiating laws and resourcing.

34. As well as the obvious deterrence from fines and losing ones license, there is an increasing degree of shame associated with drink-driving. It is not so socially acceptable. However, this does not seem to be the case with regard to other aspects of alcohol use. There is much greater clarity with drink driving – a clear amount and there is no arguments – if you are over the limit then you have committed a criminal offence. We need to increase the clarity so that people know how much alcohol will mean they will be subject to a charge of public drunkenness. The problem is that apart from driving, all other alcohol-related charges are linked behaviour and but not blood alcohol levels.

35. An upper limit of alcohol in the blood stream when in a public place (the street) might be worth considering. People do not need to get extremely intoxicated for the enjoyable effects of alcohol as a social enhancement medium to be experienced. Alcohol can be a cause of domestic violence, the drinker being the perpetrator, or the drinker provoking the perpetrator as a result of their alcohol use. Often the decision of a person to remain in a relationship as a victim is linked to their own past, and this may well have involved the abuse of alcohol for instance by parents. Public information campaigns encouraging unacceptability of domestic violence associated with alcohol use must be funded. A huge difficulty in this area is where service for victims of domestic violence do not offer anything to victims who are drinking to cope. A person is driven to drink by victimisation, finally decides they have to get out, but because they now have an alcohol problem the refuge won't take them. We need wet refuges. We need trained alcohol workers involved in domestic violence services.

36. To put it simply, those who have access and those who have a reasons. It cuts across social/economic levels. We must understand what the attraction is and deal with removing that attraction if possible. And we must reduce availability. Alcopops should be banned. The one good thing about them is that they have revealed the true motivation of the drinks industry – namely, to get more young people addicted earlier to the drug that they market.

37. Men and women of all ages seeking to come to terms with being victims of childhood sexual abuse, or any other form of abuse.

Those working in the sex industry

Increasingly, the elderly, and those experiencing loss

People with learning difficulties

Those affected by workplace stress or workplace heavy-drinking cultures

The homeless

Those using illicit drugs

People with mental health difficulties, often using alcohol to self medicate

Lack of a sense of a realistic and achievable better future to work towards leading to low motivation to change

38. Lack of adequate and supported housing. Time – people have to have engaging ways to use their time, and not just during the day, and not with a 'treatment' label all the time. Social skills need to be developed, new interests etc. The psychological impact of alcohol that can leave people struggling to cope with life generally
39. Alcohol services need to be funded in such a way that service integration is a requirement and can be monitored. Statutory and non-statutory organisations must be brought into co-operative alliance. Non-alcohol specialist services need to be prepared to work with clients with alcohol problems under some form of consultative support from specialist services. Referral routes need to be clearly defined. A spirit of joint-working needs to be encouraged. What gets in the way most are 'empire-building', services feeling threatened by others, services seeking to compete for funding with other services. Co-operation must replace competition. The client must be made the hub of the service wheel, with services bound strongly together feeding in to that centre. So often the clients have been at the rim and have tended to fly off with services more concerned with ensuring they maintain their own position at the heart of the hub.
40. There is a need for services to be offered on a case-by-case basis. Each alcohol user is unique with their own history and reasons for drinking, and their own needs in the present and hopes for the future. Yes, group programmes are important and people can be introduced to these where it is appropriate to their needs, but 'one-size-fits-all' service provision is not appropriate and, indeed, can be damaging. Some people need more time, more regular contact. Flexibility is needed. Some clients might need almost daily contact at times, others may be seen monthly at most. Some will require deep, therapeutic engagement, or the application of trained nursing skills, other will require a much more low-key person-to-person form of support.
41. Education has to be concerned with raising awareness of alcohol as a substance and its effects. It is a substance to be treated with respect and why this is so should be made clear. Information on sensible drinking is muddled and we need a clear, European-wide standard, if not international standard set by WHO. And we also need to make it clear that it is not just about quantity, but about behaviour linked to alcohol use. This has to be spelt out clearly and in very simple language. Education should be about offering people the information so that they can choose to change behaviour, and to be aware of the possible consequences if they do not make that change: health, legal, social, work, etc

