PLYMOUTH PRIMARY CARE TRUST
PLYMOUTH COMMUNITY SAFETY PARTNERSHIP

INTRODUCTION

This is a response to the Department of Health document:

National Alcohol Harm Reduction Strategy- Consultation Document

This has been developed on behalf of the Plymouth Community Safety Partnership(PCSP) in Plymouth, and has been brought together by the following people:

Gerry Cadogan – Plymouth PCT but named by the PCSP as the Alcohol Champion for Plymouth, and the co-ordinator of this response

Supported by the following Operational Project Team:

Inspector Russ Mogridge-Devon and Cornwall Constabulary
Doctor Hugh Campbell – Plymouth GP
Ms Roma French- Chief Executive of Hamoaze House (Supports parents with drug/alcohol using children)
Tricia Stewart- Harbour Centre (Drug Advisory Service)
Michael Boyne- Community Psychiatric Nurse
Ralph Kramer – Director of Youth Enquiry Service, Plymouth
Inspector Sandra Oxton- Community Safety Unit }unable to attend
Russ Hayton- Manager of PCT Community Drugs service }initial meeting
Gary Wallace – DAT Co-ordinator }but commented on document

Comments also received from Steve Moore-Manager of the Youth Offending Team

This document was also forwarded to the Plymouth Primary Care Trust Board for their views.

Therefore several people and groups have been involved in the development of this response to the consultation.

As the document is so lengthy, and a reply to the consultation is required by 15th January 2003, the questions are not repeated here (there are 61 questions in the actual document) All are answered here, but for those individuals who needed access to the Consultation document, they were provided with the information that it was on the net on:
http://www.strategy.gov.uk/2002/alcohol/consultationdoc.shtml
and/or
http://www.doh.gov.uk/alcohol/alcoholstrategy.htm

or hard copies can be obtained by 'phoning 08701 555 455 or by e-mailing doh@prolog.uk.com

OVERALL COMMENTS

The Operational group felt that the document was rather flimsy if you regard the nature and seriousness of the issue. In all, it was felt not to be a consultative document in the true sense, but a series of questions.

It is felt really important that if the questions are asked, that the answers are truly taken note of, and included in the emerging strategy.

However, we do welcome the attempt at such a document, and have responded to it fully, and to the many questions raised.

Q1: Alcohol is a drug, which can be harmful. It can cause personal and family breakdown and costs the public and private sector billions of pounds each year, (See further responses) If the Government is as motivated to deal with the alcohol problem as with other drugs, then it should be as equally focussed on the prevention of harm, treatment and social effects as well as the economic effects of alcohol.

Government intervention is justified, as it is a national problem that affects everyone, directly or indirectly. An appropriate level of ringfenced funding is required, and statutory guidance should be produced to ensure that all agencies fulfil their responsibilities. None is available directly at the moment.

Q2: Alcohol use, as with other drug use, is a matter of individual responsibility. It can be used for good or bad, but Government has a responsibility to intervene when health, education, youth offending, crime and people's communities and personal lives can be affected by some of the negative outcomes. At the moment there is little control of this, as services, with the exception of drink/driving and some licensing laws, or education through schools is not as effective as it should be-as the results from the costs to the individual and society show. It was also felt, however, that the Government does have a responsibility to protect the population through a combination of legislation, education and information.

Q3: The communities should be involved in this-and we intend to do this in Plymouth. Communities, workplaces and families need laws, policies and procedures to back them up when the problems occur. At the moment this is very indirectly managed, and difficult to implement, although the police try their best,

Q4:
I) Consumers have a role and responsibility in knowing safe limits for their health,age, gender, weight, and for drink driving.

ii) Voluntary groups. They would value the opportunity to develop the appropriate services to meet the ever-demanding need for alcohol prevention, treatment work, but need to be funded adequately through the commissioners to do so.

iii) Commercial interests. – Whilst commerce has a major role to play in our society, it also has a responsibility to its consumers. Pubs, licensed victuals, clubs and similar groups have worked with the police to try and prevent problems in Plymouth. But the drinks companies are targeting younger audiences in their advertising and marketing, and alcohol is never advertised as a drug, or with a health warning. The 'happy hour' is now an institution, and alcohol drinking at home, as retailers will indicate, has risen.

iv) Others- GPs, primary health care workers, teachers, parents all have a role and responsibility to provide adequate advice and support. However, where do they get this from, along with the time and funding to do it in the case of the professionals?