42. Educational and advertising projects in specific geographical areas with quantitative and qualitative research methods would help to ascertain what impact could be made. Say take a small town and set up a project to introduce awareness raising initiatives in schools, the workplace, pubs, supermarkets, anywhere and everywhere. Pre- and post-project questionnaires to all households in the area. Quantitative research with case studies from selected settings could be included. All services could be involved.
43. The sensible drinking message is muddled. There is clear divisions as to whether the daily or weekly figures should be used. There is clear division between countries as to what is 'safe-drinking. We need an internationally agreed figure set by WHO. Generally, most people are unclear as to what is 'safe-drinking', and that includes non-alcohol-specialist health and social care professionals.
44. What is unbiased research these days when so much is sponsored either by the pharmaceutical industry or the drinks industry? Do we need more research? We already vast numbers of professionals who know what helps clients, and vast numbers of clients who know what helped them. These are the people who need to be contacted and asked. We do not need more research as to what is effective, we need to find out what is already known to be effective. We need to look at the 'practice-based-evidence' that is already out there.
45. All people need to be made aware of the potential dangers associated with alcohol use. Government has a responsibility to reach all people and not use the language of 'targeting' which actually results in a 'rationing' of education and information.
46. They are obvious places, but it must be presented in ways that are relevant to the audience. In-school counselling and nursing services should be able to at least offer some form of brief intervention and initial assessment, and know who to refer on to if necessary. Professionals in education need to be trained and empowered to intervene effectively.
47. Most alcohol problems begin in familial experience: either the way a family is seen to use alcohol, difficulties in the family that the child uses alcohol to deal with/escape from; lack of parental monitoring so that alcohol use develops unrecognised. Parents are the best role models. They must be reached again through the workplace but through general educational campaigns. Most likely, however, will be that parents will end up being educated by their children who may take project work home.

48. Government can finance national campaigns, however, local campaigns linked to specifically local issues are perhaps best co-ordinated at a local level. Such campaigns can usefully involve professionals, parents, children, drinkers themselves, business, drinks industry. However, if some parties are unable to co-operate (drinks industry, for instance) this should not be allowed to hold back the delivery of powerful health warnings.
49. Peer education is an effective vehicle. Use of the arts can help to highlight issues. Involvement of people who have credibility as far as young people are concerned. Less of a 'though shalt not' approach and more of an empathic, understanding approach that is sensitive to the dilemmas young people face
50. Quite simply, it should not be advertised. It is a harmful drug and advertising can only add to increased use which in turn means increased problems and costs.
51. It will no doubt continue to develop and expand its markets, drawing more and more people into dependency. If regulation reduces its markets in Europe no doubt it will shift focus to other areas of the world where there is less regulation. It should be encouraged to become more socially responsible. Bars should be redesigned to afford more seated accommodation.
52. Clearly, the drinks industry has targeted young people. And we have seen a growth in alcohol use by young people, particularly young women. Much of this drinking has a certain 'designer' nature to it. This is the clearest evidence of how the drinks industry draws people into drinking, and we need clear, unambiguous statistics not only on the amount of alcohol consumed by young people, but the scale of accidents, injuries as well as health problems developing as a result.
53. Unlikely, the drinks industry lobby has too much control.
54. Health warnings on all alcohol. Units per bottle/can on the label/and on price lists in pubs/win lists etc. Banning alcopops. Placing an upper limit on the strength of lagers and ciders (6%) more non-alcohol alternatives
55. The benefits of alcohol seem largely in relation to jobs within the alcohol industry although there is also the fact that alcohol generates a cost to society of employing professionals to help people with alcohol problems, or to deal with the effects of problematic drinking.
56. It seems strange that the economic benefits of an addictive substance such as alcohol are a focus for discussion. This angle is NOT considered in relation to illegal addictive substances. The damage to people and to society in general as a result of alcohol use is clear and it is surely a matter of whether there is the political will to make changes to the availability of alcohol (cost,

- outlets) to the criminal justice response to alcohol-related crime, to increase education and
57. awareness, to encourage the debate as to why people in general and society as a whole need to consume so much alcohol.
 58. This is a difficult area because of the addictive nature of alcohol. It does however seem reasonable that producers/suppliers do bear some of the cost of the substance they are producing and selling. However, with increased education and awareness it would be reasonable for consumers to be expected to pay towards the costs. Government, as the recipient of a share in profits should also be responsible for costs.
 59. Revenue for the Exchequer and jobs, but at a cost to people who die from alcohol related problems at the rate of 1 every 15 minutes in this country.
 60. To talk about alcohol positively as a way of reducing stress is ridiculous. It only reduces the symptoms, it can never take away the cause. It should certainly not be encouraged for it is likely to lead to further problems due to tolerance. People do not need alcohol to network in the workplace, and if they appear to, then something is fundamentally wrong with the management and culture in the workplace. We know that many people do hold down good jobs whilst drinking heavily, however, it will impair performance and judgement.
 61. Surely people who are expected to make key decisions or whose performance is linked to the safety of people should be routinely breathalysed – to include politicians voting at Westminster. Would you want an alcohol-affected MP voting on your behalf?
 62. Consult with Alcohol Concern who has information on this topic.
 63. Finally, for many people alcohol use is linked to feelings and the negative effects of damaging effects of problematic relational experiences. Any form of therapeutic intervention to help someone resolve an alcohol problem MUST address this if sustainable change is to be achieved. Alcohol use and its resolution is more than cognition and behaviour, it is strongly associated with feeling and emotion. In this respect, I thoroughly recommend the 'Person-Centred Approach to counselling and psychotherapy. It offers the client the relational experience through which they can engage with their feelings in relation to what they have experienced and what has negatively conditioned their sense of self, and redefine themselves in the light of entering into a fresh and healthy therapeutic relationship.

Richard Bryant-Jefferies