Q5) We have a very rough draft of a strategy for Plymouth, which could be accepted as the principles that underpin a national harm reduction strategy:

-The core principles of the Plymouth strategy could be:

- -Focussing on those **directly** affected by alcohol misuse:the individual, the family and the employee
- -Focussing on those **indirectly** affected by alcohol misuse-the community as a whole
- - Developing **appropriate services and equality of access** to those services
- -Use a range of measures to **reduce harm** related to alcohol misuse

Q6 Alcohol misuse is anything that causes harm to the individual, family or society. It does not necessarily relate to quantity. The 'unit ' of alcohol is misleading as somebody may drink within the limits but use one drink to give then the confidence to get to work in the morning. Is this considered alcohol misuse?

We must remove ourselves from the old adage that says ' an alcoholic is somebody who drinks more than his or her doctor'. Alcohol is a DRUG that can be serious if abused either by binge drinking or by continuous drinking.

We must not forget the fact that most drug users will also drink heavily as well.

Q7 Drinking patterns that a strategy should affect in particular are:

- Women who drink heavily when pregnant (foetal alcohol syndrome is a fact that will have a lifelong affect on the child)
- Family behaviour, particularly violence in the home
- Violence in the community
- More work on drinking/driving and those publicans who continue to serve alcohol without an awareness of whether or not they are driving
- Alcohol support/policies at work (but policies are not enough-they need to be financed if they are implemented)
- Youth offending
- Teenage pregnancy rates (it is noted that the time of first sexual intercourse for young people is often under the influence of alcohol and often regretted afterwards because of that)
- PREVENTION IS CRUCIAL. Currently, as there is not enough funding for treatment, prevention is tokenistic and often futile. The young person of 13-15 years generally has no interest the health or social effects of 10 years hence.

The Government should concentrate efforts on prevention on
-primary health care
-schools
-community groups
-voluntary and youth groups

This must be adequately funded.

Q8 – There is a relationship between drinking and wider social change. Alcohol is more widely available and more widely acceptable socially, especially for young women. Women in general could not go into a pub on their own years ago- this is now accepted and is part of their right, but changes the norm for alcohol consumption.

There is much more stress at work, and drinking fills in time if you are unemployed.

Behaviour could be influenced by policies in the workplace, and support should be available for families, the unemployed and communities. Funding is required.

There are also social issues specific to Plymouth when taking into account wider social changes, we have a developing population of asylum seekers, refugees and students.

Q9) - There is no doubt that there is an increase in drinking in young people, both in rural areas (what is else is there to do) and in urban areas. As

indicated previously, young women are drinking more, both in relation to marketing, fashion , and environment. This relates to deprived and affluent areas-it is the nature of the alcohol consumed that differs in these situations-alcopops are expensive-cider isn't!

There are also issues around Black and minority ethnic communities and their use of alcohol. Chinese people, for example, do not have the enzymes to metabolise alcohol effectively so abuse may not be such a problem whilst there is at times a potential for the Sikh community to misuse alcohol. We must examine this more closely, particularly in the light of the Race Equality Schemes that all statutory agencies must have developed.

Q10) - The positive effects of alcohol are:

- It can be fun and relaxing if used moderately
- It can reduce stress if used moderately
- Red wine can reduce the incidence of strokes and high blood pressure (but increase the risk of breast cancer)
- Without alcohol, people may not socialise so much, or they may brew their own, more lethal concoctions. Prohibition didn't work!

Alcohol is here to stay, but it is the culture within which it is used that has/is changing

Q11) - There is definitely an English drinking culture:

- The lager lout
- 'Getting 'pissed' to let off steam
- The 'Hooray Henry' syndrome is still alive in more affluent areas
- We have a lot to learn from some part so f Southern Europe, where children ate taught to drink sensibly at an early age-and it is seen as an important part of the social/family meal. Drunkenness is less obvious amongst the locals.
- Binge drinking, influenced by licensing laws and opening times

Q12 - All the factors influence drinking. Look at the current adverts:

- Baileys
- Tia Maria
- Budweiser
- Bacardi Breezer

Family factors will influence drinking to a great extent, depending on experience. Some children will follow heavy drinking patterns of parents whilst other children, who have seen/been part of the damage caused, will be put off by this. Therefore it does not naturally follow that family drinking will affect the child's drinking habits, but it may affect their attitude to alcohol for good or bad.

It should be noted here that many (mostly young women) with eating disorders will drink quite heavily.

The most influential sources are:

- Fashion and marketing
- Family background
- Finance
- Legal issues (why can't we do with alcohol what we do with cigarettes-put health warnings on bottles?)

Q13. A lot of people, especially young people, like to take risks.

Unfortunately these risks often involve alcohol, other drugs, and driving.

This is also a question related to the amount of information and education that people of all ages have about alcohol.

Q14 This relates to Q6. Harmful drinking causes harm to the individual, family and society, and does not always depend on quantity but on appropriateness. Heavy drinking becomes a problem when the individual cannot live without it, when domestic violence and crime occurs, and where there is family breakdown and homelessness.

Q15 There is a lack of clarity about this. The Government, as is mentioned several times in this response, needs to access ALCOHOL CONCERN who have worked tirelessly to demonstrate the costs of alcohol to society, and the other Government departments will have evidence on the duty, taxation, and profits etc. Plymouth also wishes to undertake a local needs assessment.

Q16 Much work has been done on the effects of alcohol in acute hospitals. See later responses to questions. Less work, which is patchy, is done on effects in primary care but the costs, directly and indirectly are seen each day in human terms. More local evidence is needed and we are working on this with our acute hospital trust.

Q17- Prevention- Information and education should be given at an early stage. Parental support and cards for entry to clubs/pubs etc may help.

Multi-agency training needs to be adequately funded, supported and co-ordinated.

Q18 – Those at risk can be identified by being asked, as part of a health check when they register with a GP or other agency, what their drinking habits are-some will inevitably understate the reality. Those who have had brief interventions have found them successful.

Q19 – Some treatments work-some don't.

It depends on the relationship and motivation of the person and the professional. Community detoxification has its risks. Inpatient beds are required, even for a short period of time.

Services for young people that are approachable and non-stigmatising are crucial!

Commissioners should play an active part in the group that develops services for groups based on needs assessments in their area. Then they should be appropriately funded to monitor the service level agreements. There should be a range of services for people with alcohol problems to give them choice. Some may choose to access their GP, some youth services, drop-in services, and other generic services in addition to contacting the services defined for alcohol problems.

Q20. We have learnt from drugs prevention and treatment work that there needs to be more action, less talk, and more funding. We need Education involved in a realistic stage, not having to say 'no' but enabling debate and discussion around health and social consequences. Some of the biggest impact has been ex-users going into schools and talking about their experiences-doesn't suit everybody but it has a lasting effect on some!

With the right funding-we can thing laterally as we try to do in Plymouth-often using the local drama company as a medium.

Q21) The police are already looking at the non-glass beaker/bottle that causes less damage. We are a PCT that are trying to access information from our acute hospital A and E department but this is taking some time to develop. We also want to find out where people had their last drink (if they can remember when they turn up at A and E) to see if there is a pattern in some way. A and E could also be targetted with information on where to get help.

Work-related accidents- Policies don't always work - a contract should be developed with an appropriate counselling service that can offer help before disciplinary proceedings step in- this may prevent further work and social problems, and cause other problems drinkers to ask for help. There should be a close investigation as to how the accident occurred.

Q22) There is a major link between alcohol misuse and mental health problems-this is identified in the Mental health NSF. Depression, low self-esteem, suicidal tendencies (and successful suicides) are often linked to alcohol (the successful suicides particularly to young men).

Services should be integrated with mental health-not separated from it-there should be a continuum from the voluntary sector right through.

Q23) There are links between crime and alcohol, but as NACRO points out in its publication, 'although much crime is alcohol related, it is potentially misleading simply to say that alcohol causes crime. This is not just a quibble about words: getting things wrong here can distort the development of

effective crime reduction policy' (NACRO report –June 2001: @Drink and disorder: Alcohol, crime and anti-social behaviour')

There needs to be up to date research into re-offending behaviour on release from prison

Q24) Alcohol is a factor in reoffending, particularly if no support is given. It can lead to violent crime, domestic violence, aggressive behaviour, and can cause one-off events in street and pub brawls.

Again, the NACRO report should be referred to, and is an invaluable source of information. If some of the recommendations of the NACRO report were taken into account, re-offending behaviour, culture, town planning and other issues that are addressed in this document could be a major influence in developing strategy.

Q25) There is national evidence well documented by Alcohol Concern that there is a link between criminal and disorderly behaviour. However, alcohol disinhibits people, and many will behave in a very different manner to their normal behaviour , depending on their circumstances and that of the situation that they find themselves in, where others may equally may be at risk of anti-social behaviour.

Crime statistics and Youth offending Work will also provide adequate evidence of this. It is suggested that the various Government departments join up and compare/discuss this.

This is not a perception and should not be denied.

<u>Other factors</u>

- Layout of the town and leisure facilities. Are all the pubs/clubs in one area?
- What facilities are there in rural areas?
- How regular and safe is the transport
- How much alcohol is drunk at home in front of the TV where Eastenders, Coronation Street etc revolve around the pub?

Q27 There are major differences in rural/urban issues. In rural communities, young people get together as peer groups and could end up drinking in bus shelters if there are no other facilities. In urban communities, there may be more youth clubs, and however well the relationships are with the community police, drinking and other issues will be take place outside of these areas, in the local car park.

Good transport is a vital element in this area.

Q28 Plastic drinking glasses are helpful, but they are still breakable and can cause damage when broken. And they still contain alcohol!

Q29 Good practice should be shared –many of the problems are due to the Lack of information protocols between agencies, (which should ensure sharing of information as long as it is kept under Caldicott Guardian Rules) and the fact that many professionals do not have access to develop or access databases. Again, funding is required for this.Too little funding for a few agencies develops protective practices amongst some agencies.

Q30- We have a highly effective Youth Offending Team in Plymouth, and if we targeted our work we could possibly prevent future custodial sentences and future alcohol problems.

Q31- we should be looking at other examples in England/Scotland/ Wales and Europe where time and location of drinking hours etc are examined. There is a great deal of research on this-let us learn from this rather than be purely reactive!

Q32 – In Plymouth, we feel that positive relationships with clubs, pubs and licensed victuallers are beginning to take the lead from the police in addressing issues such as training, and making certain areas more attractive for locals and visitors. Do non-drinking zones really work? Many of them are situated in pubs where there are already pubs/clubs.
It would be impossible to legislate about the amount of home drinking, as this would be an infringement of civil liberties, but the extra cost of alcohol might affect this.

Joint working with local politicians and the licensing authorities would also be helpful.

Q33 Estate agents often note that the location of a pub will affect the sale of a house. There could be an agreement between the publican and the local community-too many complaints and there is a caution by the police perhaps?

Q34 People are afraid of hurting themselves and their families. There is a fear of the loss of licence, or public humiliation in the local newspaper. There is also the fear of a loss of job-many of which requires a car or information on points on the licence. The effectiveness of random breath testing could also be considered.

Q35 The Plymouth PCT Domestic Violence Strategy Group, and the Plymouth Domestic Violence Forum, sees a close link between alcohol and domestic violence. The phrase 'he/she is fine when they are sober' is often heard. Many survivors of domestic violence either deny that it has occurred, for fear of reprisal, or, if they do leave, return when the perpetrator vows that they 'will drink no more. In reality this occurs rarely.

Q36 Most vulnerable groups:

- Those in rural areas
- Looked after Children
- People (including children) in violent relationships
- Young people whose parents drink heavily
- Older people where dementia and frailty is setting in

Q37: Older people : how many falls are caused are caused by older people forgetting how much pills that they have drunk/how many pills they have taken?

Korsakoff's syndrome is also on the increase

Women are more at risk due to the greater social acceptability of their drinking-particularly young women who may not have had the social skills/education to deal with this.

Senior executives in the voluntary and statutory sector are at risk due to the greater stress levels associated with the roles.

Q38: The response to this is –what is the most important presenting factor that should be dealt with first? A home? The alcohol problem? Enable the organisations to work in true partnership and sort out the issues in order of priority for the user. This requires true partnership working and co-ordination. The key factors may be family situations, stress and financial problems.

Q39. Allow pooling of resources. Despite being a HAZ zone, we have still not managed to do this properly and therefore the effects of pooling of budgets and true joint commissioning may affect this. We have also signed up to the COMPACT.

In addition, there are the practicalities of some workers from one agency not being happy being managed by those from other agencies. These are the characteristics of true partnership working and therefore should be overcome Again; the Youth offending team is a model for this.

Q40. Services should be mainstreamed for recurrent funding purposes, and effective long-term planning. This will also affect recruitment and retention of staff. Again, clients need to be given choice, not stigmatised, or left without any form of support on a 7-day per week basis. Crises usually happen after 5 p,m on Fridays, at weekends, and at bank holidays.

Q41: We should:

- Raise awareness of health, social and economic aspects
- Young people, as demonstrated by smoking, can influence their parents' habits, why not with drinking?
- Could PHSE in schools look at the effects of marketing on alcohol and its image, and compare the effects between male/female?

One unsuccessful campaign-the heroin campaign of a few years ago that most girls used as a pin-up in their bedroom as they thought that the male 'addict' looked so desirable

One successful campaign- the safety belt and the 'too tired to drive campaign'-is it because this has a direct impact on the family?

Q42: Evidence of effectiveness
More people will think twice before they drink and drive, are more aware of their intake, and/or share driving

More people use seat belts-at least in FRONT SEATS

Hopefully, A and E and police crime statistics should bear this out

Q43: the sensible drinking message is not reaching its audience in general (has the audience been defined?) and is not clear. Foe example, the latest Christmas present- selling very well in supermarkets is the large glass of wine that holds a whole bottle of wine.

There is no apparent evidence of prevention affecting behaviour other than brief intervention, drinking and driving adverts.

There is also support for the 'no safe level' of drinking

Q44: Scientific research would appear to feed in piecemeal into education. It is not mainstreamed. It may be accessible to specialists but is not always produced in user-friendly ways in the media or in education programmes. Therefore we are often unaware of the source of the research and where it feeds into.

Q45: The following should be targeted for information in plain English or the appropriate language, and the effects of alcohol on health, social aspects, culture etc explained:

- Older people
- People with mental health problems
- Learning disabled
- Hearing and sight impaired people
- Black and minority ethnic Communities
- Carers Groups

Q46:

- Use science to show the effects of alcohol on the body-it works dramatically well for smoking!
- Provide funding for accredited counsellors who can support individuals and families who it is known have a problem
- Maintain confidentiality
- Provide school/college-based services. Why do University and medical Students have a drinking culture-because the Union drinks are so cheap?

- Peer pressure is crucial. In many situations- of you don't drink-you're not cool. How 'cool ' is being face down in the gutter.

Q47: Families/Parents have a role to play but they are are a part of the jigsaw.

Young people are more influenced by peers

Parents may need support themselves in how to develop a 'sensible' drinking culture

Q48: The best method is adequate funding, and giving schools/Colleges/Universities/youth groups the ability to influence peer groups. This needs to be followed up by a clear strategy in which the voluntary/community/ and statutory sector play a part. Units and health warnings should be printed on bottles.

Alcohol must no longer be seen as the 'Cinderella' drug to other legal drugs

Q49: Some methods of educational initiatives work-some don't. If some young people are caught with illegal drugs-they are excluded from school. What do we do when we accept the fact that young people will drink to excess at times? What messages are we giving about education? Sanctions? Health promotion?

Teachers/Vice-Chancellors/Governors and parents need to think about how they give messages to their children about the sensible use of a drug which if abused can be more dangerous than many of the other drugs where educational initiatives are seen as an important necessity of education

Q50: The existing regulations on alcohol have been criticised by many for a long time-there is no health warning- it is advertised everywhere as sexy/macho/ depending on the target group that the advertisers wish to aim at. Therefore it is successful. On the other hand, the drink/driving campaigns are successful for some if it makes them think twice-is there nobody in Government who wishes to take the same view for alcohol or are the taxes received from alcohol too important to the Treasury?

Q51: Over the next decade, it is unlikely that the alcohol industry will stop producing more exciting and attractive alcoholic drinks-that is part of their role. There needs to be some legislation, in the same way that there is with cigarettes, which provides information at the point of sale on the health effects.

By necessity, the alcohol industry is having to work with the police. Will it now start to work with health?

Q52; This has already been answered by other questions. Alcohol trends will follow fashion trends. Therefore young girls who can afford them will ask for alcopops This is no different from the 'vodka and lime' syndrome years ago where this was the fashionable drink because the vodka could not be tasted. However, it is more openly advertised, promoted and accepted. The alcohol industry is targeting younger and younger people, but as society we must start to consider the double standards of which the promotion of the alcohol industry is one.

The 'hangover' is almost seen as a rite of passage for some young people by their parents and carers. What happens if it is found that the young person has started to take other drugs-is this also a natural part of growing up and how should we respond to it?

The Government, education, police, social services and parents all have an equal role in this, and no one can abdicate responsibility to the other. We can learn perhaps more from the successes of cigarette smoking than from illegal drugs.

Plymouth HAZ Smoking Cessation Service has the highest 'Quit rates' in the country. Could it have done this without the massive injection of funding? Yet even now its greatest challenge is working with young people-especially young girls-who see smoking as sexy and mature.

There is plenty of research on the effects of the messages that are given to children at school, and on the effects of health promotion. The Government will have access to this. It needs to put the funding into the commissioners who can undertake needs assessment and learn to work with the agencies who can give the appropriate prevention and treatment messages to all ages, races and genders.

Q53: There is probably already research and development which will have produced solutions. The alcohol industry will have put billions of pounds into its own research.

Research takes time and a lot of funding,

The agencies/professionals on the ground know what is needed. Let them have the funding to do their own further analysis, if required, and the services will be set up and monitored effectively by the commissioners.

Q54; The Government can work best with the alcohol industry by taking a harder line. Alcohol is about choice, but you have to give people the correct information to enable them to make the choice.

Q55; The other commercial interests that will affect drinking behaviour is that magazines etc will potentially lose out on some of the profits from selling their advertising space. Restaurants and other places that put a high price on their clientele drinking heavily will also not be placed-so local businessmen may be affected.

There needs to be a debate in England about what we have decided our culture to be. What double standards do we lay down for our children and young people to follow? Alcohol is a drug that will not go away, so unless there is a strong vision and leadership from the Government and the Chief Medical Officer on the culture and attitudes, there will always be confusion about the messages that we give. People abuse alcohol because of their self-esteem, peer pressure, availability, etc regardless of age, gender or finances.

This is a case for strong leadership and policy followed by funding from the Government, however unpopular it makes itself with the alcohol industry it will save billions in the NHS, Crime reduction, and many other related areas.

Q56 We repeat that the Government will have plenty of evidence (ref Alcohol Concern) who will point them to the wider economic costs and benefits of alcohol.

However, briefly, it should be noted that the total cost of hospital *only* services in 1997, £23.4 billion, was below total consumer expenditure on alcoholic drinks-£29,1 billion in the same year.(Ref: Office of Health Economics and Office of Health statistics, 2000)

There has been a lot of research undertaken on alcohol costs in A and E departments, of which the Government should be aware (e.g. the February 2001 publication FROM THE Royal College of Physicians- ALCOHOL-CAN THE NHS AFFORD IT?) but this is only the tip of the iceberg. The Government needs only to liase with Alcohol Concern or to trawl the British Medical Journal and the Lancet to see the pieces of research affecting primary care. This does not take into account the incidence s cited of alcohol abuse and its part in child abuse, child protection issues, and crime.

We would advise the Government that the Internet is a very good place to start, and Alcohol Concern, on its Webster, has already done half the work for you.

Q57. It would be very interesting to see a comparison written down for the public on the amount that the Government receives from duty/taxation relating to alcohol and how much it spends specifically on alcohol prevention and treatment services (This amount should not be confused with other drug services)

Any health economist-of which Alan Maynard is probably one of the most obvious who does some work with the NHS, will provide information on this. There is also a health economist who is Head of performance management at

the NHS Executive in Leeds, Margaret Edwards, who could give appropriate advice.

Q58 Individuals could be taxed more on alcohol if the Government is really serious on cutting down on alcohol abuse. The Customs and Excise should be given clearer information on how to tackle the quantities of alcohol brought into England for personal use-often a year's personal use.

The alcohol industry should put some costs into the balancing of information on the benefits and downside of alcohol-more funding into health promotion. To be fair –we do hope that there is an ethical side here and the alcohol industry does not want people to die from the abuse of its products.

Workplaces should also take some responsibility in providing confidential occupational health services, either internally or externally, so that people who not only have an obvious problem, but who realise that their lives are becoming negatively affected by alcohol, can access help.

The Government should lead the way by funding the issues of prevention and treatment so that there are enough workers (not strategists) who can go out and DO THE WORK that so badly needs to be done to help society.

Q59 The Government will know the economic benefits of having an alcohol industry-there is employment, revenue etc. We are talking about how we ensure that this develops with a responsible attitude to its consumers.

The Government will already have access to the financial information if it speaks to all the relevant departments.

Q60 Again, there will be research on this. We know that many of the best works of literature and art came from, and still do, those for whom abuse of alcohol and drugs is well-known, therefore there is a beneficial side to alcohol and educational/social occupational achievement.

We are talking about the sensible use of alcohol-not banning it. Therefore people need information to make their own choices, be supportive of those whose alcohol consumption is causing concern, even indirectly through sickness, or anti-social behaviour, and know how to offer help, and to advise others how to access this. To do this there must be help on a 24 hour per day/365 day per week basis.

Q61 The best initiatives relate to those where there is a confidential policy whereby people who have, or potentially have an alcohol problem, receive initial support. If they do not comply with this then normal disciplinary procedures apply-this is not a soft option. There are more and more places where there are alcohol policies stating that alcohol should not be drunk during working hours-this includes the lunchtime birthday celebration etc